Abstract
Herpes zoster is a sporadic disease that results from the reactivation of latent Varicella zoster virus infection (VZV) from the dorsal root ganglion. We report a case of herpes zoster of lumbosacral region presenting as acute retention of urine and constipation, an uncommon presentation.

Introduction
Varicella zoster virus (VZV) causes two distinct entities i.e. chicken pox and herpes zoster, chickenpox is usually a benign illness during the childhood while herpes zoster present as dermatome rash associated with severe pain and burning sensation. The virus remain dormant in the dorsal root ganglion for many years and may get reactivated. The commonest dermatome affected are thoracic (42.4%), cranial (28.2%), lumbar (7.8%) and sacral (4.8%). The common clinical presentation is severe pain followed by vesicular rash in the affected dermatome. It last for 7 to 10 days. We report a case of herpes zoster of lumbosacral nerves (L1-L2) and (S2-S4) presenting as acute urinary retention and constipation.

Case Report
A 75 year old man non-diabetic, non-hypertensive was admitted with the complaints of urinary retention and constipation since last 24 hours. There was no history of urinary complaints in the past. There was history of rash and burning sensation on his lower back and lower abdomen on the right side, 8 days prior to admission. He was diagnosed as a case of herpes zoster infection at government medical college and was put on symptomatic treatment. Otherwise there was no significant past medical history. There was no history of chickenpox.

On examination he was afebrile, BP 120/80 mm Hg. There was no edema feet. There was vesicular rash over the lumbar and sacral dermatomes (L1-L2 and S2-S4) on right side (Figure 1). His neurological examination was normal, there was no weakness in the lower limbs, no nuchal rigidity and reflexes were normal. His bladder was palpable up to umbilicus. Other systems were normal.

His investigations revealed Hb-10.2 gm%, TLC- 8600/cmm, DLC- normal, blood sugar- 86 mg/dl. His kidney function tests and liver function tests were normal. His HIV and AA were non-reactive. His MRI of lumbosacral spine was normal, USG abdomen showed no evidence of obstructive uropathy and CT brain was normal. CSF examination done to rule out aseptic meningitis was acellular with normal proteins. His cystoscopy was normal.

Considering his typical rash over the lumbosacral dermatome he was diagnosed as case of VZV infection causing urinary retention and constipation. He underwent Foley’s catheterization. He was also treated with acyclovir for 10 days, antibiotics, and bladder training exercises.

The patient improved after 10 days. His catheter was removed and he started passing urine and anal sphincter tone became normal.

Discussion
The most common presentations were paresthesias, pain and itching. In a study conducted on 205 patients of herpes Abdul et al found that only 4.8% had sacral involvement while 42% had thoracic involvement.

There are three syndromes of zoster associated bladder dysfunction. They are zoster cystitis, zoster retention of urine and zoster myelitis. Retention is caused by spread of infection from dorsal root ganglion into the sacral motor neurons, roots or peripheral nerves causing interruption of bilateral detrusor reflex to manifest as atonic bladder.

Involvement of the sacral nerve roots (S2-S4) in herpes zoster is uncommon. The virus involves not only the ipsilateral nerve root ganglion but also the meninges and contralateral root involvement partially. Thus herpes zoster may cause bilateral pelvic nerve root involvement eventhough the skin eruption is unilateral.

Symptoms of sacral and lumbar radiculopathy in herpes cause dull or tingling pain in the lower back, buttocks or anogenital area, sciatica-like pain down the thighs, weakness of the lower limb and inability to walk on tip toes. In

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rare cases urinary retention (5%), constipation and transient paralysis occur.  

Urinary retention in herpes zoster can also occur due to aseptic meningitis, but in our patient there was no evidence of fever, nuchal rigidity, headache, weakness in the lower limbs. His CSF examination was normal.

We demonstrated a rare case of acute urinary retention and constipation secondary to herpes zoster infection of the lumbosacral nerve roots. It is speculated that neuropathic bladder develops because of involvement of detrusor reflex. VZV infection in our case also resulted in anal sphincter dysfunction resulting in constipation which fully recovered after 3 weeks. Urodynamic investigations should be considered if symptoms fail to improve within 6-8 weeks of onset.

In conclusion patient’s presenting with lumbosacral herpes zoster should be warned about possible urinary and bowel symptoms and monitored carefully.

References