

Case Report

Herpetic folliculitis: a lesser-known folliculitis and a review of herpes infections

Rashmi R. Mallya*

Department of Dermatology, Chinmaya Mission Hospital, Bangalore, Karnataka, India

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*Correspondence:

Dr Rashmi R Mallya,

E-mail: rashmirmallya@gmail.com

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ABSTRACT

Herpetic folliculitis is a rare disease that involves the pilosebaceous units. It is caused by varicella zoster virus or by herpes simplex virus. It is an infrequently reported entity in literature. Presentations of this disease are quite variable and it can mimic several other more common diseases such as acne, gram negative folliculitis, demodicosis and pustular rosacea, often leading to misdiagnosis and incorrect or delayed treatment. Diagnosis using bedside tests like Tzanck smear, serological tests for herpes and skin biopsy wherever necessary can aid in the early diagnosis and timely intervention in this condition. Herpetic folliculitis can be considered as a sign of immunosuppression and its presence warrants screening for the same. We hereby report a case of herpetic folliculitis in an anemic 23-year-old female patient admitted in a tertiary care hospital with predominantly unilateral pustular, follicular oriented lesions on the right side of her face, unexplained fever and headache.

Keywords: Herpetic folliculitis, Rare disease, Herpes infection

INTRODUCTION

Herpetic folliculitis is an uncommon disease involving the pilosebaceous epithelium. It can be caused by varicella zoster virus or herpes simplex virus. They can cause skin and mucosal infections.¹

The symptoms and clinical manifestations are quite variable. Adult populations of several countries in the world have serologic evidence of herpes simplex virus-1 exposure of over 85%. Despite this, there are only a few reported cases of herpetic folliculitis in the literature. Although the herpesvirus group of viruses is ubiquitous in its distribution, folliculitis due to these viruses might be considered a sign of immunosuppression.^{2,3}

There are more than 100 known herpesviruses, of which 8 routinely infect humans exclusively.

A common trait for all herpesviruses is that they can establish latent infections within specific tissues which can remain dormant and reactivate during periods of immunosuppression.

Herpesviruses have a unique four-layered structure consisting of a core with double stranded deoxyribonucleic acid (DNA), capsid, tegument and glycoprotein bilayered lipid envelope and they are divided into three subfamilies- alphaherpesvirinae, betaherpesvirinae and gammaherpesvirinae.^{4,5}

The alphaherpesvirinae subfamily includes herpes simplex virus type 1 (HSV-1), HSV-2 and varicella zoster virus. The betaherpesvirinae subfamily includes human cytomegalovirus, human herpesvirus 6 and human herpesvirus 7. The gammaherpesvirinae subfamily includes the Epstein-Barr virus and human herpesvirus 8.⁶

Typical infections include chicken pox, zoster, herpetic gingivostomatitis, whitlow, herpes genitalis and infectious mononucleosis.

Atypical infections include an atypical site, bilateral zoster, herpetic folliculitis, zoster sine herpete, acute retinal necrosis.⁷

We hereby report a case of herpetic folliculitis in a 23-year-old female patient.

CASE REPORT

A 23-year-old female patient was admitted in a tertiary care hospital with pain abdomen, menorrhagia. The menorrhagia was present since 1 year. Her menstrual cycles were irregular, with duration of 5-6 days of bleeding, presence of clots and need to change 6-7 pads per day. She was unmarried and not sexually active.

Her pain abdomen was present intermittently since 3 months localized to right lower quadrant of the abdomen and was associated with nausea, bloating, low grade and intermittent fever.

She had no prior history of diabetes, hypertension, epilepsy or asthma. She had past history of occasional flare up of acne prior to menstrual cycle but was not on any treatment for the same.

On general physical examination, pallor was present. Her heart rate was 110 beats per minute and temperature was 101°F. Rest of her vitals were within normal limits.

On abdominal examination, per abdomen was soft, but tenderness was present in the right iliac fossa.

She was admitted for further evaluation of pain abdomen.

After appropriate investigations, she was diagnosed with a right ovarian cyst and appendicitis, along with hypothyroidism and microscopic hypochromic anemia.

She underwent a laparoscopic right ovarian cystectomy with appendectomy under general anesthesia.

Post operation, she developed giddiness, headache and nausea and fever spikes for which neurology opinion was taken. A magnetic resonance imaging (MRI) scan was done and report was normal. She also developed clusters of comedones, papules, crusted pustules and nodules predominantly over the right cheek and forehead with few comedones on the left cheek for which dermatology opinion was taken.

She was initially diagnosed as nodulocystic acne and prescribed oral Doxycycline 100 mg twice a day, topical adapalene and clindamycin combination gel along with a moisturizer and a sunscreen.

Since the lesions were predominantly clustered and unilateral and the patient presented with headache, fever, giddiness and nausea which was unexplained, the senior consultant insisted on doing a Tzanck smear from the pustules on the right cheek.



Figure 1: Patient presented with multiple comedones, papules, crusted pustules and nodules over the right cheek and forehead.



