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DRESS with anti-IL-1 therapy for sJIA carries significant risk for poor outcome and poses a challenge for subsequent therapeutics for the underlying disease.

Figure 1. A. CT chest sagittal view showing bibasilar ill-defined parenchymal consolidations with associated septal thickening concerning for pulmonary involvement. B. CT abdomen showing hepatosplenomegaly, and abdominal lymphadenopathy. C. Skin biopsy showing interface dermatitis and perivascular dermatitis consistent with DRESS. D. Lung biopsy showing reactive pneumocytes, neutrophil margination, and few scattered eosinophils consistent with early sJIA.

M008
MANAGEMENT OF IOHEXOL-INDUCED ANAPHYLAXIS WITH ALTERNATIVE CONTRAST AGENTS
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Introduction: Recent literature suggests that many anaphylactic reactions to currently used iodinated contrast media (ICM) are IgE-mediated. In this setting, skin testing and challenge may help identify alternative agents that may be tolerated.

Case Description: An 80 year-old male with a large abdominal aortic aneurysm, type 2 diabetes, triple vessel coronary artery disease, peripheral vascular disease and chronic obstructive lung disease had a history of receiving iohexol-300 for a CT scan and experienced immediate shortness of breath, flushing, and a non-urticarial rash. Subsequently, he received prednisone 50 mg at 13, 7, and 1 hour before along with diphenhydramine 1 hour before a CT contrast with iohexol-300. Despite premedication, he became hypoxic to 86%, tachypneic and flushed. He received IM epinephrine with improvement. Intradermal testing was positive to iohexol-300, but not an immediate shortness of breath, which resolved within 2 hours. An anaphylaxis practice parameter does not recommend premedication for prevention of ICM reactions. In addition, recent consensus reports recommend skin testing to ICM in those with premedication. This case highlights these recommendations and suggests that drug challenge to skin test negative ICM should be considered in such patients in a safe environment such as an allergist’s office.

Figure 1. Changes in blood pressure after Rifampin graded challenge.

M010
DIAGNOSTIC CHALLENGE IN EVALUATING THE RISK AND MANAGEMENT OF ALLERGIC REACTION(S) TO SARS-COV-2 VACCINES
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Introduction: The frequency of immediate hypersensitivity reactions following immunization with either the Pfizer-BioNTech (BNT162b2) or Moderna (mRNA-1273) mRNA vaccines poses a clinical challenge for the allergist-immunologist. Anaphylaxis to the mRNA COVID-19 vaccines is currently estimated to occur in 2.5 to 11.1 cases per 1 million doses. Although excipients [polyethylene glycol (PEG), and polysorbate] and specific mRNA and Ad26.COV2.S components in COVID-19 vaccines have been cited as potential causative allergens, PEG is considered the likely culprit in mRNA vaccines. However, several skin testing published protocols using PEG have yielded conflicting results. We present a patient who developed anaphylaxis after the first dose of BNT 162b2 who was evaluated by PEG, polysorbate, and COVID-19 vaccine skin testing.

Case Description: A 49-year-old female, with a known atopic history, was evaluated for an anaphylactic reaction to BNT 162B2 vaccine occurring within 30 minutes after the first dose. Pruritic case of delayed anaphylactic shock to rifampin occurring many days after initiation of therapy.

Case Description: A 65-year-old female was initiated on therapy for tuberculosis with rifampin, isoniazid, pyrazinamide, and ethambutol. 10 days later she developed angioedema and rash on the arms, legs, and abdomen. All medications were stopped and cutaneous symptoms resolved within 3 days. Low-dose rifampin was restarted 9 days later, and she developed emesis, headache, body shaking, perioral cyanosis, orthostasis, and subjective fever within a few hours of ingestion. The patient refused telemedicine advice to seek care at the emergency department but recovered at home overnight without sequelae. As reaction history at the time was unclear, she underwent rifampin graded dose challenge in the ICU a month later. The patient received a cumulative dose of 600mg of rifampin over 3 hours when she developed severe hypotension requiring aggressive resuscitation with volume expansion and inotropic support (Figure 1). Alternative agents were used to complete TB treatment.

Discussion: Severe delayed reaction to rifampin is rare but has been reported with up to 18.97 days between ingestion and reaction. This atypical reaction may lead clinicians to initiate graded challenge of rifampin leading to severe reactions. Alternative medications should be considered as desensitization to rifampin has been associated with significant morbidity in the literature.

M009
A CASE OF ATYPICAL DELAYED ANAPHYLAXIS TO RIFAMPIN
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Introduction: Tuberculosis treatment requires a combination of agents, many of which have side effects including anaphylaxis. Anaphylactic reactions to medications usually occur within minutes to a few hours of administration. We report on an unusual
symptoms, facial urticaria, tongue swelling, and wheezing progressed to full body hives and difficulty breathing. Following treatment with epinephrine, IV diphenhydramine, and IV steroids, her symptoms improved. SPT and ID skin testing to PEG, polysorbate 80, and the BNT 162B2 and JNJ-78436735 (Johnson and Johnson) were negative except for positive ID testing to polysorbate 80.

**Discussion:** Negative SPT and ID skin testing with both excipients and vaccine specific components argues against an IgE-mediated mechanism and suggests a non-IgE mechanism. IgE skin testing may have no value as a predictive biomarker of susceptibility to allergic reactions of the mRNA COVID-19 vaccines and will require more research focused on non-IgE mechanisms.

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**M011**

HYPERSENSITIVITY TO AMOXICILLIN-CLAVULANATE MANIFESTING AS ACUTE LOCALIZED EXANTEMATOUS PUSTULOSIS

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**Introduction:** In 2005, Prange and colleagues identified a localized variant of acute generalized exanthematous pustulosis (AGEP) they termed ‘acute localized exanthematous pustulosis’ (ALEP). ALEP is characterized by sterile pinhead-sized nonfollicular pustules over an erythematous base typically distributed on the face, neck, or chest. Over 80% of cases are in response to medications, with beta-lactam antibiotics being frequently implicated. We describe a case of facial ALEP that developed three days after initiating amoxicillin-clavulanate therapy.

**Case Description:** A 25-year-old female with idiopathic urticaria on chronic antihistamine therapy presented to clinic with complaint of a possible drug reaction. Three days into taking amoxicillin-clavulanate after a wisdom tooth extraction she developed crops of pustules on the chin and lower cheeks bilaterally that were preceded by a flushing sensation and pruritus of the face and neck. She reported a similar rash following prior usage of amoxicillin. With drug cessation her symptoms resolved within two days of discontinuation.

**Discussion:** Both ALEP and AGEP are Type IV hypersensitivity reactions that result in CXCL8-dependent neutrophilic recruitment and pustule formation. ALEP is rarely reported, with only 38 identified cases in our literature search. Like AGEP, removal of the trigger medication usually leads to rapid improvement. Currently, treatment guidelines do not exist although thus far cases have been self-limited and without serious morbidity. As cases of recurrence with exposure to the triggering medication are common, avoidance of the inciting drug should be advised. Increased awareness of this atypical variant is necessary, as poor recognition of ALEP may account for its rarity in the literature.