Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

M059

A DELAYED GENERALIZED RASH AFTER FIRST MRNA-COVID-19 VACCINATION: TO VACCINATE OR NOT TO VACCINATE AGAIN

K. Avila*, I. Carrillo-Martin, M. Hobbs, A. Gonzalez-Estrada, *Jacksonville, FL*

Introduction: Hypersensitivity reactions (HSRs) to the first dose of COVID-19 vaccines have been reported. These reactions, delayed or immediate, may increase hesitance to the second dose.

Case description: A 62-year-old woman presented to the emergency department with a non-pruritic, maculopapular exanthema involving the torso and extremities without mucosal involvement or fever, two days after the first dose of mRNA-COVID-19 vaccine. She was treated with antihistamines and completed a five-day course of oral corticosteroids with improvement of symptoms. On the same day as vaccine administration, she also underwent a cerebral angiogram with intravenous contrast and was on day nine out of fourteen of amoxicillin/clavulanic acid (AX/CLA) (875/125 mg twice daily) for rhinosinusitis. She was reluctant to receive the second dose of the mRNA-COVID-19 vaccine. At our allergy department, skin testing to vaccine components was non-diagnostic (Table I). She received the second dose of mRNA-COVID-19 vaccine with high-dose of cetirizine for five days after her vaccination without further adverse reactions. Fifteen days later, the patient underwent a five-day AX/CLA challenge which was positive on day three, showing a rash on her back which resolved with cetirizine. An AX/CLA allergy label was updated on the patient's chart.

Discussion: Benign delayed reactions to COVID-19 vaccination are not a contraindication to receive a second dose of COVID-19 vaccine. Vaccination should be postponed after an acute illness has resolved to avoid possible adverse reactions. Allergist are equipped to decrease COVID-19 vaccination hesitation in the community.

Component	Excipient	Stock concentration	Percutaneous	Intradermal
	Miralax	170 mg/mL	1:100, 1:10, Undiluted	NA
PEG3350*	Methylprednisolone Sodium Succinate	40 mg/mL	Undiluted	1:100, 1:10
Control	Methylprednisolone Acetate	40 mg/mL	Undiluted	1:100, 1:10
Polysorbate 20	Havrix	0.05 mg/mL	1:10	1:100, 1:10
Polysorbate 80	Prevnar 13	1140 EL.U/mL	1:10	1:100, 1:10
*PEG3350: Polyethylene glycol 3350				

Table 1. Skin testing protocol for COVID-19 vaccine components

M060

SUCCESSFUL REINTRODUCTION OF MOGAMULIZUMAB VIA OUTPATIENT ONE DILUTION DESENSITIZATION PROTOCOLS FOLLOWING RECURRENT DELAYED CUTANEOUS REACTIONS

F. Young*, L. Pincus, W. Ai, I. Otani, *San Francisco, CA*

Introduction: Delayed cutaneous reactions occur in up to 24% of patients receiving mogamulizumab for cutaneous T-cell lymphoma (CTCL). This 'mogamulizumab-associated rash' is the most common adverse event leading to mogamulizumab discontinuation. Safe and effective methods to reintroduce mogamulizumab would allow continued treatment with this potentially life-saving medication. We present 2 patients with mogamulizumab-associated rash who were able to receive mogamulizumab via outpatient desensitization without rash recurrence.

Case Descriptions: A 65-year-old woman developed recurrent mogamulizumab-associated rash with onset 1 day after each infusion, refractory to oral methylprednisolone 6-day tapers (24-20-16-12-8-4mg) and cetirizine 20mg twice daily. Cellulitis developed during repeat methylprednisolone tapers. She received 3 mogamulizumab desensitizations with fexofenadine 360mg twice daily for 5 days starting the day before desensitization. Methylprednisolone was not utilized as routine premedication/comedication. Mild breakthrough rash occurred once when fexofenadine was not taken and did not recur.

A 73-year-old man developed mogamulizumab-associated rash with onset 1 day after each infusion, refractory to fexofenadine 180mg daily and diphenhydramine 25mg daily but responsive to methylprednisolone 6-day tapers. He subsequently received 4 mogamulizumab desensitizations without methylprednisolone or antihistamine premedication/comedication. No breakthrough rash occurred.

Discussion: We report 2 cases where desensitization successfully prevented mogamulizumab-associated rash. Mogamulizumab-associated rash currently poses a management challenge as symptom control and drug discontinuation are the only available approaches. Desensitization may be a novel approach for reintroduction of mogamulizumab following recurrent delayed cutaneous reactions while minimizing oral steroid requirements. Further investigation into the use of desensitization to prevent delayed cutaneous reactions may allow more patients to continue mogamulizumab treatment.

Patient	1	2
Agent	Mogamulizumab	Mogamulizumab
Number of steps	14	12
Number of dilutions	1	1
Step increments	30 minutes	30 minutes
Outcome	Tolerated well	Tolerated well

Figure 1. Outpatient Desensitization Protocols Used for Patients 1 and 2.

M061

IGE-MEDIATED REACTION TO CEFUROXIME CONFIRMED BY SKIN TESTING: IT'S ALL ABOUT THE R-CHAIN

A. Hamilton*, *Ponte Vedra Beach, FL. IgE-mediated reaction to cefuroxime confirmed by skin testing: It's all about the R-chain*

Introduction: There is up to a 48% cross-reactive between same R-chain cephalosporins. In patients with documented cephalosporin adverse reactions, a thorough evaluation for reactions to cephalosporins in other generations is warranted.

Case Description: We evaluated a 49 -year-old female patient without history of drug allergy who was referred for a suspected adverse reaction after cephalosporin. She developed upper extremity urticaria within 3 hours of receiving cefuroxime for a surgical site infection. The treatment with cefuroxime was discontinued with improvement of symptoms. Skin testing (ST) was positive for cefuroxime (0.1 mg/mL). Skin tests to major and minor penicillin antigenic determinates was negative. Based on negative ST to penicillin, and positivity of cefuroxime ST we advised the patient to avoid cephalosporins with similar R-chains.

Discussion: Cross-reactivity to other cephalosporins should always be considered in patient with a documented cephalosporin allergy. Avoiding similar R-chains and using graded challenges can allow for safe administration of alternative R-chain cephalosporins in these patients.

M062

STEVENS-JOHNSON SYNDROME OR MYCOPLASMA PNEUMONIAE- INDUCED RASH AND MUCOSITIS: A DIAGNOSTIC DILEMMA

L.G. Nair*[1], A. Ramsey[2], *1. Webster, NY; 2. Rochester, NY*

Introduction: Stevens- Johnson syndrome (SJS) and Mycoplasma pneumoniae- induced rash and mucositis (MIRM) both cause similar muco-cutaneous eruptions. Differences between the two