Abstract N°: 244

Radiation-Induced Cutaneous Metastasis in Malignant Pleural Mesothelioma: A Rare Case Report

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Introduction & Objectives:

Malignant mesothelioma (MM) is an aggressive tumor arising from the mesothelial lining, primarily affecting the pleura. While cutaneous metastasis is rare, it can occur through lymphatic spread, direct extension, or hematogenous dissemination. Radiation-associated cutaneous metastasis is an unusual phenomenon, with few reported cases.

Objective: This report highlights a case of cutaneous metastasis following radiation therapy for pleural mesothelioma, emphasizing diagnostic challenges and pathophysiology.

Materials & Methods:

A 68-year-old male with diabetes mellitus and a history of right-sided malignant pleural mesothelioma presented with dyspnea and desaturation. He had previously received chemotherapy and immunotherapy, which were discontinued three months before presentation. Due to disease progression and superior vena cava syndrome, palliative radiation therapy (30 Gy in 10 fractions) was administered to the mediastinum. Two months later, the patient developed an asymptomatic rash over the chest and neck, initially localized to the radiation field but progressively spreading. Clinical examination revealed numerous erythematous, infiltrated papules and plaques forming a necklace-like distribution across the affected area. Differential diagnoses included radiation-induced dermatitis, granulomatous dermatoses, and cutaneous metastasis. A punch biopsy was performed.

Results:

Histopathological examination demonstrated nodular proliferation of neoplastic monomorphic cells with vacuolated cytoplasm and atypia, with lymphatic invasion. Immunohistochemical studies were positive for CK 5/6, calretinin, and WT1, confirming cutaneous metastasis from pleural mesothelioma. Despite treatment, the patient's condition deteriorated, and he succumbed to the disease shortly afterward.

Conclusion:

Cutaneous metastasis of MM remains uncommon but should be considered in patients presenting with new skin lesions, particularly in irradiated areas. This case illustrates the isoradiotropic response, where metastatic deposits preferentially develop in previously irradiated tissue, likely due to immune dysregulation and impaired lymphatic drainage. Histopathological and immunohistochemical evaluation is essential for differentiation from other malignancies. As mesothelioma incidence rises, clinicians should remain vigilant for cutaneous involvement, especially in patients receiving radiotherapy.

Abstract N°: 322

Secondary Histiocytic Sarcoma with Involvement of the Skin: A Case Report.

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Introduction & Objectives:

Histiocytic sarcoma (HS) a rare malignant neoplasm originating from histiocytic and dendritic cell clones. It can present as a primary malignancy (primary HS) or, less commonly, in association with another haematological neoplasm (secondary HS), particularly those of B-cell origin. Its incidence is 0.17 cases per 1,000,000 individuals, with secondary HS accounting for 20% of cases.

The neoplasm affects the lymph nodes, intestinal tract, lungs, skin, and soft tissues, with skin involvement seen in 10–15% of cases. In some cases, skin involvement is the presenting feature. Diagnosis is only possible by histopathology and is confirmed by the immunoreactivity of neoplastic cells for one or more histiocytic markers (CD163, CD68, CD4, CD11c, and lysozyme). HS generally has a poor prognosis, and the secondary form presents with a more adverse clinical course.

This case report describes the clinical features, diagnosis, and management of a patient with this rare neoplasm.

Materials & Methods:

We present a case of a secondary histiocytic sarcoma with involvement of the skin in a 36-year-old male.

Results:

A 36-year-old man was diagnosed with acute lymphoblastic leukaemia 2 years ago. The patient had no relevant medical history prior to this diagnosis. He was treated with rituximab, hyperfractionated cyclophosphamide, vincristine, doxorubicin, and dexamethasone (R-HCVAD) therapy.

At the end of R-HCVAD phase IVB, the patient achieved complete morphological remission and was maintained on prednisone, vincristine, methotrexate, and 6-mercaptopurine therapy.

Five months later, the patient developed asymptomatic generalised dermatosis characterised by well-defined, hyperkeratotic, brown-violaceous nodules with an average diameter of 1 cm. The nodules were firm to digital palpation. The patient was admitted for an extensive diagnostic workup.

Excisional biopsy of two lesions on the right forearm and left thigh revealed histiocytic and lymphoid atypical cells spanning the papillary and reticular dermis. Immunohistochemistry showed the neoplastic cells were positive for CD163, CD68, lysozyme, and S100 (focal), with overexpression of cyclin D1. The Ki67 index was 30%, and positive resection margins of neoplasms were observed. Based on these findings, histiocytic sarcoma was diagnosed.

Subsequently, right cervical lymph node enlargement was observed. An excisional biopsy revealed similar findings to the skin biopsy.

During evaluation, pulmonary, gastrointestinal, and other extranodal involvements were ruled out. The patient was treated with ifosfamide, carboplatin, and etoposide therapy and has completed the first treatment cycle.

Conclusion:

HS represents a diagnostic challenge as it requires both clinical data and confirmation through histopathology and immunohistochemistry.

Due to its rarity, diagnosing HS can be difficult, and there are no established treatment regimens. Most cases with multisite disease have been treated by lymphoma chemotherapy. This case highlights the importance of considering secondary neoplasms in patients with haematological neoplasms who develop new cutaneous lesions. Reporting the clinical course of this rare neoplasm is crucial, as early identification can significantly impact patient management

Abstract N°: 417

Systematic Reviews and Meta-Analysis of the prevalence of cutaneous manifestations in Neurofibromatosis type 1 patients.

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Introduction & Objectives:

Neurofibromatosis type 1 (NF1) is an autosomal genetic disorder affecting 1 in 2500-3000 live births. Clinical manifestations vary widely, even within families. The National Institutes of Health (NIH) established seven diagnostic criteria, requiring at least two for confirmation. Cutaneous manifestations, including café-au-lait macules (CALMs), freckling, and cutaneous neurofibromas (cNFs), are hallmark features of NF1. This systematic review and meta-analysis highlight the prevalence of these cutaneous manifestations, which often appear early and may be the only signs in sporadic cases without family history. Nevus anemicus (NA) and Juvenile Xanthogranuloma (JXG) have also been reported in young children (<2 years). We aim to assess the prevalence of these cutaneous features across different age groups and evaluate their potential inclusion in NF1 diagnostic criteria.

Materials & Methods:

We systematically searched OVID Medline, Embase, and the Cochrane Central Register for studies on NF1 cutaneous manifestations across all ages. Studies were appraised using the Joanna Briggs Institute Prevalence Critical Appraisal tool. A random-effects meta-analysis estimated the pooled prevalence of cNFs, JXG, and NA. Subgroup analyses were conducted for children (≤10 years), pre/adolescents (10-18 years), and adults (>18 years). Meta-regression assessed the association between these features and age.

Results:

From 4161 studies, 8 duplicates were removed, 177 were fully reviewed, and 50 were included in the final analysis. The metanalysis revealed that cNFs were found in 43% of NF1 patients, increasing with age (24% in children, 80% in adults). CALMs were seen in 98% of NF1 individuals, slightly decreasing with age (96% in both children and adults). Freckling was present in 69%, increasing from 62% in children to 83% in adults. NA was observed in 31%, more common in children (45%) and adults (31%) than in pre-adolescents (17%). JXG had an overall prevalence of 7%, peaking in pre-adolescents (33%) and decreasing in children (8%) and adults (2%). Findings suggest NA should be considered for NF1 diagnostic criteria in children under 10 years, while JXG lacks sufficient evidence for inclusion.

Conclusion:

This systematic review and meta-analysis provide valuable insights into the prevalence and clinical presentation of various NF1 features. The significant eruption of cNFs in adulthood, particularly around puberty, underscores the importance of early psychological and clinical support for patients and their families. Additionally, the strong

association between NA and NF1, especially in children, suggests that NA should be considered for inclusion in the diagnostic criteria for NF1. This would improve diagnostic accuracy, particularly in children without a family history of NF1 who do not meet the National Institutes of Health (NIH) criteria by age two.

Further research is needed to explore the prevalence of JXG in the pediatric population and its potential role in NF1 diagnosis. Overall, the pooled prevalence estimates of cutaneous manifestations in NF1 patients provide a comprehensive overview, which can be particularly useful for primary care providers and newly diagnosed patients seeking to understand the progression and clinical presentation of NF1.

Abstract N°: 452

Unusual cutaneous presentation of Carpal Tunnel Syndrome with recurrent blistering

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An 88-year-old female with a background of nickel and methylisothiazolinone contact allergy, hypothyroidism, hyperlipidaemia and intermittent claudication, presented with 3-years of recurrent, atraumatic, painless blisters and ulcerations of the left first, second and third fingertips. These haemorrhagic and clear fluid-filled blisters occurred every few months, without a prodrome, were phenotypically consistent, and healed slowly. There was no history of Raynaud's phenomena.

On presentation, a 2cm shallow ulceration was present on the medial-edge of the distal left second fingertip, with a healing 1cm ulcer on the lateral-edge of the distal left third fingertip. The fingers were tapered, without sclerodactyly. No nail changes or features of scleroderma or dermatitis were noted.

The initial diagnosis was unclear. Differentials included a fixed drug eruption and localised pemphigoid; however, serological testing was negative. Routine laboratory tests yielded a normal full blood count, urea and electrolytes, thyroid function, ESR (2mm/hour) and HbA1c (35mmol/mol). ANA, rheumatoid factor, protein electrophoresis, and wound swab were unremarkable. X-rays revealed osteoarthritic changes without acro-osteolysis, and an ECG demonstrated sinus rhythm.

On re-review, the patient reported six-months of wasting in both hands, with paraesthesia of the left second and third fingers. Examination revealed significant bilateral thenar eminence wasting, with a positive Tinel's and Phalen's test. The patient was referred to neurology, and nerve conduction studies demonstrated severe bilateral carpal tunnel syndrome (CTS), possibly predisposed by hypothyroidism. Other secondary causes were ruled out, and the patient was referred for an urgent CTS decompression.

Symptoms of CTS arise due to the compression of the median nerve at the flexor retinaculum, leading to hand paraesthesia and intrinsic motor dysfunction. However, severe 'necrotic' CTS may present with poorly recognised cutaneous phenomena in up to 20% of patients. Signs include painless digital ulcers, blisters, Raynaud's phenomena, nail dystrophy, sclerodactyly, auto-amputation, and acro-osteolysis. Proposed mechanisms include autonomic and vasomotor dysfunction, and through the creation of immunocompromised districts from reduced distal neuropeptide translocation. Typically, signs and symptoms improve on surgical decompression.

We present this case to highlight the importance of CTS as a differential for both unilateral and bilateral fingertip ulcerations, given the high prevalence of CTS at 1-3%, peaking in age groups 40-60. Therefore, a thorough history and hand examination is vital, and should include changes to hand power and sensation.

Abstract N°: 455

Mucocutaneous hyperpigmentation due to Vitamin B12 deficiency at a Dermatology Clinic in Dominican Republic

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Introduction & Objectives:

Vitamin B12 deficiency is a potentially fatal disease with a wide spectrum of clinical manifestations; with cutaneous manifestations being considered rare.

The aim of this study was to determine the prevalence of hyperpigmentation due to vitamin B12 deficiency, and other cutaneous and non-cutaneous manifestations at a Dermatology Hospital.

Materials & Methods:

A descriptive, retrospective, cross-sectional study was performed. Patients referred to Hematology clinic at a dermatology hospital from June 2022 to June 2024 were included.

Results:

The prevalence of Vitamin B12 deficiency was 1.22%. Most patients were female (62.5%), mid-aged (55 years), Fitzpatrick skin phototype IV (75%) and omnivorous (62.5%). Hypertension was the main comorbidity (25%). The most frequent cutaneous manifestations were hyperpigmentation (100%), pallor (100%) and glossitis (62.5%), while the most common systemic manifestations were macrocytic anemia (100%), weakness (75%), anorexia (62.5%) and diarrhea (25%). The mean time of therapeutic response to vitamin B12 supplementation was 5 weeks.

Conclusion:

Vitamin B12 deficiency should be suspected in all patients with hyperpigmentation accompanied by pallor and/or glossitis. A high level of clinical suspicion is necessary to make a diagnosis through cutaneous manifestations. However, this represents an easy, fast and economic measure to achieve an accurate diagnosis and an opportune treatment, preventing serious and irreversible complications.

Abstract N°: 529

Calcinosis Cutis: How prevalent is it and how is it treated?

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Calcinosis Cutis: How prevalent is it and how is it treated?

Introduction & Objectives:

Calcinosis cutis (CC) is a deposition of insoluble calcium salts in skin; a rare condition that occurs in autoimmune connective tissue diseases (CTD) as Systemic Sclerosis (SSc) and in patients with nephropathy and chronic ulcers. CC is difficult to treat, causes significant morbidity and negatively affects quality of life. Management strategies in a clinical setting and a systematic review and meta-analysis of worldwide CC prevalence in SSc is reported here. ## ***Materials & Methods:*** A cross-sectional study was conducted at a Danish University Hospital analyzing 49 patients diagnosed with CC over five years. Data on CC distribution and therapy extracted from medical records. Further, using a systematic search protocol relevant articles reporting on the prevalence of CC in the period from 1980-2024 in PubMed, Embase, and Web of Science was performed. The pooled prevalence of CC in SSc was calculated using a meta-analysis based on a random-effects model. A subgroup analysis stratified by geopolitical region was performed. ## ***Results:*** CC was more prevalent in SSc patients, mostly women (94.4%), mean age 60.9 years. Lesions were located on fingers, elbows, and in vicinity of other joints. Sodium thiosulfate (STS) therapy was frequently used (87.8%), with 30% reporting positive effect. Patients received a clinical examination prior to the CC diagnosis, most of also radiography of relevant locations. Patients with CTD had multiple lesions, while patients without CTD had solitary lesions. Surgical excision was performed in 13.9%, and CO2-laser in 8.3%. A total of 1189 articles were identified 86 publications selected for data extraction and utilized in the meta-analyses. The overall globally pooled prevalence of CC among SSc patients was 22.4 % (95 % CI: 20.0-25.0). Studies conducted in Oceania reported higher CC prevalence: 44.9 % (95 % CI: 24.7-67.0), whereas lower rates were found in Africa with 13.1 % (95 % CI: 8.53 -19.6). Tables and figures illustrating all results are presented. ## ***Conclusion:*** Therapeutic management of CC remains challenging, STS shows potential efficacy, but requires further research. CC is more prevalent in female SSc patients and CC lesions are often located on fingers and joints. The systematic review indicate that CC prevalence varies significantly across different geopolitical regions. However, data should be interpreted with caution due to the heterogeneity among included studies due to methodological differences, variations in study design, diagnostic tools, sample sizes and reporting practices.

Abstract N°: 742

Pollution and Climate Change: The Unseen Enemies of Skin Health

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Introduction & Objectives:

Pollution and climate change represent two of the most urgent environmental challenges impacting public health. The skin, as the outermost and most exposed organ, bears the brunt of these environmental aggressors. While the systemic effects of pollutants have been widely documented, their dermatological impact remains underrecognized. This commentary aims to explore the current understanding of pollution- and climate-induced skin damage, evaluate the underlying pathophysiological mechanisms, and propose protective and preventive strategies. It also highlights the emerging role of dermatology in addressing these global environmental threats and calls for a unified scientific, clinical, and regulatory response.

Materials & Methods:

This article is a narrative commentary based on a systematic literature review. Sources were identified through searches of PubMed, Scopus, and Web of Science databases using keywords such as “pollution and skin”, “climate change and dermatology”, “oxidative stress”, “microbiome”, “AI in skincare”, and “environmental dermatology.” Peer-reviewed articles from 2000 to 2025 were screened and selected for relevance to skin-related effects of air pollutants, UV exposure, climate variability, and endocrine-disrupting chemicals. The selection also included studies on dermatological innovation and policy frameworks addressing environmental exposures.

