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CASE REPORT

From Denial to Near Blindness: Overcoming Herpes Zoster Ophthalmicus in a Rural Ugandan Man with HIV and Alcoholism

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Introduction: In remote Ugandan settings, HIV care retention remains poor among men and pastoralists. Despite progress toward UNAIDS 95–95–95 targets, structural barriers, geographic isolation and stigma continue to undermine long-term retention.

Case Presentation: In 2022, a male pastoralist in his early forties with heavy alcohol use presented to a rural health center in Karamoja with fever and weight loss, and was diagnosed with HIV. He declined antiretroviral therapy (ART) believing the drugs were "poisonous" and was lost to follow-up for 48 months. He re-presented in March 2026 with a one-year history of a scaly, pruritic lesion on his right hand extending to the face and neck, unresponsive to antifungal creams. Two days prior, he developed an acutely painful vesicular eruption in the right V1 trigeminal distribution, along with oropharyngeal candidiasis. CD4 count was 120 cells/μL and urine TB LAM was positive, indicating disseminated tuberculosis. While LAM is highly suggestive and warrants immediate empirical treatment, definitive diagnosis of dissemination ideally requires clinical and radiological correlation. He was treated with oral acyclovir (800 mg five times daily for 10 days), topical acyclovir, ibuprofen, intensive-phase anti-TB therapy, and fluconazole (200 mg daily for 14 days). ART was deferred for two weeks to manage acute opportunistic infections and monitor for IRIS. At two weeks, the zoster lesions had crusted, oral candidiasis cleared, and pain reduced to 2/10. ART was initiated on day 14 with village health team support. At three months, he remained adherent with no new opportunistic infections.

Conclusion: Delayed ART initiation caused years of preventable suffering. This case highlights the urgent need in low-income settings for community re-engagement strategies, integrated HIV/co-infection screening, point-of-care diagnostics, and culturally tailored care. As the patient stated: "I was sick, and now I am well. The science of HIV treatment is a miracle, and I am living proof.".

Keywords: HIV, ART denial, pastoralist, herpes zoster ophthalmicus, advanced HIV disease

Introduction

Retention in HIV care among men in pastoralist communities of East Africa remains a persistent gap.[1] The Karamoja region of Uganda has an HIV prevalence estimated at 4.5% but ART coverage below 60% among men.[2] Fear of daily medication, belief that antiretrovirals are "poisonous," and alcohol use disorder create barriers to engagement. Herpes zoster ophthalmicus (HZO) reactivation of varicella-zoster virus in the ophthalmic division of the trigeminal nerve is an ophthalmological emergency. Without timely antiviral intervention, patients risk keratitis, uveitis, scleritis, and permanent blindness.[3,4]

In people with HIV (PWH), HZO occurs at significantly higher rates, with incidence 3- to 4-fold elevated even in the ART era,[5] and prevalence ranging from 5% to 15%.[6] Notably, HZO in individuals under 45 years should prompt HIV testing.[7] Unlike many opportunistic infections that occur at low CD4 counts, HZO can present across a range of immunosuppression and often serves as an early sentinel event for HIV diagnosis.[5,8] Blindness remains a significant concern: among HZO patients, severe vision loss (≤20/200) occurs in 3.6–14.5% of affected eyes, with immunosuppression

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independently associated with poorer visual outcomes.[9] In HIV-positive cohorts specifically, ocular complications affect up to 78% of patients, with 56% sustaining some degree of visual loss.[7,10]

In immunocompromised patients, chronic skin lesions are usually infectious, either primary or disseminated.[11] Blunted immunity masks typical signs such as erythema and pus, making morphology unreliable.[11,12] The immune defect guides the differential: neutrophil disorders suggest bacteria, Candida, and molds; cellular/humoral defects point to Nocardia, mycobacteria, fungi, herpes viruses, and parasites.[13]

We report a case of a pastoralist man who avoided ART for four years, then presented with disseminated tuberculosis (based on urine TB-Lam), oropharyngeal candidiasis, and HZO, yet remarkably preserved his vision. Favorable visual outcomes are possible even in severe HZO presentations in HIV-positive patients, as demonstrated by the Saxena et al case where vision improved from 20/640 to 20/25 after combination therapy.[14] HZO can co-present with multiple opportunistic infections in advanced HIV, as shown by the 2022 Indonesian case of disseminated HZ with candidiasis and TB.[15]

