Guttate Psoriasis Secondary to COVID-19: A Quiz

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A 63-year-old man presented to the medical emergency department with 3 days of fever and expectoration. There was a past medical history of obesity, alcoholism, and chronic obstructive lung disease. He had no history of skin disease or genetic pre-disposition to dermatological disease. Severe acute respiratory syndrome virus 2 (SARS-CoV2) RNA was detected from a nasopharyngeal swab confirming COVID-19 infection. He developed complications with pneumonia, which was treated with piperacillin and tazobactam. The patient was discharged 7 days after the referral.

A couple of weeks following the onset of COVID-19, multiple erythematous lesions began to form on the truncus and extremities. The lesions failed to heal, and 4 months after the initial referral the patient sought a dermatological opinion. On examination there were multiple small, red, scaly, teardrop-like shaped spots with silvery scales appearing on front (Fig. 1A) and back of the truncus (Fig. 1B), and upper (Fig. 1C) and lower extremities (Fig. 1D). The lesions covered 40% of the total body surface area (BSA).

What is the diagnosis? See next page for answer.

*Fig.1.*The patient´s presentation at the first visit to the department of dermatology, 4 months after onset of COVID-19 infection. The patient presented with multiple small, red, scaly, teardrop-like shaped spots with silvery scales appearing on front (A.) and back of the truncus (B.), and upper (C.) and lower extremities (D.), covering 40% of the total body surface area.

Diagnosis: Guttate psoriasis secondary to COVID-19.

Treatment was commenced with clobetasol 0.05% topical cream applied once daily. However, patient-reported compliance was low, and no clinical improvement was observed. During a 15-month period after the COVID-19 infection had been diagnosed, the patient was prescribed injections of methotrexate 15 mg once a week. After a further 3-months period, the BSA had dropped to 30%.

COVID-19 has been linked to numerous dermatological conditions, predominantly in the paediatric population most commonly presenting with chilblains in relation to COVID-19 infection, but vasculitis and thrombosis are also common (1). In the adult population, however, cases with stomatitis (2) and onset or worsening of psoriasis (3) have been reported. Further, exacerbation of psoriasis after inactivated BNT162b2 mRNA COVID-19 vaccines can occur (4). The long-term course of dermatological COVID-19 are now being studied in an international registry for COVID-19 (5), which by its prospectively collected high-quality data can bring us knowledge on its long-term dermatological effects.

References

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