Bullous Herpes Zoster

Sir,
We describe here a case of bullous herpes zoster.

CASE REPORT

A 56-year-old woman was admitted to the Institute of Dermatological Sciences of the University of Milan because of an erythemato-vesicular-bullous dermatitis localized exclusively at the right sub-mammary fold. The rash had appeared about 2 weeks earlier and was accompanied by burning and pain. The patient consulted her general practitioner, who made a diagnosis of pemphigus vulgaris and referred her to our Institute.

Dermatological examination showed an erythematous area, slightly infiltrated, with a colour ranging from red to purplish-brown, smooth surface and irregular borders. Within this area, some vesicles were present: they were either round or oval, a few mm in diameter and contained a serous fluid. Furthermore, at the para-sternal region, an oval bullous lesion, 4.5×3.5 cm in size and purplish-brown in colour was present (Fig. 1). The patient complained of asthenia and fever ($<38^{\circ}C$). A general physical examination was normal.

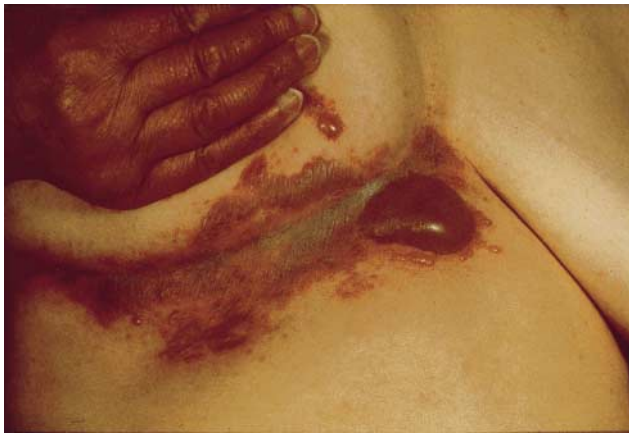

Fig. 1. A large bullous lesion at the right para-sternal area.

Laboratory examination revealed leucocytosis (12,600 wbc/mm^3) and a mild increase in inflammatory indices (ESR 45 mm in the first hour; α-1 acid glycoprotein 122 mg/dl).

Instrumental examinations were negative.

When the blister was opened, a blood-serous fluid oozed out. Cytological examination of the base of the blister showed the presence of multinucleated giant cells, with balloon degeneration, pale and vacuolized cytoplasm, and intranuclear inclusion bodies. Histopathological examination showed a dermo-epidermal detachment, with epithelial necrosis. Under high-field magnification, we observed ballooned keratinocytes, with hyperchromic nucleus and pale perinuclear halo.

Direct immunofluorescence showed IgM and C3c deposits at the dermo-epidermal junction.

Immunocytochemistry demonstrated a positivity for anti-varicella-zoster virus (VZV) monoclonal antibody in ballooned keratinocytes (APAAP/Newfucsin immunoenzymatic reaction). Anti-VZV IgG were positive.

The patient was treated with oral valacyclovir (3 g/day for 7 days), which led to complete remission of the clinical picture within 2 weeks. No recurrences were observed during a 6-month follow-up period.

DISCUSSION

On the basis of the localization of the lesions, herpes zoster may be classified as: (i) "classical"; (ii) double (mono- or bilateral, with asymmetrical (1) or symmetrical lesions (the latter is very rare)); or (iii) disseminated (2). "Herpes zoster sine eruptione" or "herpes zoster sine herpete", where pain is present in the absence of cutaneous lesions, has to be considered separately (3).

On the basis of the morphology of the lesions, 2 clinical varieties of herpes zoster have been described to date: (i) the ulcerative-necrotic-gangrenous variety almost exclusively strikes immuno-depressed patients because of malignant tumours or AIDS (4); (ii) the verrucous-crusted or hyperkeratotic variety is seen almost exclusively in patients with AIDS (5). Until now, only 1 case of the last variety in an immunocompetent patient has been published (6).

As far as we know, frankly bullous herpes zoster has not previously been reported in the literature. This variety might be due to the rapid merging of several adjacent vesicles.

The fact that the patient was not treated with any topical and/or systemic drug would exclude an irritant or allergic contact dermatitis superimposed on the herpes zoster: this was also confirmed by the histopathological examination. Furthermore, negativity of physical, laboratory and instrumental examinations allows us to exclude any type of immunodepression.

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