Collectively, these case reports illustrate that HZO in advanced HIV, even when accompanied by other opportunistic infections, does not invariably lead to blindness. Our patient's remarkable visual preservation, despite prolonged ART avoidance and concurrent disseminated TB and candidiasis, reinforces the principle that antiviral therapy should never be delayed in HZO irrespective of the patient's immune status or co-morbidities, and that favorable outcomes remain achievable with prompt, coordinated care.

Material and Methods

Case Presentation

Initial Presentation (2022)

A male pastoralist in his early forties with heavy alcohol use attended a Health Center IV in rural Karamoja with fever and weight loss. HIV testing was positive. A full blood count showed a white cell count of 3.0×10^9/L, hemoglobin of 11.5 g/dL. CD4 count was not available at that facility. He received post-test counselling but declined ART, stating he believed the drugs were "poisonous." No follow-up tracing was performed. He was lost to care for 48 months.

Subsequent Presentation (March 2026)

He re-presented with a one-year history of a scaly, pruritic lesion on his right hand extending to his face and neck. He had tried over-the-counter antifungal creams (clotrimazole, miconazole) without improvement. It remained uncertain whether the scaly, pruritic lesion involving his right hand, face, and neck was an independent dermatological entity or a component of the overarching systemic pathology. Two days before arrival, he developed an acutely painful vesicular eruption in the V1 distribution of the trigeminal nerve (right periorbital region extending to neck) (Figure 1). Pain was self-rated 7/10 and disturbed sleep. Examination also revealed confluent white patches on the hard and soft palate consistent with oropharyngeal candidiasis (Figure 2).

Investigations

- CD4 count: 120 cells/μL (advanced HIV disease)
- Urine TB-lipoarabinomannan LAM: positive. A positive LAM is highly suggestive and justifies immediate empiric treatment, though definitive dissemination diagnosis needs clinical and radiological corroboration.
- Ophthalmologic examination (bedside): no corneal ulcer or dendritic lesion; visual acuity 6/9 bilaterally

Differential Diagnosis

Disseminated herpes zoster (V1 distribution), herpes simplex (unlikely given dermatomal pattern), impetigo (excluded by vesicular appearance), and Candida infection.

Treatment

- Oral acyclovir 800 mg five times daily for 10 days
- Topical acyclovir cream twice daily
- Ibuprofen 400 mg every 8 hours for pain



Figure 1 Dermatomal vesicular eruption (right V1 distribution) consistent with herpes zoster in an HIV-positive patient.

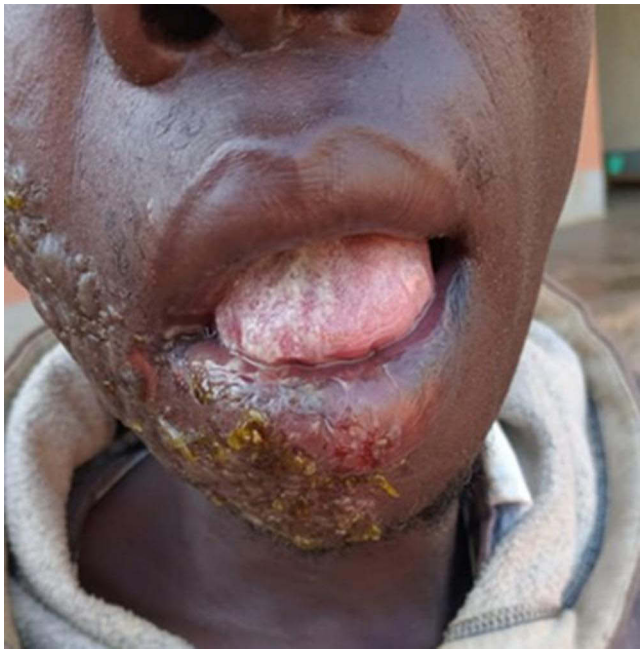


Figure 2 Oropharyngeal candidiasis showing confluent white patches on the hard and soft palate.

