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IMAGES IN INFECTION

A case of erythema multiforme followed by herpes zoster

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A 59-year-old man presented with pruritic erythematous to violaceous patches on the whole body that had first appeared 1 week previously. Mucosa was intact and he had no other medical problem including herpes simplex virus (HSV) infection and had not taken any medication for several months. Physical examination revealed typical target lesions, which were symmetrically distributed over the entire body (Fig. 1). Histopathologic findings demonstrated interface dermatitis with dyskeratosis (Fig. 2). With the typical clinical and histopathologic features, erythema multiforme (EM) minor was diagnosed. Painful erythematous grouped vesicles appeared 4 days later on the right T9 and T10 dermatomes (Fig. 3). The serologic test showed positive for varicella-zoster virus (VZV) IgM and IgG which confirm the diagnosis of herpes zoster (HZ). We prescribed intravenous acyclovir in addition to systemic steroid for erythema multiforme, which improved the skin lesion.

Erythema multiforme is an acute mucocutaneous syndrome related to infection or medication with diverse mucocutaneous manifestation [1]. Most commonly identified predisposing factor is HSV [2]. HZ is the reactivation of latent VZV in sensory ganglia [3] which is rarely reported to be associated with erythema multiforme [4]. Twelve cases of VZV-associated EM have been reported in the literature. VZV infection preceded EM in ten cases and followed EM in the remaining two cases [1] as present case. The median interval between the onsets of the two distinct lesions was 9.3 days. HSV infection was excluded with negative serology for HSV and clinical features. Although incidental coincidence of EM and HZ could not be excluded, the VZV is thought to be a more plausible causative factor regarding temporal aspects.

Conflict of interest None.

References

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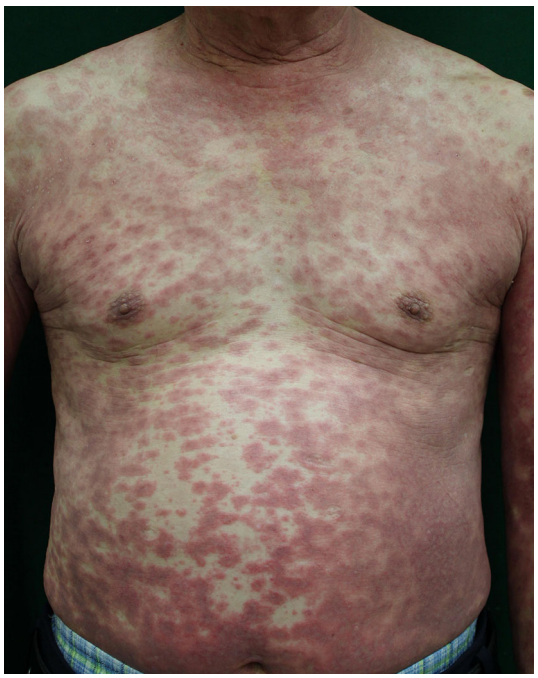

Fig. 1 Erythematous to violaceous targetoid annular patch on the trunk

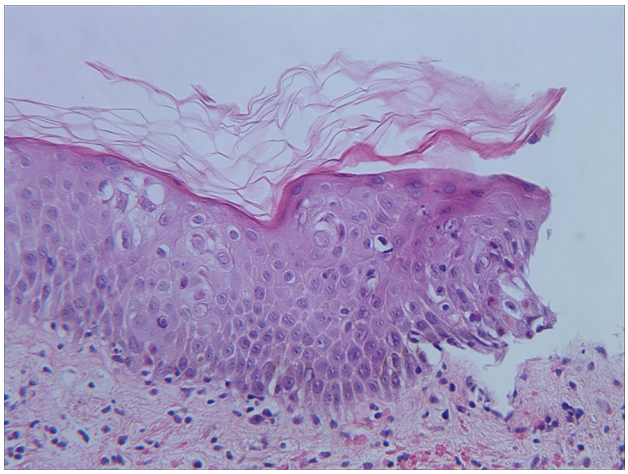

Fig. 2 Histopathologic findings revealed scattered necrotic keratinocytes, lymphocyte exocytosis, mild spongiosis in the epidermis, and inflammatory cell infiltration of the dermo-epidermal junction (H&E, ×200)

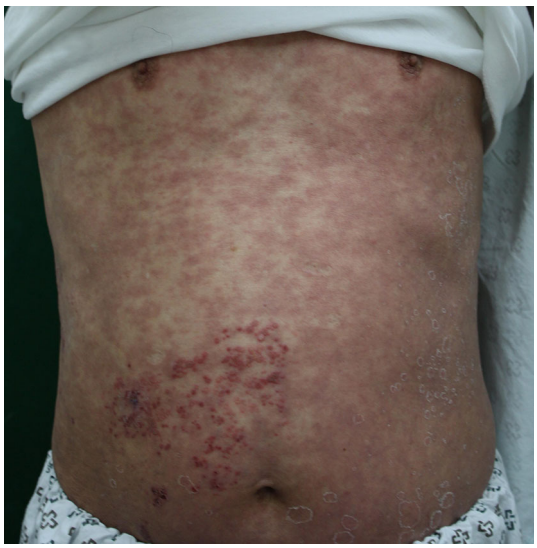

Fig. 3 Erythematous grouped vesicles along the right T9 and T10 dermatomes