

Clinical Spectrum of Herpes Zoster Involving the Ophthalmic, Maxillary and Mandibular Divisions of the Trigeminal Nerve: A Multidisciplinary Case Series

Authors:

Dr. Saniya Altaf Chalkoo¹, Dr Aruna. V²

¹Postgraduate scholar, Department of Ophthalmology, Acharya Shri Chander College of Medical Sciences and Hospital Jammu, Jammu and Kashmir, India.

²Postgraduate scholar, Department of Oral medicine and Radiology, Government Dental College and Hospital, Srinagar, Jammu and Kashmir, India.

Corresponding Author:

Dr. Saniya Altaf Chalkoo, Postgraduate scholar, Department of Ophthalmology , Acharya Shri Chander College of Medical Sciences and Hospital Jammu, Jammu and Kashmir, India, saniyachalkoo@gmail.com

DOI: <https://doi.org/10.5281/zenodo.22242184>

Article Received: 28 July 2026, Accepted: 20 August 2026, Online First: 02 September 2026

ABSTRACT

Herpes zoster (HZ) is an acute vesiculobullous disease caused by the reactivation of latent varicella-zoster virus (VZV) in individuals with a previous history of varicella infection. The trigeminal nerve is the most frequency affected cranial nerve in herpes zoster. Although herpes zoster ophthalmicus is a well-recognized clinical entity because of its potential ocular complications, involvement of the maxillary and mandibular divisions, either independently or in combination with the ophthalmic division, is relatively uncommon and may present with varied mucocutaneous and oral manifestations. This case series includes patients with herpes zoster involving the trigeminal nerve diagnosed between August 2025 and August 2026. The clinical spectrum involving the ophthalmic, maxillary, and mandibular divisions, along with the associated oral manifestations, ocular findings, and therapeutic management, is described. Early recognition of the characteristic dermatomal distribution and prompt initiation of antiviral therapy were essential for reducing disease severity and preventing long-term complications. Through a collaborative approach between Oral Medicine and Ophthalmology, this report emphasizes the importance of interdisciplinary evaluation in recognizing atypical presentations and ensuring comprehensive patient management.

Keywords: *Herpes zoster; Varicella-zoster virus; Trigeminal nerve; Herpes zoster ophthalmicus; Oral manifestations; Ocular manifestations; Antiviral therapy; Multidisciplinary management.*

INTRODUCTION

Herpes zoster is an acute viral disorder caused by the reactivation of latent varicella-zoster virus (VZV) residing within the sensory ganglia after primary varicella infection. The maintenance of viral latency and subsequent reactivation are closely associated with a decline in virus-specific cell-mediated immunity. Increasing age, immunosuppressive conditions, systemic illnesses, and stress are recognized factors that may predispose individuals to viral reactivation. Clinically, the disease is characterized by prodromal pain followed by a unilateral vesicular eruption restricted to the distribution of the affected sensory nerve.^(1,2)

Among cranial nerve involvement in herpes zoster, the trigeminal nerve is the most frequently affected due to the presence of latent virus within the trigeminal ganglion. The three divisions of the trigeminal nerve have distinct anatomical distributions, resulting in variable clinical presentations depending on the branch involved. Herpes zoster ophthalmicus (HZO), affecting the ophthalmic division (V1), is the most widely recognized form because of the risk of ocular complications such as keratitis, uveitis, and visual impairment. In contrast, herpes zoster affecting the maxillary (V2) or mandibular (V3) divisions is encountered less frequently and often presents with oral

manifestations that may initially be mistaken for odontogenic or periodontal disease.^(3,4)

Oral manifestations of herpes zoster correspond to the sensory distribution of the involved division and may affect the palate, gingiva, buccal mucosa, lips, and tongue. The associated pain may resemble odontogenic pathology, leading patients to seek dental care before the characteristic vesicular eruption becomes evident. Although uncommon, complications such as osteonecrosis of the jaws, spontaneous tooth exfoliation, and post-herpetic neuralgia have been reported, underscoring the importance of early recognition and timely intervention.^(2,5)

Although herpes zoster involving individual divisions of the trigeminal nerve has been well documented in the literature, reports describing the diverse manifestations across multiple trigeminal divisions with concurrent oral and ophthalmic evaluation remain limited. The present case series describes the clinical presentations of herpes zoster involving the ophthalmic, maxillary, and mandibular divisions of the trigeminal nerve, with emphasis on the spectrum of oral and ocular findings, diagnostic considerations, and multidisciplinary management.