Figure 2: Patient improvement after treatment with systemic antivirals and topical fucidic acid cream.

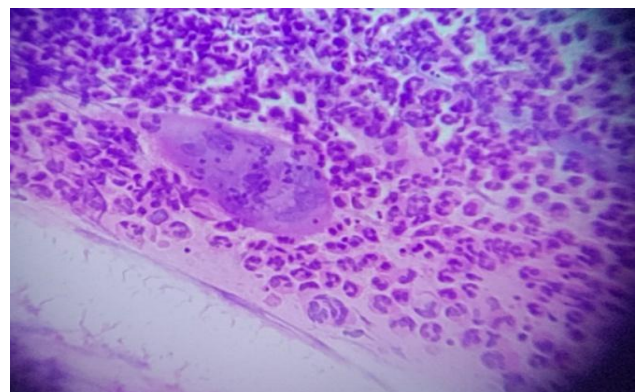


Figure 3: High power view of Tzanck smear showing many neutrophils surrounding a multinucleated giant cell.

Tzanck smear revealed multinuclear giant cells thus confirming the diagnosis of herpes infection, presenting as herpetic folliculitis and masquerading as acne.

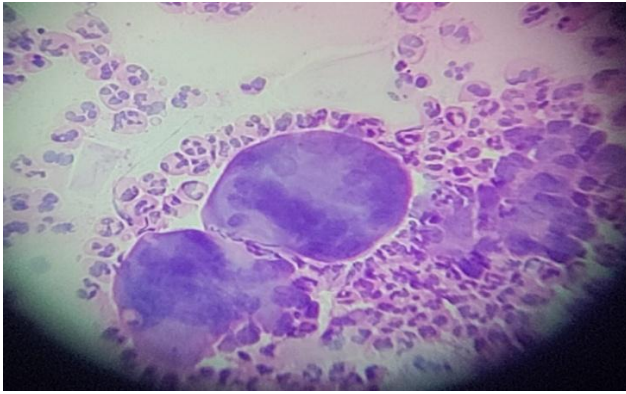


Figure 4: High power microscopic image focusing two multinucleated giant cells with nuclear moulding.

The patient's medications were changed after these findings. Oral doxycycline and topical clindamycin with adapalene gel was discontinued.

She was immediately started on IV Acyclovir 500 mg thrice a day, slow infusion for 2 days, after which her symptoms of fever, headache and giddiness improved; following which she was discharged on tab valacyclovir 1 g three times a day and topical fucidic acid cream two times a day. After a week, her skin lesions also improved, further strengthening the diagnosis of herpetic folliculitis.

She made a full recovery with no neurological sequelae. She was followed up on a monthly basis for post inflammatory pigmentation and scarring which was managed using sunscreen, moisturizer and topical tretinoin 0.025% cream.

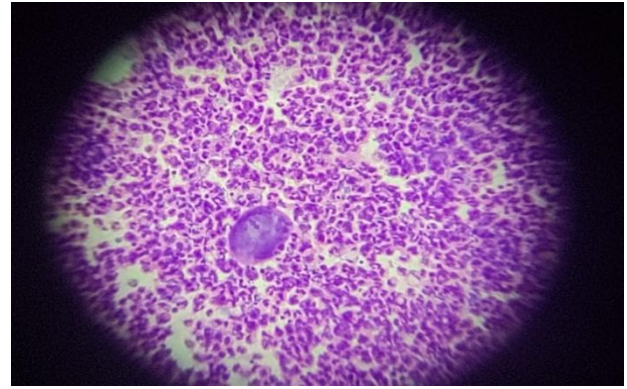


Figure 5: Low power image showing numerous neutrophilic infiltrates and one giant multinucleated cell.

DISCUSSION

Herpes viruses are double stranded DNA viruses that have a structure consisting of 4 layers, from inside to outside as follows. The first layer is the core. It contains the large, double-stranded DNA. The second layer is a capsid which is icosapentahedral in shape, it is composed of capsomers which is the unit of the capsid. The third layer is formed by an amorphous protein coat called the tegument. The fourth layer is a lipid bilayer envelope containing glycoprotein.⁴ There are nine viruses in the herpes family that cause infections in humans and they are further divided into three subfamilies: alphaherpesvirinae, betaherpesvirinae and gammaherpesvirinae based on biological features and genomic attributes.⁴⁻⁶ The diseases caused by them are depicted in Table 1.

Table 1: Diseases caused by herpesviridae family of viruses.

