






Figure 2 (a) Skin biopsy demonstrated moderate perivascular, dermal lymphoid infiltration with focal interface dermatitis (Hematoxylin-eosin, 100 \times). (b) Higher magnification revealed multiple apoptotic keratinocytes at all epidermal layers, sometimes with satellite lymphocytes (Hematoxylin-eosin, 200 \times)

Additionally, there are only two case reports of EM secondary to the COVID-19 vaccine. The first one is a 58-year-old woman with a history of EM reactive to herpes labialis who developed typical targetoid lesions limited to her palms and soles hours after each of the BNT162b2 vaccine doses.³ The second one described a 74-year-old woman who was admitted to the hospital because of disseminated atypical EM lesions that presented a day after the BNT162b2 first dose.⁴ This clinical picture has been labeled as Rowell syndrome by authors due to the patient showing antinuclear antibody (ANA) titers of 1/640.

It is necessary to underline that vaccine-induced EM has been known for a long time, with 984 cases reported to the Vaccine Adverse Event Reporting System.¹ Moreover, EM-like reactions have already been linked to COVID-19 infection, both as typical acral lesions in younger individuals and more widespread, atypical lesions in adults.⁵ SARS-CoV-2 spike protein, the structure codified in mRNA COVID-19 vaccines, has been demonstrated immunohistochemically in endothelial cells and eccrine ducts epithelium in those cases.⁵ Consequently, EM secondary to COVID-19 vaccination would be an expected complication in some cases.

It is also notable that this is the first COVID-19 vaccine-related EM having its onset after the second dose.

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Cutaneous maculopapular and vesicular lesions as the only presentation of COVID-19

Dear Editor,

The Coronavirus Disease 19 (COVID-19) is being increasingly associated with a wide spectrum of skin manifestations.¹ Although their exact timing in the disease course is still not evident, an early recognition of these cutaneous manifestations would help in a prompt diagnosis and management of this new viral illness.² Hence, identifying asymptomatic COVID-19 patients with only skin findings is of great public health value.³ To this extent, we report the case of a maculopapular exanthem



Figure 1 Maculopapular eruption on the elbow

and palmoplantar papulovesicular eruption as the sole presentation of COVID-19.

A previously healthy 26-year-old man presented to our clinic with a 2-day history of a maculopapular pruritic exanthem that initially appeared on his legs and subsequently progressed to affect his trunk and arms, sparing the face (Fig. 1). History revealed a close contact with a confirmed COVID-19 infected person, 10 days prior to the eruption. There was no previous or intercurrent viral illness, no prior

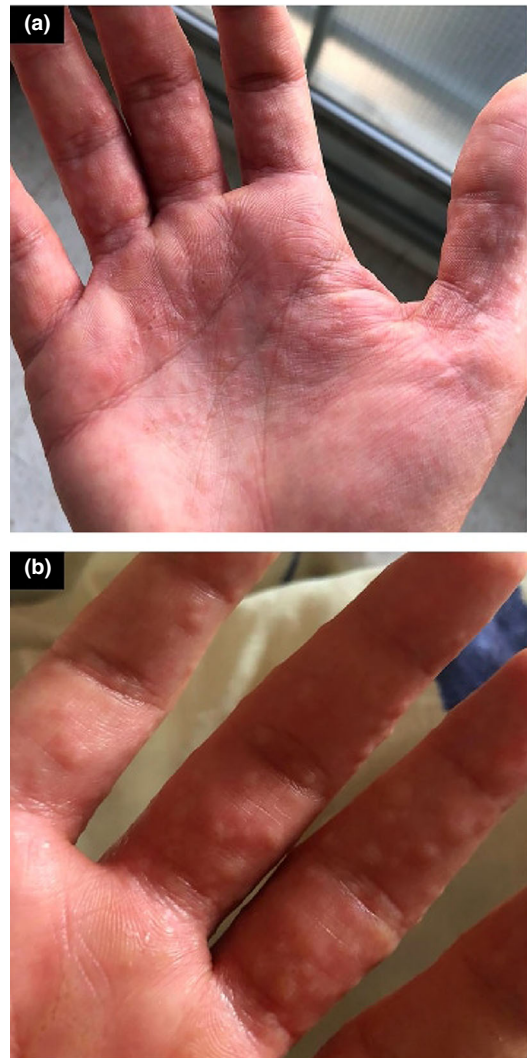


Figure 2 Erythematous and yellowish papules and vesicles on the palm (a) and fingers (b)


medication intake, and no other systemic signs and symptoms or mucosal involvement. A real-time reverse-transcription polymerase chain reaction test (RT-PCR) for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) performed from a nasopharyngeal swab was positive. The next day, the patient developed pruritic and painful erythematous-yellowish papules and vesicles on the palms and soles (Fig. 2a,b). A screening for syphilis was negative. The patient was treated with topical clobetasol 0.05% cream and an oral antihistaminic drug. On follow-up, the eruption resolved after 14 days with a negative RT-PCR test for COVID-19, and treatment was discontinued.

To date, most reported skin findings have been preceded or followed by other COVID-19 signs.² In a recent review article, Zhao et al.⁴ found that skin lesions occurred on average


10 days after the onset of systemic symptoms, however, 14.7% of patients had skin lesions as their first symptom. Interestingly, our patient's cutaneous findings were the only manifestation of this viral illness. He had no history of allergy or any similar hands or feet manifestations in the past, and his RT-PCR became negative concomitantly with the resolution of the dermatological manifestations. All in all, these findings are in favor of a viral-induced skin eruption associated with COVID-19. While recognition of COVID-19 in asymptomatic or minimally symptomatic patients is challenging, it is mandatory to public health.^{3,5} Therefore, dermatologists should be conscious of their role during this pandemic as skin findings can be the first and sometimes only manifestation of COVID-19.

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Thrombosis of the palmar digital vein after Oxford-AstraZeneca COVID-19 vaccination

Dear Editor,

In the era of COVID-19, the distribution and administration of approved vaccines is a fundamental step to control the pandemic. Although studies of the vaccination show safety and effectiveness, concerns over possible side effects affect people's willingness to accept the immunization and the extent of coverage. Oxford-AstraZeneca vaccine, a chimpanzee adenoviral vector (ChAdOx1) encoding the SARS-CoV-2 spike protein DNA, is available worldwide but notable for the rare associated thrombotic events.¹ Clarifying the plausible relationships among the adverse reaction helps to understand more about the vaccine. Herein, we encountered a 38-year-old woman who had sudden-onset intermittent swelling pain over her right index finger 8 days after receiving her first dose of ChAdOx1 nCov-19 (Oxford-AstraZeneca) vaccine on the other arm. The symptom aggravated when the hand stayed in a dependent position. Mild headache and retro-orbital pain were reported simultaneously. She denied fever, shortness of breath, chest or abdominal pain, or visual disturbance. Physical examination revealed swelling of the right index finger with a cord-like bluish engorged vessel over the palmar side (Fig. 1). Laboratory data for



Figure 1 Cord-like bluish change of the palmar digital vein over the right index finger, which was more swelling compared with the left side, 8 days after ChAdOx1 nCov-19 vaccination