Results:

Environmental pollutants such as particulate matter (PM2.5), nitrogen dioxide, ozone, and volatile organic compounds can penetrate the skin or interact with its surface, triggering the generation of reactive oxygen species (ROS), matrix metalloproteinase activation, and inflammatory cascades. These processes lead to accelerated photoaging, pigmentation disorders, atopic conditions, and barrier dysfunction. Simultaneously, climate change contributes to skin vulnerability through elevated temperatures, fluctuating humidity, and increased UV radiation, all of which exacerbate pre-existing dermatological conditions and compromise the skin’s ability to heal and regenerate.

Emerging insights into epigenetic modifications and microbiome imbalance show how chronic environmental exposure can alter gene expression, immune response, and barrier function in long-lasting and sometimes irreversible ways. Innovative strategies, such as AI-powered skin diagnostics, nanotechnology-based antioxidants, microbiome-restorative skincare, and regenerative treatments (e.g., exosomes), offer promising routes for protection and repair. However, their widespread use requires scientific validation, regulatory approval, and equitable access.

Conclusion:

The dermatological consequences of pollution and climate change are wide-ranging, scientifically supported, and increasingly visible in daily clinical practice. Addressing these challenges requires a multidisciplinary approach that integrates scientific innovation, patient education, environmental responsibility, and policy reform. Dermatologists are uniquely positioned to lead this transformation by advocating for skin-protective strategies that not only treat,

but also prevent, environmentally-induced skin damage.

Abstract N°: 743

Moving Towards an Ecologically Responsible Future

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Introduction & Objectives:

Sustainability is rapidly becoming a central tenet of cosmetic dermatology, aligning clinical practice with global environmental and public health priorities. This commentary aims to highlight the pressing need for sustainable transformation within cosmetic dermatology by evaluating ecological challenges and presenting strategic solutions. Emphasis is placed on integrating environmentally conscious practices into daily operations, from ethical ingredient sourcing to energy-efficient technologies, ultimately contributing to a more resilient, patient- and planet-centered future.

Materials & Methods:

This commentary draws on an extensive review of peer-reviewed literature, international policy frameworks, and industry innovations related to sustainability in healthcare and cosmetic dermatology. Key focus areas include environmental impact assessments, carbon footprint reduction strategies, ethical sourcing, integration of emerging technologies (AI, blockchain, biotechnology), circular economy practices, and evolving regulatory landscapes. The review also considers real-world applications and economic implications of sustainable dermatology practices.

Results:

Findings indicate that sustainability in cosmetic dermatology can be achieved through a multi-faceted approach: (1) adopting eco-friendly materials and energy-efficient technologies reduces waste and emissions; (2) integrating AI and blockchain enhances transparency, resource optimization, and personalized care; (3) ethical sourcing and fair trade improve supply chain integrity and social equity; (4) regulatory frameworks and circular economy models support systemic transformation. Clinics that implement these strategies experience improved patient trust, cost-effectiveness, and long-term viability while contributing to environmental preservation.

Conclusion:

Sustainability in cosmetic dermatology is not only a clinical and ethical imperative but also a strategic opportunity. Integrating responsible practices enhances environmental stewardship, promotes public health, and ensures long-term success in a competitive healthcare landscape. Embracing innovation, ethical responsibility, and regulatory compliance allows dermatology clinics to lead the shift toward an ecologically responsible and patient-centric model of care. This transition supports a more sustainable and inclusive future for both healthcare systems and the ecosystems they affect.

Abstract N°: 782

Beyond Mastocytosis: A Rare Case of Darier's Sign in B-lymphoblastic Lymphoma Skin Infiltrates

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Beyond Mastocytosis: A Rare Case of Darier's Sign in B-lymphoblastic Lymphoma Skin Infiltrates

Introduction & Objectives: Mastocytosis is a rare disorder characterized by pathological mast cell accumulation in various tissues, predominantly the skin. Darier's sign - a diagnostic hallmark of cutaneous mastocytosis - manifests as a localized wheal-and-flare reaction following mechanical irritation. While Darier's sign is considered pathognomonic for mastocytosis, rare exceptions have been documented.* We present an exceedingly rare case of Darier's sign occurring in B-lymphoblastic lymphoma cutaneous infiltrates - a phenomenon reported in only a handful of cases worldwide. This underscores the importance of meticulous histopathological evaluation to avoid misdiagnosis and to enable early, targeted therapeutic intervention.

Materials & Methods: A 21-year-old male patient presented to the dermatology outpatient clinic with multiple pinkish, slightly infiltrated, and coalescent lesions on the ventral and dorsal trunk. The presence of Darier's sign raised suspicion of cutaneous mastocytosis. A skin biopsy was performed, followed by comprehensive histopathological and immunohistochemical analyses. Given the unexpected findings, further hematological workup - including peripheral blood smear and bone marrow examination - was conducted to assess systemic involvement. Based on the hematological results, prompt oncological treatment was initiated by the hematology-oncology team.

Results: Histopathological examination revealed dermal infiltration by atypical immature lymphocytes with no significant mast cell proliferation. Immunohistochemistry confirmed B-lymphoblastic lymphoma cutaneous infiltrates. Subsequent hematological investigations established the final diagnosis. Although Darier's sign is a well-recognized feature of mastocytosis, its occurrence in lymphoma skin infiltrates remains an exceptional phenomenon. In this case, prompt histological examination enabled an accurate diagnosis without unnecessary delay, ensuring timely initiation of appropriate oncological management.

Conclusion: While Darier's sign is classically associated with mastocytosis, its presence in B-lymphoblastic lymphoma cutaneous infiltrates is an extremely rare finding. This case highlights the importance of maintaining a broad differential diagnosis when encountering Darier's sign and reinforces the indispensable role of histopathology in distinguishing between dermatological and hematological disorders. Awareness of such atypical presentations can aid clinicians in circumventing diagnostic pitfalls, expediting definitive diagnosis, and optimizing patient outcomes.

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Abstract N°: 863

Severe Hemorrhagic Cheilitis as the Initial Manifestation of Systemic Lupus Erythematosus: A Rare Case Report

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Introduction & Objectives:

Systemic Lupus Erythematosus (SLE) is a multisystem autoimmune disease with a diverse array of mucocutaneous manifestations. Classical oral involvement in SLE manifests as painless ulcers on the hard palate. Lupus cheilitis, particularly severe hemorrhagic form, is rarely reported. Herein, we report an uncommon case of severe hemorrhagic and crusted cheilitis as the initial manifestation of SLE, highlighting its diagnostic and therapeutic implications.

Materials & Methods:

A 58-year-old female patient presented to the dermatology unit with complaints of painless oral ulcers involving buccal mucosa and lips for the past three months accompanied by fever for last two weeks. On examination severe hemorrhagic crusting predominantly involving the lower lip was notable with ulceration of the buccal mucosa. There was no cutaneous blistering or ulceration, photosensitivity, joint pains, sicca symptoms or a family history of autoimmune disease. There was no history of prior medication use, including anti-epileptics to suggest a drug reaction. Her regular medications included: losartan, hydrochlorothiazide, and atorvastatin.

Laboratory investigations shown below confirmed SLE based on the EULAR/ACR 2019 classification criteria, with a total score of 12 points.

Test	Patient's Value	Reference range
Full blood count		
WBC	4.19	4.0-10.0 x10 ^{3} /µL
Neutrophils	70.5 %	50 -70 %
Lymphocytes	20.9 %	20 – 40 %
Eosinophils	0.2 %	0.5 -5 %
Hb	10	12.1 – 16.6 mg/dl
MCV	88.3	80 -100 fL
Platelets	92 x 10^3	150 - 400 x 10^3/µL
Blood picture	No hemolysis	
C-reactive protein	28.9	<8 U/L
ESR	30	<15 mm 1st hour
Liver function tests		
AST	102 U/L	≤ 35 U/L
ALT	40.5 U/L	≤ 45 U/L
Total protein	6.0	6.6 – 8.3 g/dL
Albumin	2.9	3.4 – 5.4 g/dL
Renal function test		
Serum creatinine	45	65 - 120 µmol/L
Sodium	135	137 – 148 mmol/L
Potassium	3.3	3.9 – 5.2 mmol/L
LDH	265	105 – 333 IU/L
UFR	Protein Nil Cells Nil	
ANA	1:320 nuclear pattern	1:80
C3	32.4	90-180 mg/dL
C4	6.8	10-40 mg/dL

She was started on oral prednisolone 40 mg daily along with HCQ 200mg after excluding any pre-existing

maculopathy.

Results:

The patient showed a dramatic clinical improvement following corticosteroid therapy, with resolution of the hemorrhagic cheilitis. However, she was lost to follow-up after initial treatment.

Conclusion:

Severe hemorrhagic cheilitis is an uncommon mucocutaneous manifestation of SLE and may be misdiagnosed due to its rarity. In this case, lower lip involvement suggested a potential role of photoaggravation. While management guidelines for oral lupus remain limited, systemic corticosteroids and HCQ showed rapid effectiveness. This case underscores the importance of recognizing atypical presentations of SLE for early diagnosis and intervention.

Abstract N°: 868

Cutaneous Clues to a Systemic Malignancy: A Case of Multiple Myeloma Presenting with Skin Plasmacytomas

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Introduction & Objectives:

Cutaneous plasmacytomas are rare manifestations of plasma cell neoplasms and may precede the diagnosis of multiple myeloma. Recognizing such skin findings is crucial for early systemic evaluation and intervention. This case highlights the importance of dermatologic examination in the early detection of systemic malignancies.

Materials & Methods:

An 85-year-old male presented with violaceous nodules under the right ear, lateral to the left eye, and on the upper lip. He had a history of coronary artery disease, hypertension, and previous excision of basal cell carcinomas.

Skin biopsies were obtained from the three nodular lesions. Laboratory evaluation included serum calcium, hemoglobin, creatinine, and glomerular filtration rate (GFR). PET-CT imaging was performed to evaluate systemic involvement.

Results:

Histopathological analysis of the skin biopsies revealed diffuse infiltration of atypical plasma cells. Immunohistochemistry showed positive staining for CD38, CD138, and lambda light chain, while staining for kappa, CD3, CD20, CK5/6, CK20, and CK7 was negative.

Laboratory tests showed serum calcium of 11.7 mg/dL, hemoglobin of 11 g/dL, creatinine of 1.43 mg/dL, and GFR of 43 mL/min. Bone marrow biopsy revealed 89% plasma cell infiltration. PET-CT demonstrated diffuse lytic lesions in bones and metabolic activity in the parotid gland, hard palate, and sigmoid colon. Serum protein electrophoresis indicated 52% gamma globulin, and immunoelectrophoresis detected a monoclonal IgG lambda band.

The patient was diagnosed with multiple myeloma and received VCD chemotherapy (bortezomib, cyclophosphamide, dexamethasone). After four cycles, clinical and laboratory improvement was observed, and the regimen was switched to lenalidomide and dexamethasone. Cutaneous lesions showed marked regression after the second cycle.

Conclusion:

Cutaneous manifestations may be the first indication of systemic malignancy such as multiple myeloma. Prompt recognition and biopsy of suspicious lesions by dermatologists can facilitate early diagnosis and treatment. This case underscores the essential role of dermatologic assessment in systemic disease identification.

Abstract N°: 949

paraneoplastic pruritus after chemotherapy in lymphoproliferative neoplasms

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Introduction & Objectives:

Pruritus is often associated with lymphoproliferative neoplasms. It can either precede the diagnosis of malignancy or can develop later after diagnosis and initiation of chemotherapy. Pruritus, in these patients is a paraneoplastic phenomenon. We here report a series of four cases of who presented after chemotherapy in various lymphoproliferative neoplasms.

Materials & Methods:

All patients of lymphoproliferative neoplasms who suffered from pruritus were referred to the department of dermatology. These patients were evaluated thoroughly for presence of any dermatological or systemic disease. After detailed history taking, clinical examination and appropriate investigations, a final diagnosis of eosinophilic dermatosis of hematological malignancy (EDHM) was established.

Results:

We identified 4 cases (all females) of EDHM over a period of 1 year. Their age ranged 26 to 76 years. All these cases were referred from the department of hematology for evaluation of generalized pruritus and skin lesions. Duration of pruritus at the time of presentation ranged from 2 to 4 weeks. All patients were diagnosed cases of lymphoproliferative neoplasms – classic Hodgkin's lymphoma (case 1), chronic lymphocytic leukemia (case 2 and 4) and low grade B cell non-Hodgkin lymphoma (case 3). All cases had generalized pruritus with moderate to severe intensity. On examination, 3 of them had multiple, erythematous, papules and small plaques with excoriations which resembled insect bites, while one (case 2) had multiple, erythematous nodular lesions. All these cases had developed pruritus after chemotherapy (table 1). All cases had peripheral blood eosinophilia as well as tissue eosinophilia as demonstrated in skin biopsy. No evidence of malignancy was demonstrated in skin lesions. On the basis of above clinical presentation and laboratory findings, we established a diagnosis of EDHM. All cases were treated with a combination of antihistamines and topical steroids. However, two of them (case 1 and 4) required additional therapy in the form of oral doxycycline (case 1) and prednisolone (case 4) after which they improved symptomatically. As EDHM is paraneoplastic in nature, treatment of malignancy was continued in all the 4 cases. Case 2 and 3 are now in clinical remission, case 1 is currently planned for bone marrow transplant (in view of disease progression) and case 4 is currently on acalabrutinib.

Conclusion:

EDHM is a rare paraneoplastic condition which can present with variable morphology in the setting of various hematological malignancies. It has a chronic, relapsing course and can develop after initiation of chemotherapy. Clinicians must be aware regarding this condition while dealing with pruritus in such cases and differentiate it from other disorders like scabies, insect bite, drug rash etc. Further studies are required to identify any gender predisposition and specific drugs precipitating this newly recognised entity and its relation to the prognosis of malignancy.

Table 1. Chemotherapeutic regimens received by patients

Case No.	Chemotherapy drugs	No. of cycles received prior to onset
1.	Bendamustine and brentixumab	One (had previously received 6 cycles of ABVD regimen)
2.	Bendamustine and rituximab	Two
3.	Bendamustine and rituximab	Two
4.	Bendamustine and rituximab	Two

Abstract N°: 958

Vanishing dermatosis: Methotrexate-associated lymphoproliferative disorder.

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Introduction & Objectives:

Methotrexate-associated lymphoproliferative disorders (LPD) are a unique type of neoplasms that are associated with a functional defect in immune surveillance induced by iatrogenic immunosuppression. On other hand, lymphomatoid granulomatosis (LyG) is a rare presentation of an EBV-associated B cell LPD not typically associated with immunosuppression that can be associated with a dire prognosis. Infrequently, these two entities can merge in a same disease.

Case Presentation:

A 64-year-old woman with a 30-year a history of rheumatoid arthritis who was treated with methotrexate for the last 10 years presented to the emergency department with 15-day history of non-specific fever and sixth cranial nerve palsy. Physical examination revealed a localized dermatosis characterized by an erythematous nodule on the chin. Within 48 hours, multiple subcutaneous erythematous nodules appeared predominating on the chest, back, and scalp. PET-CT scan demonstrated multiples lesions in soft tissue, lungs, and supra- and infradiaphragmatic lymphadenopathies with increased metabolic activity. A skin biopsy from one of the lesions on the back was performed which revealed a diffuse lymphocytic infiltrate with three cellular types identified: large size, pleomorphic lymphocytes positive to CD30 and LMP1, admixed with CD20, BCL2, PAX5 and cMYC-1 positive medium size lymphocytes and CD3-positive small lymphocytes. Considering the history of the patient, the association of the skin lesions with a nodular lung infiltrate and the histological findings, a methotrexate-associated, EBV-positive, lymphomatoid granulomatosis-like lymphoproliferative disorder was diagnosed. Methotrexate was discontinued at admission and during follow-up, skin lesions started to fade away without other treatment suggesting a LPD related to immunosuppressive therapy.

