Correspondence

Bullous Pemphigoid-Like Presentation of Disseminated Herpes Zoster: A Case Report

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Sir,

Herpes zoster is an acute viral infection characterized by vesicular skin lesions in a dermatomal pattern due to reactivation of varicella zoster virus from the dorsal root ganglion.[1,2] It is characterized by unilateral vesicular eruptions within a dermatome.[3] Disseminated cutaneous zoster has been defined as >20 vesicles outside the area of the primary and adjacent dermatomes.[3] This complication of zoster has been described in the immunocompromised in the form of human immunodeficiency virus (HIV) infections, underlying malignancies (especially lymphoproliferative), immunosuppressive drugs, and sometimes old age and diabetes mellitus.[4]

In a typical case of herpes zoster, the cutaneous lesions are largely localized to the sites of initial involvement and manifestations of a constitutional disturbance are minimal.[5] However, in about 2% to 5% of cases of zoster, hematogenous dissemination of virus occurs and leads to the development of widespread cutaneous lesions.[5]

A previously healthy 74-year-old woman presented to the emergency department with large fluid-filled blisters over the body for last one day. There was a 3-day history of the lesions being limited only to the right thigh with prior numbness and pain before a widespread eruption.

The patient did not give a history of chickenpox during childhood or any recent exposure to it. There was no past history of diabetes, cardiac or pulmonary disease, or any malignancy. The patient was not on immunosuppressive or other medications.

On examination, the patient was afebrile. She had bullae that were present in groups over the face [Figure 1] and were discrete over the trunk and limbs [Figure 2]. Over the thighs, they were large and fusing over an erythematous base [Figure 3].

Few were clear fluid filled, while few were hemorrhagic. A provisional diagnosis of disseminated herpes zoster or bullous pemphigoid was made. Tzanck smear showed multinucleated giant cells and secondary acantholytic cells [Figures 4 and 5].
Although dissemination of herpes zoster in immunosuppression is not so uncommon, this case is worth reporting due to its atypical clinical picture resembling bullous pemphigoid and other bullous disorders. This presentation is one of its kind to the best of our knowledge. It is also worthwhile to notice how a cutaneous condition was a key to the diagnosis of an underlying chronic malignancy.

**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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**Conflicts of interest**
There are no conflicts of interest.

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On clinical examination, large axillary lymphadenopathy was present and complete blood picture with peripheral smear was suggestive of chronic myeloid leukemia.

There was no hepatosplenomegaly. Liver function tests and chest X-ray were normal. Serology for HIV, hepatitis B, and hepatitis C was negative.

The patient was treated with intravenous acyclovir 800 mg 8th hourly.