Urticarial manifestations associated with herpes simplex virus type 2

The association of certain dermatoises with herpes simplex virus (HSV) infection has long been appreciated. The best-documented cutaneous association of HSV is erythema multiforme because of the detection of HSV DNA in cutaneous lesions by using PCR.\(^1\) Urticaria may be precipitated by multiple factors including infectious agents such as hepatitis B and C viruses. According to a series on additional diagnosis accompanying urticaria,\(^2\) the association with HSV has not been found in different studies.

A 58 year old woman presented with chronic urticaria for 6 weeks. At the beginning of the urticaria, treatment with oral prednisolone (1 mg/kg/day) and hydroxyzine (25 mg/day) completely cured the lesions in 24 hours. Four days after stopping her treatment, the urticaria recurred. Oral antihistamine and corticosteroids were ineffective. At the sixth week, the patient developed vesicular lesions localised on the lower back, compatible with an herpes eruption. Nevertheless, she was on no regular medication, in good health and had a long history of genital herpes infection from the age of 23 years (one eruption per year).

Local virological tests (ELISA and culture) performed on a vesicle showed HSV-2. Routine biological and biochemical screening tests, including haemoglobin, white cell count, erythrocyte sedimentation rate and liver function tests were normal. Syphilis and HIV serologies were negative. Histological examination of an urticarial lesion confirmed this diagnosis (oedema of the dermis, presence of eosinophils). Direct immunofluorescence examination was negative. The patient received treatment with acyclovir 250 mg diluted in 50 ml of isotonic NaCl by IV infusion spaced at 8 hours intervals. Six hours after the first infusion of acyclovir, she dramatically improved with a complete resolution of the urticaria. Acyclovir by IV infusion was given for 3 days and then orally for 10 days. The urticaria did not recur in the 8 months following the treatment.

Urticarial manifestations presented in this case appeared 6 weeks before the HSV lesions. The clinical appearance and histological features of the lesions were those of urticaria. This may be the predominant or sole feature of the prodromal serum-sickness-type syndrome which occurs in 20 to 30% of patients with acute hepatitis B virus (HBV) infection.\(^3\) The exact role which HSV may play in the pathogenesis of urticaria-HSV is unknown but it may be related to a hypersensitivity reaction. Deposition of immune complexes containing HBs antigen in involved cutaneous vessels as described in urticaria-HBV have not been found in our case.

To our knowledge, no previous similar case of chronic urticaria preceding genital herpes has been described in the literature.

Azithromycin and syphilis

Azithromycin, a new long-acting azalide antibiotic, became the standard treatment for uncomplicated genital chlamydial infection in the Northern Territory of Australia in July 1994. A trial of this agent in the treatment of genital donovanosis is also in progress with the approval of the responsible ethics committee. We have since recognised clinical or serological resolution of syphilis in two patients who happened to receive azithromycin for one of the above indications.

A 26 year old Aboriginal woman presented with vulval lesions consistent with donovanosis. She agreed to enrol in the trial. As stipulated in the study protocol, biopsy and other specimens were collected and azithromycin treatment (500 mg daily for seven days) commenced prior to confirmation of the diagnosis. Laboratory investigations subsequently revealed gonococcal cervicitis and a rapid plasma reagin (RPR) titre of 1:32. No Donovan bodies were seen in the biopsy and the histological appearance, particularly a dense perivascular plasmaey infiltrate, was suggestive of a syphilitic lesion. Upon review one week later the vulval lesions had completely resolved. The patient was withdrawn from the trial because secondary syphilis was considered the likely diagnosis based on the rapid resolution of the lesions, the raised RPR titre and the histological findings.

The second patient, a 32 year old Aboriginal man, took part in a screening programme for sexually transmitted diseases (STDs). He was asymptomatic and genital examination was normal. However, a leucocyte esterase dipstick test of his first void urine was positive suggesting urethritis. Urethral swab and venous blood specimens were collected and the patient given 1 g azithromycin orally. Laboratory investigations later confirmed gonococcal and chlamydial urethritis and found an RPR titre of 1:32. Eighteen months previously the patient’s RPR titre had been 1:1. He was lost to follow-up for one month. When finally reviewed his RPR titre was 1:1 though he had received no other antibiotics since the single dose of azithromycin.

Patients presenting with STDs often have multiple infections. Hence some patients receiving the new regimen of a single 1 g dose of azithromycin for chlamydial or...