Discussion:

Methotrexate-associated LPDs show a unique biology that separates it from other LPDs as they tend to show spontaneous regression once the drug is discontinued due to the recovery of immune surveillance that allows elimination of EBV-infected B-cells by cytotoxic CD8+ cells. This disease mainly manifests as lymphadenopathies but multiple cutaneous manifestations have been recently described including ulcerated nodules, deep seated nodules resembling erythema nodosum and even presentations mimicking small-vessel vasculitis. In contrast, LyG patients develop strictly extranodal manifestations such as a lung nodular infiltrate, and neurologic alterations such as dysarthria, diplopia or hemiparesis.. Skin involvement is common with two main patterns recognized: disseminated erythematous subcutaneous nodules with or without ulceration as the most frequent manifestation, followed by multiple, indurated, erythematous or whiteish plaques as an infrequent form. Diagnosis of both diseases requires histologic confirmation with demonstration of EBV-infected cells by EBER in situ hybridization. Treatment is controversial since there is no consensus over a standard, however, histologic grading of the disease is critical to select an adequate treatment strategy.

Conclusion:

LPDs are rare complications of long-term methotrexate use that show this drug is not innocuous. These variable manifestations highlight the importance of taking into consideration the patient's complete history, especially medication use, and all systemic manifestations to reach a correct diagnosis.

Abstract N°: 1026

A clinical observational study of skin changes in pregnancy

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Introduction & Objectives: Pregnancy induces significant metabolic, hormonal, and immunological changes, often leading to various dermatological manifestations. These skin changes range from common physiological alterations to pregnancy-specific dermatoses, such as atopic eruption of pregnancy, polymorphic eruption of pregnancy, pemphigoid gestationis, and intrahepatic cholestasis of pregnancy. While most are benign, some conditions may pose clinical or cosmetic concerns and, in rare cases, impact maternal or fetal health. Pregnancy can also influence pre-existing skin disorders, altering their severity or progression.

This study aims to determine the prevalence of physiological and pathological skin changes in pregnant women attending antenatal clinics in Misrata, Libya.

Materials & Methods: This cross-sectional observational study was conducted over one year in antenatal clinics across public and private healthcare facilities in Misrata, Libya. A total of 500 pregnant women were included. Data collection involved a structured proforma covering demographic details, medical and obstetric history, and dermatological complaints. Comprehensive physical and dermatological examinations were performed, with specific attention to physiological skin changes and pregnancy-specific dermatoses. Routine laboratory investigations, including CBC, urinalysis, liver and renal function tests, and infectious disease screenings (HIV, HBV, HCV), were conducted. Additional diagnostic tests, such as fungal scraping, KOH examination, and skin biopsies, were performed when indicated. Statistical analysis was conducted using SPSS v21.

Results: A total of 500 pregnant women aged 19 to 40 years (mean age: 26.2 ± 5.43 years) participated in the study. The majority (57.4%) were in the third trimester, and 60% were primigravida. Physiological skin changes were observed in 99% of participants, with pigmentary changes being the most common (82.8%), followed by connective tissue changes (56.2%). Striae gravidarum was the most frequently reported change (50.4%), predominantly affecting primigravida women ($p < 0.0001$). Specific dermatoses of pregnancy were identified in 3% of cases, with atopic eruption of pregnancy (2.4%) being the most prevalent. Coincidental and pre-existing skin diseases were noted in 40.4% of participants, with fungal infections being the most common (16.6%), followed by viral infections (7.8%) and acne vulgaris (6.8%). No cases of pemphigoid gestationis or intrahepatic cholestasis of pregnancy were recorded.

Conclusion: This study highlights that most pregnancy-related skin changes are physiological and self-limiting, with pigmentary alterations being the most common. Striae gravidarum was significantly more prevalent in primigravidas, while skin tags were more frequent in multigravidas. Pregnancy-specific dermatoses were rare (3%), with atopic eruption of pregnancy being the most common.

Abstract N°: 1028

Nagashima disease Following Bariatric Surgery: A Case Report

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Introduction: Bariatric surgery is an effective intervention for severe obesity and related comorbidities. The global increase in obesity has led to a rise in bariatric procedures, highlighting the need for evaluation and management of postoperative complications. These complications vary from minor issues to life-threatening events.

Prurigo pigmentosa (PP), also known as Nagashima disease, is an acquired dermatological condition characterized by a markedly pruritic eruption of erythematous papules and papulovesicles on the back, neck, and chest and improved leaving macular reticulated hyperpigmentation. First described in 1971 by Japanese dermatologist Masaji Nagashima, the condition was initially observed among eight patients of Asian descent. PP has been strongly associated with ketosis and a ketogenic diet; however, its precise etiology remains unclear.The condition predominantly affects young women of Asian descent. Here, we report a case of PP in a Libyan male, which developed 13 days post-bariatric surgery. This presentation could be suggestive of a stronger relationship between PP and the metabolic state of the body. It also outlines the effectiveness of treatment options currently in use for treating PP.

Conclusion: Prurigo pigmentosa (PP) is classically observed in young adult females from Eastern Asia, often associated with adherence to a ketogenic diet. In contrast, we present a case of a young Libyan male who developed PP following bariatric surgery. Treatment with doxycycline led to complete resolution of the condition. Given the largely nonspecific clinical and histopathological features of PP, a high index of suspicion is essential, as many cases may remain undiagnosed.

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Abstract N°: 1048

Persistent Vesiculopustular Eruption of Inflammatory Bowel Disease (VPE-IBD) on the scalp that responded to intravenous immunoglobulins and retinoids - A Challenging Case

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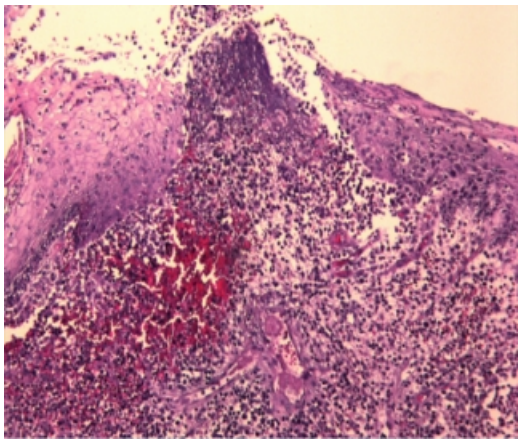
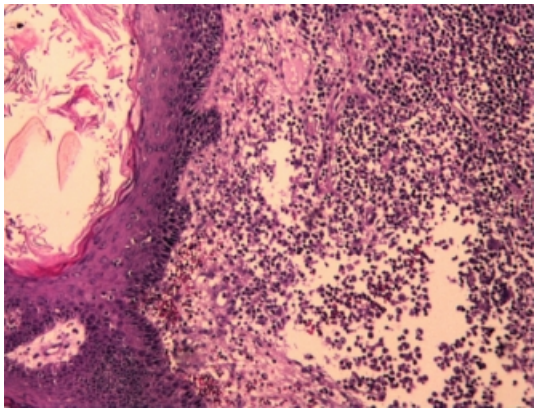
Introduction & Objectives: The Vesiculopustular Eruption of inflammatory bowel disease (VPE-IBD) is a rare reactive dermatological manifestation related to Ulcerative Colitis. It is mainly observed during flares of the disease, while, an improvement in the bowel corresponds to improvement on the skin. The pathogenesis of VPE-IBD is unclear. Histologically, a cytokine environment driven by T-lymphocytes (including TNF-a ,IL-17 and IL-22) has been described. Therefore, the analogous therapeutic options should be successful (e.g. anti-TNFa, anti-IL-17, anti-IL-22). Regarding treatment there are numerous reports on corticosteroids and anti-TNFa and minimal references to retinoids and biologics. A case of a persistent vesiculopustular eruption on the scalp associated with ulcerative colitis in remission is presented below.

Materials & Methods: A 62-year-old man, previously diagnosed with Ulcerative Colitis on Mesalazine and in remission, presented with longstanding recurrent infiltrated pustular erythematous plaques, crusted in some areas, on the scalp and chest. Clinically cervical lymphadenopathy was noted. Multiple previous trials of various antibiotics and antifungals resulted in only temporary and partial improvement leading to hospitalization of the patient for investigation and treatment.

Results: During the patient's hospitalization, pus and tissue cultures for microorganisms and fungi, two biopsies for histological examination and immunohistochemistry, immunological serology testing and imaging of the cervical lymphnodes were performed. The cultures grew Klebsiella pneumoniae sensitive to macrolides and Microsporum Canis. The biopsy revealed a dense inflammatory infiltration of the dermis, epidermis and hair follicles with erosions and folliculitis including lymphocytes, plasmatocytes, and neutrophills setting the diagnosis of vesiculopustular eruption associated with inflammatory bowel disease (figures 1,2). The rest of the investigations were unremarkable. Colonoscopy was performed which confirmed ulcerative colitis in remission. The patient received antibiotic therapy (IV Ciprofloxacin, p.os Clindamycin 300mgx2 /d for 4 weeks) and antifungal therapy (Itraconazole 200mg/d for 7 weeks) with topical and systemic corticosteroids gradually reduced from 30mg/day. Despite the initial satisfactory clinical improvement the skin soon relapsed, repeat cultures were sterile, therefore ,a trial of intravenous immunoglobulin was initiated (30gr/d for 3 days and repeat in 21d). Due to another relapse shortly after the first IvIG infusion,oral isotretinoin 20mg/d was added with a slow dosage reduction and topical combinations of calcipotriol/ betamethasone diproprionate 0.5% and erythromycin/benzoyl peroxide. Immediate improvement was noted and remission of skin and bowel remained beyond 4 months and after 8 infusions of immunoglobulin and isotretinoin at 10mg every other day.

Conclusion: This is a very rare case as ulcerative colitis was in remission despite the intense dermatological clinical picture, making the treatment challenging. The use of intravenous immunoglobulin with oral retinoids and concomitant topical therapy of calipotriol/corticosteroid/benzoyl peroxide proved to be an effective combination for the treatment of the patient. This combination has not been previously reported in the literature for the corresponding dermatological entity.





Figures 1,2.

Abstract N°: 1052

unique case of hair regrowth in a patient with lipoid proteinosis

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Introduction & Objectives: Lipoid proteinosis (LP) or hyalinosis of the skin and mucous membranes or Urbach-Wiethe syndrome is a rare hereditary disease, transmitted by a recessive autosomal gene, due to mutations in the ECM1 gene located on chromosome 1q21. It involves a collagen disorder resulting in the deposition of hyaline, a lipoprotein substance, in the skin, mucous membranes, brain and other organs. The eyelids are a characteristic location. Main clinical features of the disease include the appearance of waxy papules and nodules on the skin and oral mucosa, thickening of the tongue, while a typical finding is hoarseness, the result of hyaline infiltration of the vocal cords. Scalp involvement with accompanying , usually scarring , alopecia is a rare manifestation of the disease. We present a unique case of a patient diagnosed with lipoid proteinosis since the age of six, with hoarseness of voice, involvement of the skin, oral mucosa and reproductive system, CNS and scalp with diffuse alopecia, who, after 6 months of treatment with acitretin 25 mg bid, presented improvement in pigmentation, hoarseness of voice and spectacular regression of alopecia.

Materials & Methods: A 39-year-old patient with diagnosed lipoid proteinosis since the age of 6 with CNS involvement, presented to seek treatment for skin, mucous membrane and scalp involvement with diffuse alopecia. The patient was receiving treatment with carbamazepine, lacosamide and brivaracetam due to epileptic seizures. During clinical examination, papules and nodules of a whitish-yellow color were observed on both eyelids, face, neck and elbows. Oral mucosa involvement and extensive parietal and temporal alopecia were also observed. Laboratory tests were performed, which were normal. She was treated with topical corticosteroid and minoxidil 2% and acitretin 25 mg bid for 6 months.

Results: After the end of the treatment, spectacular improvement in alopecia, improvement in scalp and facial pigmentation, and mild improvement of hoarseness were observed.

Conclusion: LP, as a rare disease, lacks sufficient literature and consequently clearly defined guidelines for its treatment. The therapeutic options include systemic therapies (acitretin, etretinate, dimethyl sulfoxide, corticosteroids, penicillamine), surgeries and lasers. Low-dose acitretin seems to be superior therapeutically due to fewer side effects. In our case, with an unknown mechanism, a spectacular improvement in the patient's alopecia was observed. To our knowledge, our patient is a unique case of hair regrowth in a patient with lipoid proteinosis.

Abstract N°: 1153

Beyond the cervix: uncommon skin involvement in cervical cancer

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Introduction & Objectives:

Cutaneous metastases from internal malignancies are** uncommon, with an estimated incidence of approximately 5%, being more frequently** observed in women aged 50–70.

Cervical cancer is the most common gynecologic malignancy and the leading cause of death among gynecologic cancers. The most frequent sites of metastasis are the lungs, bones, and liver. Cutaneous metastases are exceptionally rare, with an incidence ranging from 0.1% to 2%, representing a significant diagnostic challenge. They typically present as nodules, plaques, or inflammatory telangiectasias, most commonly affecting the abdominal wall, vulva, and anterior chest. Cutaneous metastases signal poor prognosis and often coincide with visceral metastases at diagnosis.

We present the case of a patient with a history of cervical squamous cell carcinoma and multiple local recurrences, who developed a cutaneous metastasis.

Materials & Methods:

Data were collected from the electronic medical record system of the Government of the City of Buenos Aires for a patient admitted to the Internal Medicine Department, who presented cutaneous lesions during hospitalization, prompting a consultation with our service.

Results:

A 71-year-old female patient with a history of cervical squamous cell carcinoma diagnosed in 2006, for which she underwent hysterectomy, chemotherapy, radiotherapy, and brachytherapy. She also had a history of left dorsal herpes zoster in 2023 and 2024. She was admitted to the Internal Medicine Department due to a fall from standing position in January 2025. During hospitalization, bilateral pleural effusion, a humeral fracture, lymphadenopathy, and osteolytic lesions were documented. A cutaneous lesion on the lateral aspect of the neck, with one year of evolution, was also noted, prompting a dermatology consultation.

Physical examination revealed a dermatosis located on the left supraclavicular region, extending to the lateral neck and upper back. It consisted of a painless, irregularly bordered erythematous-violaceous plaque measuring 10×5 cm, with a centrally indurated area covered by an adherent serous crust. The periphery of the lesion showed erythematous, stone-hard nodules. Similar lesions were observed on the vulva and inner thighs, associated with regional induration.

Three punch biopsies were performed. Histopathological analysis revealed skin infiltration by poorly differentiated carcinoma with focal necrosis, p16 positivity, and evidence of angiolymphatic neoplastic emboli in the superficial dermis.

These findings, along with the patient’s oncological history, led to the diagnosis of cutaneous metastasis from cervical squamous cell carcinoma, presenting in the same anatomical region where she had previously developed herpes zoster, suggesting Wolf’s isotopic response phenomenon.

Despite medical care, the patient’s condition worsened, and she passed away a few days later.

Conclusion:

This case highlights the unusual presentation of cutaneous metastases in patients with cervical cancer. We emphasize the importance of always considering cutaneous metastases as a differential diagnosis when evaluating dermatoses in patients with a history of malignancy, particularly when manifesting as Wolf’s isotopic phenomenon, scarcely reported in the literature.