CASE REPORTS

Patients diagnosed with herpes zoster involving trigeminal nerve were included in this case series during the period from August 2025 to August 2026. A detailed history was obtained regarding demographic characteristics, systemic health status, presenting complaints, duration of illness, and associated symptoms. Clinical evaluation included assessment of the distribution of cutaneous lesions, intraoral manifestations, and ocular involvement wherever present. The diagnosis was established based on characteristic clinical findings corresponding to the sensory distribution of the affected trigeminal nerve division.

CASE 1

A 42-year-old female patient reported with a chief complaint of pain over the left side of the face and left eye for the past 3 days. The pain was described as sharp and severe in nature, preceded by a prodromal phase of burning sensation and itching over the affected region along with fever, chills and malaise. This was followed by the appearance of multiple, small fluid-filled vesicles, which ruptured spontaneously, releasing clear fluid and subsequently forming erosions. The patient gave a positive history of varicella infection (chickenpox) at 10 years of age. She also reported burning sensation, redness, and excessive watering of the left eye since the onset of symptoms.

On extraoral examination, unilateral vesicular eruptions confined to the left side of the face were noted. Mild diffuse swelling was present involving the left lower half of the face. Multiple grouped vesicles were present over the left side of the lower lip, skin superior to upper lip, angle of the mouth, and chin region, corresponding to the distribution of the mandibular division of the trigeminal nerve. Few vesicles had coalesced and ruptured, revealing underlying erythematous erosions with discharge of clear serous fluid [Figure 1a]. Left submandibular lymphadenopathy was noted.

Intraoral examination revealed multiple unilateral, well-defined shallow ulcers involving the left buccal mucosa. The ulcers were covered with a yellowish-white slough and surrounded by an erythematous halo, with lesions restricted to the left side of the oral cavity, corresponding to the distribution of the maxillary division of the trigeminal nerve [Figure 1b].



FIGURE 1 a & b

- (a) Unilateral erythematous and vesicular eruptions involving the left lower half of the face.**
- (b) Multiple unilateral shallow ulcers with a yellowish-white pseudomembranous covering involving the left buccal mucosa.**

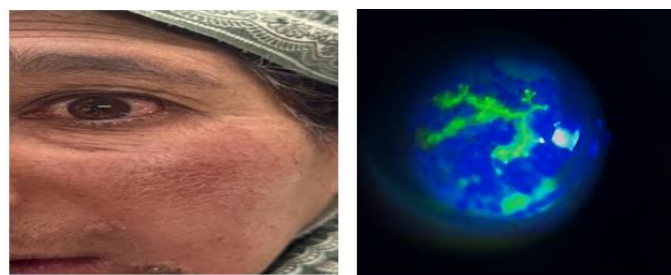


FIGURE 1 c & d

- (c) Close-up view showing erythema present in the left orbit.**
- (d) Fluorescein-stained corneal examination showing a characteristic dendritic epithelial lesion consistent with dendritic keratitis.**

Detailed ophthalmic evaluation revealed a best-corrected visual acuity of 6/9 in the left eye [Figure 1c]. Slit-lamp examination showed grade 2 conjunctival injection with mild anterior chamber cellular reaction (1+ cells), and a single dendritiform epithelial lesion

with terminal end-bulbs, staining positively with fluorescein and negatively with rose bengal, confirming active dendritic keratitis rather than a healing pseudo dendrite [Figure 1d]. Corneal sensation was reduced on gross testing over the affected cornea. Intraocular pressure was within normal limits (14 mmHg) and extraocular movements were full and pain-free, arguing against cranial nerve involvement. The patient was managed with topical acyclovir 3% ophthalmic ointment five times daily and a cycloplegic (cyclopentolate 1%) for the anterior chamber reaction, with topical corticosteroids deliberately withheld until epithelial healing was confirmed. Fundus examination was unremarkable.

