

Psoriasis Herpeticum: An infrequent entity

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Abstract Kaposi varicelliform eruption (KVE) is a distinct cutaneous eruption caused by several viruses like herpes simplex, vaccinia, varicella zoster and coxsackie A16 in preexisting dermatoses. It is most commonly associated with atopic dermatitis. Psoriasis herpeticum is the term linked with psoriasis. It manifests as disseminated vesiculopustular eruption predominating over head and neck but can also have a localized variety. Clinical diagnosis is the primary element for recognition along with Tzanck smear. The infrequent association of psoriasis and KVE is intriguing in this case. We intend to report a case of Kaposi varicelliform eruption in an adult male with psoriasis.

Key words

Psoriasis herpeticum, Kaposi varicelliform eruption, psoriasis.

Introduction

Kaposi varicelliform eruption (KVE) is a rare life threatening disseminated skin infection in patients with preexisting cutaneous disease. It is mainly caused by herpes simplex virus type 1 hence the term eczema herpeticum is used, other implicated viruses include herpes simplex virus type 2, vaccinia virus, coxsackie A16 and varicella zoster virus.¹ Most commonly related dermatosis is atopic dermatitis hence the predominance in childhood but it can be seen in other conditions like pemphigus foliaceus, pityriasis rubra pilaris, psoriasis, darier's disease, ichthyosis vulgaris, mycosis fungoides, irritant dermatitis and burns.² It is characterized by vesiculopustular eruption predominating over head, neck and trunk.

Case report

A 40-year-old male presented to Dermatology Outpatient Department with complaint of fluid filled lesions over body since 1 day. He had four years' history of psoriasis and had been on irregular treatment in the form of indigenous medications. History of intake of methotrexate before the onset of lesions was present. History of remission and relapses was also present. He developed sudden onset of fever and body aches for which he was admitted in a local hospital and treated conservatively. Within 24 hours there was eruption of fluid filled vesicles over body, predominating over trunk, head and neck. Lesions were associated with itching. On day 2, there were new vesicles along with oral ulcers associated with difficulty in swallowing. On local examination, multiple discrete umbilicated vesicles and pustules over erythematous base were present, both over psoriatic plaques and surrounding skin (**Figure 1**). The differentials of Kaposi varicelliform eruption, varicella and methotrexate toxicity were made. Patient was evaluated and routine investigations including hemogram, liver and renal function tests, chest

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Figure 1 showing multiple discrete vesicles over psoriatic plaques and surrounding skin.

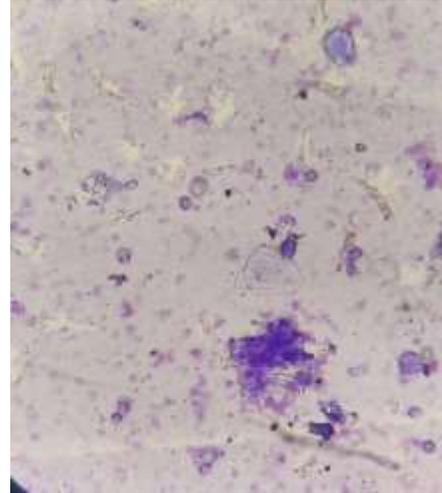


Figure 2 showing multinucleated giant cell on Tzanck smear (Giemsa stainX40).



Figure 3 showing multiple crusted plaques and hyperpigmented patches.

X ray, USG abdomen were normal except mild leukocytosis and raised liver enzymes (SGOT 113.6, SGPT 114.2). Serum methotrexate level was within normal range. Clinical diagnosis was supported by Tzanck smear which was positive for multinucleated giant cells and acantholytic cells (**Figure 2**). Skin biopsy showed acantholytic cells, multinucleated giant cells and intracellular ballooning degeneration. Patient was admitted and started on intravenous acyclovir 10-15mg/kg thrice daily for 7 days. Vesicles started regressing within 2 days of treatment and healed with formation of hemorrhagic crusts. Patient was discharged after 7 days and followed up after a week when

crusted lesions were cleared (**Figure 3**). Patient had relief from constitutional symptoms and fever. Liver function tests were repeated and they were within normal range (SGOT 17.4, SGPT 13.1). Patient was started on treatment for psoriasis.

Discussion

KVE is a rare disseminated cutaneous eruption mainly having viral etiology. Moriz Kaposi was the first to characterize this entity in 19th century. It is seen in patients with preexisting dermatoses. It is usually mild and localized but becomes florid in presence of dermatoses. Atopic dermatitis is the most common association. Hence it is more commonly seen in childhood although it can occur at any age. Most common cause is herpes simplex virus (HSV) type 1 and others include herpes simplex virus type 2, vaccinia virus, coxsackie A16, varicella zoster and smallpox virus.¹ Eczema herpeticum is the term used when HSV is involved in its pathogenesis. Various dermatoses linked to KVE are psoriasis (psoriasis herpeticum),² pemphigus foliaceus, hailey hailey disease, darier's disease, pityriasis rubra pilaris, congenital ichthyosiform erythroderma, neurodermatitis, mycosis fungoides, Wiskott

Aldrich syndrome, skin grafts, burns and rosacea. It has also been reported in adults and neonates with use of tacrolimus ointment.³ It is transmitted through contact with infected person or dissemination can occur from primary or recurrent herpes.⁴ Incubation period is 5-19 days. It can manifest as painful skin lesions that are usually vesicles and pustules but can also be in the form of bullae, punched out ulcers or crusted plaques. Lesions can also become hemorrhagic. It can be associated with high grade fever, lymphadenopathy, anorexia, malaise and systemic involvement⁵. The exact etiology is yet to be elucidated. Factors associated with increased susceptibility include impaired barrier function of the epidermis, lack of plasma cytoid dendritic cells, demasking of binding sites for viruses and aberrant host immune response.⁶ KVE can have a severe and disseminated course with occasional morbidity and mortality. Infrequent occurrence of localized KVE has also been reported.⁷ Clinical diagnosis is the mainstay along with Tzanck smear. Viral culture and PCR are the most reliable method for viral detection. Treatment should be started without delay to prevent complications.⁸ Antibiotic therapy is also recommended prophylactically to prevent secondary bacterial infections.^{9,10} In this case, morphology in the form of discrete umbilicated vesicles over erythematous base along with systemic involvement pointed towards KVE caused by varicella zoster virus. The downside here is the lack of viral isolation due to financial constraints. This case is reported due to the infrequent association of KVE in an adult patient

with psoriasis. Due to preexisting dermatoses diagnosis is often difficult hence timely diagnosis is critical in preventing complications.

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