Finally, we recall the poor prognosis associated with cutaneous metastases at the time of diagnosis.

Abstract N°: 1271

Stool Biomarkers as a Clue for Developing Crohn's Disease in Idiopathic Pyoderma Gangrenosum Patients

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Introduction & Objectives:

Pyoderma gangrenosum (PG) is a neutrophilic dermatosis characterized by rapidly progressing cutaneous ulcers, often affecting the lower extremities. In 30–50% of cases, PG is associated with systemic conditions such as inflammatory bowel disease (IBD), rheumatoid arthritis, and hematological malignancies. However, in idiopathic cases where no comorbidity is initially identified, predicting future systemic disease remains a clinical challenge. This study aimed to assess whether non-invasive stool biomarkers—specifically fecal blood and fecal calprotectin—can serve as early predictors for the development of IBD, particularly Crohn's disease, in patients with idiopathic PG.

Materials & Methods:

This retrospective cohort study included 66 PG patients diagnosed between 2000 and 2024 at a single dermatology center. Patients with known systemic diseases were excluded. The remaining 21 idiopathic PG patients underwent stool testing at baseline, prior to immunosuppressive therapy. Stool blood tests and fecal calprotectin levels were assessed, and patients were followed longitudinally for the development of IBD. Associations between biomarker results and subsequent Crohn's disease diagnosis were analyzed using Fisher's Exact Test. Sensitivity, specificity, positive predictive value (PPV), and negative predictive value (NPV) were calculated for each biomarker.

Results:

The follow-up duration ranged from 1 to 130 months (mean: 49 months). Four of the 21 idiopathic PG patients (19%) developed Crohn's disease within a median latency of 36 months.

- **Stool Blood Test:** All four patients who developed Crohn's disease had positive stool blood tests, whereas only 3 of the 17 patients without Crohn's had positive results (p=0.0058). This yielded a sensitivity of 100%, specificity of 82.35%, PPV of 57.14%, and NPV of 100%.
- **Fecal Calprotectin:** Elevated calprotectin (>50 µg/g) was found in 2 of the 4 Crohn's patients (levels: 85 and 792 µg/g) and in none of the 17 patients without Crohn's (p=0.0286). This corresponded to a sensitivity of 50%, specificity of 100%, PPV of 100%, and NPV of 89.47%.

Conclusion:

This study highlights the clinical utility of stool blood and fecal calprotectin tests as predictive, non-invasive biomarkers for Crohn's disease in idiopathic PG patients. Stool blood testing demonstrated excellent sensitivity and NPV, making it a valuable screening tool, while fecal calprotectin offered high specificity and PPV, supporting its role in diagnostic refinement. These findings emphasize the need for early gastrointestinal evaluation in idiopathic PG patients presenting with positive stool biomarkers. Despite limitations including small sample size and retrospective design, the study provides compelling evidence supporting systematic screening and follow-up in idiopathic PG to facilitate timely diagnosis and management of underlying IBD.

Abstract N°: 1334

Underrecognized Complication of Breast Cancer Radiotherapy: Arteritis and Digital Necrosis

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Introduction & Objectives: Radiation-induced arteriopathy (RIA) may develop in long-term survivors of breast cancer who have undergone radiation therapy. This condition is often underdiagnosed and may present as arm pain, chills, and ischemia due to narrowing of the subclavian artery. Risk increases significantly beyond 10 years after radiotherapy. We present the case of a patient with an 18-year history of breast cancer who developed digital ischemia secondary to radiation.

Materials & Methods: A 76-year-old female with an 18 year history of breast cancer with liver, cervical spine and thorax metastasis undergoing treatment with radiotherapy, chemotherapy with paclitaxel+doxorubicin and hormone blocker, presented a month history of cyanosis in right upper extremity. Physical exam revealed permanent purpuric violet macule on the right palm. During follow up, she developed persistent painful acral cyanosis and digital necrosis. Autoimmune vs vasculopathy syndromes were considered. The patient had no supportive clinical or laboratory findings other than an isolated elevation of ANA. Upper extremity CT revealed occlusion of the right distal subclavian and axillary arteries with reconstitution of flow. Diagnosis of arteritis secondary to radiation therapy was made.

Results: RIA involving the axillary-subclavian artery after irradiation for breast cancer (BC) has been rarely reported in the literature. Its recognition may be increasing due to long term survival, use of radiation as a therapeutic option, and imaging advances diagnosis. It is characterized by endothelium injury, inflammation and fibrosis leading to arterial thickening and stenosis. Ionizing radiation results in endothelial dysfunction and increased permeability. This damage initiates a cascade of inflammatory responses that contribute to the development of fibrointimal hyperplasia,a process in which the arterial intima thickens through smooth muscle cell proliferation and extracellular matrix deposition.

It can affect the axillary-subclavian, coronary, and carotid arteries, resulting in claudication, arm pain, and paresthesias.In this case, the patient initially presented with paresthesias along with discrete purpuric retiform macules leading to digital necrosis.

The nature and severity of RIA depends on several factors like radiotherapy techniques, and atherosclerotic risk factors. In this case, the patient’s history of reirradiation, surgery in the irradiated field, and the different techniques of RT she received could favor development.

Doppler examination, CT, and angiography can be used to confirm diagnosis. Primary prevention with control of atherosclerotic risk factors is recommended..Treatment options like surgical or endovascular interventions have also been described, but surgical approach could have more complications due to extensive tissue fibrosis induced by radiotherapy, and other complications such as neurovascular or neurological compromise. After revascularization, treatment with aspirin and clopidogrel might be recommended.

Conclusion RIA is an etiology that must be taken into account in cancer patients presenting with digital necrosis

and previous radiotherapy, even after many years. Regular monitoring and appropriate management are essential to reduce the risk of serious complications.

Abstract N°: 1538

Exogenous Exosome-Induced Linear Scleroderma (En Coup de Sabre): A Case Report

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Introduction: Exosomes are nanosized vesicles derived from stem cells that transport biomolecules involved in tissue regeneration and immune modulation. Despite their promising therapeutic potential, the lack of standardized protocols and solid clinical evidence currently limits their use in dermatology. We report a rare case of linear morphea (en coup de sabre) developing after exogenous exosome injection, raising concerns about a possible link to autoimmune disease induction.

Case Presentation: A 52-year-old woman, with no significant medical history, presented with a frontal alopecic patch at the hairline, progressively appearing over three months following intralesional injection of exogenous exosomes . Dermatological examination revealed a non-scarring band-like alopecic plaque in the mid-frontal area, extending onto the forehead, with overlying sclerotic, erythematous, and anesthetic skin . Clinical diagnosis of linear scleroderma was made. The rest of the clinical exam was unremarkable. The patient declined both skin biopsy and immunological tests, preventing assessment of autoantibodies.

Discussion: Exogenous exosomes, particularly from stem cells, play a central role in intercellular communication and can influence fibrosis by activating fibroblasts and promoting their differentiation into myofibroblasts—key drivers of tissue fibrosis. These cells are marked by stress fiber accumulation, α-smooth muscle actin (α-SMA) expression, and increased production of profibrotic extracellular matrix (ECM) proteins . In systemic sclerosis (SSc), exosomes transport profibrotic molecules such as TGF-β and IL-6, along with microRNAs (e.g., miR-21, miR-29a) that regulate collagen synthesis and metalloproteinase activity. Nakamura and Wermuth demonstrated that exosomes stimulate collagen production by fibroblasts in SSc models. Although not directly studied in localized scleroderma, similar pathways may be involved. Additionally, exosomes can modulate inflammation, another key factor in connective tissue diseases . Their elevated levels in SSc and ability to promote fibrosis via paracrine signaling support the hypothesis of their involvement in localized sclerotic processes . Thus, in a predisposed individual, exosome injection may trigger an imbalance in profibrotic and immunoregulatory signals, initiating a fibrotic response that may progress independently of the injection site.

Conclusion: This case raises the possibility of a link between linear morphea and exogenous exosome therapy. The exosomes may have triggered disease onset in a predisposed host. Although speculative, this association highlights the need for further studies to better understand the potential pathological effects of exosomes in clinical settings.

Abstract N°: 1577

A rare case of polyarteritis nodosa involving the female reproductive tract and skin

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Introduction & Objectives:

Vasculitis of the female reproductive tract is a rare and poorly understood condition, often found incidentally during histopathological examination following gynecological surgery performed for other reasons. It most commonly presents as vaginal bleeding, but can also present with pelvic pain, uterine prolapse, a pelvic mass or an abnormal cervical smear. It is usually localised to the female genital tract, particularly the cervix, and tends to follow a benign course. It can rarely be associated with systemic vasculitides including polyarteritis nodosa (PAN). Whilst testicular involvement in the form of orchitis is a hallmark of PAN in males and part of its diagnostic criteria, little is known about the female equivalent due its relative rarity, making diagnosis more challenging.

Materials & Methods:

We report a rare case of polyarteritis nodosa involving the female reproductive tract and skin.

Results:

A 42-year-old female was referred to the rheumatology clinic with vasculitis of the female reproductive tract. She had previously undergone a hysterectomy and salpingo-oophorectomy for menorrhagia, with histopathology unexpectedly showing fibrinoid necrosis and a predominantly lymphocytic perivascular infiltrate involving the vessels of the cervix and fallopian tubes, with sparing of the uterus.

Upon further questioning, the patient reported a 10-year history of relapsing-remitting painful nodules and ulcers affecting the lower limbs. She denied any other systemic symptoms and had no significant past medical history. Her family history was also unremarkable.

Clinical examination revealed livedo reticularis and post-inflammatory pigmentation changes of the lower legs and forearms. She had no active ulceration, tender nodules or palpable purpura and was normotensive. Laboratory tests, which included a full vasculitic screen, were unremarkable. Punch biopsies from affected areas of the forearm and upper thigh were performed for histopathological examination. Histology showed perivascular lymphohistiocytic inflammation with an intramural fibrinoid ring in small to medium-sized vessels in the deep dermis, consistent with a diagnosis of polyarteritis nodosa. The patient subsequently underwent a coronary angiogram, which was reassuring and showed no evidence of aneurysms or coronary artery disease. She was then commenced on methotrexate with excellent response. Her disease remains well controlled on 15mg once weekly, with no recurrence of skin lesions.

Conclusion:

In conclusion, this case underscores the diagnostic challenges associated with vasculitis of the female reproductive tract and the importance of monitoring for any systemic involvement. Our case also highlights the value of

performing full skin examinations in these patients to identify any cutaneous signs that may indicate systemic disease.

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Abstract N°: 1580

The Importance of Dermatological Evaluation in the Early Diagnosis of Li-Fraumeni Syndrome: A Case Report.

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Introduction: Li-Fraumeni syndrome (LFS) is an inherited disorder that increases the predisposition to the development of various types of cancer. Clinical manifestations are varied, depending on the presentation phenotype, and cutaneous lesions can be the initial manifestation of the disease (1). We present the case of a patient in whom LFS was diagnosed following the identification of a cutaneous lesion.

Clinical Case: A 53-year-old female patient with a personal record of hypertension and a family background of breast cancer in her paternal aunt presented with a two-year history of a slowly growing, occasionally painful, skin-colored nodule with xanthochromic areas, measuring 19 x 13 mm on the right submandibular region. On full-body physical examination, no other similar lesions were found. The initial diagnostic impression was sebaceous adenoma, and an excisional biopsy of the lesion was performed, which confirmed a mesenchymal neoplasm consistent with pleomorphic fibroma, exhibiting intense and homogeneous nuclear expression of p53 throughout the lesion. Due to the association between pleomorphic fibroma and Li-Fraumeni syndrome, genetic testing was conducted, revealing a pathogenic variant in the TP53 gene, thus confirming the diagnosis. The patient is currently under follow-up with dermatology, oncology, and genetics, with no evidence of malignant neoplasms to date.

Discussion: Li-Fraumeni syndrome (LFS) was first described in 1969 by Frederick Li and Joseph Fraumeni. It is an autosomal dominant syndrome caused by mutations in the TP53 germline gene, which encodes the p53 protein, primarily involved in regulating the cell cycle, DNA repair, cellular senescence, and apoptosis (1–3). This syndrome predisposes individuals to develop various types of cancer throughout their lifetime, with a 70-100% risk of developing at least one cancer before the age of 60. The most associated cancers include osteosarcomas, soft tissue sarcomas, breast cancer, brain tumors, and leukemias (1–3). Cutaneous malignancies such as melanoma have been described (4), and other less common lesions as pleomorphic fibroma (PF), a rare benign fibrous neoplasm first described in 1989 (5). PF is characterized by cellular atypia and pleomorphism without mitosis and presents clinically as a soft, skin colored nodule, primarily located on the face, neck, and upper trunk. Clinically, it can resemble a schwannoma or neurofibroma, and histologically, its main differential diagnoses include atypical fibroxanthoma, pleomorphic dermal sarcoma, and liposarcoma. Although PF is a benign neoplasm, it is closely associated with LFS (5–9). Therefore, dermatological evaluation can serve as the gateway for diagnosing this syndrome. Treatment of LFS depends on the malignant neoplasm that develops. Regular follow-up with imaging is recommended, with whole-body magnetic resonance imaging being preferred, along with colonoscopy, and ultrasound of the abdomen, pelvis, and thyroid at least once per year (10). This follow-up is currently being performed in our patient.

Conclusion: Dermatological evaluation plays a crucial role in the early detection of LFS, as cutaneous lesions such as PF can be the initial manifestation of this disorder. Early identification of these lesions allows for genetic testing, which can confirm the diagnosis and facilitate the prevention of malignant cancers, improving the prognosis and quality of life for patients and their families.

Abstract N°: 1692

Evaluating Neutrophil-to-Lymphocyte Ratio as a Diagnostic Marker for Deep Vein Thrombosis Versus Erysipelas

Géza Nagy[1], Mohammed Almakrami*[1]

[1]University of Szeged Albert Szent-Györgyi Medical School, Department of Dermatology and Allergology, Szeged, Hungary

Introduction & Objectives:

Deep vein thrombosis (DVT) and erysipelas are common medical conditions with overlapping clinical features, such as redness, swelling, and pain in an extremity. In clinical practice, diagnostic tools like Doppler ultrasound, serum D-dimer, and inflammatory markers are used to differentiate between these conditions. However, there are situations where these methods have limitations. Therefore, our aim was to identify new biomarkers to expedite the assessment of patients with DVT or erysipelas. One such biomarker of interest is the Neutrophil-to-Lymphocyte Ratio (NLR), known for its effectiveness in quantifying inflammation in various diseases. Our objective was to evaluate the utility of NLR in distinguishing between DVT and erysipelas.

Materials & Methods:

In this retrospective clinical study, we collected data from patients treated at the First Department of Internal Medicine and the Department of Dermatology and Allergology in Szeged from January 2022 to December 2022. A total of 75 patients were identified, and 46 patients met our inclusion criteria.

