An Atypical Presentation of a Common Disease

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REPORT OF A CASE

A 77-YEAR-OLD man presented with generalized headache and burning pain in his left temporal area. Eight days after the onset of the pain, several facial lesions were noted. On physical examination, he was afebrile. An erythematous tender plaque was present on the left frontal scalp area. Three smaller similar plaques were present on the left temple and cheek (**Figure 1**). A biopsy specimen was obtained (**Figure 2** and **Figure 3**).

What is your diagnosis?

From the Department of Veterans Affairs Medical Center, Brooklyn, NY.

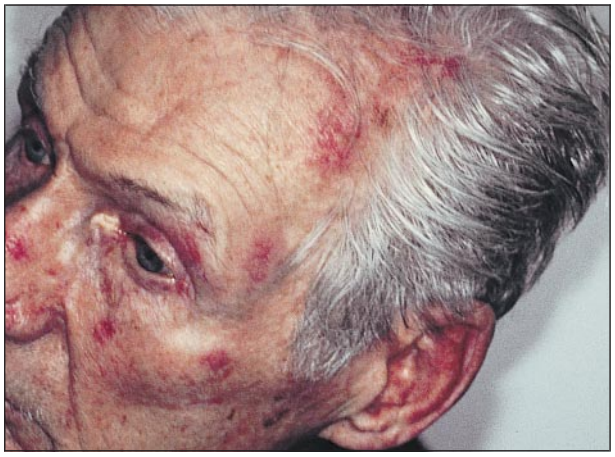

Figure 1.

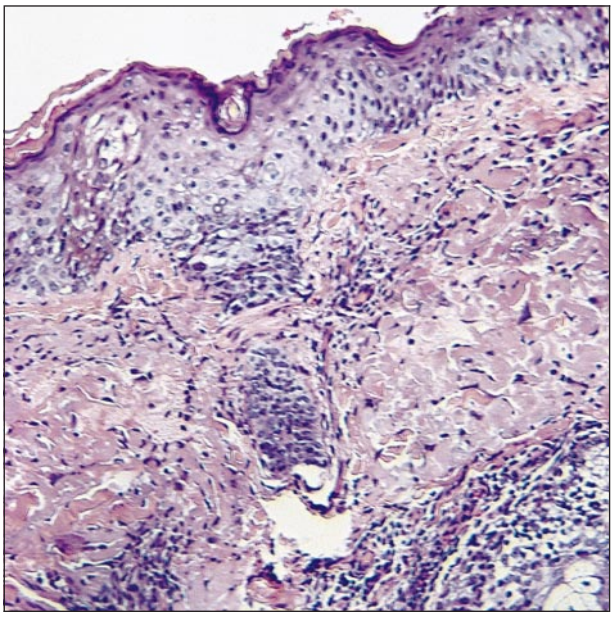

Figure 2.

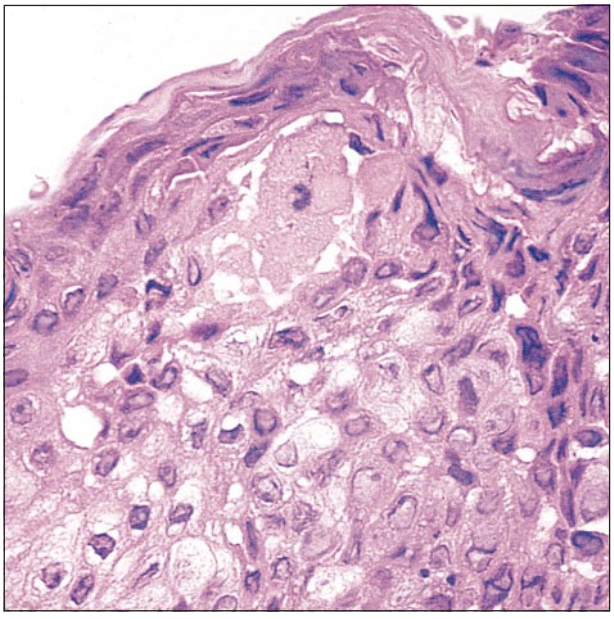

Figure 3.

