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Two Unusual Cases of Kaposi's Varicelliform Eruption

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Sir,

Kaposi's varicelliform eruption (KVE) is characterized by the sudden appearance of numerous vesicles or erosions in a patient suffering from any other skin disease. The most common causative agent is herpes simplex virus (HSV) and by far the most common underlying dermatosis is atopic dermatitis (1). We report two patients who had KVE on a background of psoriasis and lupus vulgaris, respectively, which to our knowledge has not been reported so far.

CASE REPORTS

Patient 1

A 52-year-old bus driver with previous attacks of psoriatic erythroderma presented with the sudden appearance of multiple vesicular lesions predominantly over the right side of the face. The patient had been taking methotrexate at 20 mg per week for the past 6 weeks. There was no prior history of herpes labialis or gingivostomatitis and there were no systemic symptoms. The lesions were 5–10 mm eroded papulovesicles situated over the scalp, forehead, eyebrows, nose and lips. A few isolated lesions were present on the chest and upper abdomen. A Tzanck smear taken from the lesions demonstrated numerous multinucleated giant cells. The pre-treatment HSV antibody titer in the patient's serum was 40 (starting dilution for testing 1:10). HSV-1 infection was confirmed by antigen detection using indirect

immunofluorescence (IIF) in smears as well as isolates from the scrapings and vesicular fluid processed *in vitro* cell line.

Hemogram, liver and renal function tests were within normal limits and the patient was HIV negative. A diagnosis of KVE was made because of confirmation of HSV-1. Methotrexate was stopped and the patient was given acyclovir, orally, 400 mg 3 times a day. Complete subsidence of lesions was seen after 7 days of therapy, and the HSV antibody titer fell 4-fold. The patient's psoriasis continued to improve during this period and he was restarted on methotrexate at 15 mg per week, after subsidence of the vesicular lesions. Since then, he has had no relapse of the herpes lesions.

Patient 2

A 30-year-old office attendant, known to have lupus vulgaris of the perineum and right buttock, was started on 4-drug anti-tuberculous therapy. Two weeks later, he suddenly developed multiple painful erosions along the anal verge, which rapidly spread over 24 h to involve the edge of the lupus vulgaris lesion in the form of large serpiginous erosions with polycyclic borders. There was no prior history of oral or genital herpes and the patient was heterosexual. ELISA for HIV was negative. A Tzanck smear from the erosions revealed numerous multinucleated giant cells with intranuclear inclusion bodies. Eczema herpeticum was diagnosed and he was

started on 200 mg acyclovir, taken orally 5 times a day, healing the erosions in 10 days. The anti-tuberculous therapy was continued and the lupus vulgaris lesion healed in 6 months. There has been no recurrence of herpes for one year on follow-up.

DISCUSSION

Atopic eczema is the most common predisposing condition for KVE, although many other dermatoses are known to be susceptible, for example Darier's disease, pemphigus foliaceus, benign familial pemphigus, ichthyosis vulgaris, allergic contact dermatitis, burns, congenital ichthyosiform erythroderma, mycosis fungoides, Sézary syndrome, pityriasis rubra pilaris and multiple myeloma (1–3).

To our knowledge, KVE has not been reported in any patient with pre-existing psoriasis. However, HSV-1 has been experimentally demonstrated to grow faster on explants of psoriatic skin compared to normal skin (4). Our patient was taking methotrexate for a short time and there was no evidence of immune suppression. In our experience with methotrexate in more than 130 patients with psoriasis, we have not encountered any case of KVE or any other cutaneous viral infection (5). Published reviews on the side effects of methotrexate do not mention this or indeed any infection as a consequence of methotrexate therapy (6, 7). Therefore, it appears that the underlying disease itself, not the therapy, was the cause of the eruption in our patient. A similar conclusion has been drawn by David & Longson (8) regarding atopic dermatitis and oral/topical corticosteroid therapy. Like most reported cases of KVE (9), our patient, too, had KVE localized predominantly to the head and neck region.

The second patient was unusual because KVE has never been reported to occur as a result of any infectious dermatoses. The uncommon ulcerative variant of lupus vulgaris was considered, but was ruled out by the sudden onset and rapid progression of erosions, as well as the

response to acyclovir. The isolated involvement of the lower half of the body was also unusual, because it is usually seen only in cases with very widespread disease (3, 10).

In conclusion, KVE should always be suspected when vesicles or erosions suddenly develop on any underlying dermatosis. Our cases add to the growing list of conditions that may be complicated by this eruption. Not only inflammatory dermatoses such as psoriasis but also chronic infections such as lupus vulgaris, if occurring close to the orifices, can develop KVE, as seen in our patients.

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