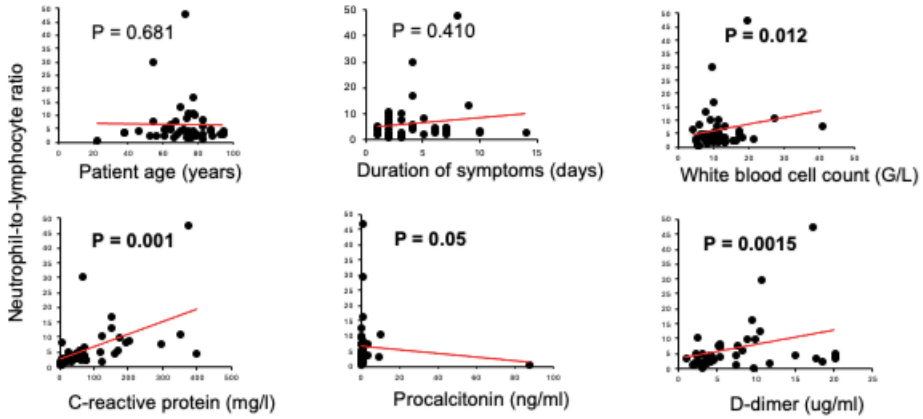
Results:

The 46 study patients were divided into two groups; half had DVT (n=23), and the other half had erysipelas (n=23). The median age was 73 years (range 22-94). We tested NLR correlations with patient age, duration of symptoms, white blood cell count, C-reactive protein, procalcitonin, and D-dimer levels using Spearman rank correlation analysis. We found a correlation between NLR and the last 4 biomarkers ($p=0.012$, $p=0.001$, $p=0.05$, $p=0.0015$) respectively. Next, using the Mann-Whitney U test, we evaluated the differences in these biomarkers between the erysipelas group and the deep vein thrombosis group, and we found a significant association between pretreatment NLR values and erysipelas ($p=0.0017$). Receiver Operating Characteristic (ROC) curve analysis determined an optimal NLR cutoff of 4.91 for predicting erysipelas, with 91% sensitivity and 70% specificity.

Conclusion:

Our findings suggest that NLR has promise as a valuable marker for differentiating between DVT and erysipelas, making it a practical tool for routine patient assessment. Furthermore, NLR is cost-effective and readily available, making it easily implementable in everyday clinical practice.

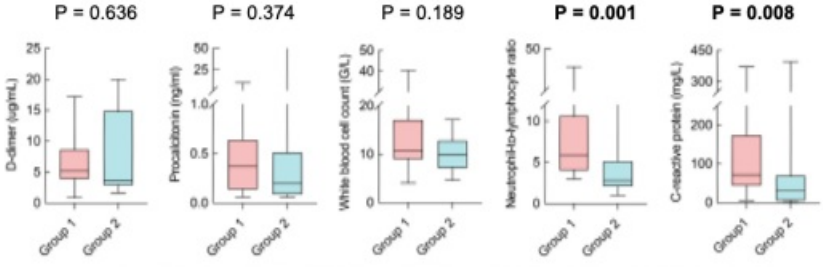
NLR correlations with patient age, duration of symptoms and other biomarkers



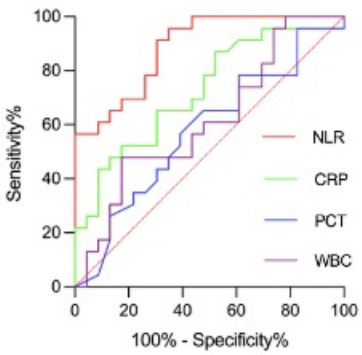
Spearman rank correlation analysis were employed.

Stratifying patients and using Mann-Whitney *U* test

Group 1: Patients who had erysipelas
Group 2: Patients who had deep vein thrombosis



Receiver operating characteristic (ROC) curve of NLR vs. other inflammatory markers



Neutrophil-to-lymphocyte ratio:
AUC: 0.8866 (95% CI: 0.795 to 0.977)
P < 0.0001

C-reactive protein:
AUC: 0.7250 (95% CI: 0.578 to 0.871)
P = 0.0089

Procalcitonin:
AUC: 0.5775 (95% CI: 0.409 to 0.745)
P = 0.3677

White blood cell count:
AUC: 0.6144 (95% CI: 0.449 to 0.779)
P = 0.1838

Optimal cut-off value for NLR to diagnose erysipelas was **4.91**, with a **specificity of 70%** and a **sensitivity of 91%.**

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Abstract N°: 1694

Can we recognize incipient calciphylaxis? An atypical clinical presentation

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Introduction & Objectives: Calciphylaxis is a rare, life-threatening disorder, caused by microvascular calcification and thrombosis, which results in tissue ischemia [1]. Intravenous and oral sodium thiosulfate is frequently used as off-label treatment [2]. Objective: to describe an atypical presentation of calciphylaxis in a patient currently using oral sodium thiosulfate.

Materials & Methods: A case of atypical clinical presentation of calciphylaxis in a patient using off-label medication prescribed by another specialist. A review of the literature was also conducted to identify reported cases of the clinical presentation of calciphylaxis in patients currently using oral sodium thiosulfate.

Results: A 55-year-old man with end-stage renal disease on daily hemodialysis since 2020 presented with pruritic, non-painful lesions on her forearms and legs, progressively appearing over two years. Past medical history included hypertension, secondary hyperparathyroidism, and a previous episode of joint calciphylaxis requiring knee surgery in 2022. Current medications included oral sodium thiosulfate and cinacalcet, prescribed by his treating nephrologist.

Examination revealed hyperpigmented, violaceous indurated plaques, retiform appearance, symmetrically distributed in arms and legs (Figure 1A). Histopathology revealed calcium deposits in dermal and subcutaneous vessels with fibrin thrombi. (Figure 1B).

Conclusion: Typical presentation of calciphylaxis is with painful, rapidly progressive necrotic ulcers in patients with chronic kidney disease, although other risk factors have been described [1]. In this case, the absence of pain and the predominance of pruritus highlight a less typical clinical variant. Skin biopsy is the gold standard to diagnose calciphylaxis, showing calcium deposition in the vessels of the dermis and subcutaneous fat [1]. Intravenous sodium thiosulfate is frequently used as off-label treatment [2]. Although recent evidence suggests no significant benefit in skin lesion improvement or overall survival, the study excluded the outcomes related to oral administration [2]. It is possible that this treatment modified the clinical presentation of the patient, revealing more incipient lesions. This underscores the need for clinical trials to establish oral sodium thiosulfate's efficacy. Early clinical suspicion, even in non-ulcerative presentations, remains essential for diagnosis and management of calciphylaxis.

References

\1. Rick J, Strowd L, Pasieka HB, et al. Calciphylaxis: Part I. Diagnosis and pathology. J Am Acad Dermatol. 2022;86(5):973–982. https://doi.org/10.1016/j.jaad.2021.10.064

\2. Wen W, Portales-Castillo I, Seethapathy R, et al. Intravenous Sodium Thiosulphate for Calciphylaxis of Chronic Kidney Disease: A Systematic Review and Meta-analysis. JAMA Netw Open. 2023;6(4):e2310068. https://doi.org/10.1001/jamanetworkopen.2023.10068

Abstract N°: 1697

Title: Underrepresentation of Visible Minorities in Medical References In a Faculty of Medicine: A Call For Inclusion Reform

Elio Kechichian*[1], Kerlysha Guerrier[1], Beatrice Andra Oaden[1], Carolina Lucena Fernandes[1]

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Introduction & Objectives:

The underrepresentation of people of color in dermatology is a persistent issue. Recognizing clinical signs across all skin phototypes is key for equitable care. Historically, training programs lacked non-white skin representation. This study aims to analyze the visibility of skin tone diversity in medical school references.

Materials & Methods:

Photos in study materials and dermatology references provided to medical students at the University were analyzed. Each was categorized by Fitzpatrick skin types I–VI and disease type, then grouped into lighter (I–III) and darker (IV–VI) skin for comparison.

Results:

Among 1,081 images, 7.4% showed darker skin (IV–VI), while 92.6% showed lighter types (I–III). In dermatology-specific materials, 8.9% depicted darker tones. No images of darker skin appeared in life-threatening or locally relevant conditions like Lyme disease.

Conclusion:

Darker skin phototypes are still underrepresented. Broader inclusion is essential for better education and equitable care.

Abstract N°: 1698

Triggers, clinical manifestations, and management of pediatric erythema nodosum: a systematic review

Elio Kechichian*[1], Florence Lagace Thomassin[1], Hannah Nguyen[1], Justin Gervais[1], Anya Bussiere Flilion[1], Imane Labzagui[1], Kerlysha Guerrier[1], Carolina Lucena Fernandes[1]

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Introduction & Objectives:

Erythema nodosum (EN) is the most common form of panniculitis, yet it is rarely reported in children and infants. There are currently no standardized diagnostic or management guidelines for pediatric erythema nodosum (PEN). This review aims to consolidate existing data on triggers, clinical features, and treatment approaches for PEN and propose a practical management algorithm.

Materials & Methods:

A systematic review of the literature on PEN was conducted.

Results:

A total of 239 articles including 959 pediatric patients were reviewed (tables 1 and 2). The mean age was 9.89 years. The most common triggers were infections—tuberculosis (19.8%) and streptococcal infections (18.8%)—followed by idiopathic causes (8.3%), IBD (6.5%), Behçet's disease (6%), and others. Diagnosis was primarily clinical, with skin biopsy performed in only 11.5% of cases. Treatment largely consisted of supportive care, particularly NSAIDs, and managing the underlying cause.

Conclusion:

PEN is mostly infection-induced, diagnosed clinically, and managed with supportive care and trigger-specific treatment.

Table 1. Summary of clinical characteristics and workup of paediatric EN patients

Variable	Result
Number of patients (n)	959
Mean age (years) [range]	10.2 [0.58-17.5]
Male gender (%)	47.5
General symptoms (n) (%)	
Fever	221 (23)
Upper respiratory tract symptoms	220 (22.9)
Arthralgia	104 (10.8)
Fatigue	51 (5.3)
Abdominal pain	51 (5.3)
Diarrhea	47 (4.9)
Distribution (%)	
Lower Extremities	63
Upper Extremities	39
Workup (n) (%)	
Blood tests	426 (44.4)
Elevated inflammatory markers*	295 (30.8)
Abnormal liver function tests	12 (1.3)
Abnormal renal function tests	8 (0.8)
Tuberculosis testing	571 (59.5)
Chest radiograph done	437 (45.6)
Abnormal findings	95 (9.9)
Streptococcal testing done	531 (55.4)
Positive streptococcal testing	240 (25.0)
Autoimmune serologies**	110 (11.5)
Stool analysis for bacterial//parasitic/viral infections	74 (7.7)
Positive stool analysis for bacterial//parasitic/viral infections	9 (0.9)
Fecal occult blood	5 (0.5)
Fecal calprotectin	11 (1.1)
Colonoscopy	19 (2.0)
Abnormal findings	16 (1.7)
Skin biopsy done	111 (11.6)
**Including ESR and CRP* ***Including ANA, C3/C4, ANCA, rheumatoid factor*	

Table 2. Countries with more than 30 reported cases of Pediatric erythema nodosum

Country of origin	Number of patients (N)	Most reported triggers (N)
United Kingdom	128	Tuberculosis (66) Bacterial infection * (31) Inflammatory bowel diseases (2)
Canada	114	Tuberculosis (55) Bacterial infection * (27) Drugs (13)
Italy	104	Bacterial infection * (28) Viral infection** (18) Inflammatory bowel diseases (7)
USA	83	Inflammatory bowel diseases (31) Bacterial infection * (15) Behçet's disease (4)
Finland	73	Bacterial infection * (31) Tuberculosis (28) Drugs (1)
France	68	Bacterial infection* (49) Leprosy (5) Drugs (3)
Greece	62	Bacterial infection * (32) Tuberculosis (10) Inflammatory bowel diseases (1)
Turkey	50	Behçet's disease (22) Bacterial infection * (13) Tuberculosis (6)
Brasil	38	Bacterial infection * (15) Leprosy (7) Tuberculosis (3)
Israel	32	Bacterial infection * (7) Behçet's disease (5) Viral infection** (4)

**Bacterial infection:* Group A streptococcus *most commonly*

***Viral infection:* Epstein-Barr virus *most commonly*

Abstract N°: 1705

Two Cases of Scleredema in the Caribbean

Zakiyyah Khan[1], Naomi Dolly[1]

[1]ReTouched by ND, Port of Spain, Trinidad and Tobago

Introduction & Objectives:

Scleredema is a rare dermatological condition characterized by symmetric induration typically of the upper body due to a thickened dermis and deposition of mucin. Its pathogenesis is poorly understood but postulated to be associated with irreversible glycosylation of collagen and resistance to degradation. There are three subtypes - type one develops after an acute infection, mostly of streptococcal origin; type two is associated with paraproteinemia; and type three is primarily seen in obese middle-aged men with type one or type two diabetes mellitus.

Objective: Reports on scleredema in the Caribbean and Latin America are sparse and few. This case aims to showcase two cases of scleredema in Trinidad and Tobago.

Materials & Methods:

Two cases of scleredema presented to our service in Trinidad and Tobago

Results:

Case 1: A 61-year-old female with a known history of diabetes mellitus presented with a two-day history of swelling to the face, neck, upper limbs, trunk, thighs and knees. This was associated with malaise and an acute onset of arthralgia to both knees. She had a recent history of travel to Mexico. She denied fever or other constitutional symptoms. Review of symptoms was nil contributory. Examination revealed facial edema and induration with peau d'orange appearance to posterior neck and upper back. Joint swelling and limited range of motion was noted to the jaw, both hands and knees.

Laboratories: leukocytes 19.34, neutrophil percentage 88.74%, c-reactive protein 9.21, erythrocyte sedimentation rate 28, HbA1c 6.5%. Anti-streptolysin O titres and serum protein electrophoresis were negative.

Case 2: A 52-year-old male with a history of diabetes mellitus presented for hyperpigmentation to face and posterior neck in keeping with Acanthosis Nigricans. Incidentally, he was found to have tight, indurated peau d'orange appearing skin to the upper back. Additionally, on examination, he had edema and limited range of motion to left shoulder. Acrochordons and acanthosis nigricans were also noted to axillae.

Laboratories: glycosylated haemoglobin 6.8%, fasting insulin 46.9. All other blood parameters were normal.

Case 1 & Case 2 Biopsy: Reticular dermis contains thickened collagen bundles and spaces between those bundles appear to contain mucin. A colloidal iron stain shows increased dermal mucin.

Definitive Diagnosis: Scleredema

Conclusion:

The intent of this report is to highlight a condition that remains rarely documented in the Caribbean and Latin America. The contrasting presentations demonstrate the clinical spectrum of scleredema, from its acute onset

following infection in type one Scleredema to the chronic, indolent course seen in diabetes mellitus associated type three Scleredema.

Increased awareness is crucial for timely diagnosis and management. Its recognition and reporting in diverse populations is also important for broadening epidemiologic and pathogenic understandings of this condition.

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Abstract N°: 1777

Leukaemia Cutis Presenting as Livedo Racemosa like Eruption: A Rare Manifestation of B-Cell Acute Lymphoblastic Leukaemia

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Introduction & Objectives:

Leukaemia cutis (LC) is the infiltration of neoplastic leukocytes into the skin and is more commonly associated with acute myeloid leukaemia (AML) and chronic lymphocytic leukaemia (CLL). It often suggests advanced disease and poor prognosis. Leukaemia cutis most commonly presents as erythematous papules and nodules. There are very few case reports on B-cell acute lymphoblastic leukaemia (B-ALL) presenting with skin manifestation chiefly, and none presented as livedo racemosa.

Materials & Methods:

We report an unusual case of (B-ALL) presenting as livedo racemosa.

Results:

A 47-year-old woman with no significant past medical history presented with a progressive cutaneous eruption. It began as erythematous papules and evolved into petechiae and purpura, eventually forming violaceous, irregular, incomplete rings and a reticular eruption on her arms and legs. On further history taking she had systemic symptoms including weight loss, bruising, and night sweats. She had no headache nor other features of neurological deficits e.g. stroke. She did not demonstrate other features of anti-phospholipid syndrome or systemic lupus erythematosus. Laboratory investigations revealed anaemia, thrombocytopenia, and leucocytosis with 72% blasts. Her bone marrow aspiration and trephine revealed ~87% blast cell infiltrate with features morphologically favoring acute lymphoblastic leukaemia. Flow cytometry noted 84.58% of B lymphoblasts expressing CD19+, cyCD79a+, cyTdt+, CD10het (71%+) CD38+, CD20+ (77%), CD66c par+, CD58dim+, CD9+, CD22+, CD24dim+, CD13+, CD123+, CD(73&304) -.

