Clinical Image

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Kaposi varicelliform eruption in a patient with atopic dermatitis

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A 23 year old woman with a history of uncontrolled atopic dermatitis presented to the emergency department with an acute onset of a painful papulovesicular facial rash that developed 1 week prior to presentation in September 2020.

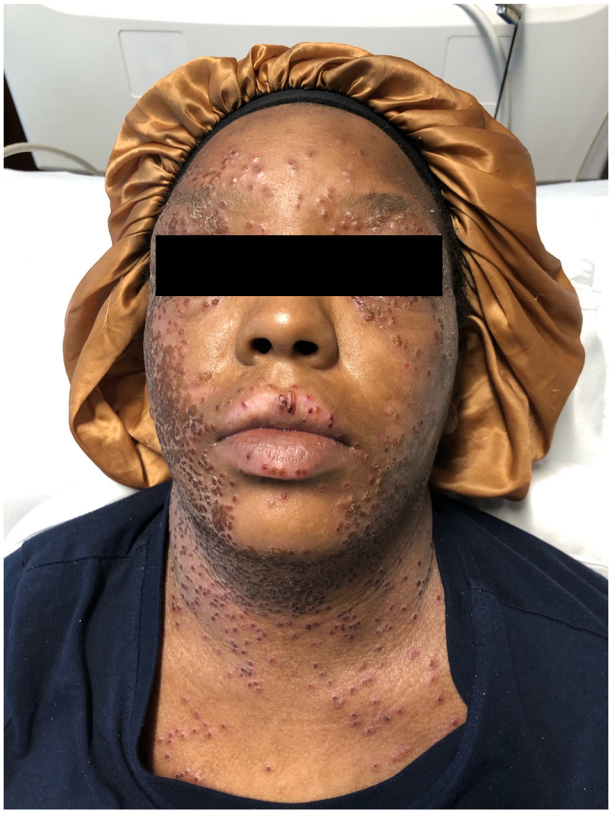

Image A

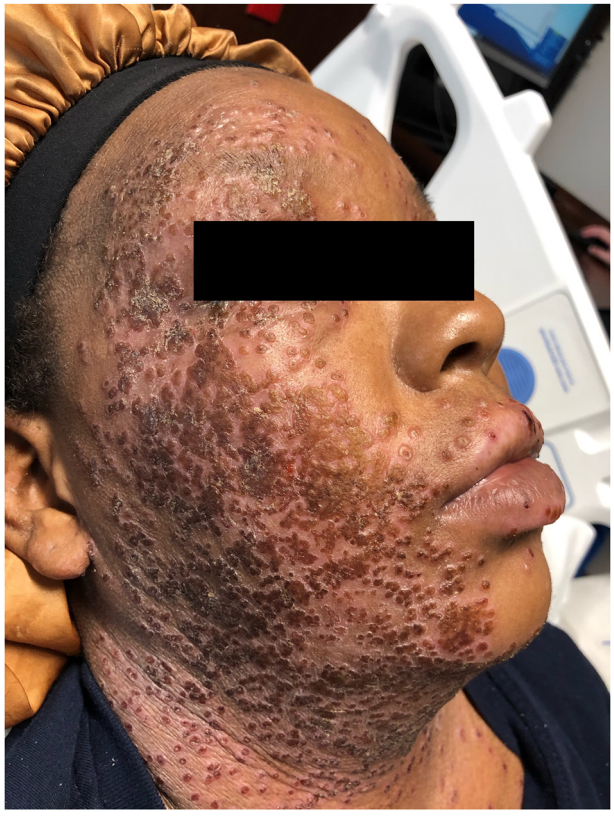

Image B

Review of systems was positive for crusting and swelling of both eyes, bilateral cervical lymphadenopathy, and headache. Physical exam demonstrated multiple umbilicated vesicles and pustules with serous crusting (Images A and B). Bilateral ocular exudate was noted without any conjunctival injection. Herpes simplex virus 1 (HSV-1) DNA was detected by polymerase chain reaction. The patient was diagnosed with Kaposi varicelliform eruption and successfully treated with acyclovir.

Kaposi varicelliform eruption, also known as eczema herpeticum, is a cutaneous dissemination of a viral etiology in the setting of certain underlying skin diseases, most commonly atopic dermatitis [1]. This is usually due to HSV-1 but can be complicated by a bacterial superinfection such as *Staphylococcus aureus* or group A *Streptococcus* [2]. It

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mostly affects infants and children, but it can present in any age demographic. Individuals present with a monomorphic eruption of umbilicated papules and vesicopustules and associated systemic symptoms such as fever, malaise, and lymphadenopathy [1–3]. Diagnosis can be confirmed with viral cultures, direct fluorescent antibody assays, polymerase chain reaction, and serologic studies [2]. Serologic testing has a limited diagnostic capacity notably in seroconverted patients, as it will not be able to distinguish if the active infection is due to this virus or another etiology [2]. Ocular sequelae including herpes keratitis is a serious complication and should be urgently evaluated by ophthalmology. In infants and young children, this condition is considered a medical emergency as systemic viremia can result in significant morbidity and mortality [2]. The mainstay treatment is with a nucleoside analog antiviral such as acyclovir, valacyclovir, or famciclovir [3]. Intravenous delivery should be considered in neonates, immunosuppressed patients, and those with severe or systemic complications. Antibiotics are not indicated unless there is any secondary bacterial impetiginization.

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Competing interests: None reported.

Informed consent: The patient in this report provided written informed consent.

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