Diagnosis and Discussion

Herpes Zoster Without Vesicles

HISTOPATHOLOGIC FINDINGS

Histologic examination of the facial lesion at low magnification revealed a superficial and deep perivascular, periadnexal, and interstitial mixed cellular infiltrate with lymphocytes and a few eosinophils (Figure 2). Higher magnification showed focal epidermal necrosis, ballooning of the keratinocytes with pale eosinophilic cytoplasm, and margination of the nucleoplasm, suggesting early viral changes (Figure 3).

DISCUSSION

Herpes zoster is usually diagnosed clinically because of the striking unilateral dermatomal distribution of the pain and rash.[1] The pain often precedes the lesions, usually by 1 to 3 days, but occasionally by as much as 1 week. The lesions begin as erythematous macules and papules and progress to grouped vesicles within 1 day, to pustules within 3 days, and to crusted erosions within 7 to 10 days. Fever and regional lymphadenopathy may accompany the rash.[2]

Laboratory tests that may be helpful in diagnosing atypical cases include Tzanck smears and viral culture of vesicle fluid. When vesicles are not present, biopsy specimens may, as in our case, show the ballooned epidermal cells and margination of the nucleoplasm that are diagnostic of herpesvirus; polymerase chain reaction on the tissue would differentiate varicella-zoster virus, herpes simplex virus type 1, and herpes simplex virus type 2.[3]

Although vesicles were not present in our patient, the diagnosis was suspected because the lesions followed the distribution of the maxillary (second) branch of the trigeminal nerve (**Figure 4**) and was confirmed by biopsy results. The symptoms and lesions resolved after 3 days of oral acyclovir therapy (4 g/d).

Selected from Arch Dermatol. *1998;134:1284. Off-Center Fold.*

REFERENCES

1. Bates B. *A Guide to Physical Examination.* 3rd ed. Philadelphia, Pa: JB Lippincott; 1983:378.
2. Rockley P, Tyring SK. Pathophysiology and clinical manifestations of varicella zoster virus infections. *Int J Dermatol.* 1994;33:227-232.
3. Nahas GT, Mandel MJ, Cook S, Fan W, Leonardi CL. Detection of herpes simplex and varicella-zoster infection from cutaneous lesions in different clinical stages with the polymerase chain reaction. *J Am Acad Dermatol.* 1995;32:730-733.

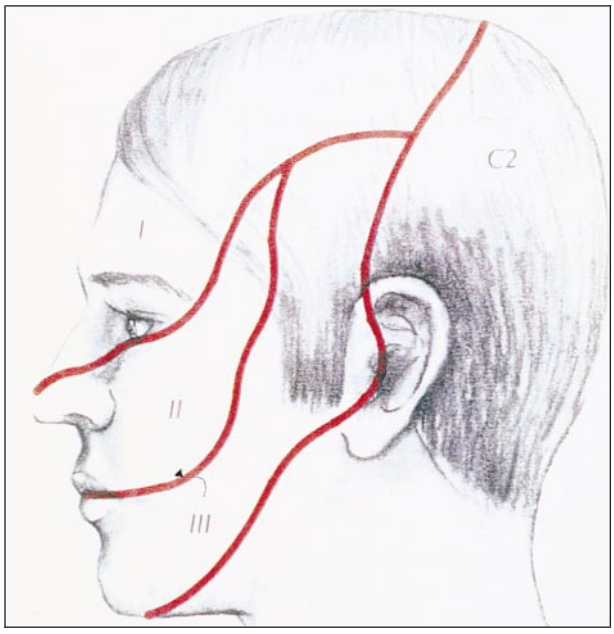

Figure 4.