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Disseminated herpes zoster

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Abstract
Herpes zoster is a clinical syndrome Which usually Presents with a Localized, vesicular rash in a Dermatomal distribution. Cutaneous Dissemination can occur in immunocompromised patients. Herein, we report a case of Disseminated Cutaneous herpes zoster in an immunocompromised patient

Keywords: herpes zoster, syndrome, localized, dermatomal

Introduction
Herpes zoster is a clinical syndrome which usually presents with a localized, vesicular rash in a dermatomal distribution. In immunocompromised patients, it may take on an unusual, often ulcerative, necrotic appearance. It can also spread to the skin or visceral level or be prolonged or recurrent. The risk of superinfection is also increased in this area [1].
Herein, we report a case of disseminated cutaneous herpes zoster in an immunocompromises patient.

Case report
A 75-year-old man adult developed a cluster of vesicular lesions over at the occipital level, which spread to involve the nape the upper part of the hemithorax and the back with associated burning-like pain over the affected area. Patient had a history of lymphoma under chemotherapy. On examination, we have found multiple vesicles surmounted haemorrhagic crusts and melliceric with some erosions. The patient was suffering a lot of pain that did not respond to paracemol.
We also found that the patient had ichthyosiform scales at the lower limbs and it was probably a paraneoplastic ichthyosis
The diagnosis of multimetameric herpes zoster was made and the patient was treated by valacyclovir VI 1g 3 times per day associated with an analgesic type of tramadol and vitamin therapy with good evolution.

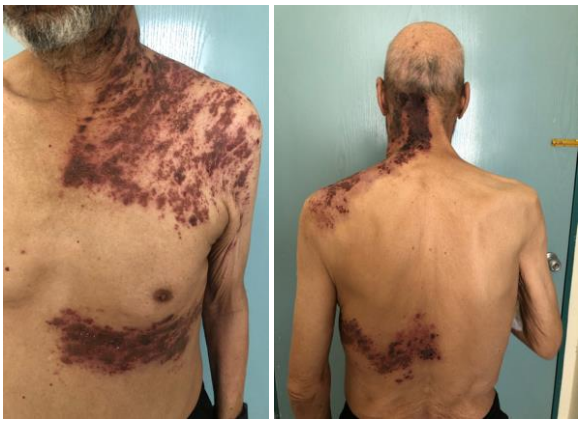

Fig 1 A, B: multiple vesicles surmounted haemorrhagic crusts and melliceric with some erosions

Discussion
Classic herpes zoster (HZ) presents as a dermatomal eruption of painful erythematous papules that evolve into grouped vesicles or bullae. Thereafter, the lesions can become pustular or hemorrhagic. Although the diagnosis most often is made clinically, confirmatory techniques for diagnosis include viral culture, direct fluorescent antibody testing, or polymerase chain reaction (PCR) assay [2, 3].
Disseminated herpes zoster is usually defined as a generalized eruption of more than 10-12 extradermatomal vesicles occurring 7-14 days after the onset of classic dermatomal herpes zoster. Typically, it is clinically indistinguishable from varicella (chickenpox). Dissemination occurs in approximately 2% of zoster cases in the general population but has been observed in as many as 35% of patients who are hospitalized or immunocompromised.
Initial cranial nerve involvement was most common which is not the case of our patient [4, 5].
The main risk factor for HZ is advanced age, most commonly affecting elderly patients.
Similarly affected are immunocompromised individuals, including those with one of the following conditions: use of antineoplastic and immunosuppressive medications, cancer, HIV infection, immunologic disorders, and organ transplants [6] milliary tuberculosis (TB) was also added to the immunosuppressive conditions, as it has been associated with T cell deficiency [7].
So we need to be careful with these patients because, we can have some atypical presentation that was described like painless HZ lesions in a nondermatomal pattern in a patient who also had AIDS., and interestingly, multiple reports have found that patients with a severe but painless rash are less likely to have experienced a viral prodrome consisting of hyperesthesia, paresthesia, or pruritus.This observation suggests that lack of a prodrome is possible in immunocompromised patients [8, 9, 10, 11].
But, like you know that reactivation of the varicella-zoster virus (VZV) causes dermatomal herpes zoster (HZ) and more rarely severe disseminated HZ including diffuse rash, encephalitis, hepatitis, and pneumonitis. The disseminated HZ has been described in immunocompetent patient but further research is needed to identify the exact mechanisms [12, 13].

As the cutaneous dissemination of HZ is thought to be via viremia, patients are often treated with intravenous antivirals to prevent cutaneous and visceral dissemination. Overall, cutaneous dissemination of HZ in the patients reviewed was associated with low morbidity and mortality.

Conclusion

Herpes zoster is a clinical syndrome that is not difficult to diagnosis, despite the low morbidity and mortality, we need to be careful with immunocompromised patient but also for possible complications.

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