Table 1 Laboratory parameters of our patient are shown

Parameters	Day 0	Day 10	Reference ranges
WBC (/mm^3)	17,500	21.000	4,600–10,200
Hemoglobin (g/dl)	11.4	10.6	12.2–18.1
Hematocrit (%)	34.9	33.4	37.7–53.7
Absolute neutrophil count (/mm^3)	12,500	16,500	2,000–6,900
Absolute lymphocyte count (/mm^3)	3,440	3,000	600–3,400
Absolute eosinophil count (/mm^3)	4	43	<700
C-reactive protein (mg/l)	11.6	<3.3	0–5
Iron (μg/dl)	31.69	41	50–170
Ferritin (ng/ml)	167.23	49.32	4.6–204
Fibrinogen (mg/dl)	270	300	200–400
D-dimer (ugFEU/l)	1,010	686	<500
LDH (U/l)	445	261.71	180–430
PT (sec)	12.2	10.7	8–13.2
APTT (sec)	26.5	34.8	18.5–33.5
INR	1.2	1.02	0.8–1.3
25-OH D3 (μg/l)	14.32	–	>20
SARS-CoV-2 PCR	Positive	Negative	

APTT, activated partial thromboplastin time; INR, international normalized ratio; LDH, lactate dehydrogenase. PCR, polymerase chain reaction; PT, prothrombin time; WBC, white blood cell;

Metapneumovirus, Bocavirus, Respiratory syncytial virus, Adenovirus, and Enterovirus), but it was found to be negative. Lung involvement was not detected in thoracic tomography. Hydroxyzine (1 mg/kg/day), systemic methylprednisolone (1 mg/kg/day), and phenyramine (1 mg/kg/day) treatments given for urticaria were thought to be resistant to treatment. Vitamin D (1,000 U/day) was added empirically to the patient's treatment. The patient's fever did not recur. The patient was discharged on the 5th day, after examinations for COVID-19 returned to normal and urticaria regressed. Overall, the therapy lasted 10 days. After discharge, hydroxyzine and phenyramine treatments were continued to the follow-up visit. On the 10th day, no pathology was observed in the physical examination and laboratory tests in the outpatient clinic control. Then, all medications were discontinued.

elIn most pediatric cases, the diagnosis of COVID-19 may be delayed because of the cases presenting as an asymptomatic individual or with rare symptoms such as skin findings initially, or these patients may be missed without any diagnosis.[2–5] Our case presented with isolated symptoms such as urticarial rash that started suddenly and had fever of 38°C for 1 day, and COVID-19 was not considered by the pediatricians in which it was seen in the first place, and the patient was sent home with an antihistamine. This may pose a risk to ensuring the transmission control of SARS-CoV-2. Clinicians should be more careful in terms of the symptoms and positive physical examination findings of COVID-19 in the pediatric population, especially because of the start of face-to-face education in schools and the removal of restrictions on children. With this presentation, when acute urticaria and/or angioedema is encountered and rarely occurs in the patient, it is of great importance to bring the COVID-19 viral infection to mind and to narrow the contact circle and to treat the disease.

Öner Özdemir[1]*, MD
Emine A. Yılmaz[2], MD
Muhammet Mesut N. Engin[2], MD

[1]Professor of Pediatrics, Division of Allergy and Immunology, Research and Training Hospital of Sakarya University Medical Faculty, Sakarya, Türkiye
[2]Specialist in Pediatrics, Department of Pediatrics, Research and Training Hospital of Sakarya University Medical Faculty, Sakarya, Türkiye
*E-mail: ozdemir_oner@hotmail.com

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Spiny keratoderma, a late COVID-19 manifestation?

Dear Editor,

The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has been a global health issue for more than a year now, and most of its cutaneous manifestations have already been described.[1] This letter reports a dermatologic finding appearing one month after mild COVID-19 diagnosis.

