

THE CLINICAL PICTURE

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Multiple huge bullae after renal transplant



FIGURE 1



FIGURE 2

A 56-YEAR-OLD WOMAN PRESENTS with multiple huge bullae and crusted erosions in her left sixth to eighth cervical and first thoracic dermatomes (FIGURE 1), accompanied by severe, sharp, lancinating pain. She underwent renal transplantation 3 months ago for end-stage diabetic kidney disease and is now taking immunosuppressants, including tacrolimus (Prograf) (trough serum level 8–10 ng/dL), mycophenolate mofetil (CellCept) 500 mg twice a day, and prednisolone 5 mg per day.

Q: What is the most likely diagnosis?

- ☐ Contact dermatitis
- ☐ Herpes zoster
- ☐ Herpes simplex
- ☐ Pemphigus
- ☐ Bullous pemphigoid
- ☐ Graft-vs-host disease

A: The correct answer is herpes zoster (shingles), which represents reactivation of varicella-zoster virus.

The diagnosis of herpes zoster is usually based solely on the clinical presentation. It is typically characterized in immunocompetent patients by a unilateral vesicular eruption

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with a well-defined dermatomal distribution. But occasionally, as in this patient on immunosuppressant drugs, it presents with atypical skin lesions such as multiple huge bullae involving multiple dermatomes.^{1,2}

Patients treated with immunosuppressive agents after organ transplantation are at high risk of herpes zoster. A recent published retrospective study of adult kidney transplant recipients showed an average incidence of approximately 28 per 1,000 person-years.³

Treatment involves analgesics and sometimes antiviral drugs, and the decisions should take into account the patient's age and immune status.¹

This patient was admitted to the hospital and was put in a private room. The lesions were protected from further breakdown and secondary bacterial infection. We discontinued mycophenolate mofetil and prescribed acyclovir (Zovirax) 250 mg intravenously every 8 hours (dose adjusted according to her

renal function) for 7 days. Antibiotics needed to be given later for cellulitis that developed as a complication. She had no sign of ophthalmic involvement, visceral involvement, or other complication. She was discharged with healing skin after 42 days of hospitalization (FIGURE 2) and is free from postherpetic neuralgia. ■

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