Clinical presentation was consistent with herpes zoster involving multiple divisions of the trigeminal nerve, including the ophthalmic, maxillary, and mandibular branches.

CASE 2

A 40-year-old female patient reported with a chief complaint of pain, redness, and swelling over the right side of the face since the past 4 days. The patient gave a history of fever, and fatigue preceding the onset of facial lesions. The pain was sharp and burning in nature, followed by the appearance of multiple fluid-filled lesions over the affected region.

On extraoral examination, diffuse swelling was noted involving the right side of the face, predominantly over the infraorbital region. Multiple grouped vesicles containing clear serous fluid were present unilaterally over the right side of the face, extending to the ala of the nose, nasal tip, and philtrum. Few vesicles had ruptured spontaneously, resulting in superficial erosions with crust formation over the upper lip. The presence of vesicles over the tip and ala of nose (Hutchinson sign) indicated involvement of the Nasociliary branch of the ophthalmic division (V1) of the right trigeminal nerve. [Figure 2 a].

On intraoral examination, multiple unilateral shallow ulcerations were noted over the right side of the palate, covered with yellowish-white slough and surrounded by an erythematous halo. The lesions were confined to the right side and did not cross the midline. [Figure 2 b]



FIGURE 2 a & b

(a) Erythematous vesicular eruptions and swelling involving the right periorbital and midfacial region.

(b) Multiple unilateral ulcerative lesions involving the right side of the hard palate.

Given the Hutchinson sign, formal ophthalmic evaluation was undertaken despite the absence of ocular symptoms. Visual acuity was 6/6 in the right eye. Slit-lamp examination revealed mild conjunctival injection with no anterior chamber reaction, and the cornea remained fluorescein-negative with intact corneal sensation. Intraocular pressure was normal, with an unremarkable fundus examination. The absence of ocular signs at presentation was explained to the patient, along with the recognized risk of delayed-onset keratitis and uveitis, and a structured ophthalmic follow-up over the subsequent four weeks was arranged.

Based on the clinical findings, including prodromal neuropathic pain, unilateral vesicular eruptions following the trigeminal nerve distribution, Hutchinson sign, and ipsilateral palatal ulcerations, a provisional clinical diagnosis of herpes zoster involving the ophthalmic and maxillary divisions of the right trigeminal nerve was established.

CASE 3

A 46-year-old male patient reported with a chief complaint of pain and swelling over the right side of the face associated with multiple blisters since the past 5 days. The patient also gave a history of fever preceding the onset of facial lesions. A history of extraction of tooth 15, performed 5 days prior to the appearance of lesions, was noted. The temporal association with the recent dental procedure was documented as a relevant clinical history; however, a causal relationship with viral reactivation was not established.

On extraoral examination, mild edema was noted over the right infraorbital region, particularly along the lateral aspect. Multiple grouped, intact vesicles containing clear serous fluid were present over the right cheek and ala of the nose. [Figure 3 a & b]

On intraoral examination, multiple unilateral vesicles were observed over the right maxillary gingiva involving the edentulous maxillary posterior region corresponding to 14, 15, 16, 17, and 18. A healing extraction socket with respect to 15 was noted. The overall distribution of the facial and intraoral lesions was predominantly consistent with involvement of the right maxillary division (V2) of the trigeminal nerve. Vesicular lesions were also noted over the **ala of the nose**. As the ala of the nose may receive sensory innervation from the nasociliary branch of the ophthalmic division (V1), while the adjacent lateral nasal region also receives sensory supply from the infraorbital branch of the maxillary division (V2), involvement of the ala of the

nose was considered a possible indicator of limited V1 involvement in addition to the predominant V2 distribution. [Figure 3 c & d]