Serological studies showed elevated antinuclear antibody (titre 1:320, homogenous pattern). Anti-thrombin III and protein C levels were not low. Otherwise, there were normal levels of fibrinogen, protein S, anti beta2 glycoprotein I IgM and IgG. She was also negative for lupus anticoagulant, anti-cardiolipin IgM and IgG antibodies.

Skin biopsy for histopathology and direct immunofluorescence over the left upper arm showed dermal vessels with perivascular infiltrates of atypical lymphoid cells with enlarged nuclei with open chromatin and focal nucleoli. There was exocytosis and infiltration into overlying epidermis; no overt blister formation seen. Immunostaining shows these atypical cells to stain positively for CD79a and TDT, with negativity for CD4 and CD117. CD3 staining highlights background T cells. Proliferation index with Ki67 is around at least 60% in the lesional population. Direct immunofluorescence is negative for significant deposition of IgG, IgA, IgM, C3 and fibrinogen. She was diagnosed with Philadelphia chromosome-negative B-ALL and treated with multi-agent chemotherapy (rituximab with hyper-fractionated cyclophosphamide, vincristine, doxorubicin, and dexamethasone). Cutaneous lesions resolved without further sequalae after treatment with chemotherapy.

Conclusion:

B-ALL rarely presents acutely with livedo racemosa. Proposed mechanisms include vascular thrombosis due to leukemic cell-induced platelet dysfunction, direct endothelial and luminal infiltration. Physicians should recognize reticular eruptions as potential indicators of hematologic malignancy. This case highlights an uncommon dermatologic manifestation of B-ALL, underscoring the importance of skin findings in early leukaemia diagnosis.

Abstract N°: 1881

Red Light Therapy for post-inflammatory hyperpigmentation and melasma: A systematic review of its efficacy, safety, and clinical applications

Nour Ghostine[1]

[1]USJ, Beirut, Lebanon

Introduction & Objectives: Melasma and post-inflammatory hyperpigmentation (PIH) account for the majority of pigmentary disorders. Although several topical creams and gels, such as hydroquinone and tretinoin, are the most commonly prescribed treatments, they are known to have various side effects, including erythema, irritation, and redness. Recently, low-level light therapy, specifically red-light therapy (RLT), has emerged as a non-invasive treatment option for such conditions.

Materials & Methods:

Following the PRISMA guidelines, articles evaluating the efficacy of RLT in treating PIH and melasma were systematically identified on PubMed and ScienceDirect databases. The articles included in this review fulfill the inclusion criteria: peer-reviewed clinical trials, case controls, case series, and pilot studies from 2014–2025.

Results:

This review included four studies with a total of 148 participants. The studies revealed that red and infra-red light therapies significantly reduced melasma area and severity index (MASI), melanin index (MI) and global aesthetic improvement scale (GAIS). Our findings suggest that RLT can be considered a potential therapeutic alternative in reducing pigmentation and improving skin elasticity and texture.

Conclusion:

RLT emerges as a promising option for treating PIH and melasma with a relatively low risk of adverse events. This research highlights the capacity of RLT to effectively manage pigmentation issues and heal the skin from environmental damage in a wide variety of patients. It promotes further within the scope of minimally invasive techniques for common dermatological concerns.

Abstract N°: 1888

Dermatological manifestations of GLP-1 receptor agonists: A systematic review

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[2]Hotel Dieu, Beirut, Lebanon

Introduction & Objectives: Glucagon-like peptide-1 receptor agonists (GLP1 RAs) play a pivotal role in treating type 2 diabetes and are now being used to manage obesity. Despite their growing and already widespread use, their dermatological manifestations remain under recognized, hence the interest of this systematic review.

Materials & Methods: ** to systematically assess the dermatological outcomes associated with GLP1 RA therapy, focusing on both adverse events and potential therapeutic benefits. Following the PRISMA guidelines, articles that evaluated dermatological outcomes in patients receiving GLP1 RAs were systematically searched using PubMed, and ScienceDirect databases. Only randomized controlled trials (RCTs) and observational studies involving human subjects were included, while case reports, reviews, and in vitro or animal studies were excluded. Data was extracted on study design, sample size, types of GLP-1 RAs used, dermatological outcomes, and study limitations. Quality assessments were conducted with the Cochrane RoB-2 tool for RCTs and the Newcastle-Ottawa Scale for observational studies.

Results:

Five studies were included (one randomized controlled trial and four observational studies). Hair loss was the most significant side effect unlike the usually reported injection-site reactions, lipodystrophy, and interestingly, several studies found that liraglutide and semaglitude therapy improved psoriasis lesions.

Conclusion:

The most frequent side effect associated with GLP1-RA use in this systematic review appeared to be hair loss, in contrast to the more frequently described injection-site complications and lipodystrophy. Importantly, some GLP1-RA have been shown to improve psoriatic lesions.

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Abstract N°: 1904

Chronic Kidney Disease-Related Itching and Dry Skin: Effects on Quality of Life

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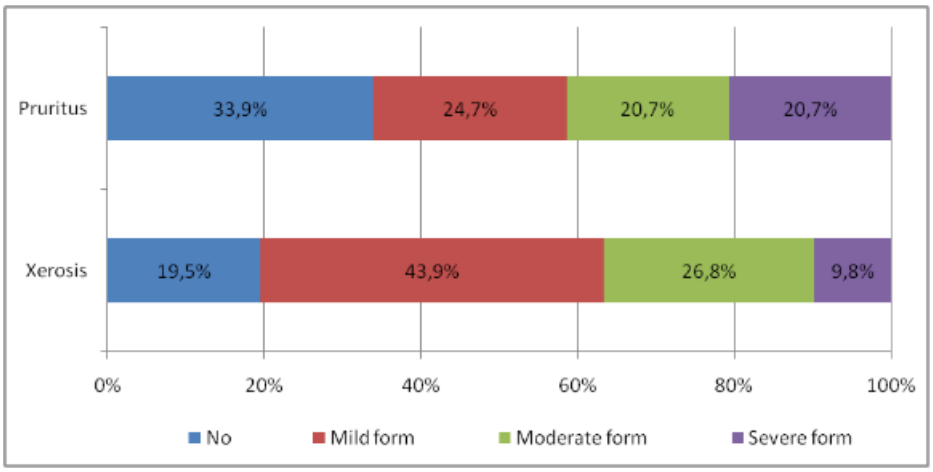
[2]Tbilisi State Medical University, Nephrology, Tbilisi, Georgia

Introduction & Objectives. Patients undergoing chronic hemodialysis often experience various mucocutaneous manifestations, including pruritus and xerosis. Thus, our study aimed to investigate the progression of chronic kidney disease-associated pruritus and xerosis, along with their impact on quality of life (QoL).

Materials & Methods: Our observational cohort study was conducted from December 2023 to December 2024. After obtaining informed consent, 82 patients (36 females, 46 males) were selected to participate in the study. Their ages ranged from 28 to 89 years. All patients underwent comprehensive general and dermatological examinations. Laboratory investigations, including complete blood counts, kidney and liver function tests, serum parathormone levels, serum electrolytes, alkaline phosphatase, random blood sugar, and Hepatitis C virus (HCV) antibodies, were conducted. The adequacy of hemodialysis was assessed using equilibrated Kt/V (eKt/V). Quality of life was evaluated with the Dermatology Life Quality Index (DLQI).

Results: Xerosis was identified in 66 cases (80.5%). The rates of mild, moderate, and severe forms were 43.9%, 26.8%, and 9.8%, respectively. Pruritus was noted in 54 cases (65.9%) with eKt/V < 1.0, primarily related to vascular access issues and reduced dialysis session time. The rates of mild, moderate, and severe forms of pruritus were 24.4% (eKt/V 0.9), 20.7%(0.80.9), and 20.7% (eKt/V 0.75), respectively. The mean DLQI score was 10.8 (SD = 8.3). A significant association was identified between the adequacy of hemodialysis and quality of life, as assessed by the Pearson correlation coefficient, with r = -0.224 (p = 0.043). Additionally, the correlation betweenKt/V and the duration of hemodialysis session time was significant, with r = 0.333 (p = 0.002).

Conclusion: Patients with chronic kidney disease who are undergoing hemodialysis experience a high prevalence of xerosis and pruritus, resulting in a lower quality of life (QoL). Our research revealed a significant association between the adequacy of hemodialysis and QoL, as well as the duration of hemodialysis.



Abstract N°: 1908

Impact of Type 2 Diabetes Mellitus on Pruritus, Xerosis, and Quality of Life in Patients Undergoing Hemodialysis and Peritoneal Dialysis

Medea Ebralidze[1], Irma Tchokhonelidze[2], Maia Matoshvili[1]

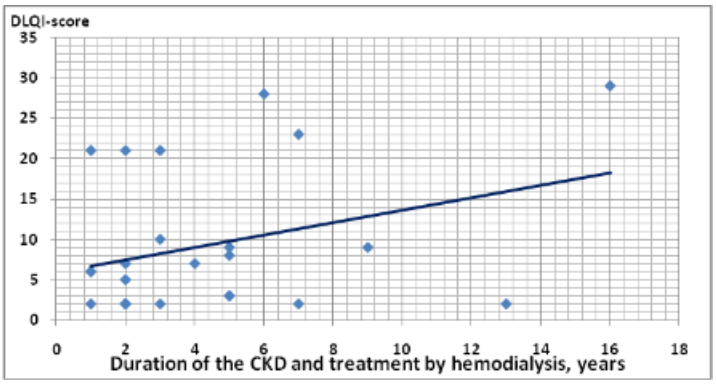
[1]Tbilisi State Medical University, Dermatology and Venereology, Tbilisi, Georgia
[2]Tbilisi State Medical University, Nephrology, Tbilisi, Georgia

Introduction & Objectives. Patients with chronic kidney disease (CKD) and type 2 diabetes mellitus (DM2) often experience a variety of mucocutaneous manifestations, including pruritus and xerosis. Therefore, the aim of our investigation was to study the impact of CKD and DM2 on pruritus, xerosis, and the quality of life (QoL) of patients undergoing hemodialysis.

Materials & Methods: Our observational cohort study was conducted from December 2023 to December 2024. After obtaining informed consent, 82 patients (36 females, 46 males) were selected for participation in the study. Their ages ranged from 28 to 89 years. Twenty-five patients with DM2 were selected for the study group, while the other 57 were considered controls. All patients underwent thorough general and dermatological examinations. Laboratory investigations included complete blood counts, renal and liver function tests, serum parathormone levels, serum electrolytes, alkaline phosphatase, fasting plasma glucose (FPG), and Hepatitis C virus (HCV) antibodies. The adequacy of hemodialysis was assessed by Kt/V. Quality of Life (QoL) was evaluated using the Dermatology Life Quality Index (DLQI).

Results: In the study group, xerosis was noted in 18 cases (72.0%). The frequencies of mild, moderate, and severe forms were 60.0%, 4.0%, and 8.0%, respectively. Xerosis was also noted in 48 controls (84.2%), with frequencies of mild, moderate, and severe forms being 36.8%, 36.8%, and 10.5%, respectively. The difference between groups was not significant. In the study group, pruritus was observed in 15 cases (60.0%). The frequencies of mild, moderate, and severe forms were 32.0%, 4.0%, and 24.0%, respectively. Pruritus was found in 39 controls (68.4%), with frequencies of mild, moderate, and severe forms at 21.1%, 28.1%, and 19.3%, respectively. The difference between the groups was not significant. The mean DLQI score in the study group was 9.3 (SD = 8.9), while in the control group it was 11.5 (SD = 8.0). The difference between the groups was not significant. However, a significant association was revealed between the duration of CKD and treatment by hemodialysis with QoL, as assessed by the Pearson correlation coefficient ($r = 0.398$, $p = 0.049$), in patients with DM2. In the study group, the DLQI score significantly correlated with FPG ($r = 0.416$, $p = 0.039$).

Conclusion: Patients with chronic kidney disease undergoing hemodialysis experience a high prevalence of xerosis and pruritus, along with a diminished quality of life (QoL). The dermatological condition has worsened due to the presence of type 2 diabetes mellitus (DM2).


DLQI-score
35
30
25
20
15
10
5
0
0
2
4
6
8
10
12
14
16
18
Duration of the CKD and treatment by hemodialysis, years

Abstract N°: 1912

Association of Hemodialysis Adequacy with on Non-Specific Skin Disorders in Patients with End-Stage Renal Disease

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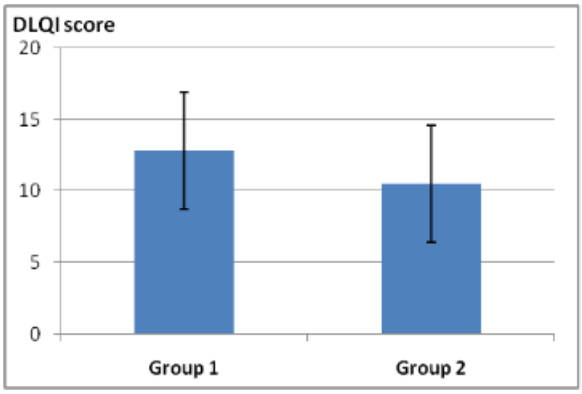
Introduction & Objectives. Patients undergoing chronic hemodialysis often experience various mucocutaneous manifestations, including pruritus and xerosis. Thus, our study aimed to investigate the prevalence of CKD-associated pruritus and xerosis in hemodialysis patients. Additionally, the study sought to examine the relationship between hemodialysis adequacy and the progression of these nonspecific skin disorders.

Materials & Methods: Our observational cohort study was conducted from December 2023 to December 2024. After obtaining informed consent, 82 patients (36 females, 46 males) were selected for participation in the study. Their ages ranged from 28 to 89 years. Selected patients were divided into two groups according to the adequacy of hemodialysis assessed by Kt/V values: group 1 -Kt/V <1.3 – n=22; group 2 - Kt/V ≥ 1.3 – n=60. All patients underwent thorough general and dermatological examinations. Laboratory investigations included complete blood counts, renal and liver function tests, serum parathormone levels, serum electrolytes, alkaline phosphatase, fasting plasma glucose (FPG), and Hepatitis C virus (HCV) antibodies. The adequacy of hemodialysis was assessed by Kt/V. Quality of Life (QoL) was evaluated using the Dermatology Life Quality Index (DLQI).

Results: In group 1, xerosis was found in 15 cases (68.2%). The distribution of mild, moderate, and severe forms was 45.5%, 18.2%, and 4.5%, respectively. In group 2, xerosis was identified in 51 cases (85.0%). The distribution of mild, moderate, and severe forms was 43.3%, 30.0%, and 11.7%, respectively. In the group 1 CKD-associated pruritus was observed in 15 cases (68.2%). The distribution across the mild, moderate, and severe forms was 22.7%, 18.2%, and 27.3%, respectively. In group 2, xerosis was identified in 39 cases (65.0%). The distribution among the mild, moderate, and severe forms was 25.0%, 21.7%, and 18.3%, respectively. The QoL score assessed by the DLQI in group 1 was 12.8 (SD=4.3), while in group 2 it was 10.5 (SD=4.1). The difference between groups was significant ($p = 0.029$). This indicates that the quality of life of patients with inadequate hemodialysis worsened compared to those with adequate hemodialysis.

Conclusion: Patients with chronic kidney disease and undergoing hemodialysis have a high frequency of xerosis and pruritus, and worse QoL. The dermatology status may be worsened by the inadequacy of hemodialysis. Our research revealed significant association of the treatment by hemodialysis and QoL and the duration of hemodialysis.


