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Beyond Expectations

Little wins in psoriatic disease start here

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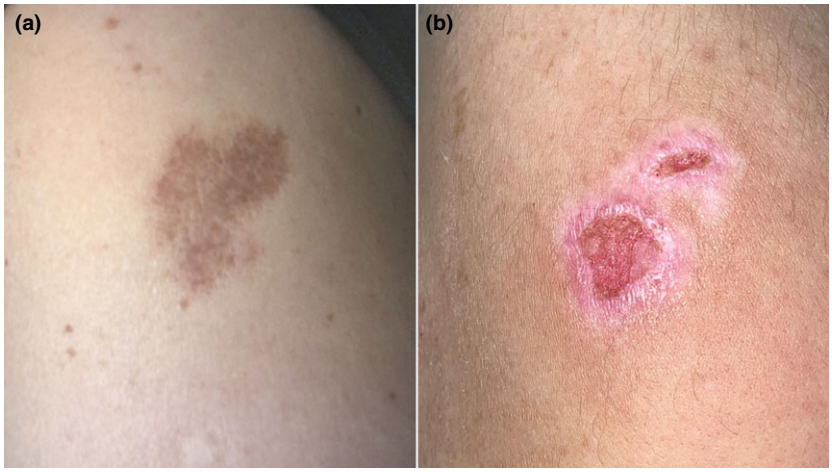

Figure 2 Clinical aspect of the lesions after about 1 week of onset: (a) hyperchromic patch or crusted lesion (b).

reactions. In conclusion, although some patients reported local adverse reactions after the first dose of their COVID-19 vaccine, it is essential to encourage all patients to complete vaccination because these reactions are not a contraindication.

Acknowledgement

The patients have given written informed consent to the publication of their case details and photos.

Conflict of interest

The authors have no relevant conflict of interest.

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Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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References

1 Polack FP, Thomas SJ, Kitchin N *et al*. Safety and efficacy of the BNT162b2 mRNA covid-19 vaccine. *N Engl J Med* 2020; **383**: 2603–2615.
2 Pulsipher K, Presley C, Waller J *et al*. Coronavirus vaccination adverse reactions and the role of the dermatologist. *J Drugs Dermatology* 2021; **20**: 351–352.
3 Blumenthal KG, Freeman EE, Saff RR *et al*. Delayed Large Local Reactions to mRNA-1273 Vaccine against SARS-CoV-2. *N Engl J Med* 2021; **384**: 1273–1277.
4 Fernandez-Nieto D, Hammerle J, Fernandez-Escribano M *et al*. Skin manifestations of the BNT162b2 mRNA COVID-19 vaccine in healthcare workers. 'COVID-arm': a clinical and histological characterization. *J Eur Acad Dermatol Venereol* 2021; **35**: e425–e427.
5 Corbeddu M, Diociaiuti A, Vinci M *et al*. Transient cutaneous manifestations after administration of Pfizer-BioNTech COVID-19 Vaccine: an Italian single centre case series. *J Eur Acad Dermatol Venereol* 2021; **35**: e483–e485.
6 McMahon DE, Amerson E, Rosenbach M *et al*. Cutaneous reactions reported after moderna and pfizer COVID-19 vaccination: a registry-based study of 414 Cases. *J Am Acad Dermatol* 2021; **85**: 46–55.
7 Stone CA, Jr, Rukasin CRF, Beachkofsky TM *et al*. Immune-mediated adverse reactions to vaccines. *Br J Clin Pharmacol* 2019; **85**: 2694–2706.
8 Garvey LH, Nasser S. Anaphylaxis to the first COVID-19 vaccine: is polyethylene glycol (PEG) the culprit? *Br J Anaesth* 2021; **126**: e106–e108.
9 Benjamin B, Chris F, Salvador G *et al*. Visual and confocal microscopic interpretation of patch tests to benzethonium chloride and benzalkonium chloride. *Ski Res Technol* 2012; **18**: 272–277.
10 Hoffmann A, Dumke C, Hanschmann KMO, Wicker S. Local thermal reaction after influenza vaccination: quantification by infrared imaging and biometric considerations. *Vaccine* 2018; **36**: 2783–2787.

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Eosinophilic cellulitis after BNT162b2 mRNA Covid-19 vaccine

Dear Editor,

We observed a case of eosinophilic cellulitis or Wells syndrome after the BNT162b2 vaccine.

