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Psoriasis Herpeticum in an Immunosuppressed Female Patient

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Abstract

Kaposi's varicelliform eruption (KVE) is a disseminated life threatening cutaneous infection caused by several viruses, mainly herpes simplex virus (HSV) 1 and 2 in patients with an underlying dermatosis. It is potentially life-threatening and is more common in children, mainly suffering from atopic dermatosis (AD), although it can occur at any age. Nevertheless, it occurs rarely in patients with psoriasis and this type is named "psoriasis herpeticum". The diagnosis is mainly clinical. However, in case of doubt, there are several tests that can be useful. The most common complications are bacterial infection and systemic antibiotics are used to control the bacterial colonization. We report a case of a psoriasis herpeticum occurring in an immunosuppressed female patient treated with chemotherapy for a metastatic melanoma.

Keywords: Kaposi's varicelliform eruption; Psoriasis herpeticum; Chemotherapy; Tzanck smear; Herpes

Abbreviations: KVE: Kaposi's Varicelliform Eruption; HSV: Herpes Simplex Virus; CT: Computed Tomography; AD: Atopic Dermatosis.

Introduction

Kaposi's varicelliform eruption (KVE) is a disseminated life threatening cutaneous infection caused by several viruses, mainly herpes simplex virus (HSV) 1 and 2 in patients with an underlying dermatosis [1]. Other viruses such as coxsackievirus A16 and vaccinia virus have also been implicated in its pathogenesis, but are less common [2]. Multiple skin disorders have been associated with KVE, including acantholytic dermatosis [3]. However, the most common association is with atopic dermatitis [4]. Nevertheless, it occurs rarely in patients with psoriasis and this type is named "psoriasis herpeticum" [1]. To our knowledge, only 7 cases of psoriasis herpeticum have been reported in the literature. We report a case of a psoriasis herpeticum occurring in an immunodepressed female patient treated with chemotherapy for a metastatic melanoma.

Case Report

A 51-year-old female patient, followed in our dermatology department for psoriasis of the scalp, with a history of a metastatic melanoma of the face from 18 months, treated with resection of the tumor with tumor free margins, followed by chemotherapy with dacarbazine. The patient

reported the appearance of a pustular and painful erythematous and infiltrated placard of the face the day after her fourth treatment with dacarbazine.

She was seen in the emergencies and was putted under oral corticosteroid therapy combined with traditional treatments with unidentified plants that the patient applied herself by self-medication with worsening of the lesions. These lesions had become extensive and oozing with major infiltration of the underlying skin, and appearance of fever with chills. Dermatological examination noticed an erythematous infiltrated placard of the face, reaching to the eyelids which were edematous, and surmounted by multiple pustules and umbilicated vesicles, grouped in bouquets, in the periorificial areas (Figure 1).

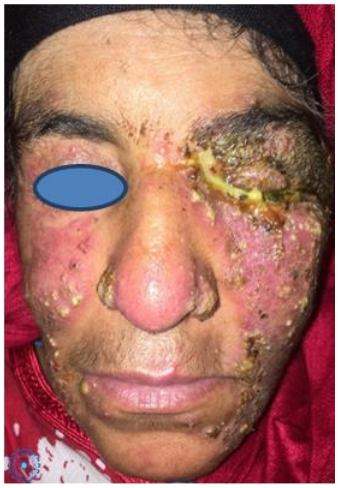

Figure 1: Clinical image showing erythematous infiltrated placard of the face, reaching to the eyelids, and Surmounted by multiple pustules and umbilicated vesicles, grouped in bouquets, in the periorificial areas.

The Tzanc smear was positive with an associated suppurative omphalite and lactescent intermammary pustules. The rest of examination noticed the presence of a mobile cervical lymphadenopathy. Laboratory tests were performed with a craniofacial CT that showed the presence of an important infiltration of the soft tissues, without collection. A systemic antiviral treatment with systemic acyclovir 10 mg/Kg thrice daily was initiated by the patient for 10 days combined with a systemic double antibiotics treatment made of a combination of amoxicillin-clavulanic acid 4 g/day for 15 days and gentamycin 160 mg/day for 5 days with good clinical improvement. A wound culture was done to identify the bacteria, and showed positive to staphylococcus aureus. A biopsy of the pustules was done and showed a pustular psoriasis, thus, oral retinoids were initiated with a good evolution (Figure 2).

Figure 2: Clinical image after 10 days of systemic antiviral treatment associated to double antibiotics treatment showing a net regression of the infiltrated placard of the face with clearance of the pustules and umbilicated vesicles.

Discussion

KVE, also known as eczema herpeticum, refers to a widespread cutaneous viral infection that normally causes localized or mild vesicular eruptions, occurring in a patient with pre-existing skin condition [5]. It is potentially life-threatening and is more common in children, mainly suffering from atopic dermatosis (AD), although it can occur at any age. Although the exact pathogenesis of KVE is unclear, increased susceptibility to infections due to altered host defense and impaired skin barrier function are implicated [1,2].

Multiple skin disorders have been associated with KVE, including AD. Other cases have been described in conjunction with Grover's disease, bullous pemphigoid, Darier disease, Hailey-Hailey disease, burns, and Staphylococcal scalded skin syndrome [4]. KVE is typically described as a monomorphic eruption of dome-shaped vesicles and blisters with hemorrhagic crusting, most often occurring on the upper body, with a predilection for the head and neck [6]. It usually begins as a sudden eruption of painful, edematous clusters of umbilicated vesiculopustules on the skin affected by a pre-existing dermatosis and may be accompanied by a flu-like syndrome, general alteration and adenopathies [3,7]. Other features include erosions without vesicles or pustules and worsening of the preexisting dermatosis [4].

Vesicles usually dry and form crusted papules within 2 weeks [6]. A delay in diagnosis often occurs because the eruption is confused with the underlying disease [3].

The diagnosis is mainly clinical. However, in case of doubt, there are several tests that can be useful. Among of them, the Tzanck smear allows a diagnostic approach that is rapid and economical, though not specific [2]. Differential diagnoses include impetigo, scabies, eczema vaccinatum, and primary varicella infection [8]. The most common complications are bacterial infection with possible evolution to sepsis and systemic viremia, with multiorgan involvement causing an important morbidity and mortality [1]. Therefore, rapid diagnosis with early use of both antiviral agents with intravenous or oral acyclovir (10 to 15 mg/Kg/day) and a prophylactic antibiotic therapy with a topical antibiotic cream is recommended and should not be delayed pending laboratory tests [2]. In some cases, it may progress to fulminating, life-threatening infection and can have severe sequelae [3], especially with immunodepression as our patient.
Bacterial superinfection is an important consideration [8]. Thus, systemic antibiotics targeting especially Staphylococcus aureus are used to control the bacterial colonization. Relapses may occur, which should be recognized [2]. However, patients with recurrent HSV infections and chronic skin disease predisposing to KVE should be offered prophylaxis [3].

Conclusion

Although rare, clinicians should keep in mind the diagnosis of psoriasis herpeticum in case of psoriasis patients presenting with an unclear source of fever and vesicular lesions, especially immunosuppressed ones [1]. Early diagnosis with rapid initiation of adequate treatment with antiviral agents and prophylactic antibiotics while diagnostic confirmation is pending is extremely important. This can prevent serious systemic complications

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