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Perilesional urticaria in a varicella patient; another trigger?

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Sir,

A 17-years-old female patient presented to the dermatology OPD with complaints of swelling of the lips and around the eyes along with multiple, raised, reddish, itchy swellings all over the body since 2 days. She gave history of numerous similar episodes for the past 2 years, which responded to medicines but subsequently recurred. On examination, multiple erythematous wheals were seen over the trunk and extremities along with peri-orbital and lip edema. The patient did not give history of any trigger factors or recurrent abdominal pain. Therefore, a diagnosis of chronic idiopathic urticaria with angioedema was made. The patient was admitted. She was given a stat dose of Inj. adrenaline tartarate 0.4 ml subcutaneously and put on oral H1 and H2 blockers. Her



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lesions resolved but recurred the next day. Her hematological and biochemical investigations were normal with mild eosinophilia. At this stage, she was given oral prednisolone 1 mg/kg body weight per day. Her lesions subsided, and she was discharged after 5 days with oral prednisolone 30 mg daily. She was asked to follow-up in the dermatology OPD after 10 days. After 7 days, she presented to the casualty with fever, recurrence of the lesions, swelling of the face [Figure 1] along with multiple fluid-filled lesions over the trunk and few on the extremities. On examination, she had urticaria, angioedema, and multiple vesicles on erythematous bases, diagnosed as varicella. She gave no history of varicella in childhood, but gave history of contact with a friend who had varicella around 10 days ago. On closer examination, few vesicles were found to be umbilicated, and most of the urticarial wheals were centered on varicella lesions [Figure 2] and [Figure 3]. Tzanck smear, done from one of the vesicles, showed multinucleated giant cells [Figure 4]. Oral steroid was stopped, and she was given acyclovir 800 mg, 5 times-a-day for 7 days, along with continuation of anti-histamines. She recovered completely from varicella at the end of 7 days and did not have urticarial wheals when she was discharged on anti-histamines.



Figure 1: Facial angioedema with urticaria

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Figure 2: Peri-lesional urticaria around varicella vesicles on the back

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Figure 3: Peri-lesional urticaria around varicella vesicles on the abdomen

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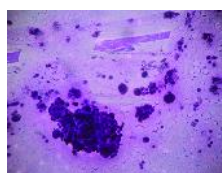


Figure 4: Multinucleated giant cells

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The term urticaria is defined as a transient eruption of circumscribed edematous and usually itchy swellings of the dermis. The term angioneurotic edema denotes similar but larger swellings of the deep dermal, sub-cutaneous, and sub mucosal tissues. [1] Acute urticaria is diagnosed retrospectively with a history of less than 6-8 weeks duration. The causative factor is easily identified in acute urticaria, whereas it is difficult in chronic urticaria. When there is no detectable cause in chronic urticaria, it is also known as chronic idiopathic urticaria. [2] Circulating antibodies against the high affinity IgE receptors and anti-FCεRIa antibodies have been detected on mast cells in about 30-50% cases of chronic urticaria. [3] Varicella is a viral infection caused by primary infection of varicella zoster. This patient already had chronic idiopathic urticaria with angioedema. She was on systemic corticosteroids, which could have predisposed her to develop varicella. Her urticarial wheals recurred after contracting varicella, and they developed around varicella vesicles, a very unusual feature. Chronic idiopathic urticaria can have numerous etiologies and triggering factors. Viral infections are among them, but varicella specifically has not been described. [3] Urticaria and peri-orbital edema has been described as prodromal presenting signs of acute hepatitis B infection. [4] Cold urticaria was found to be associated with infectious mononucleosis. [5] Valaciclovir has been used successfully in a case of recurrent urticaria associated with genital herpes. [6]

The appearance of urticarial wheals around the varicella vesicles indicates the probability that local viral multiplication, and the resulting cytokine secretion may be a triggering factor for mast cell degranulation causing urticarial wheals. Our patient was on systemic steroids and anti-histamines when she developed varicella. Systemic steroid was stopped on admission. Administration of acyclovir resulted in resolution of varicella as well as urticaria and angioedema. She remained lesion-free on only oral anti-histamines at discharge. This further strengthens our speculation that varicella triggered the recurrence of urticaria in this case.

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Figures

[\[Figure 1\]](#), [\[Figure 2\]](#), [\[Figure 3\]](#), [\[Figure 4\]](#)



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