Mr. M underwent renal transplant with mother as donor in 2007. He was started on Cyclosporin, Mycophenolate mofetil and steroids. One year post-transplant he presented with fever and generalized vesicular rash. The graft function was normal. He did not have any other systemic features. He gave a history of similar illness in his village. He did not suffer from chicken pox in his childhood. He did not receive varicella vaccine prior to transplantation. Tzanck smear showed varicella. He was initiated on IV Acyclovir 10mg/kg/dose for 10 days. The lesions resolved gradually and he recovered completely in 2 weeks.

Varicella-zoster virus (VZV; human alpha herpesvirus) can result in two types of infections- Primary infection usually manifests as chicken pox (varicella) with typical vesicular eruptions of generalized onset without dermatomal localization. Primary infection in the transplant recipient may result in encephalitis, disseminated intravascular coagulation, pneumonia, bowel involvement, pancreatitis, dermatitis, and hepatitis.

Reactivation infection - Reactivation of virus from dorsal root ganglion results in the development of herpes zoster or Shingles. The most common presentation is vesicular rash, which affects a thoracic dermatome. Pain, itching and paraesthesia are the first symptoms. The rash begins as erythematous macules and papules on one side of the trunk, face, abdomen, arms or legs and progress to vesicles within 24 hours. The vesicles eventually crust and resolve within two weeks, and no longer contain any virus.

Diagnosis is by clinical presentation, Tzanck preparation (giant epithelial cells with 2-15 nuclei), culture, immunofluorescent staining with monoclonal antibody and PCR help in confirmation. Treatment of patients with the primary varicella post-transplantation or diffuse zoster should be with intravenous acyclovir, 10 mg/kg, three times/day or high-dose oral acyclovir 800 mg five times/day, valacyclovir (1 g tid) or famiciclovir. (treat within 48hrs of onset of rash). Foscarnet is used for resistant strains.

Prevention- Passive immunization with VZV hyperimmune globulin within 72 h of exposure. Non immune individuals should receive vaccination with a live attenuated strain prior to transplantation. Live vaccine strain can reactivate after transplantation, hence inactivated vaccines (presently undergoing trials) may be safer post transplant.

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