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Morphea and COVID-19 mRNA vaccine

Dear Editor,

We would like to share ideas on the publication "A case of morphea following the COVID-19 mRNA vaccine: on the basis of viral spike proteins.[1]" Metin and Celepli mentioned that "*The pathogenesis of post-vaccination vasculitis remains unclear. To our knowledge, this is the first report of large vessel vasculitis following by BNT162b2 vaccination*. . .. . ..[1]" We agree COVID-19 vaccination might cause adverse effect and the dermatological problem is a possible example. Metin and Celepli reported an interesting case of vaccine recipient presenting with morphea or localized scleroderma. In the current example, however, no definite pathophysiology has been suggested. Atypical immunological responses are frequently cited as a cause of the COVID-19 vaccine's side effects. It will be beneficial in this scenario if a thorough investigation is conducted. Prior to vaccination, there is also no information on the patient's immunological condition or dermatological health. Morphea in a COVID-19 immunization recipient could be caused by an underlying disease or a concurrent medial problem. Dengue fever could emerge in a vaccine recipient as an example of a concomitant medical illness.[2] Dengue fever is also a probable cause of dermatological sclerosis in some people.[3]

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Post-COVID-19 hair loss: prevalence and associated factors among 5,891 patients

Dear Editor,

Post-acute COVID-19 syndrome comprises several clinical and neuropsychiatric manifestations that are prolonged for or emerge several months after COVID-19 infection. Its prevalence ranges from 33 to 88% among patients, who report symptoms like weakness, anosmia, dyspnea, arthralgia, and hair loss (HL).[1]

This study's aim was to evaluate the prevalence of HL, trichodynia, and other clinical complaints within 3 months following COVID-19 infection through an electronic survey conducted in Brazil. The participants were recruited between May 3 and May 25, 2021, through 88,648 SMS messages to registered cell phones randomized from a countrywide database. They were invited to complete an electronic form (https://bit.ly/3tyseVk) and share it with people known to have had COVID-19 (snowball sampling).

The questionnaire comprised baseline demographic and clinical questions related to COVID-19 infection as well as questions related to the 3-month period following the end of acute COVID-19 symptoms. The prevalence of the post-COVID-19 findings was assessed according to disease severity and the patients' main clinical and demographic data. Only confirmed COVID-19 cases were analyzed. The database was checked for duplicate registers. The significance level was set as $P \leq 0.001$ in a two-tailed analysis. The data were analyzed using IBM SPSS v25.

The valid registers comprised 5,264 (89.4%) participants treated at home, 396 (6.7%) treated at hospital, and 231 (3.9%) treated at an ICU. At least one post-COVID-19 manifestation was reported by 5,062 (86%) patients (Table 1), and the majority were independently associated with disease severity.

HL was the most commonly reported post-COVID-19 manifestation (2,800; 48%), and it was associated with disease length and inflammatory symptoms such as high fever, severe dyspnea, and myalgia (Table 2). The onset of HL occurred within 30 days after the acute COVID-19 symptoms in 2,156 (77%) patients and between 30 and 60 days after such symptoms in 421 (15%) patients. Moderate or severe HL followed COVID-19 infection in 1,761 (44%) women and in 163 (9%)

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