A case of herpetic sycosis: a frequently unrecognized manifestation of a common pathogen

Dahlia Saleh, DO1 Ashley Rice, DO2 Hannah Pile, OMS-IV3 Christopher Cook, DO FAAD FAOCD1, Daniel Zedek, MD5 Dermatology Department; Campbell University School of Osteopathic Medicine/Sampson Regional Medical Center

Clinical Presentation

Figure 1 (A, B, and C): Scattered, excoriated papules and vesicles on the bilateral cheeks, neck, and chest of a Caucasian male.

An 84 year old male presented with an eruption on the face, neck, and trunk present for several weeks. He reported itching and burning with no improvement with the use of triamcinolone acetonide cream. Past medical history significant for hypertension, hyperlipidemia, coronary artery disease, COPD, and hypothyroidism. He also reports a history of cold sores. Current medications included aspirin, carvedilol, furosemide, pravastatin, levothyroxine, tamulosin, doxast sodium, loperamide, milks of magnesium, and an albuterol inhaler. Patient reported daily close razor blade shaving with a straight razor.

Physical examination was remarkable for scattered pink follicular-based papules and vesicles on the bilateral cheeks, neck, and chest (Figure 1A,B,C). There were secondary exorations overlying the primary lesions.

At time of presentation, the differential diagnosis included folliculitis, allergic/irritable contact dermatitis, drug eruption, neurotic excoriations, arthropod assault, widespread actinic keratoses, or a photosensitive/poikiloeritic process. A 4-mm punch biopsy was taken from a papule on the posterior neck (Figure 1C).

Figure 2: Trunk smear. Multinucleated giant cells present.

Discussion

- Herpetic folliculitis is most frequently caused by VZV, followed by HSV-1, then HSV-2.
- Increased risk in men with a history of recurrent facial HSV who shave closely with a blade razor (herpetic sycosis).
- Virus establishes latency in dorsal root ganglia and is able to evade the immune system via several mechanisms, including down-regulating various immunologic cells and cytokines and inducing intracellular accumulation of CD11d molecules in antigen presenting cells (normally, these CD11d molecules are transported to the cell surface, where they stimulate natural killer (NK) cells, promoting an immune response).
- Tranzck Smear (Fig. 2) o biopsy revealing multinucleated giant cells are commonly used for diagnosis; other options include direct fluorescent antibody (DFA) assay (Fig. 3), HSV serology (gold standard), or polymerase chain reaction (most sensitive and specific).
- Healthy patients typically self-resolve within 2-3 weeks although clearance may be hastened with antiviral therapy.
- In the immunocompromised population, lesions may be widespread or purpural.

Abstract

There are few reported cases of herpetic folliculitis in the literature. Herpetic folliculitis represents a rare and frequently unrecognized manifestation of a common pathogen; either varicella zoster virus (VZV) or herpes simplex virus (HSV). When affecting the beard area specifically, it is termed herpetic sycosis. Herein, we present a case of a 3 week long, pruritic and burning pink to red papulo-vesicular eruption with secondary erosions on the face, neck, and trunk of an elderly male with a history of cold sores. The rash was initially mistaken for an allergic or irritant contact dermatitis and was treated with low and medium potency topical corticosteroids with no improvement. Eventually, a punch biopsy was performed and upon visualizing classic histopathologic findings of a herpes virus infection the patient was diagnosed with herpetic sycosis. While this eruption commonly self-resolves, this patient experienced full recovery following treatment with oral antiviral therapy. This case illustrates the importance of histopathologic evaluation and a broad clinical differential diagnosis in the setting of a nonspecific erythematous papulo-vesicular eruption that is unresponsive to therapy.

The Takeaway

A diagnosis of herpetic folliculitis should be considered in a folliculitis-like dermatosis that is refractory to antimicrobial therapy or topical corticosteroids, especially when a history of prior HSV infection is present.

Figure 3. DFA assay. A keratinocyte infected with HSV fluoresces green.

Figure 4. Multinucleated keratinocytes within an area of follicular epithelium. Some of these cells show a “ground glass” nuclear appearance and peripheral margination of chromatin. These may represent either HSV or VZV (H&E, original sections at low, medium, and high power).

- On histopathology, partial or complete necrosis of the hair follicle with exocytosis of lymphocytes into the follicular wall and sebaceous gland may be appreciated.
- There may be a perivascular and interstitial dermal inflammatory infiltrate that mimics pseudolymphoma or lymphoma.
- Multinucleated giant cells, +/- Cowdry A inclusion bodies, herpetic cytopathic effect (peripheral margination of chromatin), and ballooning degeneration of keratinocytes may be seen but not always present (Fig. 4).

Histopathological Findings

- The Takeaway

Treatment

A diagnosis of herpetic folliculitis was made. A 7-day course of oral valacyclovir (500mg PO TID) was prescribed with complete clearance of eruption. Alternate regimens include famciclovir 500mg PO TID for 5-10 days or acyclovir 200mg PO q4h for 5-10 days.

References
Not provided.