Atypical and disseminated herpes zoster

A 60-year-old woman with a history of surgery and chemotherapy for breast cancer presented with a large angiomatous plaque with bullae on the left side of her torso (*Figure 1*). It was causing her excruciating pain. Multiple vesicular lesions were covering her entire body. Skin biopsy confirmed the diagnosis of herpes zoster. The patient received intravenous aciclovir 10 mg/kg/8 h for 4 days followed by oral valaciclovir 3 mg/day for 10 days with complete clearance of the rash.

Dr H Amarouch is Resident in the Dermatology Department, University Hospital of IBN SINA, and University Hospital of Avicenna, University of Mohamed V, Rabat, Morocco

Dr H Zaouri is Resident in the Dermatology Department, University Hospital of IBN SINA, Rabat, Morocco

Professor B Hassam is Head of the Dermatology Department, University Hospital of IBN SINA, Rabat, Morocco

Professor N Ismaili is Professor of Dermatology in the Dermatology Department, University Hospital of IBN SINA, Rabat, Morocco

Correspondence to: Dr H Amarouch (hajar.amarouch@gmail.com)

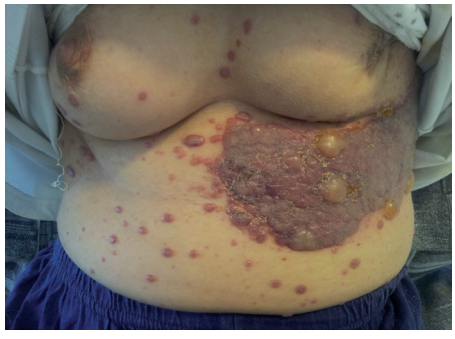
Herpes zoster is a reactivation of latent varicella zoster virus (Gnann and Whitley, 2002). The risk of occurrence increases by 20–100 times in immunocompromised patients (Thomas and Hall, 2004). Dissemination of herpes zoster is defined as more than 20 vesicles outside the primary and adjacent dermatomes (McCrary et al, 1999). Patients undergoing chemotherapy have a decreased number and activity of T lymphocytes, which explains the occurrence of disseminated and atypical clinical presentations. Early onset of parenteral treatment is mandatory. **BJHM**

Gnann JW Jr, Whitley RJ (2002) Clinical practice: herpes zoster. *N Engl J Med* **347**(5): 340–6 (doi: 10.1056/nejmcp013211)

McCrary ML, Severson J, Tyring SK (1999) Varicella zoster virus. *J Am Acad Dermatol* **41**(1): 1–14

Thomas SL, Hall AJ (2004) What does epidemiology tell us about risk factors for herpes zoster? *Lancet Infect Dis* **4**(1): 26–33 (doi: 10.1016/s1473-3099(03)00857-0)

Figure 1. Angiomatous plaque with bullae wrapping the left side of the torso along with multiple vesicular lesions and a rim of angiomatous erythema.



Exercise-induced erythema nodosum

A 30-year-old male competitive cyclist presented with painful, symmetrical 'bruising' of his forearms (*Figure 1*). He denied trauma and was systemically well. The lesions were raised, tender, circular, erythematous and well demarcated, with an erythema nodosum-like appearance. Examination was otherwise unremarkable as were blood tests and a chest X-ray. Biopsy was declined.

Dr Razan Saman is Core Medical 1 Trainee in the Department of Cardiology, Northern General Hospital, Sheffield

Dr Emma Withycombe is Foundation Year 2 Trainee in the Department of Emergency Medicine, Northern General Hospital, Sheffield

Dr Paul D Morris is Senior Cardiology Registrar in the Department of Cardiology, Northern General Hospital, Sheffield

Dr David R Warriner is Senior Cardiology Registrar in the Department of Cardiology, Northern General Hospital, Sheffield S5 7AU

Correspondence to: Dr DR Warriner (d.r.warriner@sheffield.ac.uk)

The lesions initially improved with topical steroids, but returned shortly after extreme exertion, e.g. sustained periods at maximal heart rate, whether topical steroids had been used or not. The differential diagnosis, in the absence of systemic symptoms, included urticaria, panniculitis (cold or ossificans), trauma or subcutaneous fat necrosis.

The lesions were attributed to exercise-induced erythema nodosum. This is the first description of such lesions in this distribution and with this aetiology. On retiring from competitive cycling, they did not return. A putative mechanism could include ischaemia or thrombophlebitis of the superficial venous microcirculation, caused by sustained exertion to near exhaustion, resulting in panniculitis.

This case highlights that over 30% of cases of erythema nodosum are idiopathic and they are not always classically found on the shins. **BJHM**

Figure 1. Bilateral, symmetrical, erythematous and nodular lesions over the radial border of both forearms.