Occurrence of Necrotizing Fasciitis on Zoster Thorax in HIV Negative Patients

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Abstract

The commonly preferred area and the risk factors of necrotizing fasciitis are respectively limbs and traumatism. We report a case of localization of zoster in the thorax in a 70-year-old woman HIV immune-competent.

Keywords: Fasciitis; Zoster; Thorax

Introduction

The necrotizing fasciitis (NF) is a condition of life in jeopardy, made of a soft tissue infection with a rapidly fascial necrosis [1]. Indeed, necrotizing fasciitis usually starts with traumatism. This traumatism can be as seemingly harmless as a simple contusion, mild burning, erosions or an insect bite. Rapid diagnosis is imperative because necrotizing infections usually spread rapidly and can lead to multi-organ failure. The FN rarely involves areas such as the head, neck, and the chest. We report a case of a woman who developed a necrotizing fasciitis consecutive to a thoracic zoster.

Case Report

A 70-year-old woman with no particular history was admitted to our service for necrotic ulcers of the left hemithorax. During the consultation, the patient reported a pain in the left hemithorax the night of her elder brother funeral. The next day, some vesicular lesions occurred in the painful area, all operating in a context of flu-like symptoms. This motivated a self-medication made of anti-malaria medicines, paracetamol and application of poultice on the left hemithorax. In the absence of improvement the patient consulted our service where a zoster was diagnosed (Figure 1).

A prescription was made including acyclovir for injection, tramadol for injection and aqueous eosin 2% after cleansing with saline. The blood count showed mild anaemia normochromic normocytic at 10 g/l. The leukocyte rate was normal; the glucose at 0.87 g/l. The retroviral serology was negative.

After 2 days of treatment, the patient decided to go back home due shortage of means to cope with the medical expenses. A traditional treatment was carried out including poultice, bath forbearance which,
according to a certain belief, would be an aggravating factor, and decoction plant. Twenty-three days later, before the worsening of the signs: general condition impairment, disturbance of consciousness, the patient was received in our service. A physical examination revealed a necrotic area on the left hemithorax with extension of necrosis over the right breast of the patient (Figure 2). The necrotizing fasciitis was diagnosed. The surgical debridement was performed quickly. Unfortunately, for lack of means the patient died in an array of septic shock two days later.

Discussion

Our case report highlights the development of necrotizing fasciitis in a 70 year-old patient, HIV negative on chest zoster lesions. To the best of our knowledge, no case in Africa has been described, yet. The FN occurring on herpetic lesions is rarely described in the literature. Jarett [2] in 1998 described a case occurring in an elderly woman. The other authors reported the FN on chickenpox lesions in children [3-7]. Apart from traumatisms, a number of additional risk factors may contribute to the prevalence of necrotizing fasciitis. The erosive lesions of zoster seem to play an important role in the occurrence of the disease, but also poultice especially in our African beliefs and conditions. The advanced age of our patient was the age of the recurrence of the zoster virus. There was no co-morbidity in our patient. However Jarett [2] described his case with an immune-suppression history. Atypical localizations including cephalic [8] were found in the literature. In the case of Fung [8], the FN occurred on ophthalmic zoster lesion. In our case the lesion was located on the chest. This thoracic location was described by several authors [9] and seems to be the second area of the FN after the limbs [9].

Conclusion

Physicians should be aware of the risk factors causing the occurrence of the FN. Early detection and early surgical debridement are crucial to limiting morbidity and mortality of severe forms of the disease.

Conflicts of Interest

The authors declare no conflict of interest.

References