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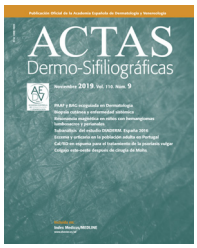

LETTER TO THE EDITOR

Comment on ''Pityriasis rosea in a COVID-19 Pediatric Patient''

Comentario sobre «Pitiriasis rosada en un paciente pediátrico de COVID-19»

Dear Editor,

The article on pityriasis rosea (PR) in a Coronavirus disease 2019 (COVID-19) pediatric patient by Öncü INS et al.[1] recently published in your journal prompted us to make some observations and describe our experience. The authors correctly state that PR is associated with HHV-6 and/or HHV-7 systemic reactivation[2] but include in the PR pathogenesis also autoimmunity, psychogenic factors, vaccines and drugs without making any distinctions between PR and PR-like eruptions[3]. In fact, though is true that different factors, including autoimmunity, psychogenic factors, vaccines and drugs may cause HHV-6/7 systemic reactivation and thereby indirectly cause the onset of PR, actually, vaccines and drugs are mostly involved in causing PR-like eruptions[3,4]. We fully agree with the authors that during COVID-19 pandemic, the diagnosis of PR has become more common[5] and after the introduction of the COVID-19 vaccinations also the diagnosis of PR-like eruptions has increased[6].

The patient described by Öncü INS et al.[1] received a diagnosis of PR but, regrettably, several peculiar features of the disease have not been reported. The authors did not mention the possible presence of the herald patch and of oropharyngeal lesions[7], the latter common in children[2], nor systemic/local symptoms that can justify the treatment with betamethasone valerate ointment, 10% urea and cetirizine. Indeed, to date, no treatment is recommended on the basis of evidence-based medicine since PR is a self-limiting exanthemous disease that needs just reassurance and rest[6]. Low-dosage antiviral treatment with acyclovir should be considered only in cases of extensive, relapsing/persistent PR with associated systemic symptoms to shorten the course of the disease[8]; moreover, in pregnancy PR may herald a possible human herpesvirus (HHV)-6/7 intrauterine fetal infection with premature delivery and fetal death. More specifically, the PR onset before week 15, the presence of enanthem and the involvement of >50% of the body are risk factors for negative pregnancy outcome and, in such cases, appropriate antiviral therapy may be considered[9].

Unfortunately, the patient described by Öncü INS et al.[1] did not perform serology and polymerase chain reaction (PCR) in serum for HHV-6/7 DNA nor for SARS-CoV-2 RNA. These investigations would have been useful to clarify the possible role of SARS-CoV-2 in the pathogenesis of PR associated with COVID-19. In fact, SARS-CoV-2 may play a role as a trans-activating agent, triggering HHV-6 and/or HHV-7 reactivation and causing, thereby indirectly, the onset of PR[10], as the authors hypothesized[1]. We therefore strongly recommend that these tests be carried out in patients with PR developing in the setting of Covid-19.

Histopathology of the lesional skin biopsy, (that should be numbered in the article as Figure 2)[1] really shows extravasated red blood cells in the dermis, that is quite typical of PR, but that the authors incorrectly described as ''perivascular erythocyte infiltration''[1]. Lastly, the defined ''COVID-19 infection'' should be changed more properly with ''SARS-CoV-2 infection''.

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