At admission, the child was in no acute distress, but his temperature was 40.1°C. The heart rate was 137, the respiratory rate was 30, and the blood pressure was 121/75 mm Hg. He had clear rhinorrhea and flat scattered petechiae on his face, chest, upper back, and right arm. The lesions on the face and trunk were very small (1–2 mm in size), while the ones on the right hand had a purpuric appearance due to apparent coalescence.

Laboratory studies disclosed the following: WBC count, 8,400/mm³ (with 77% neutrophils, 15% lymphocytes, 6% monocytes, and 2% basophils); hemoglobin level, 14.3 g/dL; platelet count, 119,000/mm³; and erythrocyte sedimentation rate, 16 mm/h. Urinalysis was unremarkable, and blood culture for bacteria revealed no growth. Nasal washing was performed, and a specimen was submitted for virus culture and direct viral antigen detection. Influenza A virus was isolated on day 3 in rhesus monkey kidney cells by shell vial culture.

In summary, we describe a child with an acute illness suggestive of bacteremia (fever and petechial rash) that was associated with influenza A virus infection. As in the summer and fall when fever and petechial rash illnesses due to enterovirus infections are common, children with this syndrome in other seasons should be treated for meningococcemia even though a viral etiology may be likely.

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References


Ecstasy Secondary to Herpes Simplex Virus Infection

Ecstasy is a cutaneous disease generally caused by bacterial organisms. We report the first case of ecstasy caused by herpes simplex virus (HSV).

A 73-year-old male with a 2-year history of IgA κ subtype multiple myeloma presented with erythematosus papules and plaques with central ulceration and necrosis. The multiple myeloma had been previously treated with a course of cyclophosphamide and prednisone followed by a course of cyclophosphamide and chlorambucil. Because the most recent bone marrow biopsy revealed >75% plasma cells and the patient was developing progressive renal insufficiency, he was treated with methylprednisolone (2 g intravenously three times per week) during the 2 weeks before presentation.

Physical examination was significant for several erythematous, edematous plaques (~2–3 cm in diameter) with prominent central necrotic eschars that were present on the patient’s midback (figure 1). One of the lesions had two 2-mm vesicles...
Several well-demarcated erythematous plaques with central eschars (arrows) on the back of a patient with ecthyma secondary to herpes simplex virus infection.

Laboratory evaluations were significant for a leukocyte count of 1,500/mm³ (normal value, 4,500–11,000/mm³) and macrocytic anemia (hematocrit, 30%; hemoglobin level, 9.8 g/dL; mean corpuscular volume, 104.6 fl). The absolute neutrophil and lymphocyte counts were 870 and 600/mm³, respectively. The blood urea nitrogen level was 34 mg/dL (normal value, 7–22 mg/dL), and the creatinine level was 1.8 mg/dL (normal value, 0.6–1.3 mg/dL). Blood cultures were negative.

Direct fluorescent antibody staining of fluid from one of the vesicles was positive for HSV, and viral cultures subsequently yielded HSV. A punch biopsy of one of the lesions revealed epidermal ulceration with florid viral cytopathic changes consistent with herpesvirus infection. Secondary bacterial colonization was noted. The patient was treated with intravenous acyclovir (5 mg/kg three times a day), and there was subsequent resolution of the lesions with scarring.

Ecthyma refers to a cutaneous infection resembling impetigo but affecting areas deeper in the skin. The lesions are characterized by localized, well-demarcated, erythematous plaques with ulceration that reaches the dermis. Therefore, the lesions often have a central eschar and cause scarring [1]. Ecthyma is almost always secondary to streptococcal and staphylococcal infections, in particular *Streptococcus pyogenes* infection; therefore, treatment for ecthyma generally consists of oral antimicrobials that are active against *S. pyogenes* and *Staphylococcus aureus*. However, mucormycosis [2, 3], molluscum contagiosum [4], cutaneous diphtheria [5], and gonococcal infections [6] have all been associated with ecthyma-like cutaneous eruptions. Review of the literature with use of MEDLINE revealed no previously reported cases of an ecthyma-like presentation of HSV infection.

On the basis of nomenclature, ecthyma should be distinguished from two similarly named conditions, ecthyma gangrenosum and contagious ecthyma. Ecthyma gangrenosum is a life-threatening condition secondary to bacterial septicemia with gram-negative bacteria, in particular *Pseudomonas aeruginosa*. It is characterized by well-demarcated, indurated, weeping, necrotic eschars in areas rich in apocrine glands. Contagious ecthyma, also known as orf, is a parapoxvirus infection of the skin acquired from sheep that is characterized by ulcerated erythematous nodules with white halos. A history of contact with sheep is almost invariably present.

This case presents a novel manifestation of HSV infection in immunocompromised hosts. Other such manifestations include painful ulcerative lesions of the genitalia, perianal area, and lips and follicular facial lesions [7]. Moreover, HSV infections should be considered in the differential diagnosis of ecthyma-like skin lesions in immunocompromised patients, and biopsies and virological studies should be performed to exclude HSV infections.

**Severe Hepatic Failure Related to Nevirapine Treatment**

Nevirapine, a nonnucleoside reverse transcriptase inhibitor, has recently been introduced in combination antiretroviral therapy for HIV type 1-positive patients. Major adverse effects associated with nevirapine are rash (occurring in ~32%–48% of patients) [1, 2], transient sedation, headache, nausea and/or vomiting [3], and other severe mucocutaneous reactions [4]. Herein, we report the case of an HIV-positive patient who developed severe hepatic failure related to nevirapine.

A 61-year-old man who had been HIV-positive since 1992 and did not have any specific HIV-related infections was admitted to our hospital with fever, arthralgia, abdominal pain, vomiting, and dark urine. In 1996, he began receiving antiretroviral therapy with di-