

LETTER TO THE EDITOR

Reactive infectious mucocutaneous eruption triggered by COVID-19 infection in an adult patient

Editor,

The term reactive infectious mucocutaneous eruption (RIME) has recently been described and is characterized by mucositis affecting at least 2 mucous membranes with limited or no cutaneous rash, secondary to diverse respiratory infections.^{1,2} These cases had previously been associated with *Mycoplasma pneumoniae* (*Mycoplasma* induced rash and mucositis), although RIME can be triggered by adenovirus, influenza virus, parainfluenza virus, *Chlamydia pneumoniae* or SARS-CoV-2, among others.² COVID-19 infection, caused by SARS-CoV-2, can present with a wide variety of mucocutaneous manifestations. Here, we report a case of RIME secondary to SARS-CoV-2.

An otherwise healthy 39-year-old man was referred by his family physician to the Dermatology department due to a 2-week history of cough, low-grade fever and multiple oral erosions along with ocular, nasal, urethral and anal pain. He explained a 6-kg weight loss and denied taking medication or drugs during the previous 3 months. Physical examination revealed severe oral and genital mucositis (Fig. 1a,b), and a few erythematous round plaques affecting the penis and left thigh. Laboratory tests were normal and serologies for *Mycoplasma pneumoniae*, *Chlamydia pneumoniae*, influenza virus A/B, parainfluenzavirus 1–4, adenovirus, herpes simplex virus types 1 and 2, parvovirus B19, human herpesvirus 6, syphilis, HIV and Epstein–Barr virus were negative. He tested positive for SARS-CoV-2 by polymerase chain reaction (PCR) of a nasopharyngeal swab. Oral prednisone 30 mg daily was prescribed. At a follow-up visit 10 days later, all mucosal lesions and respiratory symptoms had resolved. He has remained asymptomatic during a 2-month follow-up.

Differential diagnosis of mucositis is broad, including severe drug reactions such as toxic epidermal necrolysis or Stevens–Johnson syndrome, bullous disorders, autoimmune diseases, erythema multiforme, Kawasaki syndrome in children and hand-mouth-foot disease caused by Coxsackie A16, among others. In our case, the nasopharyngeal PCR was the key to establishing the diagnosis of RIME secondary to SARS-CoV-2.

Approximately 11% of patients with COVID-19 infection have oral involvement,³ including aphthous-like lesions, herpetiform lesions and petechiae, as well as red and white plaques. We have found six reported cases of RIME secondary to COVID-19:

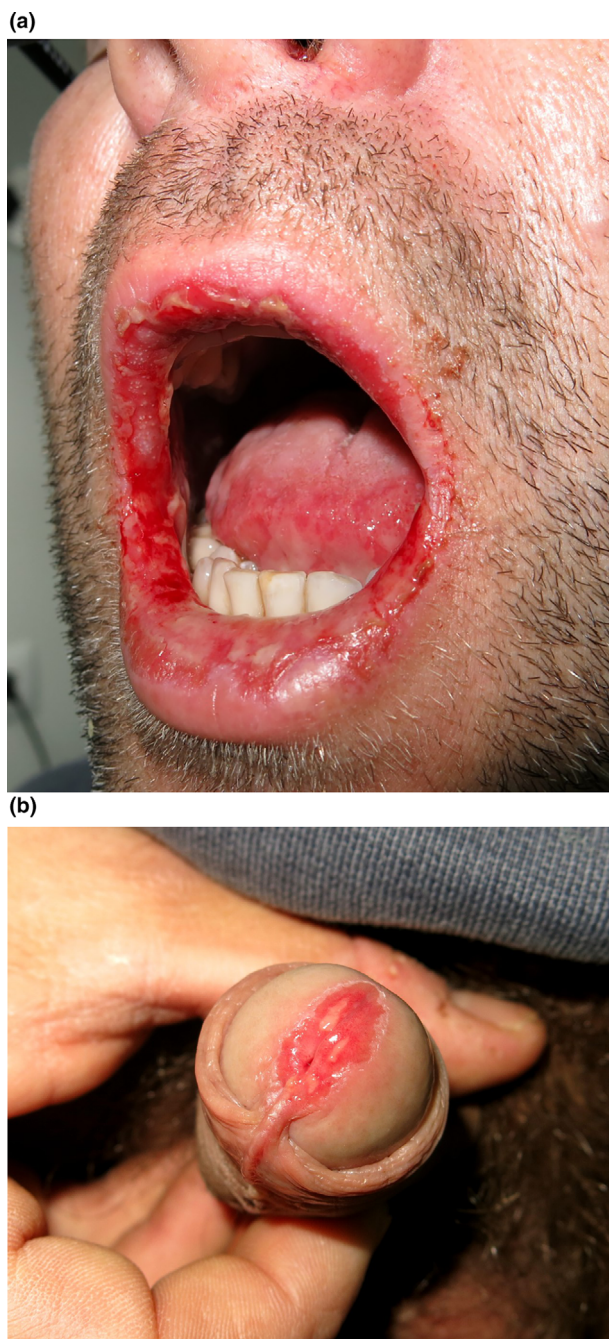


Figure 1 Reactive infectious mucocutaneous eruption triggered by SARS-CoV-2. (a–b). Multiple erosions on oral mucosa (a) and urethral mucosa (b).

five adolescents (ages 14 to 17),^{1,2,4,5} and only one adult, a 23-year-old woman presenting with recurrent RIME since age 18. Her first episode was triggered by *M. pneumoniae*, the second by influenza A, and the third by SARS-CoV-2.¹

Mucocutaneous lesions of RIME appear with a latency of 4 days to 12 weeks after symptoms of COVID-19 infection.⁵ Several pathogenic mechanisms have been proposed, including immune complex deposition, complement activation and molecular mimicry.¹ The treatment for RIME is merely supportive since it is self-limited, resolving in 1–3 weeks, although corticosteroids have been indicated in severe cases.⁴ In one non-responding patient, cyclosporine was successfully prescribed.⁵ The recurrence rate of RIME is unknown, but MIRM has been reported to recur in up to 8% of patients.

The differential diagnosis of mucositis can be challenging. RIME can be secondary to diverse infectious agents. Although more frequent in adolescents, RIME secondary to SARS-CoV-2 can also appear in adults. Our case underlines SARS-CoV-2 infection as a potential cause of mucositis.

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Conflict of interest




None declared.

Informed consent

The patient in this manuscript has given written informed consent to the publication of his case details.

Data availability statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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