DLQI score
20
15
10
5
0
Group 1
Group 2

Abstract N°: 2069

Incorporating joint pain screening into the pediatric dermatologic examination

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Incorporating joint pain screening into the pediatric dermatologic examination

Introduction & Objectives:

Joint manifestations are a feature of many pediatric skin disorders, among them psoriasis, autoimmune and autoinflammatory diseases, hypermobility disorders, and as an adverse effect of certain medications. Identifying joint disease early is important for intervention and prevention of chronic damage. However, pediatric musculoskeletal complaints are common and determining whether symptoms warrant a rheumatology referral for arthritis can be challenging.

Materials & Methods:

Pediatric dermatologists were surveyed for their frequency and confidence in performing joint examinations, frequency of rheumatology referrals, concern about the extra time required to perform a joint examination, and interest in watching a training video on a simple joint examination for dermatologists. Through literature review and interviews with three pediatric rheumatologists, key joints involved in disorders with skin manifestations and arthritis were identified and the essential evaluations were determined.

Results:

Of 100 surveyed practicing board-certified pediatric dermatologists, 79% did not feel confident in their ability to perform a joint-focused physical examination, a key step in screening for joint disease. 95% were interested in learning joint examination techniques from an instructional video. A rapid joint examination technique (R-JET) was developed focusing on six key sites – the hands, wrists, knees, feet, ankles, and spine (sacroiliac [SI]) joint, along with an accompanying three-question survey and body diagram for patient self-report of symptoms. This joint examination takes less than one minute to perform, and is performed concurrently with inspection of the skin. A detailed video demonstration of the R-JET was created as a teaching tool.

Conclusion:

Teaching and incorporation of a rapid screening examination for arthritis by pediatric dermatologists has the potential to identify pediatric arthritis earlier, facilitate referral, and reduce the risk of progressive joint disease. These instruments can easily be incorporated into a pediatric dermatology office visit. Future directions include assessing confidence levels of and frequency of joint examinations performed by pediatric dermatologists before and after viewing the training video.

Abstract N°: 2124

Lichen myxedematosus associated with HIV and hepatitis B

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Lichen myxedematosus associated with HIV and hepatitis B

Introduction: Cutaneous mucinoses are a heterogeneous group of dermatoses characterized by abnormal mucin deposition in the dermis, leading to waxy papules and plaques. Lichen myxedematosus (LM) is a rare idiopathic cutaneous mucinosis that has sometimes been linked to HIV and Hepatitis C infections.

Case Report: We report the case of a 51-year-old woman referred for evaluation of asymptomatic dark lesions on the trunk and upper extremities, present for approximately nine years. There was no history of systemic diseases, local trauma, medication use, nor family history of similar disorders. Clinical examination revealed a bilateral and symmetrical dermatosis affecting the upper trunk and extensor surfaces of the upper limbs, characterized by brownish, smooth, waxy, non-shiny micropapules arranged in a linear pattern. Histopathology confirmed the diagnosis of LM. Laboratory workup revealed neutropenia, monoclonal IgG peak, and positive serologies for HIV and Hepatitis B, with viral loads of 10,400 copies/mL and 978 IU/mL, respectively. The patient started topical mometasone furoate for symptomatic relief and was referred to the Infectious Diseases Department, where antiretroviral therapy with TAF/FTC was initiated.

Discussion and Conclusion: Due to the rarity of this condition, there is no standardized therapeutic consensus. Various treatment options have been described with variable efficacy, including topical corticosteroids, calcineurin inhibitors, and systemic agents such as isotretinoin. In this particular case, therapeutic options were limited given the presence of multiple active infections. This case highlights the importance of recognizing rare dermatoses and investigating potential systemic associations.

Abstract N°: 2185

Scalp Plasmacytoma Revealing Multiple Myeloma with Cranial Vault Involvement: A Dermatologic Gateway to a Systemic Diagnosis

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Introduction & Objectives:

Plasmacytomas are monoclonal plasma cell tumors that may appear as solitary bone or soft tissue lesions, or as manifestations of multiple myeloma (MM). Cranial plasmacytomas with cutaneous extension are rare and often underrecognized in early stages. We describe an uncommon presentation of MM initially identified through a dermatologic lesion on the scalp, underscoring the importance of early skin assessment in systemic disease detection.

Materials & Methods:

A 69-year-old man was referred for evaluation of a painless, progressively enlarging and firm scalp mass of two months' evolution. He denied systemic symptoms aside from mild mechanical back pain. Past history included prostate adenocarcinoma (treated with surgery and radiotherapy) and ischemic heart disease. Imaging studies revealed multiple osteolytic lesions of the cranial vault, notably a 31 mm left frontal lesion with bone destruction and associated soft tissue extension into epicranial and intracranial compartments. MRI of the spine showed no suspicious lesions. Skeletal survey was otherwise unremarkable. Laboratory work-up revealed a monoclonal IgG kappa gammopathy (M-protein 0.55 g/dL), normal immunoglobulin levels, preserved renal function, and no anemia or hypercalcemia. Free light chain ratio was 2.11. Bone marrow aspirate showed 2.5% plasma cells; immunophenotyping by flow cytometry detected an aberrant phenotype in 0.5% of these cells.

Results:

Punch biopsy of the scalp mass showed diffuse dermal infiltration by atypical plasma cells, confirming a diagnosis of cutaneous plasmacytoma. Together with the presence of multiple cranial osteolytic lesions and monoclonal gammopathy, this fulfilled the criteria for MM with extramedullary disease. Despite the absence of end-organ damage, the cranial vault involvement and evidence of clonality led to diagnosis. The patient was staged as ISS (*International Staging System*) I and treatment was initiated with bortezomib, lenalidomide, and dexamethasone (VRD), followed by referral for autologous stem cell transplant and lenalidomide maintenance. One year after initial presentation, the patient remains in excellent clinical condition, with full resolution of the scalp lesion and sustained remission under regular hematology follow-up.

Conclusion:

This case highlights the diagnostic significance of scalp lesions in plasma cell neoplasms. Plasmacytomas of the scalp are rare and may be the first visible sign of systemic myeloma. Dermatologists play a key role in prompt recognition, biopsy, and referral. Timely diagnosis allows for early initiation of therapy, which may improve

prognosis in patients with extramedullary MM.

Abstract N°: 2322

When Empirical Treatment Fails: Think Beyond the Obvious in Reticulated Pigmentation

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Title: "When Empirical Treatment Fails: Think Beyond the Obvious in Reticulated Pigmentation"

Introduction & Objectives:

Reticulated hyperpigmentation is often clinically attributed to benign conditions such as pityriasis versicolor, especially in young adults. However, uncommon inflammatory dermatoses like Prurigo Pigmentosa (PP) should be considered, particularly in patients undergoing rapid metabolic changes such as severe dieting.

Case Presentation

A 25-year-old female presented with a mildly pruritic, hyperpigmented, reticulated rash involving the upper chest, back, and neck for over three months. She reported a significant weight loss of nearly 20 kg over three months following a restrictive crash diet. Previous treatment for presumed pityriasis versicolor with topical antifungals failed to achieve improvement, and the lesions progressively worsened.

Clinical examination revealed symmetric reticulated hyperpigmentation without involvement of the face, scalp, mucosae, or extremities. Dermoscopy showed pigment accentuation around hair follicles and subtle scaling. A 3 mm punch biopsy was performed.

Histopathological Findings

Histology demonstrated spongiosis, a superficial perivascular lymphocytic infiltrate, necrotic keratinocytes, and pigmentary incontinence—findings consistent with Prurigo Pigmentosa.

Management & Outcome

The patient started doxycycline 100 mg daily, topical emollients, and moderate-potency topical corticosteroids. Along with pharmacologic therapy, she was strictly advised to discontinue the severe dietary restriction and resume balanced nutrition. A complete clinical resolution was achieved within 8 weeks.

Conclusion:

Prurigo Pigmentosa is a rare but underdiagnosed inflammatory dermatosis. It predominantly affects young women and is often triggered by ketosis, including from crash diets. Its hallmark reticulated pigmentation and histopathologic signature should prompt clinicians to think beyond fungal etiologies when faced with "treatment-resistant versicolor." We will also provide a focused literature review of similar reported cases, underscoring the diagnostic and therapeutic approach to this reversible but frequently misdiagnosed condition.

Abstract N°: 2334

Relapsing polychondritis and aortic aneurysm

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Introduction & Objectives: Relapsing polychondritis (RP) is a systemic disease characterized by recurrent inflammation of the cartilage affecting the ear, nose, peripheral joints, larynx, and tracheobronchial tree. Other structures rich in proteoglycans like the eyes, heart, blood vessels, inner ear, skin, and kidneys are also affected. Cardiovascular complications are observed in 24 to 52% of patients during the course of the disease. We report a case of RP associated with an aortic aneurysm.

Materials & Methods: A 54-year-old hypertensive male consulted for swallowing and inflammation of the earlobes progressing in flare-ups. A biopsy with histopathological examination was performed and revealed well-differentiated cartilaginous tissue surrounded by an inflammatory reaction consisting of lymphocytes, plasma cells, intact and altered neutrophils, with numerous congestive blood vessels arranged within dense fibrosis. Physical examination and ophthalmological assessment were normal, ruling out systemic involvement. The diagnosis of RP was confirmed by applying the Damiani and Levine criteria, which allow the diagnosis to be made with a single clinical criterion (recurrent chondritis of both ears) when histological evidence is present. Treatment with Colchicine 1 mg daily was initiated, leading to clinical improvement by the 2nd week of treatment. The patient was regularly followed up, achieving complete clinical remission for a period of 2 years. One year later, the patient developed dyspnea. The chest X-ray revealed dilation of the aortic ring and widening of the mediastinum. A thoracic CT scan was performed, revealing a fusiform aneurysm of the ascending and descending aorta extending to the eighth dorsal vertebra.

Results: Cardiovascular complications of RP are rare but represent the second cause of mortality after chondritis of the respiratory tract. The most common complications include valvulopathies and aortic aneurysms, myocarditis, pericarditis, arterial and venous thromboses, rhythm and conduction disorders, myocardial infarctions, and vasculitis. Aortic aneurysms are described in approximately 5% of patients with RP. They most commonly develop in the ascending aorta and are often associated with dilation of the aortic ring with aortic insufficiency and left ventricular dysfunction. These aneurysms can be multiple (50% of cases in the series by Cipriano et al.), affecting both the thoracic and abdominal aorta, simultaneously or not. The progression of aortic aneurysms often is not parallel with extravascular manifestations. Due to the rarity of the disease, there is no standardized treatment approach, and the treatment is guided by the clinical presentation and the severity of the disease.

Conclusion: RP is a rare autoimmune condition which presents as recurrent episodes of cartilaginous inflammation. Cardiovascular complications are rare but serious and must be ruled on even if the patient is in remission.

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Abstract N°: 2355

A Case of Milia-like Calcinosis Cutis Complicated by Syringoma in Down Syndrome

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Introduction & Objectives:

Milia-like idiopathic calcinosis cutis (MICC) is a very rare skin disorder characterized by small, firm, milia-like papules that are white to skin-colored and commonly occur on the hands and feet. To date, only a few dozen cases have been reported in the English medical literature, with most of these associated with Down syndrome. Although syringoma is also known to occur predominantly in patients with Down syndrome, it typically presents during adolescence or adulthood and rarely in childhood. Herein, we report an extremely rare case in which MICC and syringoma developed concurrently in the same anatomical region, with MICC affecting the face and syringoma appearing in childhood.

Case Report:

A 12-year-old Japanese girl presented with a 7-year history of an asymptomatic lesion in the periorbital region. She had previously been treated with a topical corticosteroid for one week without improvement, followed by delgocitinib ointment for three weeks, also without effect. The patient had trisomy 21 (Down syndrome) and a history of patent ductus arteriosus. Her mother denied any history of trauma, wounds, or prior medical procedures at the lesion sites. On clinical examination, multiple 1 to 2 mm well-demarcated white papules were observed bilaterally around the eyelids, along with continuous brownish discoloration and erythema. Dermoscopy revealed round, symmetrical, white, homogeneous lesions. Laboratory testing showed normal serum calcium, phosphate, and parathyroid hormone levels. Histopathological examination of both the papular and erythematous lesions demonstrated dense basophilic amorphous deposits in the upper dermis, consistent with calcinosis, and the presence of syringoma in adjacent tissue. Based on these findings, we diagnosed the lesion as MICC complicated by syringoma.

Discussion:

In the present case, both MICC and syringoma were observed in the same anatomical region. With regard to it, there is no evidence of a direct correlation between them, as they were observed independently in the histopathological examination; the areas of calcified deposits and sweat duct proliferation did not overlap, and no calcification was found within the sweat ducts. However, we consider that the occurrence of MICC is associated with syringoma based on the following insights: i) there have been a few reports of syringoma coexisting with MICC in the same region; ii) MICC appeared along with syringoma in the periorbital region, which is the predilection site for syringoma, without the involvement in the hand, which is the most predilection site for MICC. The observations indicate that syringoma may primarily arise in association with Down syndrome, followed by degenerative changes that result in calcium deposition and ultimately lead to MICC formation.

Conclusion:

To our knowledge, this is the first reported case in which MICC appeared along with syringoma on the periorbital region. The present case suggests that MICC potentially occurs in association with syringoma. Therefore, we propose the disease synonym “milia-like dystrophic calcinosis cutis” instead of MICC for the cases with milia-like

carcinosis cutis associated with other diseases.

Abstract N°: 2384

AI skin cancer

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Introduction & Objectives: : The detection of skin cancer has shown promise thanks to artificial intelligence (AI), especially deep learning models. The purpose of this systematic review and meta-analysis is to assess how well AI models detect skin cancer in comparison to human specialists and conventional medical procedures.

Materials & Methods:

To find research published between 2020 and 2025 that used AI for skin cancer diagnosis and provided quantitative data, a comprehensive search was done in PubMed and ScienceDirect. The included research evaluated AI performance against biopsy-confirmed diagnoses, general practitioners, and dermatologists. A random-effects model was used to compute sensitivity, specificity, and area under the receiver operating characteristic curve (AUC-ROC). I2 statistics were utilized to evaluate the heterogeneity of the study. Details of ethical approval were acquired from the relevant research, if appropriate.

Results:

AI models were able to discriminate between benign instances with an 81% specificity and identify malignant lesions with an 83% sensitivity after analyzing 10 studies that included approximately 13,800 skin lesions. Although performance fluctuation was seen, the overall diagnostic accuracy, as determined by AUC-ROC, was 0.87, suggesting that AI models are quite successful in identifying skin lesions.

Conclusion:

AI models are useful tools in clinical dermatology because of their high sensitivity and strong diagnostic accuracy. Variations in specificity and the need for real-world validation, however, continue to be significant obstacles. this study addresses issues with clinical application and validation while showcasing the accuracy of AI's potential in dermatological diagnostics.

Abstract N°: 2390

Diagnostic Challenges of Eosinophilic Fasciitis

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Introduction & Objectives:

Eosinophilic fasciitis is a rare systemic disorder from the scleroderma spectrum, characterized by induration of the skin and fascia of the extremities (less commonly the trunk), peripheral eosinophilia, and hypergammaglobulinemia. The diagnostic complexity arises from its clinical and histological resemblance to systemic scleroderma, necessitating a careful and differential diagnostic approach.

Materials & Methods:

A review and analysis of original research and review articles published over the past five years in databases such as ScienceDirect, Scopus, PubMed, Elsevier, and others.

