Kaposi's varicelliform eruption: a case report

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Dear Editor,

Kaposi's varicelliform eruption (KVE) is a type of skin disorder caused mainly by herpes simplex virus (HSV) type 1 and 2 and occasionally by coxsackie A 16 and vaccinia virus, which is commonly found in the second and third decades of life. It is predominantly associated with atopic dermatoses. Therefore, it is also termed eczema herpeticum (EH) [1]. Herein, we report a case of Kaposi's varicelliform eruption triggered by HSV infection.

A 26-year-old woman was admitted to a tertiary care hospital with complaints of sudden vesicular skin eruptions on different parts of the body, particularly prominent over the face, chest and abdomen, both upper and lower limbs, along with fever and malaise for the last three days. The fluid-filled itchy skin rashes that were blackish red in color appeared first on the face and then gradually spread to other parts of the body. There was no history of drug adiminstration in last one month but the past history was positive for recurrent episodes of respiratory tract infections and flares of dermatitis. On physical examination, clusters of confluent blackish red papules and plaques were present over the face, chest, abdomen, and both upper and lower limbs with erosion and hemorrhage from papules in some areas (Figure 1). There were punctate hemorrhagic lesions on the hard palate. Fever was present intermittently which subsided on paracetamol intake. Hematological findings revealed increased ESR and leukocytosis with a neutrophilic preponderance. *Staphylococcus aureus* growth was observed on a culture of pus from the vesicles. Skin scrapings were taken from the lesions for Tzanck smear revealed the presence of numerous multi-nucleated giant cells (Figure 2). Treatment was started with oral acyclovir, amoxicillin-clavulanic acid fixed dose combination, and antipyretics. The lesions gradually diminished and healed in about 10 days.

KVE infections are usually mild and localized, but can be present in a disseminated manner [1]. The actual incidence of KVE is not known due to its rarity and lack of large scale studies. EH can be either a primary or a recurrent type of infection. The primary type of EH is mainly found in infants or children and can be fatal with viremia and internal organs involvement which result in death, while the

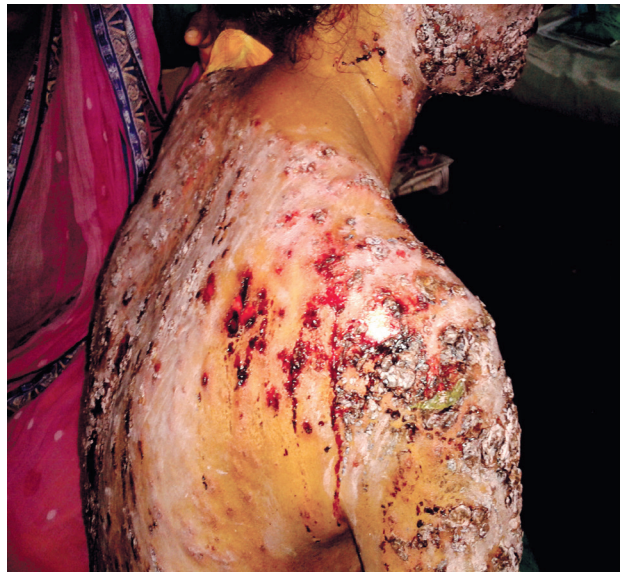

Figure 1. Erythematous papules and crusts scattered on the trunk and back

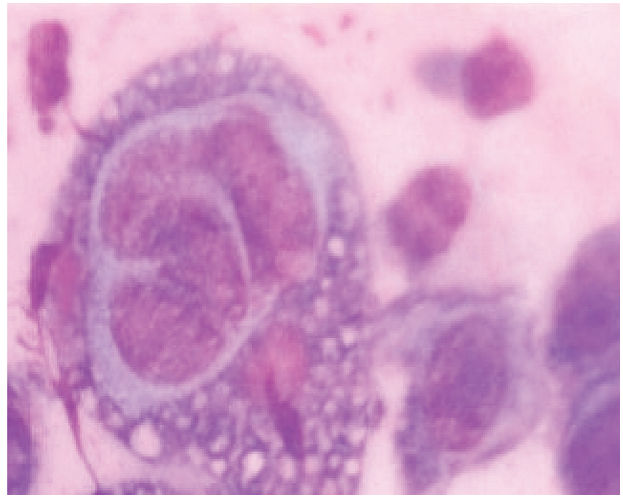

Figure 2. Tzanck smear showing characteristic multinucleated giant cells (Giemsa*100)

recurrent type generally shows no viremia, except in immunologically compromised patients [2]. The exact pathogenesis of KVE is not properly known but some studies have reported that disruption of the stratum corneum secondary to the skin disease due to HSV specific cell mediated immune defect could be the reason [3]. A Tzanck smear taken from opened vesicles showing the characteristic multinucleated giant cells and acantholysis is helpful for rapid diagnosis but the Tzanck smear is neither sensitive nor specific for the HSV infection [4]. Viral culture of the fresh vesicular fluid and direct observation of the infected cells scraped from the ulcerative lesion by direct fluorescence antibody staining are the most useful and reliable diagnostic tests [4]. In our case, the diagnosis was confirmed by clinical manifestations, laboratory findings, pus culture, and Tzanck smear findings of the skin scrapings.

The treatment of KVE includes early initiation of both anti-viral drugs and antibiotics. Empirical treatment with antivirals should be started as awaiting the laboratory reports may have serious consequences. In the absence of antiviral therapy, death may occur secondary to rhabdomyolysis and renal failure [5]. Our patient was requested to return for a follow-up visit after two weeks. On follow-up, his lesions were completely healed with no further complications.

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