**Infectious mononucleosis (IM) and Epstein-Barr virus (EBV)**

The virus is acquired from asymptomatic excreters **via saliva**, by **droplet** infection, or by **kissing**.

**Whereas ~90%** of cases of **IM** are due to **EBV,**

**5–10%** of cases are due to Cytomegalovirus (**CMV**)**.**

CMV is the most common cause of **heterophile-negative mononucleosis.**

**Clinical features**

**fever,** headache and malaise, succeeded with severe pharyngitis,, and **non-**tender cervical lymph**adenopathy.**

**periorbital** oedema, **splenomegaly,**  **rashes** may occur.

In most cases fever resolves over 2 weeks, and other abnormalities settle over a further few weeks.

EBV may present with jaundice, pyrexia of unknown origin

Death is rare but can occur due to

1. Respiratory obstruction.

2. Haemorrhage

3. Encephalitis.

In children under 10 years the illness is

mild and short-lived, but in adults over

30 years of age it can be severe and

prolonged.

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| **Investigations**  **Atypical lymphocytes** are common in  EBVinfection  **A 'heterophile' antibody** is present during the acute illness detected by the  **Paul-Bunnell** or the slide test  **'Monospot'.**  **Specific EBV serology** (immunofluorescence) can be used to confirm the diagnosis if necessary.  **CNS** infections may be diagnosed by detection of **viral DNA** in cerebrospinal fluid. | **Management**  1-If a throat culture yields  aβ-haemolytic streptococcus, a course of **penicillin** should be prescribed  **When pharyngeal oedema** is severe, a short course of corticosteroids  **Antivirals** are not sufficiently active against EBV. |

**Shingles (herpes zoster)**

Varicella zoster virus ,(VZV) persists in latent form in the dorsal root ganglion of sensory nerves and can reactivate in later life as a localised rash or with other clinical manifestations.

Commonly seen in the elderly, shingles

may also present in younger patients

with immune deficiency.

Chickenpox may be contracted from

acase of shingles but not vice versa.

**Clinical features**

Burning discomfort occurs in the affected dermatome, where discrete vesicles appear

, associated with a brief viraemia and can produce distant satellite 'chickenpox' lesions.

**Severe disease**, a prolonged duration of rash, multiple dermatomal involvement or recurrence suggests underlying immune deficiency.

Thoracic dermatomes are most

Commonly involved .

Ophthalmic division of the

trigeminal nerve is also frequently

affected;vesicles may appear on the

cornea and lead to ulceration,and

can lead to blindness.

Bowel and bladder dysfunction

occur with sacral nerve root

involvement.

The virus occasionally causes

myelitis or encephalitis.

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| **Post-herpetic neuralgia**  Postherpetic neuralgia arises in approximately 20% of patients .  . It is more common with advanced age. | **Ramsay Hunt syndrome**  Involvement of the Geniculate ganglion causes facial palsy, loss of taste and buccal ulceration, plus a rash in the external auditory canal. |

**Management and prevention**

Aciclovir has been shown to reduce both early- and late-onset pain.

valaciclovir and famciclovir . are with superior efficacy and good safety and tolerability.

Post-herpetic neuralgia requires aggressive analgesia, along with amitriptyline or gabapentin. Capsaicin cream may be helpful.

controversial, corticosteroids reduce post-herpetic neuralgia

. Aciclovir is therefore cost-effective in shingles but not chickenpox.

**Human VZ immunoglobulin (VZIG)** is used **to :**

attenuate infection in people who have had significant contact with VZV

are susceptible to infection

are at risk of severe disease

Newborn whose mother develops chickenpox no more than 5 days before delivery or 2 days after delivery.

**Susceptible contacts who develop severe chickenpox after receiving VZIG should be treated with aciclovir.**

**VZV vaccine ,. Is a live, attenuated**

**should not be given to** individuals who have

A weakened immune system

Individuals with active, untreated tuberculosis.

Pregnant women should not receive this vaccine.