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- Intensive phase anti-TB therapy (rifampicin, isoniazid, pyrazinamide, ethambutol)
- Fluconazole 200 mg daily for 14 days
- Initiation of ART was deferred during the initial two weeks to allow management of acute opportunistic infections and to monitor for possible paradoxical immune reconstitution inflammatory syndrome (IRIS).

Outcome and Follow-Up

At two weeks, zoster lesions crusted and healed (Figure 3). Oral candidiasis cleared. Pain reduced to 2/10. Visual acuity remained 6/9 with no corneal involvement. ART was initiated on day 14 (tenofovir + lamivudine + dolutegravir) first-line ART regimen. The patient was linked with a village health team (VHT) member for adherence support. At 3-month follow-up, he remained adherent to ART and TB treatment with no new opportunistic infections.

Discussion

In northeastern Uganda, the post-conflict, pastoralist region of Karamoja faces a triad of linked issues: geographic isolation, weak health communication, and HIV-related misbeliefs and stigma that mirror those in other rural African settings.[16] Home to roughly 1.4 million people across nine districts, the area is described in research as poor, semi-arid, and low-literacy, with a historical lack of adequate health and educational support.[17–19]

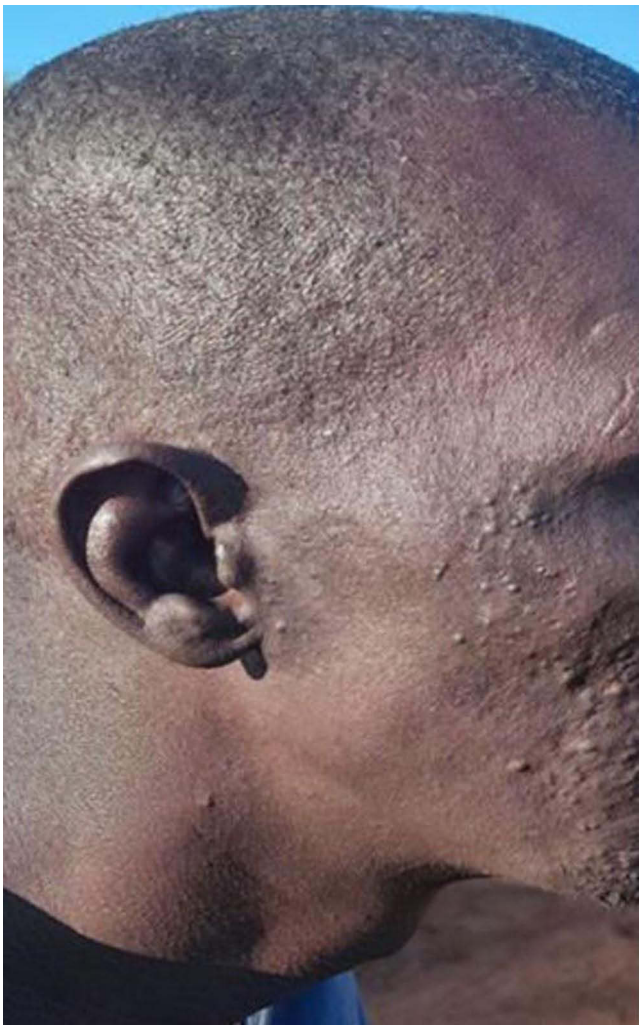


Figure 3 Crusted and healed lesions 3 months after initiation of acyclovir and supportive therapy.

In 2022, a failure occurred when no CD4 count was performed at the time of HIV diagnosis. As a consequence, the patient remained unaware of the severity of his disease, hindering appropriate risk stratification and urgent management. The proposed solution is to implement point-of-care CD4 testing at the Health Center III level, enabling immediate results and better informed clinical decisions.[20,21]

After antiretroviral therapy (ART) was initiated, the patient missed their first follow-up appointment. There was no tracing or outreach effort, leading to the consequence of the patient being lost to follow-up for four years. To prevent this, the solution requires Village Health Team (VHT) members to conduct a home visit within one week of any missed appointment, ensuring rapid re-engagement in care.[21,22]

