Two types of varicella zoster in one patient

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DESCRIPTION

A 79-year-old patient, with a background of chronic lymphocytic leukaemia, presents with herpes zoster (HZ) affecting the left C2/3 dermatome (figure 1). Three days after initial development, a secondary diffuse vesicular papuloblistering rash developed on the trunk, resembling varicella zoster virus (VZV) infection (figure 2).

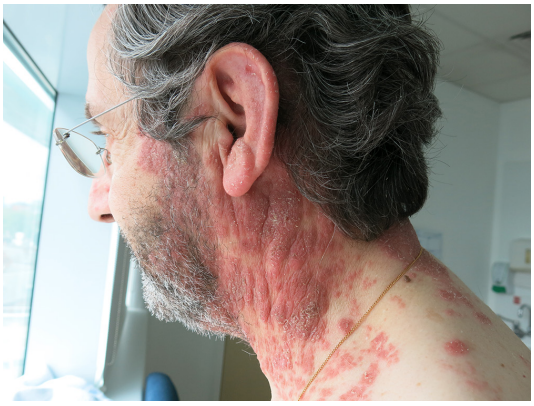

Figure 1 Vesicular plaque located to C2/3 dermatome.

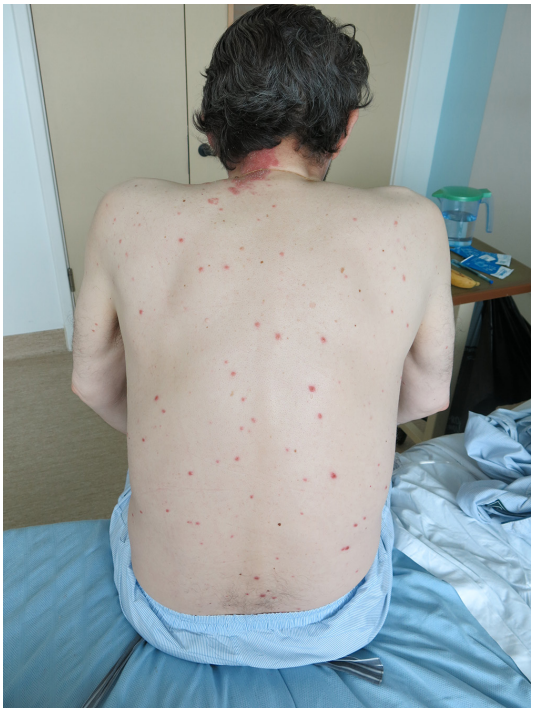

Figure 2 Disseminated vesiculopapular lesions.

Vesicular fluid from both rashes was positive for VZV on Fast Track Diagnostic multiplex real-time PCR assay, which has a specificity of 100% and sensitivity of 100% to 10^3 copies/mL dilution. Other methods of detection include directly with viral isolation and culture, detection of antigen in cell specimens, visualisation via light microscopy with Tzanck smears or electron microscopy or indirectly with western blotting or IgG detection.[1] Further samples were sent for bacterial and fungal microscopy, culture and sensitivity to investigate bacterial or fungal infections as possible differential diagnoses, which were negative. Treatment with intravenous aciclovir resulted in clinical remission.

VZV presents with two clinically distinct forms of disease: primary vesicular lesions (chickenpox) and secondary reactivation of HZ, in a restricted dermatomal vesicular patches or plaques (shingles).[2] It is thought that all HZ is associated with viraemia, which immunocompromised patients cannot control.[3]

Learning points

- Two manifestations of VZV exist; disseminated (chickenpox) and localised (shingles).
- Immunocompromised patients are unable to control viraemia and can develop disseminated VZV.

Contributors Sole contributor.

Competing interests None declared.

Patient consent Obtained.

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