Case Report

An atypical presentation of multidermatomal herpes zoster A Case Report

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Abstract

Herpes Zoster occurs due to reactivation of the latent varicella-zoster virus and typically presents as a grouped vesicular rash following a dermatomal distribution. Rare variants, such as bullous or multidermatomal zoster, can occur in elderly and immunocompromised individuals, and only a few cases are reported in the global literature.

Here we present an 84-year-old male with multiple co-morbidities, who developed multidermatomal herpes zoster with predominant bullous lesions involving left C3, C4, and C5 dermatomes. A clinical diagnosis of herpes zoster was made based on the clear midline demarcation of the lesions, confirmed by blister fluid polymerase chain reaction (PCR) for varicella zoster virus DNA. Intravenous acyclovir was initiated, given his immunocompromised state, and the lesions began to improve by the third day of treatment. However, the patient's hospital stay was complicated by other medical conditions.

Prompt identification and early antiviral therapy are crucial for reducing complications, especially in immunocompromised individuals.

Keywords: *Herpes zoster, Multidermatomal, Bullous lesions, Impetigo, IV acyclovir*

Introduction

Herpes zoster infection is a reactivation of the latent varicella-zoster virus and predominantly affects immunocompromised individuals.[1] It typically manifests as a grouped vesicular rash in a single dermatomal distribution. It rarely presents as bullous lesions with multidermatomal involvement.[2]

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Case presentation

An 84-year-old male with a past medical history of hypertension, type 2 diabetes mellitus (DM), stage IV chronic kidney disease (CKD), and advanced chronic liver cell disease (adCLCD) presented with a two-day history of a painful, itchy, blistering rash over the left side of the neck and shoulder following a one-day history of fever and lethargy. He lives in an elder's home and had been in his usual state of health before onset of symptoms.

On examination, tense bullae with serous fluid were noted predominantly with only a few vesicles in a clustered pattern without significant erythema, distributed over the left C3, C4, and C5 dermatomes (Figure 1A). Some large bullae were ruptured, leaving a superficial ulcer. The lesions showed a clear midline demarcation (Figure 1B).

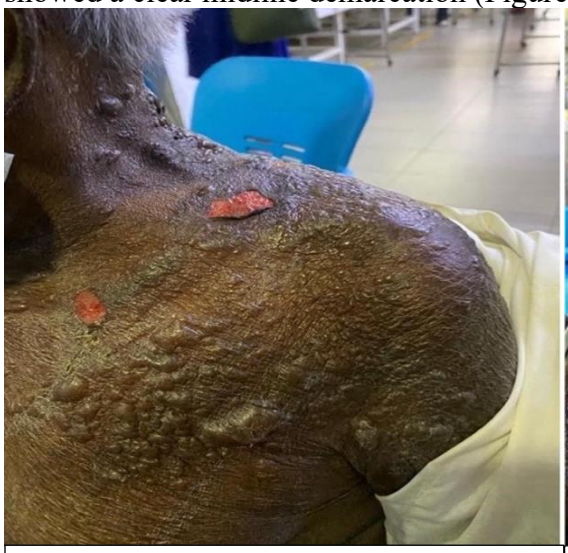


Figure 1A: Tense large blisters over dermatomes.

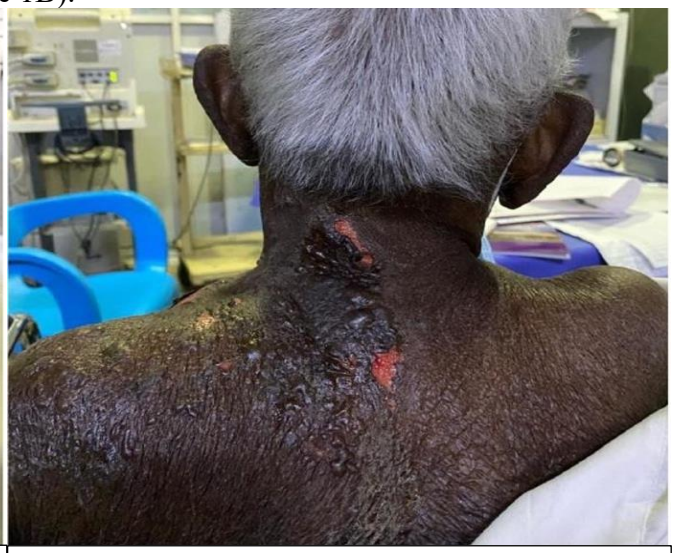
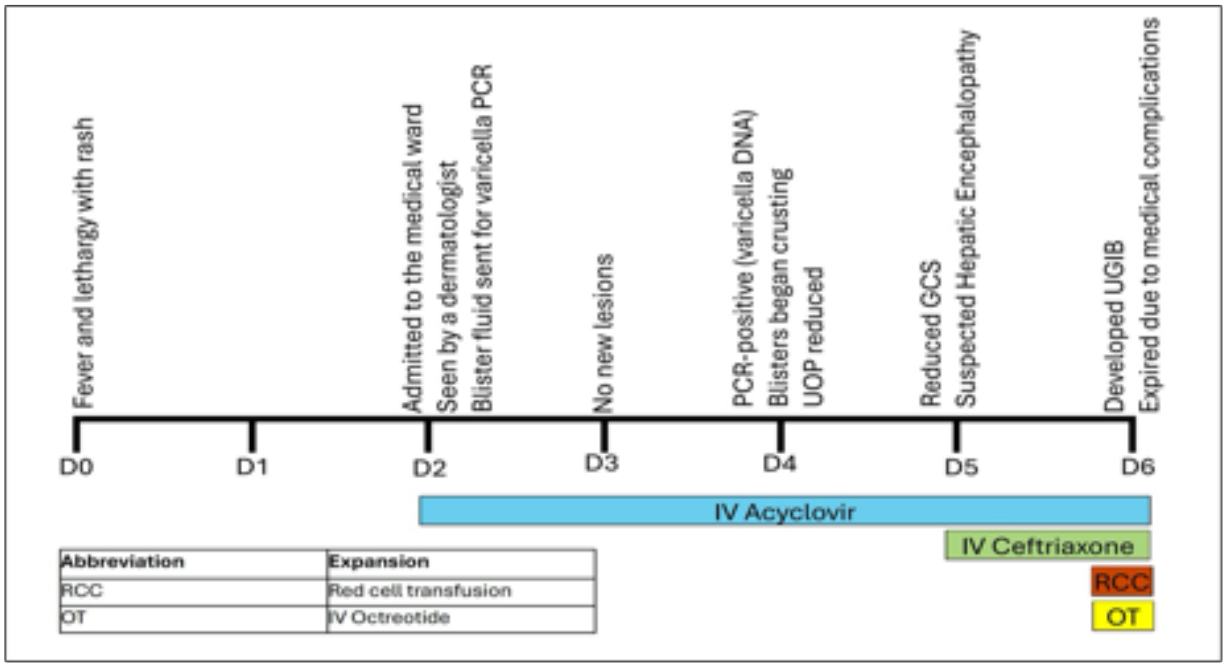


