# Genital herpes zoster—an unusual but important cause of acute nontraumatic vulvar ulcers

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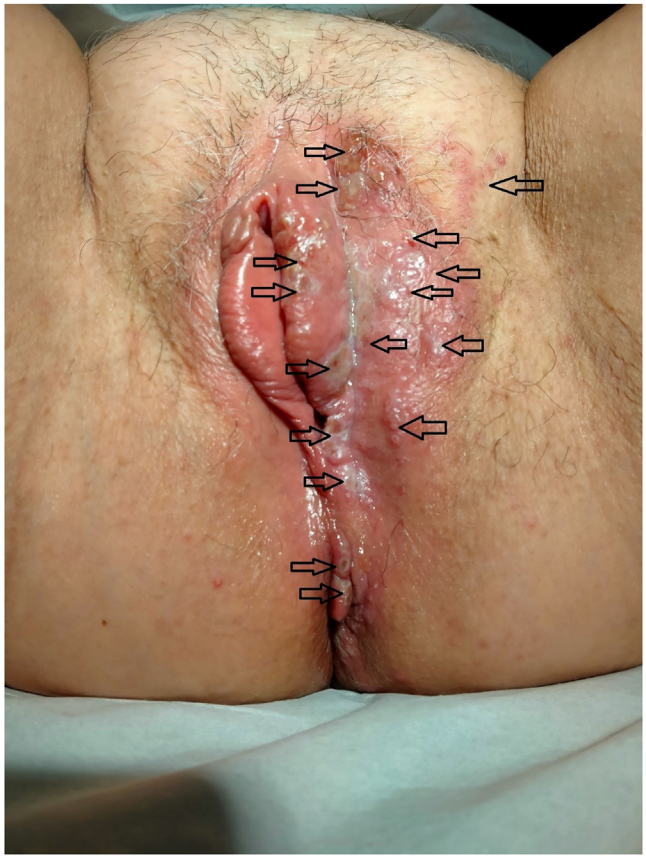
A woman in her late 60s with diabetes, in-remission gastric adenocarcinoma, and no sexual activity for the last 2 years presented to the emergency room due to painful ulcers in the left inner labia and vulvar bleeding for the last 3 days. Left vulvar ulcers were observed during the patient's gynecological exam, with no other relevant findings. A lesion swab was taken for molecular biology and serology testing. The patient was also asked additional questions concerning genital herpes zoster (GHZ): she was unsure about a prior history of varicella, denied previous episodes of shingles or herpes, and had not received herpes zoster vaccination. Valacyclovir 1000 mg daily, fluconazole, and a topical lidocaine were then prescribed to the patient.

The patient returned 24 hours later due to worsening lesions and pain. Ulcers were present from the left inner and outer labia to the inner left intergluteal region, and edema was present in the inner labia bilaterally (Figure 1). The area affected by the lesions was compatible with a S3 to S4 distribution (Figure 2). The clinical diagnosis of GHZ was then made. Valacyclovir 1000 mg was adjusted to 3 times daily, and additional analgesia was prescribed with paracetamol, tramadol, and ibuprofen.

At a follow-up visit 4 weeks later, the patient reported improvements of all symptoms, with a full disappearance of the vulvar ulcers, as seen in Figure 3. The lesion swab was positive for varicella zoster virus (and negative for herpes simplex virus I and II), confirming the diagnosis of GHZ. Serologies were negative for HIV, hepatitis B, and syphilis and showed previous contact with cytomegalovirus and herpes-virus I.

Herpes zoster, or shingles, is caused by the reactivation of the varicella zoster virus. It is characterized by painful vesicular lesions with a unilateral dermatomal distribution, though disseminated cases have been reported.[1] About 30% of people will develop herpes zoster, especially after the age of 50.[2] The wide majority of cases involve thoracic and lumbar dermatomes; the involvement of sacral dermatomes is rare, reported in about 2% of cases.[3] Herpes zoster is also a rare cause (about 2%−3%)[3] of acute genital ulcers, compared with the much

FIGURE 1
**Genital herpes zoster - vulvar ulcers**



Genital herpes zoster—photo of the vulva at the second visit to the emergency room; note that the vulvar ulcers (*arrows*) are present only in the left part of the vulva.

