Pityriasis rosea in otherwise asymptomatic confirmed COVID-19—positive patients: A report of 2 cases

To the editor: We enjoyed reading the case series on pernio-like eruptions in skin of color and appreciate the awareness the authors brought to this COVID-19—associated manifestation, previously largely documented in Fitzpatrick skin types I and II and darker skin types. Pityriasis rosea-like manifestations have been reported in COVID-19—positive patients, though similar published images largely show presentations in lighter skin types. Here, we present 2 cases of pityriasis rosea in Fitzpatrick types III and IV skin in otherwise asymptomatic COVID-19—positive patients. We hope that they contribute to an accurate diagnosis of COVID-19 manifestations in darker skin types.

CASE 1
A 39-year-old woman with no significant medical history presented to her primary care provider with a pruritic rash ongoing for 2 weeks. Dermatology was consulted via teledermatology store-and-forward photographs. The rash initially presented on her abdomen and subsequently spread to her axillae and upper extremities. Review of systems was otherwise unremarkable, and she was afebrile (37.8°C). She denied new medicines or any sick contacts. The photographs revealed Fitzpatrick type III skin with multiple scattered erythematous patches, some with collarettes of scale, located in a Blaschkoid distribution on the trunk, extremities, and groin without mucosal or acral involvement (Figs 1 and 2). Her clinical presentation was consistent with that of pityriasis rosea. Basic laboratory findings were within normal limits, and rapid plasma reagin testing was nonreactive; however, a polymerase chain reaction test performed for SARS-CoV-2 was positive. She was prescribed 0.1% triamcinolone cream as needed for pruritus. At follow-up 18 days later via teledermatology, she was still asymptomatic for COVID-19, and her rash had nearly resolved except for a few persistent areas on the lower extremities.

CASE 2
A 23-year-old woman with no significant medical history presented for urgent care with a 1-week history of an asymptomatic diffuse rash of unknown etiology. Dermatology was consulted via teledermatology store-and-forward photographs. The rash began as a few patches and disseminated after a few days. Review of systems was otherwise negative, and she was afebrile (37.2°C). She denied new medicines or known COVID-19 exposures; however, she notably worked in health care, with patient contact. Polymerase chain reaction testing result for SARS-CoV-2 performed 3 weeks prior was negative. The photographs revealed Fitzpatrick type IV skin with scattered, thin, erythematous-to-hyperpigmented plaques and patches with scale on the upper and middle portions of the chest, abdomen, back, and flanks in a Blaschkoid distribution (Figs 3 and 4). Larger patches with visible collarettes of scale led to the clinical diagnosis of pityriasis rosea. Rapid plasma reagin testing was nonreactive, and repeat SARS-CoV-2 testing result was positive. She was prescribed 0.1% triamcinolone ointment as needed for pruritus. The patient relocated and, therefore, has not undergone follow-up examination.

Fig 1. Photograph of scattered erythematous patches, some with a collarette of scale, located in a Blaschkoid distribution on the trunk and groin.

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We hope that our cases help to diversify the available images of the skin manifestations of COVID-19. Additionally, only 2 cases of pityriasis rosea in COVID-19 patients have been published.3,4 Our cases highlight the need for SARs-CoV-2 testing in patients presenting with pityriasis rosea-like eruptions, even if otherwise asymptomatic, for appropriate diagnosis and contact tracing.

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Fig 2. Close-up photograph of erythematous patches with a central collarette of scale located on the right portion of the upper chest.

Fig 3. Photograph of scattered, thin, red-to-hyperpigmented plaques and patches with scale on the upper and middle portions of the chest in a Blaschkoid distribution.

Fig 4. Photograph of scattered, thin, red-to-hyperpigmented plaques and patches with scale on the left flank in a Blaschkoid distribution.

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