A 71-year-old woman with a history of treated high blood pressure and atrial fibrillation presented with a painful eruption

of the right arm and forearm. Symptoms started the day following the second dose of the BNT162b2 COVID-19 vaccine (Pfizer/BioNTech) with a localized injection site reaction that progressively worsened. She had no reaction after the first vaccine injection 3 weeks before. At the time of admission, day 12 after the second dose of the vaccine, clinical examination revealed an erythematous swollen arm and forearm with some linear vesiculobullous lesions and large superficial post-bullous erosions (Figure 1a). The patient was afebrile. Laboratory analyses showed normal white-cell counts and non-elevated C-reactive protein levels. Nevertheless, oral amoxicillin-clavulanic acid was initiated for a suspected bacterial cellulitis.

Day 15 after the second dose of the vaccine, a generalized pruritic papulovesicular eruption appeared (Figure 1b). As the clinical presentation was suggestive of varicella, oral aciclovir was started.

Day 22 after the second dose of the vaccine, a generalized erythema multiform-like eruption developed with annular, targetoid and coalescing lesions (Figure 1c,d). The arm remained swollen and painful. Laboratory tests revealed normal WBC with hypereosinophilia (15.9% of WBC, 1520/μL, normal value 30–600/μL), and slightly elevated C-reactive protein levels (7.2 mg/L, normal value <5 mg/L). RT-PCR of vesicle swab was negative for VZV DNA. Skin biopsy specimens showed mild spongiotic dermatitis, with intra and subepidermal vesicles and mixed dermal infiltrates with lymphocytes, histiocytes and numerous eosinophils (Figure 2). Direct immunofluorescence was negative. The rash resolved within 2 weeks with oral methylprednisolone.

The clinical presentation, the hypereosinophilia and the histopathological image of subepidermal blistering with important eosinophilic infiltrate met the diagnostic criteria for Wells syndrome/eosinophilic cellulitis proposed by Heelan *et al.*[1] 'Flame figures' were not observed probably due to the early skin biopsy.[2] Linear disposition of vesiculobullous lesions was uncommon even if lesions following lines of Blaschko have already been described in eosinophilic cellulitis.[3]

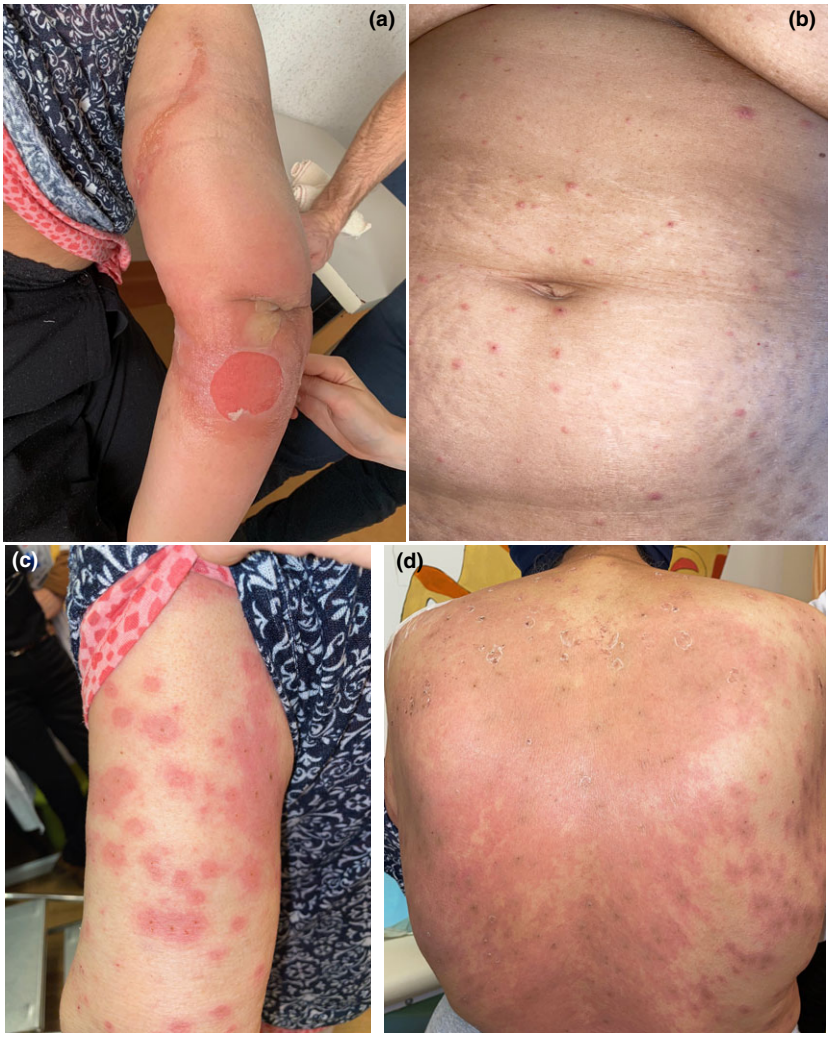

Figure 1 (a) Erythematous swollen arm and forearm with some linear vesiculobullous lesions and large superficial post-bullous erosions. (b) Generalized papulovesicular eruption. (c and d) Erythema multiform-like eruption with annular, targetoid and coalescing lesions.

