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Siddha Management of Herpes Zoster Developing Secondary Bacterial Infection During the course of illness: A Case Report

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ABSTRACT:

Herpes zoster is caused by the reactivation of latent Varicella-zoster virus and is characterized by painful unilateral vesicular eruptions distributed along a dermatome. Secondary bacterial infection is a recognized complication that may delay healing and increase morbidity. A middle-aged female presented with painful vesicular eruptions associated with a burning sensation along a unilateral dermatome, consistent with herpes zoster. Two weeks after the onset of illness, the lesions developed secondary bacterial infection with pus formation. The patient was managed exclusively with Siddha medicine, without antimicrobial therapy. Progressive clinical improvement was observed during follow-up, with complete healing of the skin lesions and resolution of the secondary infection. At the final follow-up, the patient experienced only mild residual pain, with no recurrence or other complications. This case demonstrates successful clinical management of herpes zoster with secondary bacterial infection using *Siddha* medicine alone. Although the outcome was favourable in this patient, further well-designed clinical studies are needed to evaluate the safety and effectiveness of *Siddha* interventions in the management of herpes zoster and its associated complications.

KEYWORDS: Herpes zoster, Secondary bacterial infection, *Siddha* medicine.

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INTRODUCTION:

Herpes zoster (HZ), commonly known as shingles, is caused by the reactivation of the latent Varicella-zoster virus (VZV), the same virus responsible for chickenpox. It is characterized by unilateral, painful, vesicular eruptions distributed along one or more dermatomes. The disease predominantly affects older adults, particularly individuals aged over 50 years, and those with impaired cell-mediated immunity due to conditions such as diabetes mellitus, malignancy, or immunosuppressive therapy. Neuropathic pain is a characteristic feature of HZ and often precedes the appearance of the skin lesions by several days. [1]

The burden of herpes zoster is increasing globally. In India, the estimated incidence ranges from **1.2 to 5.4 cases per 1,000 person-years**, with the highest prevalence observed among older adults and individuals with underlying comorbidities such as diabetes mellitus. This growing burden underscores the need for timely diagnosis and effective management to prevent disease-related complications.

Herpes zoster exhibits a wide spectrum of clinical manifestations, ranging from uncomplicated dermatomal eruptions to severe forms associated with significant complications. These include post-herpetic neuralgia, ophthalmic involvement, neurological complications, and secondary bacterial infection. Secondary bacterial infection of the vesicular lesions may result in pustule formation, cellulitis, delayed wound healing, increased pain, and greater morbidity, thereby complicating the clinical course and necessitating prompt therapeutic intervention.

Nevertheless, these observations have renewed interest in understanding the pathophysiology, risk factors, and optimal management strategies for HZ. Consequently, effective treatment and preventive measures, including vaccination in eligible populations, remain important components of clinical care.[2] Conventional management of herpes zoster primarily consists of antiviral agents, analgesics for neuropathic pain, and antibiotics when secondary bacterial infection is present. Despite the effectiveness of these therapies, interest in traditional systems of medicine has grown as alternative approaches to improve symptom control, promote wound healing, and enhance overall quality of life.

Siddha medicine, one of India's oldest traditional systems of medicine, adopts a holistic approach by integrating internal herbal and mineral formulations, external therapies, dietary regulation, and lifestyle modifications. *Siddha* therapeutics have been traditionally employed in the management of infectious and inflammatory skin disorders, and their potential clinical benefits continue to be explored through scientific research. In this context, the present case report describes the successful management of herpes zoster complicated by secondary bacterial infection using *Siddha* therapeutic interventions alone. The patient demonstrated marked clinical improvement, complete healing of the

lesions, resolution of infection, and minimal residual symptoms, highlighting the potential role of Siddha medicine in the management of complicated herpes zoster.

CASE REPORT:

A 59-year-old female presented with severe pain over the left costochondral region, which was followed by the development of multiple erythematous, fluid-filled vesicular lesions arranged in a unilateral dermatomal distribution. The lesions were localized to the left side of the chest and did not cross the midline. The pain was intense, neuropathic in nature, and preceded the appearance of the skin lesions. There was no history of fever or other systemic symptoms. The patient had a past history of thyroid dysfunction and dyslipidaemia. At the time of presentation, her thyroid function tests were within the normal range, and she was not receiving any medication for thyroid dysfunction. She was under regular follow-up with an endocrinologist. For the management of dyslipidaemia, she was receiving Siddha medications, namely *Maruthampattai Chooranam* at a dose of 2 g twice daily and *Keezhanelli* Tablet at a dose of two tablets twice daily. She had undergone a hysterectomy in 2012. There was no history of diabetes mellitus, hypertension, chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), epilepsy, blood transfusion, or known immunocompromising conditions. She also had no history of food or drug allergies. The patient had a documented history of COVID-19 infection in 2020 and had received two doses of the Covaxin vaccine in 2021 and 2022.