A 68-year-old male presented to our dermatology department in January 2021 with what he referred to as gritty palms. He reported that the episode started one month before dermatologic consultation. No new drugs had been initiated the year prior to this episode. He reported that he developed a mild case of COVID-19, with cough and fever but no associated pneumonia, in November 2020. He did not require hospitalization. He was only taking enalapril and hydrochlorothiazide for chronic arterial hypertension, initiated more than 3 years

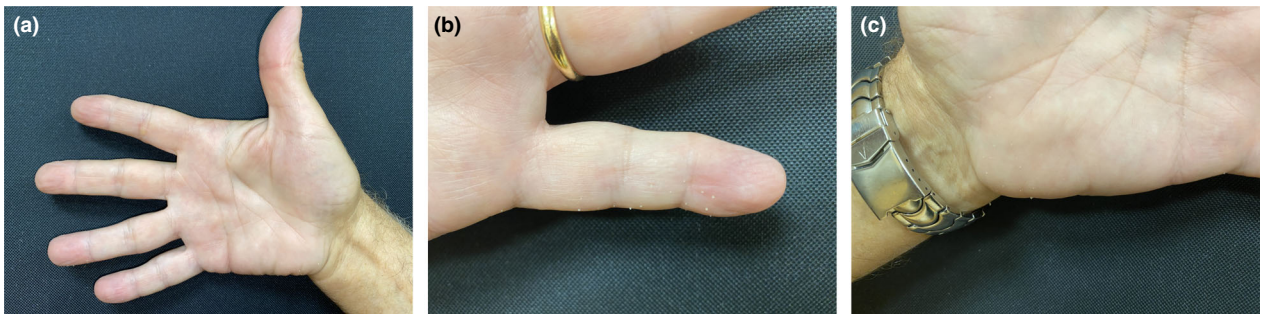

Figure 1 Millimetric keratotic spiny papules in the ventral right hand, predominantly along the palm and digit lateral margins (a). Close-up view of the fifth finger (b) and hypothenar eminence (c)

before the onset of the cutaneous symptoms. The patient reported that no other family members had similar symptoms or signs.

Dermatological examination showed millimetric keratotic spiny papules distributed in both palms, predominantly along the palm and digit lateral margins (Fig. 1a–c). No plantar lesions were seen. Thus, the clinical diagnosis of spiny keratoderma was made.

A 4-mm punch biopsy was taken from one of the spiny papules of the right palm to confirm the diagnosis. H&E showed a column of compact parakeratotic hyperkeratosis overlying an epidermal depression.

Complete blood count and peripheral blood smear were normal. Serologies for syphilis, hepatitis A virus, HBV, HCV, and HIV were negative. Serum proteinogram was normal. Serum tumor markers were normal. Fecal occult blood test was negative. Computed tomography was performed to rule out associated malignancy, showing no signs of malignant disease. There was no familial history of keratoderma.

The patient was treated with salicylic acid 10% cream b.i.d., which softened the rough texture of his palms. Although the lesions did not disappear, he refers that he is much more comfortable now.

Most of the cutaneous manifestations of SARS-CoV-2 have already been described, but we have much to learn about rare and late cutaneous manifestations of COVID-19.[1]

Spiny keratoderma (punctate palmoplantar keratoderma type 2) is an autosomal dominant entity, but it can also be an acquired condition due to a triggering cause.[2] There are numerous reports of triggers for acquired spiny keratoderma, most of them being malignant conditions (such as chronic lymphoid leukemia, lung cancer, or multiple myeloma, among others).[3,4] The mechanism by which these triggers may produce spiny keratoderma is still unknown.[3] In our case, malignancy was ruled out, and no other plausible triggers for spiny keratoderma were present. The fact that the temporality criterion for causality is present and being that spiny keratoderma is such a rare disease, we believe these two findings might be correlated.

By sharing this case, we hope to further complement the knowledge we have on this disease.

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

*Miguel Dominguez-Santas**, MD
Borja Diaz-Guimaraens, MD
Patricia Burgos-Blasco, MD
Emilio Garcia-Mouronte, MD
Carlos Azcarraga-Llobet, MD
Ana Suarez-Valle, MD

Dermatology Department, Ramon y Cajal University Hospital, Madrid, Spain
*E-mail: miguel.dominguez@salud.madrid.org

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