A failure to address alcohol use disorder meant the patient did not receive any intervention. This resulted in poor judgment, which likely contributed to inconsistent health-seeking behavior and treatment non-adherence. The recommended solution is to integrate the AUDIT-C screening tool into routine visits and provide brief motivational interviewing to reduce harmful drinking and improve decision-making.[23]

A prodromal scaly lesion, present for one year, was not recognised as herpes zoster (shingles). The consequence was a delay in antiviral therapy, allowing the infection to progress unnecessarily. The solution is a training intervention reinforcing the diagnostic rule that any chronic unilateral dermatomal rash should be treated as varicella-zoster virus (VZV) until proven otherwise.[24]

Two salvageable successes occurred: (2) Urine TB-LAM testing was accessible at the hospital at roughly $3 per test and required no electricity, allowing for immediate empirical TB treatment, although the test itself is not confirmatory (3) the patient spontaneously returned after four years most lost patients die at home.[21]

HZO in advanced HIV typically causes ocular complications in 50–70% of cases if treatment is delayed beyond 72 hours.[3] This patient presented on day 3, received acyclovir, and retained normal vision. Factors likely include: acyclovir initiated just within the 72-hour window, absence of nasociliary branch involvement (Hutchinson's sign negative), and eventual immune recovery on ART. Clinicians should not interpret this case as evidence that delayed HZO treatment is safe.

In rural Karamoja, vast distances, limited communication, and HIV-related stigma severely hinder tracing patients lost to follow-up. The availability of CD4 and urine TB LAM testing at a rural hospital enabled rapid staging and empirical treatment, highlighting the need for diagnostic investment. Four years of ART denial led to disseminated herpes zoster, tuberculosis, oropharyngeal candidiasis, and risk of blindness costs far exceeding daily ART. This case underscores integrated HIV/TB/fungal services: every HIV patient needs TB and candidiasis screening, and every TB patient needs HIV testing.

Ultimately, the implications of this study findings reveal that medical treatment alone is not enough. For survival in post-conflict, remote regions, care must be wraparound blending active case-finding, rapid diagnostics, co-infection management, food assistance, and stigma-sensitive messaging. Omitting any piece of this puzzle nullifies the very miracle that ART promises.

Study Limitations

Limitations include a single CD4 measurement without viral load or trend data; uncertain generalizability; urine TB LAM's inability to distinguish pulmonary from disseminated TB without culture or molecular confirmation; and unverified post-discharge ART adherence beyond VHT support.

Conclusion

Delayed ART initiation caused years of preventable suffering. Successful treatment was possible, but low-income settings urgently need community re-engagement, integrated HIV/co-infection screening, point-of-care diagnostics, and culturally tailored care. Urine TB-LAM, though non-confirmatory, facilitated same-day empirical TB treatment at the hospital. The patient is now on ART yet remains vulnerable a testament to leaving no one behind. Patient quote: "I was sick, and now I am well. The science of HIV treatment is a miracle, and I am living proof."

Patient's Perspective

"After my HIV test in 2022, I told myself I would rather die than take those drugs. I thought they were poisonous. I watched my skin lesion grow for one year. Then the pain on my face I could not sleep. When the health worker told me

I might go blind, I was afraid. But the medicine worked. Now I tell other men in my manyatta (homestead): do not wait like I did. The treatment is not poison. It is life". The patient, translated from Ng'akarimojong language, May 2026.

Abbreviations

ART, Anti-retroviral therapy, HIV, Human Immuno deficiency Virus, UNAIDS, United Nations, Aids, TB, Tuberculosis, TB LAM Tuberculosis-lipoarabinomannan, HZO, Herpes zoster ophthalmicus, IRIS, immune reconstitution inflammatory syndrome. VHT, Village health team.

Ethics and Patient Consent

Ethical approval was not required for this case report as it describes a single patient's clinical management and did not involve any experimental intervention or alteration of standard care. The report adheres to the principles outlined in the Declaration of Helsinki. Written informed consent was obtained from the patient for publication of the case and accompanying images. All patient identifiers have been anonymised to protect confidentiality.

Disclosure

The author(s) report no conflicts of interest in this work.

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