

Extensive cutaneous involvement due to herpes simplex virus infection

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DESCRIPTION

A 39-year-old woman, with a medical history of oligofrenia, obesity and varicella at 8 years of age, presented to the emergency department (ED) with multiple skin lesions of upper limb, which began with the appearance of vesicles, associated with intense pain and pruritus and with 3 days of evolution. No fever was reported. She was discharged home medicated with acyclovir and hydroxyzine.

Three days later, she returned to the ED with worsening complaints of pain and itching, and extension of cutaneous lesions throughout the body.

On physical examination, she was febrile (T: 38.5°C), with erythematous-pruriginous lesions, some of which were typically targeted, associated with numerous bullae dispersed throughout the body with oral mucosa involvement (figure 1A–C).

Laboratory investigation revealed normal complete blood count. Serology tests confirmed that the patient was positive for herpes simplex virus (HSV) and there was threefold rise in antibody titre. Serology for other infectious agents, microbiology and autoimmune blood work studies were negative.

At this point, extensive cutaneous involvement due to HSV infection was assumed as a diagnosis.

Learning points

- ▶ HSV infections are the most frequent within the herpes virus group and generally have a benign and self-limiting course. However, its presentation may be atypical in some cases, manifesting itself as a widespread infection and, rarely, life-threatening.^{1,2}
- ▶ Reactivation of HSV after childhood may occur spontaneously or through a state of immunosuppression. In fact, the more exuberant manifestations occur more frequently in immunocompromised patients.² However, the authors emphasise the exuberance of cutaneous lesions that can occur in an immunocompetent patient, as we reported in our case.
- ▶ Given these cutaneous lesions, we have to keep in mind differential diagnoses that manifest in a similar way as, for example, autoimmune blistering disorders.³ Thus, the authors highlight the importance of clinical awareness of these atypical manifestations, so that we can arrive at a correct diagnosis with the least delay.



Figure 1 (A) Erythematous lesions associated with numerous bullae dispersed throughout the right upper limb. (B) Erythematous lesions associated with numerous bullae dispersed throughout the left upper limb. (C) Erythematous lesions some of which were typically targeted in abdomen.



Figure 2 (A) Erythematous lesions in healing phase (right upper limb). (B) Erythematous lesions in healing phase (left upper limb). (C) Erythematous and target lesions in healing phase (abdomen).



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The patient was treated with a 7-day course of acyclovir (1000 mg/day) and with topical corticosteroid. She also was medicated with hydroxyzine (25 mg/day), while she had itching complaints.

After 1 week, the patient presented significant improvement of the lesions (figure 2A–C).

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