postexposure prophylaxis for contacts, varicella infection should be excluded in patients with COVID-19 presenting with vesicular eruptions.

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‘Vesicular eruption in COVID-19 – to exclude varicella’: reply from the authors

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Dear Editor, We agree with Drs Lim and Tey on the need to exclude varicella in vesicular eruptions in patients with COVID-19, as this diagnosis has important implications.[1]

Once it is established that some patients with COVID-19 can have a vesicular eruption,[2] there is a need to characterize this group of patients further. The association of some of these lesions with herpesvirus infections is very likely. One patient was excluded from our study with a diagnosis of varicella or disseminated herpes zoster. The list of case reports or case series is growing fast,[3] and other authors have shown that patients with COVID-19 can have a vesicular eruption with presence of several herpesviruses.[4] Their images show haemorrhagic bullae of different sizes and with a diameter > 1 cm, larger than the eruption described in our paper,[2] with many equal, 2–3-mm vesicles. As the paper by Drs Lim and Tey does not include pictures, we wonder whether this could be a sign suggesting herpesvirus infection (including varicella).

However, other reports have described a histological pattern of acantholysis and dyskeratosis with a suprabasal unilocular vesicle, different from varicella histology, indicating that at least some patients can have a disease that is not varicella. The diagnosis of these eruptions includes pseudoherpetic Grover disease,[5] or they might be due to SARS-CoV-2 infection.

We suggest that further research should be done with consecutive patients, optimally including lymphocyte count, histology and/or Tzanck smear, and SARS-CoV-2 and herpesvirus detection in the vesicles, to delineate better the possible diagnoses for patients who show a vesicular eruption associated with COVID-19.

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