Pityriasis rosea and pityriasis rosea-like eruptions after COVID-19 vaccines

To the Editor: The article by Jordan et al on pityriasis rosea (PR) and PR-like eruptions (PR-LE) after COVID-19 vaccination prompted us to highlight the differences between these eruptions according to our experience. Although the reported data are not homogeneous because the diagnosis has been formulated by several authors using different PR/PR-LE definitions, we greatly appreciated the efforts to collect from the literature the PR/PR-LE cases occurring after COVID-19 vaccination. However, different authors have not usually carried out adequate investigations to distinguish the 2 eruptions with reasonable accuracy. The very similar clinical features between PR and PR-LE make it difficult to distinguish them simply by physical examination. However, they have different pathogenesis, and it is just starting from this assumption that some criteria can be found to distinguish them. Unlike PR, PR-LE is not associated with human herpesvirus (HHV) 6 and/or 7 systemic reactivation, but it has a pathogenesis more similar to that of drug eruptions. In short, PR-LE can be compared with PR just as measles eruptions to measles. Clinical, histopathological, and mainly virological criteria have been proposed for distinguishing the 2 forms. Regrettably, the authors who described PR/PR-LE after COVID-19 vaccination never performed specific investigations for HHV-6/7 reactivations, namely detection of HHV 6/7 DNA in plasma and positive IgM antibodies against HHV-6/7 in serum. Likewise, in the cases of PR/PR-LE described during COVID-19, viral reactivations were very rarely investigated. HHV-6, HHV-7, and Epstein-Barr virus systemic reactivations have been described only in 1 patient with PR and COVID-19. Furthermore, in the different cases collected in the literature, various clinical features, such as the lesion’s morphology, the presence of prodromal symptoms, and oropharyngeal lesions, important data to distinguish the 2 types of eruptions, were never reported. However, despite these missing data, the previously described criteria to distinguish between PR and PR-LE, if applied to Buckley et al’s data, would confirm the authors’ definition of the skin eruptions. Indeed, the time elapsed between vaccination and onset of the eruption (10 vs 5 days for PR and PR-LE, respectively), the presence of herald patch (83% vs 40% of cases for PR and PR-LE, respectively), and the exanthem duration (1.6 vs 6.1 weeks for PR and PR-LE, respectively) are important features for distinguishing between the eruptions. Therefore, we emphasize that a set of described criteria may definitely help distinguish typical PR from PR-LE. In case of eruptions occurring after vaccines/drug intake, researchers should collect the data from medical history and physical examination and should perform specific virological investigations for HHV-6/7 reactivation. Distinguishing between PR and PR-LE is not secondary because the latter may be a hypersensitivity response to a vaccine as well as to a drug and is less predictable in its course. In the case of a booster dose, the clinical manifestation may not recur, be different from PR-LE, or even present with systemic symptoms. For drug-related PR-LE, it is preferable to promptly withdraw the drug to avoid the development of more dangerous reactions.

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Funding sources: None.

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Conflicts of interest None disclosed.

REFERENCES


https://doi.org/10.1016/j.jdin.2022.03.018