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A widespread varicelliform rash complicating intercostal Herpes Zoster in an immunocompromised: Case report

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Abstract
Background: It is reported in the literature that an extensive varicelliform rash can occur in 2% to 10% of unknown patients with herpes zoster.
Case presentation: We report the case of a 65-year-old man with several vesicles eruptive, distributed all over the body and diagnosed as herpes zoster.
Conclusions: The objective of our observation is to underline the interest of knowing this diagnosis which is often wrongly taken as a Varicella-herpes zoster association.

Keywords: varicella, herpes zoster, immunocompromised, case report

Introduction
Disseminated herpes zoster is reported in the literature as a zosteriform rash following a metameric path, it is made of twenty vesicles responded to on the body, going beyond the affected dermatome. It is mainly observed in patients whose immunity is faulty either in the context of lymphoma as is the case with our patient, leukemia or receiving chemotherapy or any immunosuppressive treatment [1].

Case presentation
This is a 65-year-old patient, who never had chickenpox during his childhood, and who did not report any similar cases in people in contact. He is followed in internal medicine an anon-Hodgkin lymphoma at the level of the lymph nodes for four years, having received chemotherapy type BEACOP protocol, declared in remission. Who presented to the emergency room for the acute appearance of vesicular, pruritic, and painful skin lesions following a trip on the back, preceded by a flu-like syndrome with the appearance a few days before of arthralgia and myalgia evolving in a feverish context. Two days later the patient spread his lesions over the whole body, justifying his consultation.
Clinically, the patient presented multiple raised lesions with liquid contents, re-reading clear umbilicated vesicles, in places they are necretic on the surface and resting on an erythematous skin, by the other they carry out elements of different ages affecting the members, the trunk, face and scalp, as well as the genitals, with a chicken-like appearance [Figure 1, 2]. In addition, our patient also presents several vesicles of hemorrhagic content with necrotic surfaces on the back, grouped in a bouquet and following a metameric path from the middle part of the back to the anterior axillary line, along the fifth intercostal path [Figure 3]. The rest of the somatic examination was unremarkable.
In the blood count, we noted neutropenia explained by his hematological disease, and lymphopenia at 430 elements / mm3. The chest X-ray was normal. The patient was put on local treatment, analgesic and antiviral treatment based on Acyclovir intravenously at a rate of 10mg / Kg / 8H for 10 days, with a good improvement.

Discussion
Chickenpox is secondary to the latent VZV virus, it can be reactivation and sometimes even re-exposure [2]. The body reacts via cell-mediated immunity as an antiviral action, unlike humoral immunity which is not always enough to provide antiviral protection against the virus. Immunocompromised subjects, on the other hand, have poor cellular immunity, and therefore they are more likely to develop severe or atypical forms in the clinical presentation of this viral attack [3].
VZV is able to reactivate after years of infection with this virus, in the presence of promoting factors, such as the decrease in anti-anti-VZV cellular immunity [2]. The association of chickenpox and herpes zoster, secondary to one in a rapid reactivation concomitant with primary infection by VZV, observed in immunocompromised patients [4] was discarded in our case, this is explained by the beginning of the rash, which initially interested a specific dermatome, preceding the generalized rash which appeared later. The absence of a history of chickenpox or of contact with people who present it, is also an argument in favor of our final retained diagnosis, which is disseminated herpes zoster.
In the literature, the interval between localized shingles and the spread of the varicelliform rash is estimated from 2 to 12 days. In our Observation, this interval was 2 days [5]. The indication of acyclovir for the management of VZV has been proven [6]. In our case, we administered 10 mg / kg of acyclovir intravenously every 8 hours, suggested by Uri *et al*, with good remission.

Conclusion
In conclusion, disseminated shingles, particularly in immunocompromised patients, is an entity often misdiagnosed as a varicella-herpes zoster association. We report through our observation a new case.