Figure 1B: Dermatomal distribution with midline demarcation.

The tense nature of the bullae closely resembled lesions similar to bullous pemphigoid. However, the dermatomal distribution, clear midline demarcation, and short duration of the lesions supported the clinical diagnosis of multidermatomal herpes zoster. Although herpes zoster is a clinical diagnosis, considering the atypical nature of the lesions, blister fluid was sent for PCR for confirmation and came as positive for varicella-zoster virus DNA.

Considering the immunocompromised status of the patient, he was initiated on intravenous acyclovir, adjusted to his renal function, and by the third day of therapy, blisters began to crust and heal. Unfortunately, the patient's hospital stay was complicated by acute kidney injury (AKI) and decompensation of cirrhosis with massive upper gastrointestinal bleeding (UGIB), and he succumbed to illness on the fifth day of admission.

Figure 2: **Timeline:**



Discussion

Herpes zoster, also known as shingles, is the result of the reactivation of the varicella-zoster virus, which remains dormant in sensory ganglia following initial varicella infection.[2] The incidence of herpes zoster increases with age and immunocompromised status.

In the prodromal phase, patients usually experience localised pain or a burning sensation over the affected dermatome days before the rash appears. The characteristic rash appears as a cluster of vesicles on an erythematous base, typically limited to one dermatome.[1] Diagnosis is primarily clinical, depending on the classical presentation of the rash in dermatomal distribution and associated burning pain.

Bullous lesions are a documented presentation, but predominant tense bullae create an atypical picture in contrast to more commonly seen vesicular lesions. This pattern can mimic other vesiculobullous disorders like bullous impetigo and localised bullous pemphigoid, and can pose a diagnostic challenge.[2] Although herpes zoster is a clinical diagnosis, in atypical cases like this case, laboratory confirmation can be obtained through polymerase chain reaction testing (PCR), direct fluorescent antibody testing (DFA), or viral culture of lesion samples which has a lesser sensitivity.[4] If the tests are unavailable, simple tests like the Tzank smear test can be performed to identify multinucleated giant cells, which are characteristic of herpes virus infection but not specific for varicella zoster virus.[5] In the absence of direct viral identification methods, serological assays with lesser sensitivity may also be used for diagnosis.

Further workup for underlying immunosuppression, such as human immunodeficiency virus (HIV) infection, malignancy, defective cell-mediated immunity, and underlying co-morbid conditions, should always be considered in case of multidermatomal or disseminated zoster.[4] In

this case, the patient had multiple risk factors for varicella zoster virus reactivation, including advanced age, DM, CKD, and adCLCD. In such cases, early initiation of treatment with antivirals is crucial to prevent complications like post-herpetic neuralgia or even mortality.[3] The timing of the initiation of antivirals is controversial, and is most favourable if given during the viral replication time, which is <72 hours.[1] In our case, we started antivirals on the third day, and we noticed fast healing of skin lesions, although his status deteriorated due to his underlying medical conditions. Dose adjustment for renal function is essential due to the nephrotoxic potential of acyclovir, particularly in patients with chronic kidney disease.

Conclusion

Herpes zoster with predominantly bullous lesions and multidermatomal involvement is a rare presentation. Timely clinical recognition and treatment are essential to reduce morbidity and mortality. Greater awareness of such atypical presentations is important for accurate diagnosis and effective management.

Declarations

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Conflict of interest: There are no conflicts of interest.
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Author contributions:
STH: Case management, conceptualisation, writing and reviewing the manuscript
NMMR: Case management, reviewing the manuscript
JGRRJ: Case management, reviewing the manuscript
DL: Case management, reviewing the manuscript
JKJ: Case management, reviewing the manuscript

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