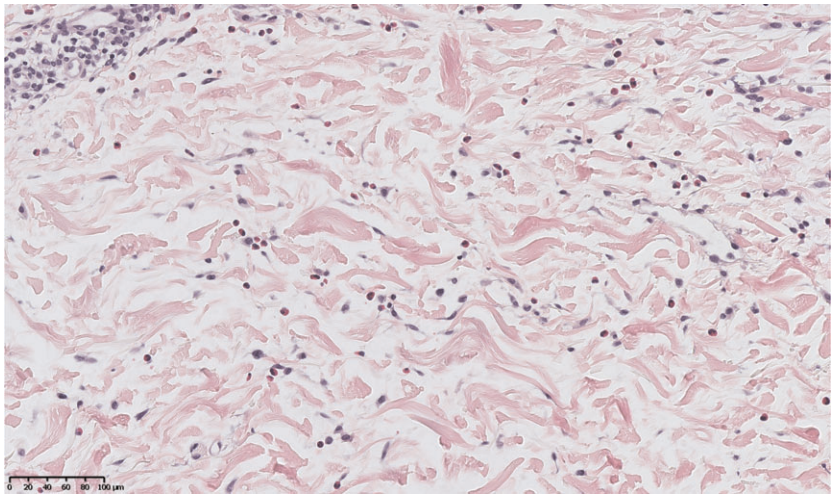

Figure 2 Skin biopsy showed mild spongiotic dermatitis with mixed dermal infiltrates with lymphocytes, histiocytes and numerous eosinophils. Haematoxylin and eosin, magnification x20.

Eosinophilic cellulitis is an inflammatory skin disease with a broad spectrum of skin manifestations including cellulitic lesions sometimes associated with blisters, and rash with annular or circinate erythematous plaques. Peripheral eosinophilia (15%–67%) and diffuse dermal infiltrate of eosinophils with sub-epidermal oedema and 'flame figures' can be present. Although aetiology remains unknown, a type IV hypersensitivity reaction has been suggested. Triggering factors include infection, insect bites, hematologic disorders, drugs and vaccines. Cases of eosinophilic cellulitis reported after vaccinations have been attributed to thiomersal, neomycin or aluminium.[1,4] However, BNT162b2 vaccine does not contain these components.

To our knowledge, this is the first case describing eosinophilic cellulitis associated with the vaccine against SARS-CoV-2.

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The patients in this manuscript have given written informed consent to the publication of their case details.

Conflict of interest

The authors disclose no conflict of interest.

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References

1 Heelan K, Ryan JF, Shear NH, Egan CA. Wells syndrome (eosinophilic cellulitis): Proposed diagnostic criteria and a literature review of the drug-induced variant. *J Dermatol Case Rep* 2013; **7**: 113–120.

2 Eduardo Calonje JE, Brenn T, Lazar A, Billings S. McKee's Pathology of the Skin, 5th Edition. Vol 1: Elsevier; 2020.

3 Sommer S, Wilkinson SM, Merchant WJ. Eosinophilic cellulitis following the lines of Blaschko. *Clin Exp Dermatol* 1999; **24**: 449–451.

4 Yu AM, Ito S, Leibson T *et al*. Pediatric Wells syndrome (eosinophilic cellulitis) after vaccination: A case report and review of the literature. *Pediatr Dermatol* 2018; **35**: e262–e264.

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COVID vaccine-induced lichen planus on areas previously affected by vitiligo

Dear Editor,

We recently came across a 64-year-old woman who developed pruritic papules on both hands previously affected by vitiligo since 30 years earlier. The lesion first appeared 5 days after the first dose of BNT162b2 mRNA COVID-19 Vaccine, then faded away, thus recurring 24 h soon after the second dose with a more extensive and symptomatic eruption. The patient noticed and referred a worsening of skin condition after sun exposure.

Clinical examination revealed reddish polygonal papules, somewhere merging in small plaques with secondary excoriation, exclusively located on lateral aspects of dorsum of hands, formerly affected by a long-standing vitiligo (Fig 1). Dermoscopy revealed Wickham striae combined contoured by erythema and associated

