Prepubertal PHL and prepubertal hypertrichosis share common findings of prepubertal onset, absence of endocrinological abnormalities, androgen independence and persistence into adulthood while being amenable to treatment. Further laboratory evaluations seem to be indicated only when prepubertal PHL is associated with evidence of premature puberty or presents with MPHL.

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Symmetrical drug-related intertriginous and flexural exanthema like eruption associated with COVID-19 vaccination

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Dear Editor,

A 61-year-old patient presented with a 4-week history of tender rash on the bilateral groins, with no associated rash elsewhere. The rash had appeared 1 day after he had received the second ChAdOx1 nCoV-19 (AstraZeneca-Oxford) vaccine. His medical history included type 2 diabetes, which had been well-controlled with oral antidiabetic medications.

Physical examination revealed a florid, symmetrical rash with a well-demarcated inflammatory border on both groins (Fig. 1a) and well-defined patches of erythema involving the gluteal area (Fig. 1b). This was associated with superficial erosions, skin desquamation and crusting on the scrotal skin. There was no mucosal involvement. Skin swabs and scrapings were negative for bacterial and fungal growth, respectively, and viral PCR for herpes and varicella zoster viruses was also negative. Blood tests showed normal levels of inflammatory markers but slightly raised white cell and neutrophil counts. Zinc level was normal. The patient declined a diagnostic skin biopsy.

In view of the clinical history and examination finding, a diagnosis of symmetrical drug-related intertriginous and flexural exanthema (SDRIFE)-like eruption was considered. The patient was subsequently treated with oral prednisolone 30 mg for 2 weeks, then 20 mg for 2 weeks, followed by a taper of 5 mg/week. He was also

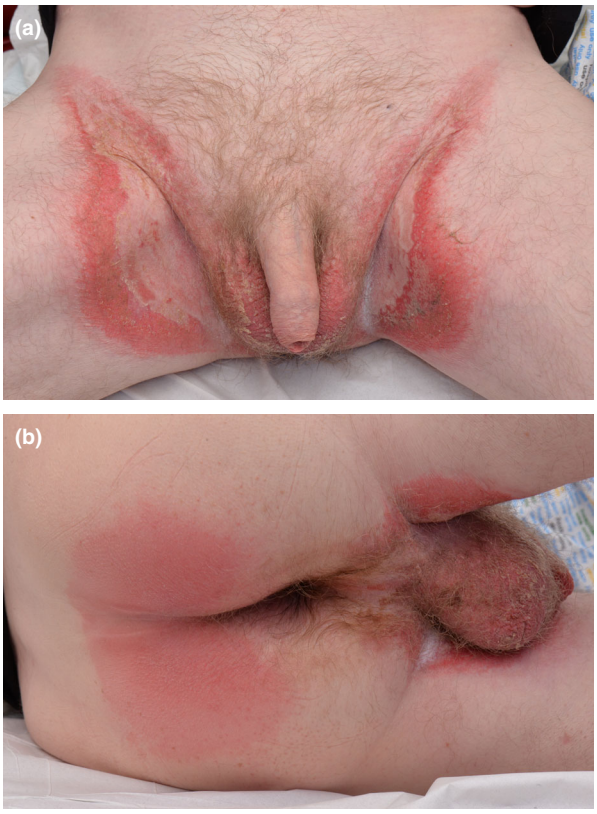

Figure 1 (a) Symmetrical rash with well-demarcated inflammatory border on both groins; (b) well-defined patches of erythema on the gluteal area.

prescribed betamethasone/clotrimazole cream (Lotriderm; Organon Pharma, Hoddesdon, Hertfordshire, UK) and potassium permanganate soaks to weeping areas. This led to a significant improvement after 1 month of treatment.

The AstraZeneca-Oxford vaccine is a recombinant, replication-deficient chimpanzee adenoviral vector vaccine that contains the genetic material to encode the S glycoprotein of SARS-CoV-2. The vaccine was approved in late December 2020 by the Medicines and Healthcare products Regulatory Agency after being shown to be safe and effective following an interim analysis of phase III trials.[1] Cutaneous reactions are less commonly reported with adenoviral vaccines such as AstraZeneca-Oxford compared with messenger RNA (mRNA) vaccines such as BNT162b2 (Pfizer-BioNTech) and mRNA-1273 (ModernaTX). Vaccine-associated cutaneous reactions commonly include delayed large local reactions, local injection-site reactions, urticaria and maculopapular reactions.[2] AstraZeneca-Oxford has been associated with a rare risk of thromboembolism and vaccine-induced prothrombotic immune thrombocytopenia, which may appear as purpura, erythema and oedema of the extremity.[3] Other cutaneous reactions include injection-site reactions and delayed local reactions.[3,4] AstraZeneca-Oxford contains the excipient polysorbate 80 (E433), which is thought to induce hypersensitivity reactions such as dermatitis, urticaria and anaphylactoid eruptions.[3] This is different from mRNA vaccines in which the excipient polyethylene glycol is thought to be the cause.[2] SDRIFE is a type IV delayed hypersensitivity drug reaction characterized by a symmetrical eruption affecting the inguinal/genital, gluteal/perianal areas and other intertriginous areas such as the axillae, elbows and knees, and typically occurs hours to days following exposure to a systemic agent without systemic involvement. Common drug causes are β-lactam antibiotics, terbinafine, iodine radio-contrast media and monoclonal antibodies such as infliximab.[5]

To our knowledge, this is only the second case of SDRIFE-like eruption secondary to COVID-19 vaccines. The first case was reported following administration of CoronoVac vaccine, which contains an inactivated form of the COVID-19 virus. This case report adds to the collection of cutaneous reactions assocated with AstraZeneca-Oxford.

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Successful use of dupilumab for the treatment of atopic dermatitis on the genitals, a neglected anatomical site

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Dear Editor,

Atopic dermatitis (AD) is a chronic inflammatory disease that may involve any cutaneous site, including the genital area. The involvement of the genital area may greatly impair patient quality of life.[1] However, inspection of genitals in clinical practice is not usually conducted during routine physical examination of patients with AD and patients may be reluctant to inform the clinician or show this area.[2,3] Therefore, genital presentation of AD is frequently neglected and underreported.[2]

We performed a study to evaluate the incidence of genital AD in patients with moderate to severe AD and the relative response to the interleukin (IL)-4/IL-13 inhibitor, dupilumab.

As this study was not invasive and used data from routine visits, ethics approval was not required. All the participants involved in the study provided written informed consent.

The study was performed in two different Italian medical centers (Ospedale San Raffele IRCCS in Milan and Sapienza University of Rome). In total, 146 patients with AD were enrolled, of whom 27 (18.7%) had involvement of the genital area (13 women, 14 men; median 33 years range 18–81 years). Severity of AD was assessed by means of Eczema Area and Severity Index (EASI; scoring range 0–72, with higher scores indicating greater severity), Dermatology Life Quality Index [DLQI; 0–30, with higher scores indicating worse quality of life (QoL)] and

