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Case Report
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Pseudoherpetiform Presentation of Grover's Disease: A Rare Presentation

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Abstract

Observation: *Grover*'s disease is a common pruritic skin disease which is also known as persistent and transient achantolytic dermatosis. It is characterised by crusted, pruritic, erythematous papulovesicular eruption and more common in Caucasians, males and usually seen after fourth decade. Lesions may persist for years. Differential diagnosis is made by numerous prurutic papulovesicular diseases.

We want to present a 28-year-old female patient with relapsing, crusted, reddish to brown 3-5 mm papulovesicular lesions on her chest and back. She was misdiagnosed as recurrent herpes simplex infection before and systemic acyclovir was precribed but she was resistant to this therapy. Histopathological examination was consistent with *Grover*'s disease.

We want to remind *Grover*'s disease in differential diagnosis of relapsing papulovesicular eruptions.

Introduction

Grover's disease is a common disorder but its pathogenesis is still unknown. Clinical manifestation is characterised by pruritic, erythematous papules and papulovesicules [**1, 2**]. Lesions are mainly localised on trunk and extremities and may be triggered with exposure to UV radiation, excessive sweating, heat and friction [**1**] This disorder is more common in males especially over 50 years of age. Differential diagnosis is made by miliaria, folliculitis, Darier's disease, pemphigus foliaceus, lichen planus- like keratoses, arthropod bites, scabies, drug eruptions and actinic keratoses [**1**]

We want to present a young female patient with a relapsing papulovesicular eruption on her back who was misdiagnosed as recurrent herpes infection before. Her lesions were resistant to systemic acyclovir treatment. Her diagnosis was confirmed with pathological examination which was consistent with *Grover*'s disease. We want to remind *Grover*'s disease in differential diagnosis of papulovesicular eruptions on trunk even in young population and in females.

Case Report

A 28-year-old female patient presented to our outpatient clinic with relapsing crusted erythematous pruritic papulovesicular eruption on her bilateral scapular area and chest (**Figures 1 and 2**). These lesions were relapsing every two-three months for last 2 years. She had admitted to other

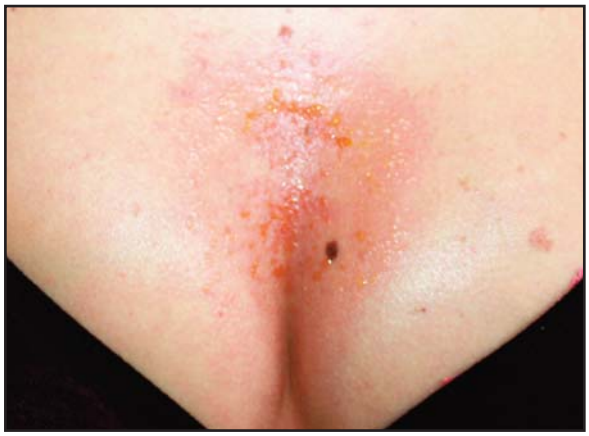

Figure 1. Crusted erythematous papulovesicular eruption on her chest

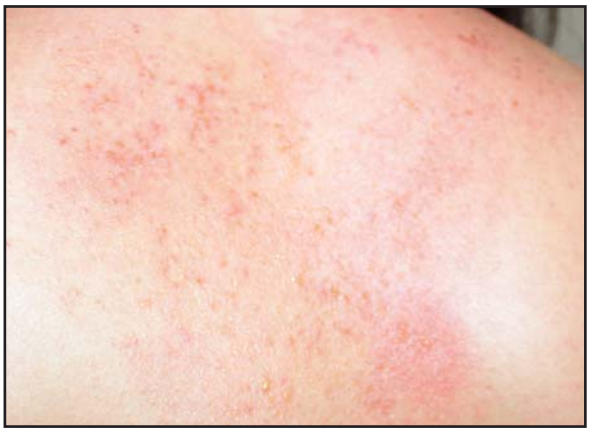

Figure 2. Erythematous papulovesicular eruption on back

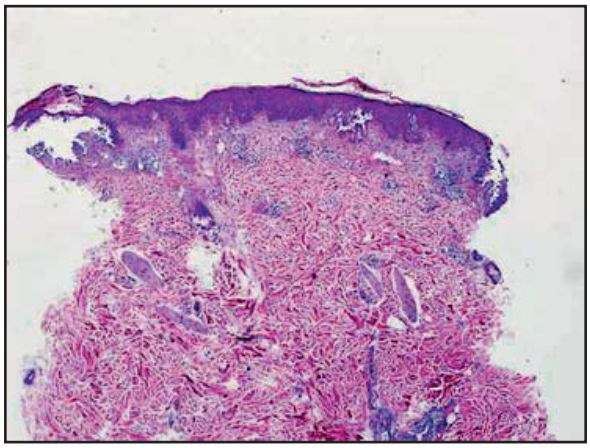

Figure 3. Focal acantholysis in epidermis (H&Ex4)