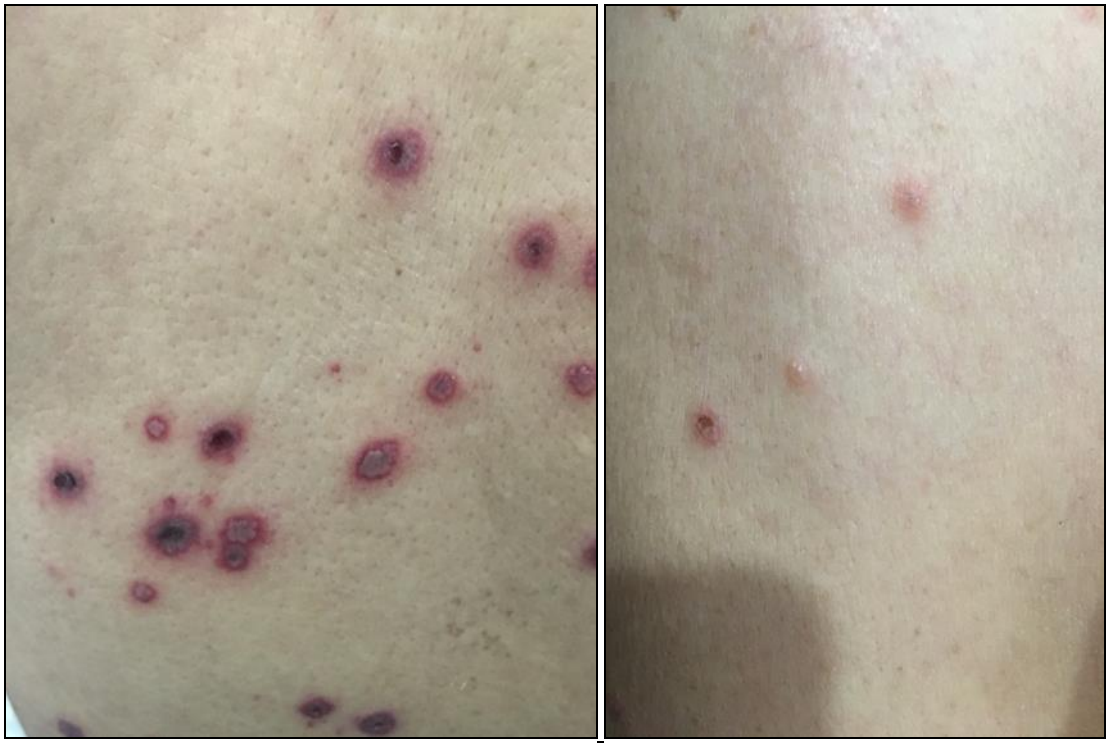

Fig 1: Vesicular lesions umbilicated, and of different ages, with liquid content, resting on erythematous skin

Fig 2: Lesions similar to that of the body at the genital level

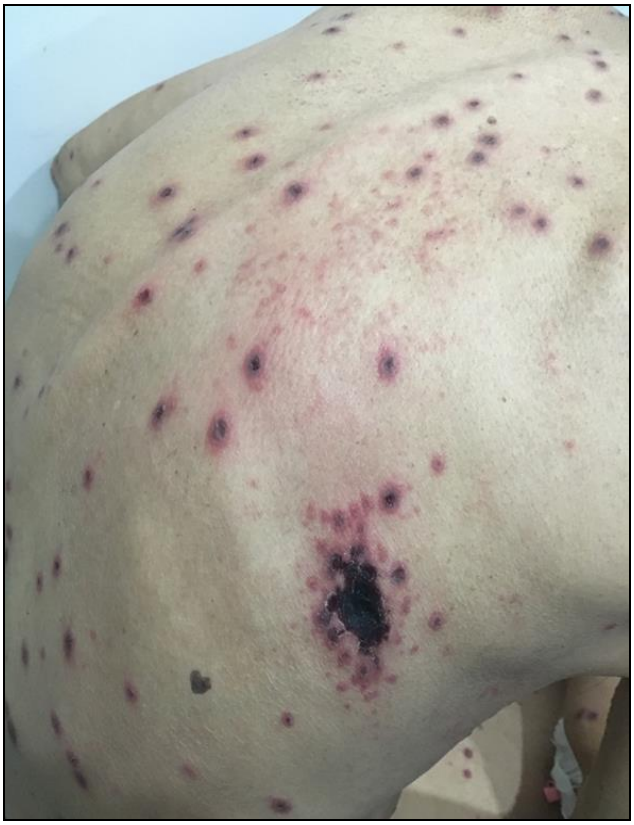

Fig 3: vesicles with hemorrhagic content and necrotic surface on the back, grouped in a bouquet and following a metameric path from the fifth intercostal space

Conflicts of interest

Author declares that there is no conflict of interest

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