Erythromelalgia associated with small-fibre neuropathy
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Erythromelalgia (EM) is characterized by a triad of recurrent redness, burning pain and warmth of the extremities. We present a case of EM associated with small-fibre neuropathy (SFN). A 25-year-old woman presented with a 2-year history of recurrent swelling, redness and burning pain on her extremities, face and earlobes. Each episode lasted between 10 min and 3 h. The episodes were exacerbated by heat, stress, prolonged standing and physical activity, and relieved by leg elevation and cooling. There was associated myalgia, fatigue, paraesthesia of the feet and 25 kg weight loss. The patient had persistently low mood and prolonged work absences. She suffered from migraines and her regular medications included imipramine, metoclopramide and sumatriptan. On examination, she had ill-defined erythematous patches on her hands, arms, knees and ankles, with oedema in some areas. Neurological examination of cranial and peripheral nerves was normal. In view of her symptoms and striking weight loss, she was reviewed by physicians in multiple medical specialties, including rheumatology, gastroenterology, haematology and immunology. Full blood count, liver function tests, renal profile, connective tissue disease screen, upper and lower gastrointestinal endoscopies, haematinics, blood film, lymphoma screen, trypase, C1 esterase inhibitor levels, borrelia screen, cortisol and urine electrophoresis were normal. Skin biopsy showed normal histology and negative immunofluorescence. Following these investigations, we made a clinical diagnosis of EM. The patient was referred to the neurology team who performed nerve-conduction studies, which were normal, and genetic testing, which was negative for the common mutations associated with EM. The neurology team referred the patient to a specialist SFN unit, where a skin biopsy demonstrated a reduced intraepidermal nerve fibre density, consistent with SFN. The patient’s symptoms are now controlled with a combination of carbamazepine and duloxetine, under the care of the neurology team. SFN is a generalized peripheral neuropathy affecting the small nerve fibres abundantly present in mucosa and skin. Patients with SFN experience sensory symptoms such as burning, stinging and pain in the extremities, and/or autonomic symptoms. EM as a manifestation of SFN is not well recognized; however, it may present as a predominant SFN with disturbance of control of vascular tone. We present our case for dermatologists to be aware of this association and to consider neurology referral in patients who present with EM.

CPC08
New-onset pemphigus foliaceus following COVID-19 vaccine
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Pemphigus vulgaris (PV) and pemphigus foliaceus (PF) are a rare group of immunobullous disorders that can lead to high morbidity and mortality. The produced antibodies, via the aberrant B cells, are considered to be the culprits responsible for the disease development. We present a patient with PF whose disease developed after administration of the first dose of ChAdOx1 nCoV-19 (AstraZeneca) vaccination and exacerbated following the second dose of this vaccine. A 62-year-old female, with no previous history of skin diseases, received the first dose of AstraZeneca COVID-19 vaccine on 26 February 2021. She developed a generalized erythematous itchy rash in early March 2021, a few days after her vaccination. She received the second dose of the AstraZeneca COVID-19 vaccine on 14 May 2021, which resulted in significant worsening of her skin in just a couple of days, with extensive scaling and erythema. Physical examination demonstrated large erosive annular erythematous plaques on her face, trunk and limbs. No mucosal involvement was present. Histology demonstrated subcorneal pustules containing few acantholytic keratinocytes and a large number of neutrophils. Direct immunofluorescence revealed fishnet-like positivity for IgG and C3 at the intercellular epidermal spaces. Based on the characteristic clinical and histological findings, the diagnosis was confirmed as new-onset PF following COVID-19 AstraZeneca vaccination. Two patients with PV flare-up following COVID-19 Moderna and Pfizer vaccine administration (Damiani G, Pacifico A, Peloni F, Iorizzo M. The first dose of COVID-19 vaccine may trigger pemphigus and bullous pemphigoid flares: is the second dose therefore contraindicated? J Eur Acad Dermatol Venereol 2021; 35: e645–7), and a single patient with new-onset PV occurring after vaccination with COVID-19 Pfizer vaccine...
(Solimani F, Mansour Y, Didona D et al. Development of severe pemphigus vulgaris following SARS-CoV-2 vaccination with BNT162b2. J Eur Acad Dermatol Venereol 2021; 35: e649–51) have been reported. The main proposed mechanisms for AstraZeneca vaccine-induced pemphigus could be a hyperimmune reaction in genetically predisposed individuals, with eventual formation of anti-desmoglein antibodies. An alternative hypothesis is that vaccine components could act as foreign antigens resulting in a cross-reaction with pemphigus antigens. The close association of COVID-19 vaccination with the acute onset of pemphigus in our patient, as well as exacerbations after subsequent vaccine administration, is more than coincidental. Considering the recent pandemic with COVID-19 and the widespread administration of the COVID-19 vaccine, continued observation and documentation of true adverse events is essential.

CPC09
A contrasting diagnosis: iododerma
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An 86-year-old woman presented to the emergency department with acute shortness of breath. She was treated with intravenous furosemide for acute-on-chronic heart failure. Her past medical history included atrial fibrillation, hypertension, diverticulosis and hypothyroidism. Rivaroxaban and levothyroxine were her only long-term medications. On day 5 of hospital admission, she developed painful haemorrhagic and purulent bullae on her dorsal hands, head and neck. These lesions, which showed mild bilateral pleural effusions in keeping with fluid overload secondary to heart failure. A biopsy of bulla formation subepidermally. There was a dense neutrophilic infiltrate with microabscess formation with scattered eosinophils and lymphocytes. There was no evidence of vasculitis. Direct immunofluorescence was negative and the widespread administration of the COVID-19 vaccine, continued observation and documentation of true adverse events is essential.