FIGURE 3 a & b

- (a) Frontal view showing unilateral swelling and erythematous eruptions involving the right side of the face.**
- (b) (b) Lateral view showing erythematous and vesicular lesions involving the right cheek and ala of nose with swelling in infraorbital region , particularly along the lateral aspect.**



FIGURE 3 c & d

- (c) Intraoral view showing vesicular lesions involving the right maxillary gingiva in the edentulous region.**
- (d) Recently extracted socket with respect to tooth 15 in the right maxillary posterior region.**

Ophthalmic screening was therefore performed in view of the involvement of the ala of the nose and the possibility of concomitant ophthalmic division involvement. Visual acuity was 6/6, and slit-lamp examination showed a quiet anterior segment with no conjunctival injection, corneal epithelial defect, or anterior chamber reaction. Corneal sensation and intraocular pressure were normal. No lesions were observed over the nasal tip or other areas classically associated with nasociliary involvement, and no Hutchinson sign was present. The ophthalmic examination was documented as a baseline, and the patient was advised to report promptly if ocular symptoms developed.

The clinical presentation, characterized by fever, neuropathic pain, and unilateral vesicular eruptions predominantly corresponding to the right maxillary division (V2), with additional involvement of the ala of the nose raising the possibility of limited V1

involvement, was consistent with herpes zoster involving the ala of the nose with predominant V2 distribution.

CASE 4

A 50-year-old male patient presented with painful swelling and vesicular eruptions over the right side of the face for the past 5 days. The patient reported a history of fever, chills, fatigue, and itching prior to the appearance of cutaneous lesions. The facial pain was described as severe, sharp, and burning in character, followed by the emergence of multiple blisters.

Extraoral examination revealed diffuse swelling involving the right side of the face with prominent swelling in the right infraorbital region. Multiple closely grouped vesicles filled with clear serous fluid were noted over the right forehead, cheek, upper lip, lower lip, and ala of the nose. Few lesions showed rupture with subsequent crusting over the right forehead, upper lip, lower lip, and ala of the nose. Right-sided regional lymphadenopathy was appreciable on palpation. [Figure 4 a & b]



FIGURE 4 a & b

- (a) Frontal view showing unilateral vesicular eruptions involving the right side of the face & forehead**
- (b) Lateral view showing vesicular and crusted lesions involving the perioral region with infraorbital swelling**



FIGURE 4 c

- (c) Intraoral view showing unilateral ulcerative lesions involving the right side of the palate.**

Intraoral examination demonstrated multiple unilateral vesicular lesions involving the right half of the palate, confined to the affected side without crossing the midline. [Figure 4 c]

Considering the characteristic prodromal symptoms, unilateral vesicular eruptions, neuropathic pain, regional lymph node involvement, and distribution of lesions corresponding to the three divisions of the trigeminal nerve, a provisional diagnosis of herpes zoster involving the ophthalmic (V1), maxillary (V2), and mandibular (V3) divisions of the right trigeminal nerve was established.

Given multidivisional involvement including the ophthalmic division, complete ophthalmic examination was carried out. Visual acuity was 6/6 bilaterally. Slit-lamp examination revealed mild lid margin vesiculation with an otherwise quiet anterior segment, no corneal staining, normal corneal sensation, and no anterior chamber reaction. Intraocular pressure and fundus examination were unremarkable. In the absence of active ocular disease, the patient was managed with oral antiviral therapy alone and scheduled for ophthalmic review at two weeks to monitor for delayed keratitis or uveitis.

