intrauterine event or aberration, or a combination of factors may have led to the same result.

This case highlights the difficulties in ascertaining the aetiology of this rare condition in twin pregnancies, particularly in dizygotic twins conceived through egg donation.

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Short back and sides: photodermatosis presentation related to hairstyling during the COVID-19 pandemic

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Dear Editor,

We present a case of a 13-year-old boy presenting with a pruritic eruption on the ears. This had occurred 2 days following an outdoor sporting event on a cold but sunny day in May. A similar eruption had occurred in previous years but to a lesser extent and severity, and presenting earlier in the spring. Seven days prior to this episode, the patient's hair had been cut following relaxation of the COVID-19 lockdown restrictions. His hairstyle had previously been longer on the parietal scalp at the sides, and had covered the helices of the ear.

On physical examination, a vesiculopapular eruption was seen on the helical rims bilaterally with associated lymphadenopathy (Fig. 1). The clinical appearances and history were in keeping with juvenile spring eruption (JSE). Treatment with potent topical steroids led to resolution within 1 week.

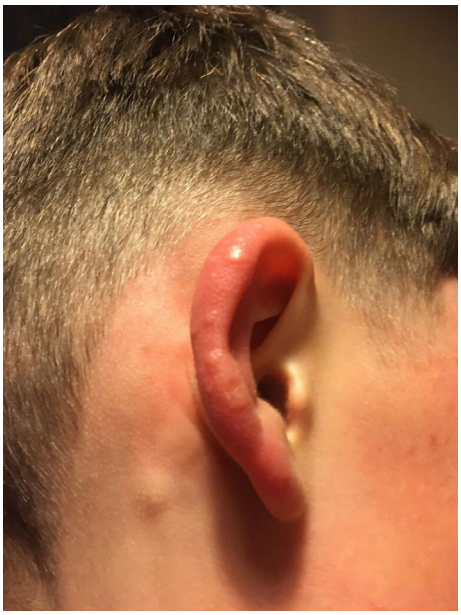

Figure 1 Vesiculopapular eruption present on the helix with cervical lymphadenopathy.

Considered to be a variant of polymorphic light eruption, JSE occurs in early spring with resolution over several weeks, likely due to photohardening of the skin.[1,2] We propose that as a result of the COVID-19 pandemic restrictions on barbers, our patient had a relatively longer hairstyle, resulting in relative shielding of the helices to sun exposure. In comparison to the presentation in previous years, this protection from the hair appeared to lead to a later-onset and more severe presentation of JSE.

Reports of clusters of perniosis cases during the COVID-19 pandemic have been suggested as a result of lifestyle changes rather than direct infectious aetiology.[3] This case represents a novel presentation of a photodermatosis in a more severe form in the same patient related to grooming practice behaviour as a result of the COVID-19 restrictions.

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Erythema nodosum in patients with kerion of scalp

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Dear Editor,

Erythema nodosum (EN) is the most frequent variety of acute panniculitis in children. Rarely, it may be considered as a dermatophytid reaction to tinea of the scalp.[1] A few cases of EN associated with dermatophyte infections have been reported in the literature. We describe three cases of EN complicating kerion of the scalp.

Three boys presented with patches of hair loss associated with pustular lesions on the scalp (Fig. 1a). Mycological examination confirmed the diagnosis of kerion. A few days after the onset of oral therapy with griseofulvin, the patients presented with painful erythematous papulonodular lesions on their legs (Fig. 1b), which were clinically consistent with EN. The aetiological assessment of EN for each patient was without abnormalities. The diagnosis of EN-type dermatophytid reaction was retained. Treatment with griseofulvin was continued. The lesions of EN in all cases, resolved spontaneously in the following days without sequelae. The main features of our patients are summarized in Table 1.

Dermatophytid reaction is an immunologically mediated skin manifestation secondary to sensitization to a dermatophyte infection.[2] It is an acute skin reaction to a variety of dermatophytotic stimuli. It may be due to tinea of the scalp, particularly inflammatory forms such as kerion celsi.[1] The literature reports that the clinical manifestation of dermatophytid reaction can change depending on the host's immunological response, and it can be localized or generalized.[2] Eczematous papules or patches are the most commonly reported. Other rare dermatophytid manifestations that have been reported include EN, erysipelas-like dermatitis, generalized exanthematous pustular eruption and erythema annulare centrifugum.[3]

The EN in our three patients was considered a dermatophytid reaction to kerion, based on three diagnostic criteria that have been proposed[1,2] to identify a dermatophytid eruption: (i) proven dermatophyte infection, (ii) distant eruption in skin free of fungal organisms and (iii) resolution of the dermatophytid with antifungal therapy.

The pathogenetic mechanism of this eruption has not been fully elucidated. It is considered a hypersensitivity reaction to fungal antigens at a site distant from the primary dermatosis.[2] One theory involves an antigen–antibody reaction and immune complex deposits around the septa of the hypodermis, which have been shown.[4] Another theory suggests a type IV hypersensitivity reaction.[1] Indeed, this immunological response involves release of fungal antigens from the site of infection, opsonization by antibodies and spread of T-helper (Th)1 cells and their cytokines to other parts of the body.[5] Immunological studies of patients with dermatophytosis have demonstrated the presence of cellular immune response that might explain the appearance of the dermatophytid reaction.[1] These studies showed the appearance of delayed hypersensitivity reaction to an intradermal injection of trichophytin and increase in interferon-γ synthesis by blood cells in response to *Trichophyton* infection.[1] This Th1 immune response is responsible for EN-type dermatophytid reactions. Other authors have linked the origin of this dermatophytid eruption to the administration of griseofulvin, but against this is the fact that in some cases the appearance of EN

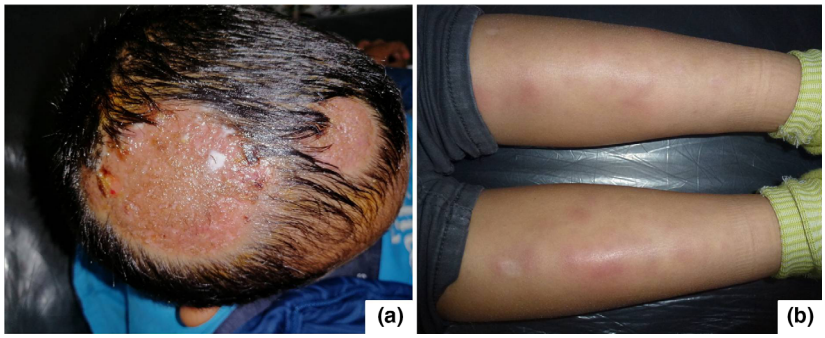

Figure 1 (a) Large plaques of hair loss with multiple pustules; (b) painful erythematous papulonodular lesions on the legs.