Dear Editor,

A 17-year-old immunocompetent boy presented to the emergency department with multiple discrete hemorrhagic and clear vesicles over the face (confluent vesicles), neck, trunk, upper limbs, and also over well-defined erythematous, polycyclic to annular plaques with peripheral scaling, on the buttocks, groin, and left knee, thigh, and the popliteal fossa, for 3 days [Figure 1a and b]. There was facial edema and yellowish-brown crusted plaques over the face, frontal scalp, and ear conchae. He did not have any constitutional or systemic complaints.

Routine laboratory evaluation was normal, and HIV serology was negative. Tzanck smear from the vesicles showed multinucleated giant cells. KOH mount from the scaly lesions showed the presence of fungal hyphae. Skin biopsy from the hemorrhagic lesion over the face revealed focal and full-thickness necrosis of the epidermis along with ballooning degeneration. Dermis showed leucocytoclasia and nuclear dust around vessels. Few vessels showed fibrinoid necrosis [Figure 2a-c]. Antivaricella IgM antibodies were positive. A resident of our department (co-author, NM) developed varicella within a few days of admission of the patient.

Thus, a diagnosis of hemorrhagic varicella (HV) with tinea corporis et cruris was made. He was treated with intravenous acyclovir, 10 mg/kg 8 hourly, for 10 days that led to complete resolution of the vesicular eruptions. Tinea lesions were left behind and were treated with oral itraconazole and terbinafine cream [Figure 1c and d].

In immunocompetent individuals, varicella has a benign course without complications. However, in states of immunosuppression, it can present with severe internal organ involvement in the form of hepatitis, encephalitis, pneumonitis, and disseminated intravascular coagulation. Varicella eruption may be atypical with extensive lesions, continued appearance, and hemorrhagic lesions. Hemorrhagic complications are common in the form of purpura and internal organ bleeding.[1,2]

Charkes et al.[3] classified HV into five different types based on pathogenesis, the relative timing of bleeding with respect to fever and vesicles, and systemic features. They are febrile purpura, malignant chickenpox with purpura, postinfectious purpura, purpura fulminans, and anaphylactoid purpura.

Febrile purpura is a benign and transient form characterized by hemorrhage in the vesicles and the surrounding areola. Hemorrhage is usually noted on the first day of skin eruptions and persists for the duration of fever.[3] Malignant chickenpox with purpura is fatal with high fever, delirium, convulsions, and coma. It begins within 5 days of the onset of skin eruptions. There are hemorrhagic vesicles and areola, and hemoptyisis, hematemesis, melena, and genitourinary bleeding are frequently associated.[3] In postinfectious purpura, bleeding begins 7–14 days after varicella eruptions. There is prolonged bleeding and thrombocytopenia. Purpura fulminans is a rapidly progressive hemorrhagic gangrene of the extremities. Anaphylactoid purpura is the same as Henoch–Schoenlein purpura.[3]

Our patient had hemorrhagic vesicles from the onset without petechiae, constitutional, or systemic features, as reported in febrile purpura. Febrile purpura is primarily related to increased capillary pressure secondary to hyperemia. There could be metabolic derangements leading to capillary damage.
and thrombocytopenia. However, frank vasculitis changes demonstrated in our case are not seen in febrile purpura.

Another interesting feature in our case is Wolf’s isotopic phenomenon. It is the occurrence of a new skin disease at the exact site of an unrelated skin disorder (mostly herpes zoster) that had healed previously. Our case had varicella at all the sites of active dermatophytosis.

In conclusion, we report an exceedingly rare case of HV with vasculitis and Wolf’s isotopic phenomenon.

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**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Nil.

**Conflicts of interest**

There are no conflicts of interest.

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