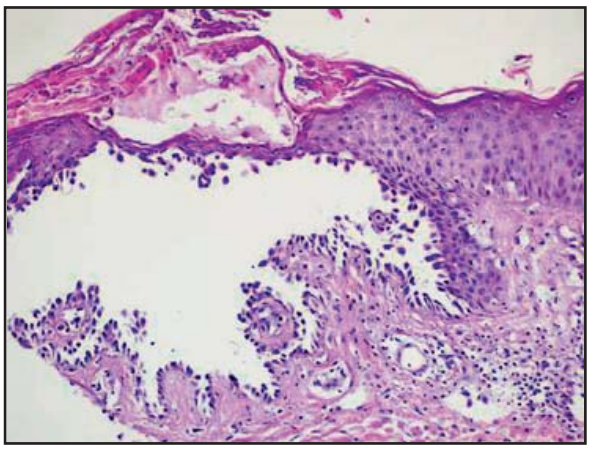

Figure 4. Pemphigus vulgaris like acantholysis in suprabasal region

clinics for these lesions and misdiagnosed as recurrent herpes simplex infection. Systemic acyclovir treatment was given but these lesions were resistant to this treatment.

A 4 mm punch biopsy specimen was performed from the papulovesicular lesions on her right scapula with initial diagnoses of prurigo pigmentosa, *Grover*'s disease, contact dermatitis, herpes simplex infection. Histopathological examination revealed parakeratosis, focal suprabasal acantholysis, perivascular lymphocytes and sparse eosinophils in superficial dermis (**Figures 3 and 4**). Direct immunflorescence was negative. Her laboratory examination was totally normal. Herpes simplex virus type 1 and 2 Ig M, and Ig G were negative. She was diagnosed with transient achantolytic dermatosis with her physical examination and laboratory findings. Her lesions were controlled with topical corticosteroid therapy.

Discussion

Grover's disease was first described by *Ralph* W. *Grover* in 1970 as a non-familial, non-immune-mediated, acantholytic disorder which is characterised by asymptomatic or extremely pruritic, erythematous, nonfollicular crusted papules and papulovesicules which lasts for weeks or months [**1, 2, 3**]. Lesions are mainly localised on upper to mid trunk, lower trunk and on extremities. These lesions may be triggered with sun exposure, sweat inducing exercise, heat, infections (includes malassezia furfur and demodex folliculorum), [**1**] ionizing radiation [**4**] and may be associated with hematologic malignancies, [**5**] chronic renal failure, [**6**] HIV infection, [**3**] drugs [**6, 7**] especially with chemotherapy [**8**] and heart, [**3**] renal, [**9**] liver [**10**] and/or bone marrow [**11**] transplantation, atopic dermati-

tis, allergic contact dermatitis, and asteatotic eczema [**1**].

Histopathologic feature reveals achantolysis, dyskeratosis, intraepidermal clefting and vesicule formation. Because of increased incidence with transplantation, immunological mechanisms are mainly suspected in pathogenesis [**9**]. Our patient has no history or clinical finding of a systemic disease, sun exposure or radiation. Sweating was major factor in our case when we asked about triggering factors. It is known to be more common in white men in the 4th-6th decades [**7**]. Our case is a 28 year-old-female patient against to common data.

Grover's disease is a self limited disease and this disorder may resemble other pruritic papulovesicular diseases as Darier disease, dermatitis herpetiformis, folliculitis, scabies, miliaria, lichen planus-like keratosis, actinic keratosis, arthropod bites and pemphigus foliaceus because of different variants [**1**]. Pustular, bullous, nummular, follicular, herpetiform and zosteriform variants have been reported before [**4**]. Our case was misdiagnosed with recurrent herpes infection before and did not respond to the systemic acyclovir treatment. *Wiersma* et al reported two pseudoherpetic cases similar to our case. These patients lesions were localised on seborrheic areas just like our patient but in their cases they have reported intraepidermal vesicule formation histopathologically [**4**]. In our case we did not see intraepidermal vesicule formation in histopathological examination. Our case was clinically mimicking herpes virus infections. Avoiding from exacerbating factors is the first step of treatment. Topical corticosteroids, keratolytic agents, topical calcipotriol, topical calcineurin inhibitors, systemic antihistaminics are useful for controlling symptoms [**1**]. For severe and refractory cases oral corticosteroids, retinoids and photochemotherapy and trichloroacetic asid are the treatment options [**1**]. Lesions were controlled with mometasone furoate cream in two weeks.

We want to present this case to notice that *Grover*'s disease might be seen also in young females and we also want to remind *Grover*'s disease in differential diagnosis of relapsing papulovesicular eruptions.

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