Isolated palmar located postherpetic Erythema multiforme: unique pathognomonic clinical presentation!

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We present a 37-year-old woman complaining of recurrent herpes simplex infections in the genital area. Episodes of herpes recurrence have been observed within the last 2-3 years. The patient treated the viral infection in the past with acyclovir 3x400mg / day with a temporary improvement. At the time of the clinical examination, the complaints were about the appearance of oval red lesions on the palms and fingers (Fig.

1a-b) with a duration of several weeks. In the course of the dermatological examination, we detected disease progression as well as the presence of polymorphic rash units with the appearance of erythemo-edematous cockades-concentric circles with a peripheral erythematous ring and central clearing in the area of the palms and fingers (Fig. 1a-c). Based on a clear clinical picture and histological finding, a palmar form of erythema

Figure. 1a-c: polymorphic rash units with the appearance of concentric circles with a peripheral erythematous ring and central clearing in the area of the palms and fingers. Photos 4 weeks before hospitalization.

Figure. 1d-e: erythema multiforme picture - clinical status after worsening of the condition.

multiforme was diagnosed as a result of recurrent infection with herpes simplex virus in the genital area. There was no evidence of a general disorder as well as mucosal involvement within the erythema multiforme. Systemic therapy with methylprednisolone 60 mg was started under a regimen initially followed by 40 mg / day p.o. in reduction scheme for one month. Esomeprazole 40 mg once daily for the duration of corticosteroid intake, as well as desloratidine 5mg / day, and topical administration of methylprednisolone aceponate cream 0.1% x 2 per day.

In outpatient treatment, prophylaxis for recurrent herpes infections with acyclovir 2x400mg was initiated for a period of 6 months.

HSV infection is considered to be one of the major etiologic causes of acute or sequellar EM lesions [1]. Usually, the predisposing factors are unknown, with the condition being considered an immune-mediated reaction, which is more common

in HSV-1 compared to HSV-2 in the context of herpes infection [2]. Although it is generally accepted that EM has a self-limited course of development in some cases timely adequate treatment of erythema multiforme remain a major challenge, especially within recurrent herpes-associated erythema multiforme (HAEM), as in the patient described by us [2,3].

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