Subfamily	Virus	Diseases caused	Properties and remarks
Alphaherpesvirinae (wider host range, short reproductive cycle)	Human herpes virus 1 (HHV1) or herpes simplex virus 1 (HSV1)	Both can cause oral gingivostomatitis, herpes genitalis, herpetic keratitis, herpetic whitlow. Neonatal herpes simplex virus infection and herpes simplex virus encephalitis, erythema multiforme	Above waist lesions generally caused by HSV1. Below the waist lesions are generally caused by HSV2. Both can interchangeably cause either infection. Transmission requires intimate contact/direct contact
	Human herpes virus 2 (HHV2) or herpes simplex virus 2 (HSV 2)	Chicken pox/varicella	First infection causes chicken pox after which the virus remains latent in the sensory nerve ganglia and reactivate years later during stress/immune-suppression to produce herpes zoster/shingles
	Human herpes virus 3 (HHV3) or varicella zoster virus (VZV)	Herpes zoster/shingles	
Betaherpesvirinae (narrower host range, longer reproductive cycle)	Human herpes virus 5 (HHV5) or cytomegalovirus	Congenital infection, microcephaly, seizures, hypotonia, spasticity, Guillain-Barre syndrome, and acute brachial plexopathy	These viruses can remain latent infection in the reticuloendothelial cells, the kidneys and in secretory cells of glands.

Continued.

Gammaherpesvirinae (very narrow host range)	Human herpesvirus 6 (HHV6) Or T-cell lymphotropic virus	Roseola, Pityriasis rosea, febrile seizures, and fulminant hepatitis	They have an ability to form enlarged cells which help in their identification.
	Human herpesvirus 7 (HHV 7)	Pityriasis rosea, encephalitis	
	Human herpesvirus (HHV4) or Epstein-Barr virus	Infectious mononucleosis, nasopharyngeal carcinoma, Burkitt's lymphoma, encephalitis, T cell lymphoma, SLE	They remain latent in lymphoid tissue and can cause lytic infections in certain targeted cells.
	Human herpesvirus (HHV8) or Kaposi's sarcoma-associated herpesvirus	Kaposi's sarcoma	

Sometimes, especially in immunocompromised patients, herpes can present atypically few examples include the following.

Herpetic folliculitis-folliculitis from herpes is infrequently reported and might be considered a sign of immunosuppression. It can be caused by HSV1, HSV2 and varicella zoster virus (VZV).⁷

Zoster sine herpete- few to no cutaneous lesions in a patient of herpes zoster. Serological testing is often useful to confirm diagnosis in such cases.⁸

Atypical site-in more than half the reported cases, lesions usually develop on the trunk. Sometimes, the face, scalp, neck or extremity may be involved. Typically, a single dermatome is involved. Lesions rarely occur distal to the elbows or knees and rarely crosses the midline.⁹

Herpes zoster duplex-zoster involving two different dermatomes.

If it occurs in non-contiguous dermatomes on the same side of the body, it is called herpes zoster duplex unilateralis.

If it occurs bilaterally, it is called symmetric herpes zoster duplex bilateralis. If it is in the same dermatome, it is called symmetric herpes zoster duplex bilateralis. If it occurs in different dermatomes bilaterally, it is called asymmetric herpes zoster duplex bilateralis.¹⁰

Fulminant herpetic sycosis: extensive herpetic folliculitis in the beard area is a rare clinical manifestation of herpes infection which comes in the context of viral recurrence in immunocompromised patients. In the presence of a folliculitis of the beard, more common differential diagnoses should be considered. A fungal sycosis of the beard is characterized by presence of fungal filaments on potassium hydroxide (KOH) examination and fungal culture. Bacterial folliculitis of the beard caused most often by staphylococcus aureus is called sycosis barbae. This condition is frequently seen in patients who use contaminated razors. In an atopic patient, eczema herpeticum must also be excluded. In immune-

compromised patients, it is also necessary to exclude folliculitis due to molluscum contagiosum.¹¹

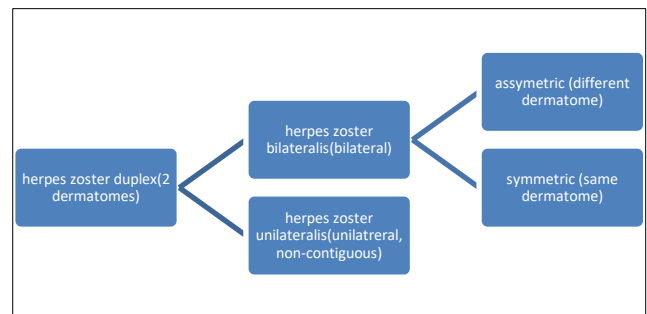


Figure 6: Types and classification of herpes zoster duplex.

CONCLUSION

Herpes infection can present in several different ways, often leading to diagnostic difficulties.

This occurs more frequently in immunocompromised cases.

In cases where patient of acne has unilateral or clustered lesions, especially in the clinical context of prodromal symptoms such as headache, vomiting, nausea, giddiness, fever and if they are unresponsive to acne treatment, herpes folliculitis must be included in the differential diagnosis.

High index of suspicion is required for diagnosis as it is a relatively rare presentation of herpes infection. After clinical examination, bedside investigations like Tzanck smear, and skin biopsy along with serological tests for herpes simplex virus IgM are very useful and often required to confirm the diagnosis of this condition.

Often, dramatic clinical improvement is seen within 72 hours of on initiation of antiviral medicines.

Underlying immunosuppressive conditions should be screened for in such patients. In our patient, chronic anemia, hypothyroidism along with appendicitis and

surgical stress were the underlying immunosuppressive conditions which triggered the infection.

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