Clinical Examinations:

On general examination, the patient was afebrile, conscious, and well oriented to time, place, and person. There was no evidence of pallor, icterus, cyanosis, clubbing, lymphadenopathy, pedal oedema, or varicose veins. Her nutritional status was adequate, and all vital signs were within normal limits.

Naked eye examination revealed multiple painful, grouped, fluid-filled vesicular lesions distributed over the left anterior chest near the costochondral junction in a unilateral dermatomal pattern, without crossing the midline, consistent with herpes zoster. The patient reported severe pain preceding the appearance of the skin lesions. Approximately two weeks after the onset of the eruption, the vesicles progressed to pustular lesions, which subsequently ruptured and became complicated by secondary bacterial infection, as evidenced by purulent discharge. The patient's baseline clinical findings and prognosis are summarized in Table 1.

Diagnostic Assessments:

The diagnosis of herpes zoster was established based on the patient's detailed clinical history, physical examination, and characteristic dermatological findings. The patient presented with severe unilateral pain over the left costochondral region, followed by the appearance of multiple grouped, clear fluid-filled vesicles on an erythematous base distributed along the left thoracic dermatome. The lesions

were confined to one side of the body and did not cross the midline, which is a classical clinical presentation of herpes zoster. (Figure 1)

The differential diagnosis considered included herpes simplex infection, contact dermatitis, impetigo, cellulitis, and varicella. Herpes simplex infection was considered unlikely because the lesions followed a dermatomal distribution and there was no history of recurrent episodes. Contact dermatitis was excluded due to the absence of recent exposure to allergens or irritants and because the lesions were predominantly painful rather than pruritic. Impetigo was ruled out by the absence of superficial pustules and honey-coloured crusting, while cellulitis was excluded because there was no diffuse erythema, warmth, swelling, or other features suggestive of a bacterial soft tissue infection. Varicella was excluded as the lesions were localized to a single dermatome without generalized vesicular eruptions occurring at different stages of evolution.

Based on the characteristic unilateral dermatomal vesicular rash, preceding neuropathic pain, and exclusion of other differential diagnoses, a final clinical diagnosis of Herpes zoster involving the left thoracic dermatome was established. Laboratory confirmation was not considered necessary because the diagnosis was clinically evident.

THERAPEUTIC INTERVENTION:

From the Siddha diagnostic perspective, the patient was assessed using *Naadi (pulse)* examination, which revealed *PithaNaadi* predominance, indicating derangement of *Pitham,* one of the three fundamental humours *(Mukkutram)* described in Siddha medicine. [3]. Based on the *Naadi* findings and the patient's clinical presentation, an individualized Siddha treatment regimen was initiated.

During follow-up, the patient demonstrated progressive clinical improvement. At the end of 3 weeks of treatment, there was a marked reduction in pain, burning sensation, and inflammatory changes, with cessation of pus discharge from the lesions. Continued treatment for 1 months resulted in complete healing of the vesicular lesions with minimal residual scarring and no evidence of new lesion formation. The patient tolerated the treatment well, and no adverse drug reactions were observed during the course of therapy. The details of the therapeutic regimen are presented in Table 2.

Outcome and follow-up

The clinical progression of the lesions was assessed through naked-eye examination during the treatment period. The patient was initiated on Siddha medications prescribed by the outpatient department of the National Institute of Siddha and was followed up regularly. (Table 1)

After three weeks of treatment, the patient showed significant clinical improvement, with reduction in pain, burning sensation, wound severity, and pus discharge from the lesions. The patient continued the same treatment regimen and was followed up for an additional one month. At the end of the

follow-up period, complete resolution of the lesions was observed, with no evidence of disease progression, spread, recurrence, or worsening of symptoms.

Clinical photographs documenting the lesion status before treatment (figure 1), after three weeks of treatment (Figure 4), and after one month of follow-up are presented in the [figures 5]. No adverse drug reactions were reported throughout the treatment period.

Table 1: Observations and Line of treatment:

Date	Observations	Intervention
24.4.2025	Severe pain over the left costochondral junction, followed by the appearance of fluid-filled blisters, erythematous in left costochondral junction.	Siddha medicine (Table-2) was started for 1week with diet restriction.
1.5.2025	Severe pain with increase in blister size and erythematous persists.	Same medication(Table-2) is continuing for one week with diet restriction.
8.5.2025	The lesions progressed to pustule formation, followed by rupture and signs of secondary bacterial infection evidenced by pus formation.	Same medication(Table-2) is continuing for one week with diet restriction.
11.5.2025	The pus formation subsided and the wound started to heal.	Same medication(Table-2) is continuing for one week with diet restriction.
18.5.2025	The blistering and pus formation completely reduced, leaving only a scar with mild pain.	Same medication(Table-2) is continuing for one week with diet restriction.

