Tozinameran

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Genital necrosis with cutaneous thrombosis: case report

An 84-year-old woman developed genital necrosis with cutaneous thrombosis following administration of tozinameran COVID-19 vaccine.

The woman presented with a three-day history of genital necrosis. Around 26 days before admission, she had received her first dose of tozinameran [BNT162b2 mRNA vaccine; manufactured by Pfizer–BioNTech] COVID-19 vaccine [*dosage and route not stated*]. Nine days following the vaccination, she developed increasing pain in her genital region. Any trauma or precipitating event was denied. Her medical history was significant for deep vein thrombosis following orthopaedic surgery, for which she had been receiving edoxaban over the past three years. There were no other risk factors for thrombosis. On admission, febrile to 37.5°C. Dermatological examination showed extensive necrosis with surrounding purpura that involved the mons pubis, labia majora and perineum. Laboratory test showed leukocytosis with a left shift and slightly elevated platelet count. The coagulation profile was normal. Biochemical parameters were at baseline except for an elevated C-reactive protein. A thrombophilia screen including antithrombin, protein C, protein S, lupus anticoagulant, anti-cardiolipin antibodies and anti-b-2-glycoprotein-1 antibodies was unremarkable. Serological tests for rheumatoid factor, anti-nuclear antibody and anti-neutrophil cytoplasmic antibodies were all negative. Pelvic CT was performed to show subcutaneous fat stranding without fascial thickening. No haemorrhage or haematoma was noted. CT angiography showed no evidence of thrombosis. Skin biopsy revealed epidermal necrosis, scattered neutrophils and lymphocytes in the dermis. A thrombotic occlusion of dermal vessels with mild perivascular infiltration was also noted. Immunohistochemistry revealed that the thrombi were positive for CD61. Considering the clinical and histopathological findings, a diagnosis of cutaneous necrosis with platelet thrombi formation and secondary infection was made.

The woman was treated with ampicillin/sulbactam along with local wound care. Within the first week, her fever, leukocytosis and genital pain resolved. The skin lesions improved. After one month of admission, more than 80% of the eschar had fallen off as she was discharged. A month later, epithelisation was almost completed.

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