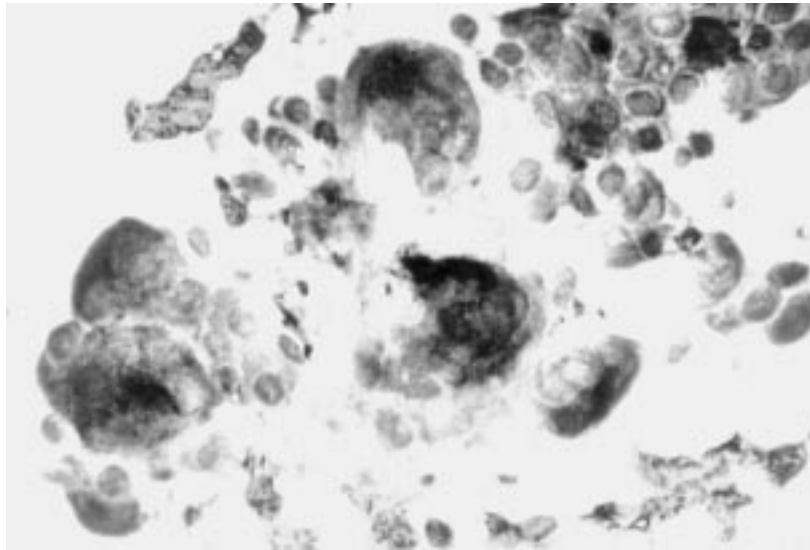


## Herpes Zoster

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**Fig 1.** Herpes zoster in a 32-year-old HIV<sup>+</sup> patient. Grouped vesicles on an erythematous base are seen in the distribution of the first division of the trigeminal nerve. Note that the lesions do not cross the midline.



**Fig 2.** Tzanck smear demonstrates several multinucleated giant cells, a characteristic finding in herpes infections. Although not specific for herpes zoster, it confirms the diagnosis in the proper clinical context. (Giemsa stain, original magnification 40x)



**Fig 3.** Same patient after three days of intravenous acyclovir therapy. Significant improvement is manifested by crusting and drying of the lesions.

THE PATIENT, a 32-year-old HIV<sup>+</sup> African-American male, presented with grouped vesicles on an erythematous base in the distribution of the first

division of the trigeminal nerve (Fig.1). A Giemsa stain was performed on a scraping from the base of a vesicle (Tzanck preparation); it

demonstrated multinucleated and giant epidermal cells (Fig.2). The direct fluorescent antibody (DFA) test detected varicella-zoster virus antigen, confirming the diagnosis. Most of the vesicles had crusted and dried after only three days of treatment with intravenous acyclovir (Fig.3).

Herpes zoster (HZ) represents the reactivation of a previous varicella-zoster virus infection. Characterized by unilateral pain or burning sensa-

tion, a vesicular or bullous eruption is limited to the dermatome(s) innervated by the corresponding sensory ganglion(s). In the immunocompromised host, lesions occur with increased frequency and severity and are more likely to be multidermatomal, recurrent or chronic. The latter form is seen almost exclusively in HIV<sup>+</sup> patients, in whom thickly crusted, hyperkeratotic, ulcerated lesions may be closely grouped or disseminated.

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