CLINICAL SNAPSHOT

COVID-19 Rash

A 31-year-old female patient presented at the Infection Emergency Clinic with fever, a positive SARS-CoV-2 swab test result and a skin rash. Scabies was diagnosed and treated on an outpatient basis. A short time later, she presented again at the Infection Emergency Clinic, this time with the teledermatological diagnosis of “erythema multiforme”, possibly toxic epidermal necrolysis (Lyell’s syndrome)“. In addition to the fever, which was still present, she had newly developed a loss of smell and taste. On clinical examination, she had a non-pruritic morbilliform to erythema multiforme,

mostly on the trunk, without mucosal involvement. In the further course of the disease, her clinical symptoms, especially the skin changes, started to resolve with symptomatic treatment. After seven days, the patient was afebrile and asymptomatic. Up to 20% of COVID-19 patients develop a rash which is located primarily on the trunk. While a maculopapular rash is the most common manifestation, an urticarial, vesicular (varicelliform) or erythema multiforme may also occur, although less frequently. Later in the course of the disease, acral chilblain-like skin changes (pseudo-chilblains) with erythema, swelling and purple-colored discolorations may appear. The pathogenesis of these polymorphic skin changes is poorly understood. Thus, in febrile patients with a rash, especially if associated with loss of smell and taste, COVID-19-associated skin changes should be considered in the differential diagnosis and distinguished from maculopapular, urticarial drug eruptions and viral exanthems.

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