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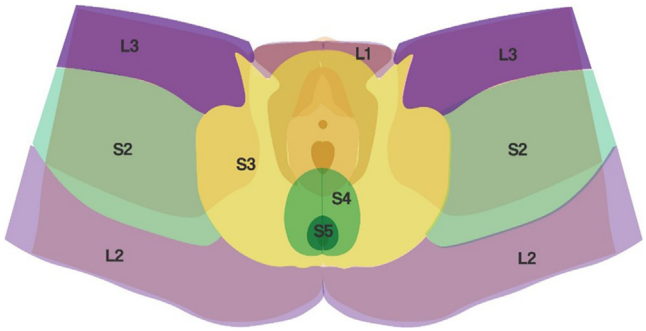
FIGURE 2
**Vulvar dermatomes**




Vulvar dermatome—a scheme of vulvar dermatomes; note that the distribution of the vulvar ulcers follows a left S3 to S4 distribution.

more prevalent herpes simplex virus, with documented impact in patient counselling, treatment, and follow-up.

Risk factors for herpes zoster include age and immunosuppression, including HIV, cancer, diabetes, or use of immunosuppressants.[1,3,4] The most frequent complication is postherpetic neuralgia (5%−30%).[2] Vaccination against herpes zoster is available, potentially reducing these complications, and is thus advisable for aging patients.[4]

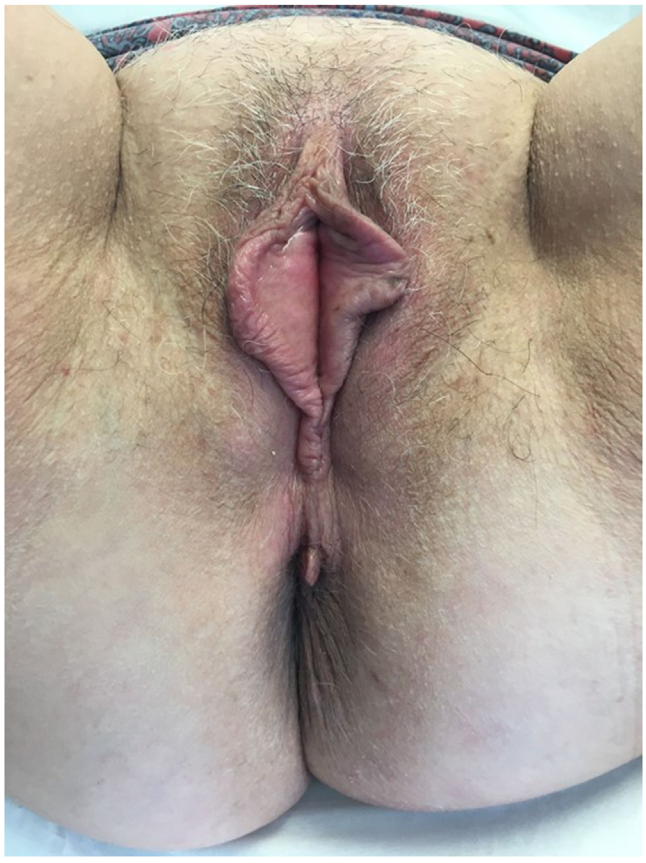
Diagnosis of herpes zoster is usually clinical,[2] but lesion swabs can be tested using multivirus molecular panels.[5] These molecular diagnostic tests have suggested that varicella zoster virus might be a more common cause of genital ulcers than previously thought.[5]

Treatment of GHZ usually involves antivirals such as acyclovir, valacyclovir, and famciclovir.[4] Patient counseling differs between GHZ and genital herpes simplex: GHZ is caused by the reactivation of varicella zoster virus and is not classified as a sexually transmitted disease as a herpes simplex infection is; recurrence of herpes zoster is low (<1.5%),[2] while this is more common with herpes simplex virus.[4] Furthermore, treatment protocols differ slightly between herpes zoster and herpes simplex.[4] It is therefore important to raise awareness about GHZ in order to better manage and counsel patients.

## CRediT authorship contribution statement

**Joana Galvão:** Writing − original draft, Resources, Methodology, Conceptualization. **Marta Xavier:** Writing − review & editing, Validation. **Joana Ventura Lourenço:** Resources. **Inês Gouveia:** Writing − review & editing, Validation. **Mónica Melo:** Writing − review & editing, Resources. **Ana Nogueira:** Writing − review & editing, Resources. **Inês Nunes:** Writing − review & editing, Validation. ■

FIGURE 3
**Follow-up visit - genital herpes zoster**



Follow-up visit—photo of the vulva 4 weeks later in the follow-up visit, showing the disappearance of the vulvar ulcers.

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