CLINICAL SPECTRUM OF HERPES ZOSTER INVOLVING TRIGEMINAL NERVE IN THE REPORTED CASES

Clinical Comparison of Trigeminal Herpes Zoster Cases

Case	Age/Sex	Divisions	Extraoral site	Intraoral site	Ocular findings
1	40/F	V1 + V2 + V3	Left facial/perioral region	Left buccal mucosa	Dendritic keratitis
2	32/F	V1 + V2	Right midface/nose/lip	Right palate	No ocular involvement
3	46/M	V1 + V2	Right cheek + ala of nose	Right maxillary gingiva	No ocular involvement
4	50/M	V1 + V2 + V3	Right forehead/face/perioral region	Right palate	No active ocular disease

Therapeutic Intervention

All patients were managed with oral antiviral therapy and supportive symptomatic treatment. Valacyclovir 1000 mg orally three times daily for 7 days was prescribed, with treatment initiated promptly following clinical diagnosis. For painful intraoral lesions, topical anesthetic gel was advised for local symptomatic relief and to facilitate oral intake.

Patients with ophthalmic division involvement underwent ophthalmological evaluation. In Case 1, which demonstrated active dendritic keratitis with mild

anterior chamber reaction, topical acyclovir 3% ophthalmic ointment five times daily and cyclopentolate 1% were prescribed. Topical corticosteroids were deliberately withheld until confirmation of corneal epithelial healing.

In Cases 2, 3 and 4 - although the ophthalmic division was involved, no active ocular disease was identified on examination; therefore, no additional ocular medication was required at that time.

Follow-up & Outcomes

Patients were followed clinically after initiation of antiviral therapy. Progressive resolution of the vesicular and ulcerative lesions was observed, with reduction in pain and associated mucocutaneous symptoms. No significant complications were noted during the follow-up period. Patients with ocular involvement were monitored in collaboration with the Ophthalmology team for resolution of ocular manifestations and detection of any residual complications.

DISCUSSION

Pathogenesis and Clinical Spectrum of Herpes Zoster

Herpes zoster (HZ) is an acute neurocutaneous disorder resulting from the reactivation of latent varicella-zoster virus (VZV) following primary varicella infection. After initial infection, VZV establishes lifelong latency within sensory ganglia, including the dorsal root ganglia and cranial nerve sensory ganglia such as the trigeminal ganglion. Reactivation of the virus results in viral replication, neuronal inflammation, and migration of viral particles along sensory nerve pathways, producing characteristic unilateral pain and vesicular eruptions restricted to the sensory distribution of the affected nerve.^(1,6,7)

The maintenance of viral latency and subsequent reactivation are closely associated with the status of virus-specific cell-mediated immunity. A decline in immune surveillance associated with advancing age, immunosuppressive conditions, systemic illnesses, or other immune-modulating factors is considered an important contributor to viral reactivation.^(1,7)

The characteristic neuropathic pain associated with herpes zoster occurs due to viral-induced inflammation and injury of sensory neurons, resulting in altered neuronal excitability. Clinically, the disease is usually preceded by a prodromal phase consisting of pain, burning sensation, itching, dysesthesia, or altered sensory perception, followed by the appearance of unilateral grouped vesicles over the involved dermatome. Constitutional symptoms such as fever, chills, malaise, and fatigue may accompany the prodromal phase^(1,8). The vesicular lesions typically undergo progression from erythematous papules to

vesicles, which may rupture and subsequently form erosions and crusts during the healing phase⁽⁸⁾.

When reactivation occurs within the trigeminal ganglion, lesions may involve the facial skin and oral mucosa supplied by the ophthalmic (V1), maxillary (V2), or mandibular (V3) divisions of the trigeminal nerve, resulting in diverse craniofacial manifestations^(2,4). In the present case series, all patients demonstrated characteristic neuropathic symptoms preceding vesicular eruptions, supporting the classical sequential progression of herpes zoster. The varied clinical presentations observed, ranging from predominant involvement of individual trigeminal divisions to multidivisional involvement, emphasize the importance of correlating lesion distribution with trigeminal nerve anatomy for accurate diagnosis and appropriate management.

