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Visual Diagnosis Pearl

Worse with Age: A Case of Adult Chickenpox with Severe Rash

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A 34-year-old male with a past medical history of hyperlipidemia presented to primary care clinic for a diffuse rash. One week prior, he experienced epigastric abdominal pain with subsequent fevers, chills, fatigue, and nausea. He presented to an outside urgent care, where he had a positive point of care influenza test, and he was prescribed Tamiflu. He woke up the next day with a diffuse rash and returned to the urgent care, where he was suspected to have chickenpox.

The following day, he presented to an emergency department for fever and malaise. He again was advised that his rash was likely from chickenpox. There, he had an unremarkable chest X-ray, and he was discharged with valacyclovir.

At his primary care visit, he denied having chicken pox as a child, and he was unsure if he had been vaccinated for varicella. He did not have any known exposures to shingles or chickenpox prior to his presentation. That day, the urgent care informed him that the varicella-zoster virus (VZV) antibodies (IgM and IgG) were negative.

On exam, he was lethargic and tachycardiac to 111 but appeared in no acute distress. He had a maculopapular rash with pustular lesions in various stages on his scalp, face, neck, chest, back, abdomen, groin, arms, and legs, while sparing his palms and soles. Some lesions exhibited central necrosis. There were no signs of pneumonia, keratitis, or cellulitis. He did not have abdominal pain at the time of visit, and no hepatosplenomegaly was noted. Given his exam, he was advised to return to the emergency room for possibly IV acyclovir and fluids and to evaluate for organ dysfunction.

There, repeat VZV antibodies returned positive (both IgM and IgG). He had transaminitis with AST 132 U/L (normal 13 – 40 U/L) and ALT 193 U/L (normal 10-41 U/L). Bilirubin and creatinine were normal. HIV and acute hepatitis panel were normal. He was discharged and prescribed 5 additional days of valacyclovir.

While Varicella is primarily a childhood disease, adults often present with more severe symptoms and are at higher risk of complications. Prodromal symptoms include myalgias, nausea, headaches, and anorexia.² Patients then develop the characteristic pruritic rash. Skin lesions have been described as “dew drops on a rose petal” – clear vesicles with surrounding red halos that can develop into pustules over time. Chickenpox is characterized as having lesions at different developmental stages. The rash often starts on the face and trunk then expands to extremities. Lesions usually heal after 7 to 10 days.²

Complications can include pneumonia, secondary soft tissue/ skin infections, and less commonly hepatitis, ophthalmologic complications (including keratitis), or neurologic complications (including encephalitis).² Because even immunocompetent adults are at higher risk, it is important to make a diagnosis early, start treatment, and monitor closely for complications. Outpatient treatment for adults includes oral acyclovir or valacyclovir along with symptomatic management.

When evaluating patients, it is important to distinguish varicella from other similarly presenting conditions including mpox, disseminated herpes simplex virus, drug eruptions, and bullous rashes. While mpox can present similarly, the lesions are generally of the same stage. PCR testing of vesicular fluid or antibody testing can confirm the diagnosis if necessary.

The effectiveness of vaccination has demonstrated a significant improvement in preventing disease and complications. The implementation of the United States national varicella vaccination program in 1995 led to a decline of varicella cases by 97% from 1993-1995 to 2013-2014, and the decline was seen across all age groups.¹ Offering it to unvaccinated patients remains an essential aspect of management.

DISCUSSION

Chickenpox is caused by VZV. Transmission occurs by inhalation of aerosolized VZV (from respiratory tract secretions or vesicular fluid) or from direct contact with vesicular fluid.¹ The incubation period after exposure is 10 to 21 days.² Outbreaks occur commonly in settings of numerous children and in congregations of other age groups including hospitals and military and correctional facilities.³





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