Varicella gangrenosa

D D KIDNEY, J B G WATSON, AND N NISAR

Cork Regional Hospital, Cork, Eire

SUMMARY

A four year old girl presented with varicella gangrenosa, and haematological investigations showed a disseminated intravascular coagulation. The child subsequently developed a unilateral deep venous thrombosis. She was treated with oral steroids and intravenous heparin and made a full recovery.

Gangrene of skin and deeper tissues is an unusual complication of varicella. The term varicella gangrenosa has been applied to various conditions. In 1881, Hutchinson1 coined the term varicella gangrenosa and referred to Stokes earlier description in 1807 of gangrenous changes after chickenpox. In 1977, John described three distinct varieties: (a) moist, infective gangrene; (b) dry gangrene, secondary to arterial thrombosis; (c) purpuric fulminans—that is, gangrene associated with a disseminated intravascular coagulation.2 The child we studied presented with purpuric fulminans and subsequently developed a unilateral deep venous thrombosis.

Case report

A 4 year old girl developed chickenpox and initially had a relatively mild clinical progress. On the seventh day of the illness her parents noted bruising of the child’s legs that was distributed over her thighs and calves. The areas affected became swollen, painful, and exquisitely tender. The child was admitted to the children’s unit on the 10th day.

On admission an examination showed a child whose weight and height were both on the 55th centile for her age. The patient was in no distress and had normal vital signs. Her skin showed evidence of healing chickenpox lesions. Both limbs were swollen, with large ecchymotic areas and surrounding erythema over the anterior and lateral aspects of thighs and calves (figure). The lesions were painful and extremely tender and covered 9% of her total body surface. Lower limb pulses were normal. Examination was otherwise normal. Initial haematology results showed a haemoglobin of 115 g/l, white cell count of 6.6 x 10⁹/l, platelet count of 95 x 10⁹/l, prothrombin ratio of 1.6 (normal 1.0) cephalin-kaolin time of 48 seconds (normal range 35–45 seconds) and fibrinogen degradation products were raised at 40 mg/l (normal range <10 mg/l). All the blood cultures during the patient’s stay in hospital were negative.

Treatment was started with intravenous phenoxy-methylpenicillin, as prophylaxis against infection, and oral steroids. Over the next few days the ecchymotic areas became gangrenous with subsequent formation of bullae. On day 17 she complained of a painful right calf. Clinical impression of a deep venous thrombosis was confirmed on venography. Full anticoagulation treatment was started with intravenous heparin for 10 days. A further 10 weeks of anticoagulation treatment was completed with oral warfarin. Steroid doses were decreased and stopped on day 24; the phenoxy-methylpenicillin was also stopped. During her subsequent hospital stay a thick eschar formed over the lesions. On separation there was evidence of re-epithelialisation at the edges with central scar tissue formation.

Discussion

Chickenpox, caused by Herpesvirus varicella, is in general a benign condition. Many complications, however, may occur: sepsis resulting in septicaemia; osteomyelitis; pneumonia; postinfectious encephalitis, and occasionally myelitis and polyradiculitis. Other complications are pneumonitis with nodular infiltration seen on x ray film of the chest, myocardi-
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Because of the rarity of this condition no definitive treatment can be recommended. Treatment in the acute phase is largely supportive. Heparin treatment has been used with some good results. The dose and duration of treatment vary widely, but most reports suggest a high dose over at least three weeks. Controlling the coagulopathy does not affect the ecchymosis or the incidence of gangrene and there are many reports of unfavourable experiences. Steroids have been used in many cases with varied results. Our patient responded well to steroids and heparin without resort to skin grafting or amputation.

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References

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Correspondence to Dr D Kidney, General Hospital, Tralee, Co Kerry, Ireland.

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