Trigeminal Nerve Involvement in Herpes Zoster

Among cranial nerve involvement, the trigeminal nerve represents one of the most frequently affected cranial nerves due to its extensive sensory distribution over the facial region and oral cavity. The trigeminal dermatome is involved in approximately 15% of herpes zoster cases, making cranial involvement an important clinical manifestation of the disease⁽⁹⁾. Herpes zoster of trigeminal nerve occurs following reactivation of VZV within the trigeminal ganglion, with lesions appearing along one or more divisions of the nerve. The ophthalmic division (V1) is reported to be more commonly affected, whereas isolated maxillary (V2) and mandibular (V3) involvement are relatively less frequently encountered.⁽⁴⁾

Although herpes zoster typically follows a single dermatome, involvement of adjacent dermatomes may occur due to the anatomical proximity and overlapping sensory distribution of trigeminal branches. The present case series demonstrates the varied spectrum of trigeminal involvement, ranging from predominant involvement of individual trigeminal divisions to multidivisional involvement, including extensive involvement of all three divisions (V1, V2, and V3). Such varied presentations emphasize the importance of careful mapping of cutaneous and intraoral lesions according to the anatomical distribution of the trigeminal nerve.

Clinical Significance of Ophthalmic Division Involvement and Hutchinson Sign

Herpes zoster involving the ophthalmic division of the trigeminal nerve, termed herpes zoster ophthalmicus (HZO), requires particular clinical attention because of the potential for ocular involvement. The ophthalmic division provides sensory innervation to the forehead, upper eyelid, cornea, and the dorsum, tip, and side of the nose through its branches. The nasal region, particularly

the ala, may receive overlapping sensory innervation from the nasociliary branch of the ophthalmic division and the infraorbital branch of the maxillary division. Among the branches of the ophthalmic division, involvement of the nasociliary branch is clinically significant because of its sensory supply to the cornea and other ocular structures.⁽¹⁰⁾

The presence of vesicular lesions over the tip, side/ala, and root of the nose is referred to as Hutchinson's sign and indicates involvement of the nasociliary branch of the ophthalmic division. Although Hutchinson's sign is an important clinical indicator of possible ocular involvement, its presence does not invariably predict the development of ocular complications⁽¹¹⁾. In the present series, one patient demonstrated Hutchinson's sign with V1 involvement but no ocular manifestations at the time of examination, whereas another patient with V1 involvement exhibited ocular manifestations in the form of conjunctival injection, anterior chamber reaction, and dendritic keratitis. Another patient with V1 involvement but without Hutchinson's sign had no ocular manifestations on examination.

Ocular complications associated with HZO may involve different anatomical structures, including the conjunctiva, cornea, and uveal tract. Therefore, early ophthalmological evaluation is essential in patients with ophthalmic division involvement to identify and manage ocular complications promptly⁽³⁾.

Because Hutchinson's sign has an imperfect predictive value for ocular involvement, ophthalmic evaluation is recommended in patients with ophthalmic division involvement regardless of whether the sign is present. Patients with HZO may also develop delayed or recurrent ocular complications following the acute episode; therefore, appropriate ophthalmic follow-up is important. In patients with recurrent HZO-related ocular disease, long-term low-dose oral valacyclovir has been shown to reduce recurrence and may be considered in consultation with ophthalmology⁽¹²⁾.

Oral Manifestations of Herpes Zoster involving trigeminal nerve

Oral involvement in herpes zoster involving trigeminal nerve results from viral reactivation within sensory pathways supplying the oral cavity. Depending on the affected trigeminal division, lesions may involve the palate, buccal mucosa, gingiva, tongue, and lips. Initially, lesions may present as vesicles that subsequently rupture to form erosions or shallow ulcers. The characteristic unilateral distribution of oral lesions, with relative respect for the midline, and their correspondence with the sensory territory of the affected trigeminal division are important diagnostic features.^(2,4)

In the present case series, intraoral involvement was observed in patients with maxillary division involvement, with lesions affecting the palate, buccal mucosa, and maxillary gingiva. Recognition of these manifestations is particularly important in oral medicine because oral lesions may accompany cutaneous lesions and may occasionally be prominent enough to lead patients to seek dental care. The clinical appearance may resemble other vesiculobullous or ulcerative disorders; therefore, correlation of the lesions with their unilateral anatomical distribution and associated neuropathic symptoms is essential for accurate diagnosis.

