Vesicles and Erosions in a Patient with Chronic Eczema: Is It Just Eczema?

An 80-year-old man was diagnosed with erythroderma secondary to seborrhoeic eczema 5 years before. His condition had been controlled with emollients, moderate potency topical steroids and antihistamines. He developed painful rashes over the genitals, suprapubic area and upper thighs of 1 week duration. There was associated low grade fever. The rashes were different from the appearance of his chronic eczema. On examination, there was a large area of erosion at the suprapubic area surrounded by satellite erosions (Fig. 1). Multiple smaller erosions were seen on the penile shaft, the glans and prepuce were spared. On the thighs, there were monomorphic grouped vesicles and erosions with erythema (Fig. 2). There were no oral ulcers.

What is the diagnosis for these cutaneous lesions?

A. Acute eczema
B. Candidiasis
C. Eczema herpeticum
D. Impetigo
E. Herpes zoster

Discussion

The diagnosis of cutaneous herpes simplex infection including eczema herpeticum (EH) is primarily clinical. In this patient, Tzanck smear showed multinucleated giant cells. Polymerase chain reaction (PCR), viral culture and immunofluorescence were not performed. He was treated with oral acyclovir and cefuroxime, and all his lesions cleared within a week. EH is a recognised infective complication of eczema due to herpes simplex virus type 1 or type 2. Impetiginised eczema due to *Staphylococcus aureus* or *Streptococcus pyogenes* is a common bacterial super infection. EH occurs mainly in patients with severe atopic eczema, it has also been described in patients with other chronic skin diseases. Patients with EH present with a rapid onset of vesicles in clusters. The vesicles break easily leaving small painful punched out erosions. Pustules may be observed. Frequently, there is associated fever, malaise and lymphadenopathy. Tzanck smear is a quick bedside test to support the clinical diagnosis of EH. Confirmatory investigations include immunofluorescence test of scraping from the vesicle base, PCR of the vesicle fluid and identification of the virus in the vesicle fluid by electron microscopy. The management of EH includes systemic acyclovir 400 mg, administered 5 times per day for 7 days. Cloxacillin or cephalaxin with *S. aureus* coverage may be prescribed for concomitant bacterial superinfection. Continuous wet dressing with potassium permanganate is useful to dry up the lesions. Emollients like white soft

Answer: C
paraffin will facilitate the healing of dry crusted erosions. EH should be recognised and treated early to prevent morbidities due to viremia and multiorgan involvement.  

REFERENCES


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