ORIGINAL IMAGE ORİJİNAL GÖRÜNTÜ

DOI: 10.5336/dermato.2024-102684

Gangrenous Herpes Zoster in an Immunocompetent Male

İmmünokompetan Bir Erkekte Gangrenöz Herpes Zoster

Tasleem ARIF[a]

[a]Department of Dermatology, STDs, Leprosy and Aesthetics. Dar As Sihha Medical Complex; Dammam, Saudi Arabia

A 49-year-male, normotensive, euglycemic, presented with severe painful fluid filled lesions over right half of abdomen and back of 2 days duration. On clinical examination, there were multiple grouped vesicles and bullae with erythematous base present in a dermatomal distribution (T10 dermatome) over right half of abdomen and back not crossing midline (Figure 1A). At several places, large flat bullae with gangrenous changes as well as ulcers with gangrenous bases were present. His routine laboratory tests including human immunodeficiency virus (HIV) testing was unremarkable except for monocytosis of 20% (normal range 2-8%). Diagnosed as gangrenous herpes zoster (HZ), he was treated with valacyclovir (Valtrex™ GlaxoSmithKline, Ontario, Canada) 1g TID for 1 week, methylcobalamine (Methycobal™, Eisai, Co., Ltd., Tokyo, Japan) 500 mcg TID, diclofenac (Emifenac,™ Global Pharma, UAE) 50 mg on need basis, amoxclav (Megamox™, Jazeera Pharmaceutical Industries, KSA) 1g BID for 3weeks and regular antiseptic dressings. At 4 weeks follow up, all lesions had healed with atrophic scarring and dyspigmentation at some places (Figure 1B).

HZ is a viral disease caused by varicella-zoster virus which affects the skin and nerves in a typical zosteriform distribution along the distribution of the nerve.[1] Clinically, it is characterized by painful grouped vesicles and bullae that are present in a unilateral distribution usually not crossing the midline with associated neuralgia.[2] In healthy and immunocompetent cases, this condition is mainly self-limiting without complications. On the contrary, a cohort of patients with HZ may develop complications like ophthalmic, visceral, cutaneous, or neurological complications. Such patients include old age (age more than 60 years), immunosuppression (patients taking systemic steroids or immunosuppressant drugs), HIV/acquired immune deficiency syndrome, malignancy, diabetes, chronic renal disease, renal transplant, lupus erythematosus, etc.[2-4] However, in our case, the patient was otherwise healthy, with no evidence of immunosuppression/malignancy or diabetes. Gangrenous HZ should be differentiated from hemorrhagic HZ; in the latter the contents of vesicles and bullae are hemorrhagic while in the present case the contents were clear or straw colored. Hemorrhagic HZ has been de-

TO CITE THIS ARTICLE:
Arif T. Gangrenous herpes zoster in an immunocompetent male. Turkiye Klinikleri J Dermatol. 2024;34(3):121-2.

Correspondence: Tasleem ARIF
Department of Dermatology, STDs, Leprosy and Aesthetics. Dar As Sihha Medical Complex; Dammam, Saudi Arabia
E-mail: dr_tasleem_arif@yahoo.com

Peer review under responsibility of Turkiye Klinikleri Journal of Dermatology.

Received: 10 Mar 2024 ***Received in revised form:*** 25 Jun 2024 ***Accepted:*** 13 Aug 2024 ***Available online:*** 20 Aug 2024

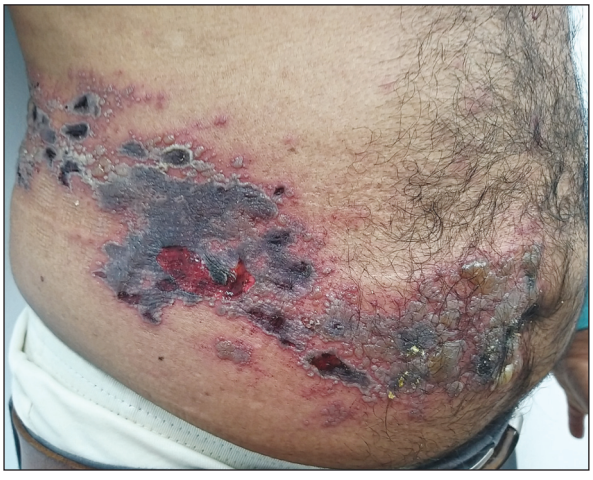

FIGURE 1A: Multiple grouped vesicles and bullae with erythematous base present in a zosteriform distribution over right half of abdomen with several gangrenous lesions

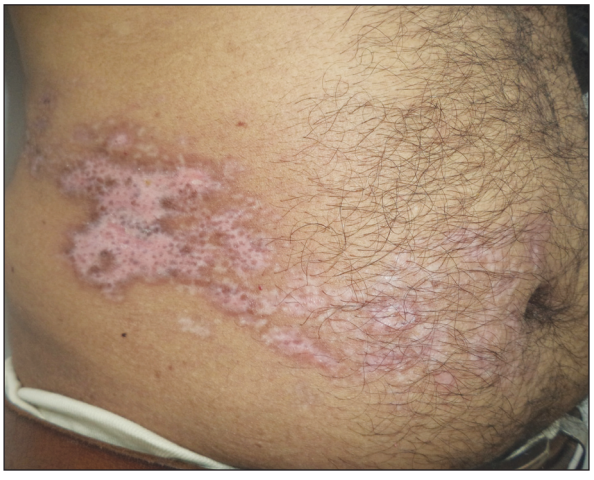

FIGURE 1B: At 4 weeks follow up, lesions have healed with scarring and dyspigmentation at some places.

scribed in patients having severe thrombocytopenia (<10,000/mm^3), immunosuppression, or taking anticoagulant drugs.[5] However, our patient was not having any of these features. This case highlights the importance that gangrenous HZ can occur in immunocompetent patients as well.

Written informed consent was obtained from the patient.

Source of Finance

During this study, no financial or spiritual support was received neither from any pharmaceutical company that has a direct connection with the research subject, nor from a company that provides or produces medical instruments and materials which may negatively affect the evaluation process of this study.

Conflict of Interest

No conflicts of interest between the authors and / or family members of the scientific and medical committee members or members of the potential conflicts of interest, counseling, expertise, working conditions, share holding and similar situations in any firm.

Authorship Contributions

This study is entirely author's own work and no other author contribution.

REFERENCES

1. Cohen JI. Clinical practice: Herpes zoster. N Engl J Med. 2013;369(3):255-63. [Crossref] [PubMed] [PMC]
2. Kawai K, Gebremeskel BG, Acosta CJ. Systematic review of incidence and complications of herpes zoster: towards a global perspective. BMJ Open. 2014;4(6):e004833. [Crossref] [PubMed] [PMC]
3. Marra F, Parhar K, Huang B, Vadlamudi N. Risk Factors for Herpes Zoster Infection: A Meta-Analysis. Open Forum Infect Dis. 2020;7(1):ofaa005. [Crossref] [PubMed] [PMC]
4. Wang D, Xu Z, Zeng L, Zhang J, Zhang G. A case of gangrenous herpes zoster complicated with candida albicans infection. Clin Cosmet Investig Dermatol. 2023;16:1737-40. [Crossref] [PubMed] [PMC]
5. Reichl A, Yao M, Spiker M. Hemorrhagic herpes zoster as a harbinger of malignant transformation. Brown Hospital Medicine. 2023;2(4). [Crossref]