Association of Dental Procedures with Herpes Zoster Reactivation

Local trauma has been proposed as a possible trigger for herpes zoster reactivation. Cases of herpes zoster occurring after dental extraction have been reported, including cases involving the trigeminal nerve. However, such reports establish a temporal association rather than a definitive causal relationship between the dental procedure and VZV reactivation.^(13,14)

In the present series, one patient reported extraction of tooth 15 approximately 5 days before the appearance of vesicular lesions predominantly involving the right maxillary division, with possible limited involvement of the ophthalmic division based on the presence of lesions over the ala of nose. Although this temporal relationship was noted, the dental procedure cannot be considered a definitive cause of viral reactivation. Nevertheless, such presentations emphasize the importance of considering herpes zoster in patients presenting with persistent or unexplained pain, vesicular eruptions, or unilateral oral lesions following dental treatment.^(13,14)

Diagnosis and Importance of Early Recognition

The diagnosis of herpes zoster involving trigeminal nerve is primarily clinical and is based on the characteristic combination of prodromal neuropathic pain, unilateral vesicular eruptions, and distribution along the affected sensory dermatome. In typical presentations, laboratory confirmation is generally unnecessary. However, virological confirmation, particularly polymerase chain reaction (PCR) testing for VZV DNA, may be useful in atypical presentations or when the clinical diagnosis is uncertain.^(1,6)

Early recognition is clinically important because antiviral treatment is most beneficial when initiated early in the course of the disease. Systemic antiviral agents such as acyclovir, valacyclovir, and famciclovir can accelerate lesion healing, reduce the formation of new lesions and decrease the severity of acute pain, with the greatest benefit when treatment is initiated early.^(6,8)

Treatment is particularly important when the ophthalmic division is involved because of the potential for ocular complications. Prompt ophthalmological assessment is therefore warranted in patients with suspected herpes zoster ophthalmicus.⁽³⁾

Clinical Relevance of the Present Case Series

The present case series demonstrates the varied clinical spectrum of herpes zoster involving trigeminal nerve, ranging from predominant involvement of the maxillary division to simultaneous involvement of multiple trigeminal divisions. The cases also illustrate important associated manifestations, including ocular involvement, Hutchinson sign, oral mucosal lesions, regional lymphadenopathy, and a temporal association with a recent dental procedure. These findings emphasize that herpes zoster involving trigeminal nerve may present with diverse cutaneous, oral, and ocular manifestations.

A thorough clinical examination with careful assessment of the distribution of cutaneous and intraoral lesions, associated neuropathic symptoms, and ocular findings is essential for early recognition. Correlation of these findings with trigeminal nerve anatomy can facilitate prompt diagnosis and appropriate referral, particularly when the ophthalmic division is involved. A multidisciplinary approach involving oral medicine and ophthalmology is important in patients with craniofacial herpes zoster with ocular manifestations.

CONCLUSION

Herpes zoster involving trigeminal nerve demonstrates considerable clinical variability, with the affected division determining the distribution and nature of cutaneous, oral, and ocular manifestations. While ophthalmic involvement warrants particular attention because of the risk of ocular morbidity, involvement of the maxillary and mandibular divisions may produce predominantly oral and facial lesions that can pose diagnostic challenges. Careful assessment of the dermatomal pattern, recognition of associated mucosal and ocular findings, and timely antiviral treatment are central to effective clinical care. The present case series underscores the complementary role of Oral Medicine and Ophthalmology in identifying the diverse manifestations of herpes zoster involving trigeminal nerve and providing appropriate, coordinated patient care.