Table 2: Advised treatment therapy:

Drug name	Dose	Adjuvant	Root
Plain Amukkara Chooranam	2gm two times in a day	Hot water	Per oral
SilasathuParpam Tablet	2tablets two times in a day	Hot water	Per oral
Santhasanthrothayam Tablet	2tablets two times in a day	Honey	Per oral
Keezhanelli Tablet	2tablets two times in a day	Hot water	Per oral
Kaavikalchooranam	Nil	Panneer	External application
KungiliyaVennai	Nil	Nil	External application
Mathan Thylam	Nil	Nil	External application



Figure-1: Herpes zoster before treatment



Figure-2: After one week of treatment (Severe pain with increase in blister size and erythematous persists)



Figure-3: After two weeks of treatment (The lesions progressed to pustule formation, followed by rupture and signs of secondary bacterial infection evidenced by pus formation)



Figure-4: After three weeks of treatment (The pus formation subsided and the wound started to heal)



Figure-5: After four weeks of treatment



Figure-6: After 2 months (The blistering and pus formation completely reduced, leaving only a scar with mild pain)

DISCUSSION:

Herpes zoster is caused by the reactivation of latent Varicella-zoster virus infection and typically presents as unilateral, painful vesicular eruptions distributed along a dermatome, as observed in this case. The progression of lesions to pustulation with pus formation indicated a secondary

bacterial infection, which is a recognized complication that may delay healing and increase morbidity. Conventional management of herpes zoster includes antiviral therapy, with antibiotics prescribed when secondary bacterial infection is suspected.[4-5] However, modern antimicrobial therapy has several limitations, including the emergence of antimicrobial resistance due to irrational and prolonged use. It may also cause adverse drug reactions such as gastrointestinal disturbances and allergic reactions, while broad-spectrum antimicrobials can disrupt normal microbiota and lead to opportunistic infections. These challenges highlight the importance of rational antimicrobial use and exploration of alternative therapeutic approaches.

In this case, the patient was managed exclusively with Siddha medicine and showed gradual but consistent clinical improvement. Within four weeks of treatment, a reduction in burning sensation and pus formation was observed, along with initiation of wound healing. Over a one-month follow-up period, the lesions resolved completely, leaving only minimal residual scarring and no further complications. [6-7]

According to Siddha literature, shingles is associated with the derangement of *Pitham*. Therefore, medicines with cooling properties were selected to balance the aggravated *Pitham. SilasathuParpam* Tablet, *Santhasanthrothayam* Tablet, and *Keezhanelli* Tablet were prescribed with adjuvants such as warm water and honey to alleviate *Pitha dosha* imbalance. These formulations are traditionally indicated for skin disorders and ulcerative conditions. Additionally, *Mathan Thailam* was used as an external application due to its reported antimicrobial and wound-healing properties.

The clinical progression of the lesions is documented through photographs showing the condition before treatment (Fig. 1), after treatment with resolution of blisters and presence of residual scar tissue (Fig. 5), and after two months with complete healing and minimal scar formation (Fig. 6). This case highlights the potential role of Siddha management in herpes zoster with secondary bacterial infection and may encourage further clinical research to evaluate its therapeutic efficacy.

CONCLUSION:

This case demonstrates that Herpes zoster associated with secondary bacterial infection can be effectively managed with Siddha therapeutic interventions alone, resulting in complete healing of lesions, resolution of infection, and minimal residual symptoms without adverse drug reactions. The findings suggest a potential role for Siddha medicine as an alternative approach in such cases; however, larger studies and controlled clinical trials are necessary to validate its efficacy and safety.

Limitation of study:

This report is limited by its single-patient case design and the absence of a control or comparator group. The clinical diagnosis was based primarily on clinical history and examination, and laboratory confirmation of herpes

zoster or microbiological confirmation of the secondary bacterial infection was not performed. Further prospective, controlled clinical studies with larger sample sizes, objective outcome measures, and longer follow-up are required to establish the efficacy and safety of Siddha interventions in herpes zoster with secondary bacterial infection.

Declaration of Patient consent:

Oral informed consent was obtained from the patient for the publication of her clinical details and accompanying clinical photographs. The patient was informed about the purpose of the case report and agreed voluntarily to the use of her clinical information and photographs for academic and scientific publication.

Conflict of interest: The author declares that there is no conflict of interest.

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