DECLARATION OF PATIENT CONSENT

Written informed consent was obtained from all patients for publication of their clinical details and accompanying clinical photographs for academic and scientific purposes. The patients were informed that their clinical information and images would be published in a medical

journal, and consent was obtained prior to manuscript submission.

FINANCIAL SUPPORT AND SPONSORSHIP

Nil

CONFLICTS OF INTEREST

There are no conflicts of interest

CONTRIBUTION

Both authors have equally contributed in this research work.

REFERENCES

1. Cohen JI. Clinical practice. Herpes zoster. *N Engl J Med.* 2013;369(3):255-263. doi:10.1056/NEJMcp1302674.
2. Glick M, Greenberg MS, Lockhart PB, Challacombe SJ, editors. *Burket's Oral Medicine*. 13th ed. Hoboken (NJ): Wiley-Blackwell; 2021.
3. Liesegang TJ. Herpes zoster ophthalmicus: natural history, risk factors, clinical presentation, and morbidity. *Ophthalmology.* 2008;115(2 Suppl): S3-S12.
4. Sharma A, Pagare JS, Kasat VO, Parate AR. Herpes zoster of trigeminal distribution – A case series. *J Indian Acad Oral Med Radiol.* 2020;32(4):417-421.
5. Jain MK, Manjunath KS, Jagadish SN. Unusual oral complications of herpes zoster infection: report of a case and review of literature. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod.* 2010;110(5):e37-e41.
6. Gnann JW Jr, Whitley RJ. Herpes zoster. *N Engl J Med.* 2002;347(5):340-346. doi:10.1056/NEJMcp013211.
7. Gershon AA, Gershon MD, Breuer J, Levin MJ, Oaklander AL, Griffiths PD. Varicella zoster virus infection. *Nat Rev Dis Primers.* 2015;1:15016. doi:10.1038/nrdp.2015.16.
8. Dworkin RH, Johnson RW, Breuer J, Gnann JW Jr, Levin MJ, Backonja M, et al. Recommendations for the management of herpes zoster. *Clin Infect Dis.* 2007;44(Suppl 1):S1-S26. doi:10.1086/510206.
9. Nair PA, Shah M, Patel BC. Herpes zoster. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2026 Jan-. Updated 2026 Jul 5.
10. Galarza-Paez L, Marston G, Downs BW. Anatomy, Head and Neck, Nose. [Updated 2023 Jul 24]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2026 Jan-.
11. Mihalache A, Yu P, Tao BK, Xie JS, Margolin EA, Micieli JA. Hutchinson's Sign in Herpes Zoster Ophthalmicus: A Systematic Review and Meta-Analysis. *Ophthalmology.* 2026 Mar;133(3):411-422. doi: 10.1016/j.ophtha.2025.10.019. Epub 2025 Nov 10. PMID: 41223901.
12. Cohen EJ, Troxel AB, Liu M, Hochman JS, Baratz KH, Mian SI, Choulakian MY, Warner DB, Lu Y, Twi-Yeboah A, Lee TF, Kim J, Lopez-Jimenez C, Laury SC, Jeng BH; ZEDS Trial Research Group. Low-Dose Valacyclovir in Herpes Zoster Ophthalmicus: The Zoster Eye Disease Randomized Clinical Trial. *JAMA Ophthalmol.* 2025;143(4):269-276. doi:10.1001/jamaophthalmol.2024.6114.
13. Guttiganur N, Devanoorkar A, Aspalii S, Shetty S. Herpes zoster of trigeminal nerve after dental extraction. *Indian J Dent Res.* 2013;24(3):396. doi:10.4103/0970-9290.118011.
14. Christy AW. Rare occurrence of herpes zoster of trigeminal nerve following extraction of tooth. *Case Rep Dent.* 2015;2015:891618. doi:10.1155/2015/891618.