Results:

The pathogenesis of eosinophilic fasciitis is associated with immune dysregulation, supported by the presence of hypergammaglobulinemia, circulating immune complexes (CICs), elevated IgG levels, and autoimmune inflammation of the fascia and adjacent tissues. Although eosinophilic fasciitis shares clinical features with systemic sclerosis, Raynaud's phenomenon and visceral involvement are typically absent.

Histopathological examination remains the gold standard for diagnosis. A full-thickness biopsy including skin, subcutaneous tissue, and fascia is required. Histology typically reveals marked thickening of the fascia due to coarse fibrosis and sclerosis, with inflammatory infiltrates composed of lymphocytes, histiocytes, and plasma cells. The presence of eosinophils is characteristic in early stages, though not always observed. Dermal findings may include foci of fibrosis and sclerosis, along with moderate chronic perivascular inflammatory infiltrates.

Imaging plays a critical role in diagnosis. According to the most recent diagnostic criteria, magnetic resonance imaging (MRI) is the only imaging modality formally included. Nevertheless, ultrasound (US) may provide supportive evidence during the preliminary assessment and assist in identifying optimal biopsy sites. Some authors suggest that increased dermal thickness and echogenicity on ultrasound may indicate eosinophilic fasciitis in patients with a scleroderma-like phenotype.

Conclusion:

Eosinophilic fasciitis and its complications often mimic other scleroderma-spectrum diseases. In addition to typical laboratory findings (eosinophilia, hypergammaglobulinemia, elevated ESR), imaging methods should be considered in the diagnostic process. Given its accessibility, safety, and diagnostic utility, ultrasound can be a valuable adjunct for early detection and monitoring of treatment response.

Abstract N°: 2402

Eosinophilic Fasciitis: Lack of Consensus in the Management of a Rare Disease

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Introduction & Objectives:

Eosinophilic fasciitis, also known as Shulman's syndrome, is a rare fibrosing connective tissue disorder characterized by painful swelling and induration of the skin and subcutaneous tissues, primarily affecting the limbs. First described by L.E. Shulman in 1974, eosinophilic fasciitis remains a diagnostic and therapeutic challenge due to its clinical overlap with systemic sclerosis and the limited data available on its pathogenesis and optimal management. Although several hundred cases have been reported worldwide, the disease continues to be underrecognized, and there is currently no standardized approach to treatment.

Materials & Methods:

A search and analysis of original research and review articles from databases such as ScienceDirect, Scopus, PubMed, Elsevier, and others over the past five years.

Results:

Eosinophilic fasciitis typically presents acutely or subacutely, often following triggering events such as intense physical activity, trauma, infection, or psychological stress. Patients commonly report limb pain, skin tightness, and progressive joint stiffness. Physical examination reveals symmetrical, woody induration of the extremities, sometimes accompanied by the "groove sign" or a "peau d'orange" appearance. In contrast to systemic sclerosis, eosinophilic fasciitis rarely involves Raynaud's phenomenon or internal organ involvement. Laboratory findings frequently include peripheral eosinophilia, elevated erythrocyte sedimentation rate, and hypergammaglobulinemia. Histopathological confirmation is essential and reveals fascial thickening with inflammatory infiltrates composed of lymphocytes, plasma cells, and occasionally eosinophils. Magnetic resonance imaging has emerged as the key imaging modality for diagnosis and monitoring, while ultrasonography, although not included in formal diagnostic criteria, can assist in biopsy site selection and follow-up due to its accessibility and safety profile. Therapeutic strategies vary widely, reflecting the absence of consensus guidelines. Systemic glucocorticoids remain the mainstay of first-line treatment, typically administered in doses of 20 to 60 milligrams per day of prednisone or an equivalent corticosteroid. In cases of steroid resistance or intolerance, immunosuppressive agents such as methotrexate, cyclosporine, cyclophosphamide, or mycophenolate mofetil are employed. Physiotherapy is recommended for patients with joint contractures, and surgical intervention may be considered in refractory cases.

Conclusion:

Despite increasing recognition, eosinophilic fasciitis remains a rare and poorly understood disorder. Diagnostic delays are common due to its clinical similarity to other sclerosing conditions. There are no standardized therapeutic protocols, and current treatment remains largely empirical. While many patients respond to corticosteroid therapy, a significant proportion require additional immunosuppressive treatment. The variability in clinical response highlights the urgent need for further research to establish evidence-based management strategies.

Abstract N°: 2450

Beyond Sweet: Diagnosing Cutaneous VEXAS Syndrome Through Histiocytoid Sweet Morphology in Myelodysplastic Syndrome

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Introduction & Objectives: Histiocytoid Sweet syndrome (HSS) is a variant of Sweet syndrome characterised by a dermal or subcutaneous infiltrate of immature myeloid cells, morphologically resembling histiocytes. We report a 73-year-old male with known myelodysplastic syndrome who presented with acute erythematous dermal nodules, plaques, and right periorbital erythema and oedema, along with fevers and lassitude. A clinical diagnosis of HSS was considered.

Materials & Methods: -

Results:

Despite initial improvement with prednisolone and topical corticosteroids, the lesions exacerbated upon steroid tapering. Skin biopsy revealed a perivascular and periadnexal infiltrate of neutrophils, leukocytoclastic debris, and mononuclear cells with histiocyte-like morphology. Immunohistochemistry showed positivity for CD163 and myeloperoxidase while being negative for CD34 and CD117. Gene sequencing identified UBA1 and DNMT3A mutations identical to those in the bone marrow, but the BCORL1 mutation was not detected in the skin sample. A diagnosis of cutaneous vacuoles, E1 enzyme, X-linked, autoinflammatory, somatic (VEXAS) syndrome with histiocytoid Sweet morphology was made. The patient was treated with prednisolone and colchicine, resulting in significant improvement, with plans for 5-azacitidine therapy.

Painful erythematous, violaceous indurated plaques and nodules with neutrophilic infiltration are seen in classical Sweet's and HSS. HSS involves immature myeloid cells resembling histiocytes and is often associated with haematological malignancies. VEXAS, a recently identified syndrome linked to UBA1 mutations, presents with various inflammatory manifestations and haematologic abnormalities. The shared mutations in marrow and skin samples in VEXAS highlight a continuum in its cutaneous manifestations, including Sweet-like and histiocytoid Sweet-like morphologies.

Conclusion: This case underscores the diagnostic importance of sequencing skin biopsies in

histiocytoid Sweet presentations to identify underlying myeloid neoplasms like VEXAS syndrome or myelodysplasia cutis. Recognising these conditions can guide treatment decisions, such as the use of hypomethylating agents over steroids, improving patient outcomes. Further research is warranted into the prospective sequencing of skin biopsies for UBA1 mutations in atypical Sweet syndrome cases.

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Abstract N°: 2536

Cutaneous sarcoidosis in Singapore: A 20-year retrospective study of a multi-ethnic population

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Introduction & Objectives: Sarcoidosis is a rare, multisystem granulomatous disease commonly presenting with cutaneous disease. There is a paucity of data in Asia regarding cutaneous sarcoidosis. The aim of this study is to characterise the clinic-epidemiological features of cutaneous sarcoidosis in multi-ethnic Singapore.

Materials & Methods: A retrospective medical records review included all patients diagnosed with cutaneous sarcoidosis at the National Skin Centre, Singapore, from 1 January 2004 to 26 July 2024. Clinical features, histopathology findings, comorbidities, systemic involvement, and treatment responses were reviewed.

Results: Thirty-six patients (55.6% male) were diagnosed with cutaneous sarcoidosis. Indians and Chinese (36.1% each) were most commonly affected. When compared to racial proportions in Singapore, there were more Indians ($p=0.005$) and fewer Chinese ($p=0.002$) than expected. The median and mean ages at diagnosis were 45.2 (IQR 37.8 – 59.4) and 48.4 (±14.7) years respectively. Males were more likely to be diagnosed at an earlier age ($p<0.001$) with mean ages of 41.3 years (±12.8) and 57.2 years (±12.3) for males and females respectively.

Asymptomatic or pruritic (47.2% each) papules and nodules (60.0%) over the head and neck and/or upper limbs (31.3% each) were the commonest presenting morphology. Two patients presented with tattoo sarcoidosis and one developed scar sarcoidosis related to Kavadi insertion for the Thaipusam festival.

The median time from disease onset to presentation was four months (IQR 2.0 – 12.0). Sarcoidosis was rarely the suspected diagnosis at presentation (27.8%); most commonly considered differential diagnoses were lichen planus (11.1%), granuloma annulare and lichen simplex chronicus (8.3% each). One presented with lupus pernio, while three presented as discoid lupus erythematosus (DLE)-like sarcoidosis. All had consistent histology findings.

Majority (58.3%) had evidence of extracutaneous disease, most commonly in the lungs (27.6%), lymph nodes (20.7%) and eyes (17.2%). Pulmonary disease presented largely with stage 0 or stage 1 disease (68.8%). The commonest treatment modalities employed were topical (77.8%) or oral (44.4%) corticosteroids and hydroxychloroquine (36.1%); others included tetracyclines (16.7%), azathioprine (8.3%), methotrexate and mycophenolate mofetil (2.8% each). Median follow up duration was 24 months (IQR 1.0 – 68.25) with 63.9% responding to treatment. For patients with recurrence after initial response (16.7%), mean time to recurrence was 16.3 (±11.6) months.

Conclusion: Cutaneous sarcoidosis is rare in our population, with patients of Indian descent disproportionately affected. Patients most commonly present with papules and nodules in the head and neck region that may be asymptomatic or pruritic. Lupus pernio, tattoo sarcoidosis, scar sarcoidosis including those related to Kavadi insertion and DLE-like sarcoidosis are notable variants. Histological confirmation is essential. Extracutaneous disease, especially early stage lung disease, is common, and should be adequately evaluated for. The limitations of our study include its retrospective nature, missing data and patients lost to follow-up.

Abstract N°: 2602

Recommendations on diagnosis and treatment of adult-onset IgA Vasculitis proposed by the European IgA Vasculitis Study Group: focus on skin involvement

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Introduction & Objectives:

IgA vasculitis (IgAV) is a small-vessel vasculitis with predominant IgA deposits that involves the skin, the joints, the gastrointestinal tract and the kidneys, but may also remain clinically restricted to the skin. Adults more often than children show a relapsing/refractory course. As the diagnosis and management of IgAV remain controversial especially for adults, our committee has developed guidelines to cover these aspects.

Materials & Methods:

The European IgA Vasculitis Study Group (EUGAVAS), a multidisciplinary group of 38 experts in the field of IgAV, was endorsed in 2023 by European Vasculitis Society (EUVAS). It includes 11 nephrologists, 10 internists/rheumatologists, 4 dermatologists, 4 pediatricians, 4 fellows, 2 pathologists, 1 representative IgAV patient, 1 vasculitis nurse, and 1 methodologist. A Delphi approach was used to identify key questions to be addressed. Key questions that achieved a level of agreement ≥70% among group members drove a systematic literature review (SLR) on Medline/Pubmed, Cochrane and Embase databases. Small working groups of 4-5 members drafted recommendation statements based on the SLR results and, where required, expert opinion. The preliminary statements were then discussed and amended by the whole group and are currently being voted on in

the second Delphi round.

Results:

Following the first Delphi round, 14 out of 16 key questions were retained. The SLR identified 335 relevant publications out of 3,784 abstracts reviewed (1,058 excluded as duplicates). The group agreed that the level of evidence available in the literature was insufficient to establish guidelines and drafted recommendation statements on diagnosis and classification, disease staging, treatment, disease assessment and patient follow-up. Some proposed statements which concern particularly the skin are: 1) a skin biopsy for direct immunofluorescence (DIF) should be taken from early lesions, characterized morphologically as partially blanchable macules with only a minor petechial and papular component and in proximity to palpable purpura, 2) palpable purpura in IgAV should be differentiated from skin involvement in ANCA associated vasculitis, cryoglobulinemic vasculitis, rheumatoid vasculitis, cutaneous vasculitis in systemic lupus or in Sjøgren´s syndrome, vasculitis in IgA gammopathy and IgG/IgM vasculitis 3) No skin-specific treatment for skin manifestations is needed when systemic glucocorticoid/immunosuppressive therapy is prescribed for severe intestinal or renal involvement (defined so far as nephrotic-range proteinuria or persisting proteinuria > 0.5 g/24h while on renin-angiotensin-aldosterone-blockers or crescentic glomerulonephritis). For relapses limited to the skin, colchicine or dapsone may be considered; compression stockings may also help alleviating lower leg purpura.

Conclusion:

Once the set of recommendations on management of adult-onset IgAV is officially finalized, it will help also dermatologists to manage patients with this condition and improve their prognosis.

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Abstract N°: 2661

Skin Physiologic Parameters and Their Relationship to Sarcopenia: A Cross-Sectional Study

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Introduction & Objectives:

Sarcopenia, characterized by age-related loss of skeletal muscle mass and function, is a growing concern with multisystem implications. Though links have been drawn between sarcopenia and various organ systems, its relationship with skin health remains underexplored. This study investigated potential associations between common physiologic skin parameters and established measures of sarcopenia in an aging population.

Materials & Methods:

We conducted a cross-sectional analysis of 255 healthy participants from the SG70 cohort, a population-based prospective aging study. Skin physiologic parameters assessed included stratum corneum hydration, surface pH, sebum content, and transepidermal water loss (TEWL). Self-reported skin measures were collected via questionnaires in English and Mandarin addressing dry skin, itchy rashes, and eczema history. Sarcopenia risk was assessed using the SARC-F questionnaire. Objective sarcopenia diagnosis followed Asian Working Group for Sarcopenia (AWGS) 2019 criteria, comprising appendicular skeletal muscle mass (via DEXA), handgrip strength, and physical performance (5-time chair stand and 6-meter walk tests). Statistical analysis included Pearson's correlation coefficient (PCC) and multiple logistic regression controlling for demographics and BMI.

Results:

Demographic characteristics and descriptive data on skin and sarcopenia measures are shown in Table 1. Multiple logistic regression revealed that of all skin parameters, only TEWL had a statistically significant inverse association with AWGS-defined sarcopenia (OR 0.970, 95% CI 0.945–0.995, p=0.029). Correlation analysis (Figure 1) showed modest but significant associations between SARC-F scores and subjective skin measures, including dry skin (PCC 0.182, $p<0.01$) and itchy rashes (PCC 0.148, p=0.0177). However, these self-reported measures did not correlate with objective skin physiology. SARC-F scores did not significantly correlate with AWGS-defined sarcopenia in this cohort.

Conclusion:

Our findings demonstrate a modest but significant inverse relationship between TEWL and objectively defined sarcopenia. A disparity between self-reported symptoms and objective measurements was also noted. This suggests that exclusive reliance on objective measures may underrecognize clinically significant subjective symptoms. Patient or environmental factors may also influence perceived health across domains. Study limitations include potential selection bias toward healthier individuals, ethnic homogeneity, and focus on eczematous features. Longitudinal studies of skin-muscle interactions may clarify sarcopenia pathophysiology and inform future interventions.

Variable	Values
Sample size, *n*	255
Age, *mean (SD)*	73.3 (1.87)
Gender, *n females (%)*	143 (56.1)
BMI, *mean (SD)*	24.0 (3.48)
Skin pH, *mean (SD)*	4.87 (0.624)
SC hydration (arbitrary units), *mean (SD)*	34.7 (16.0)
Sebum content (ug/cm2), *mean (SD)*	22.6 (18.6)
TEWL (g/m^2h), *mean (SD)*	5.94 (2.00)
SARC-F Score, *median (IQR)*	0 (1), Range 0-6
Sarcopenia (AGWS), *n with sarcopenia (%)*	70 (27.5)

Table 1: Baseline demographics and descriptive statistics of skin physiologic parameters and sarcopenia

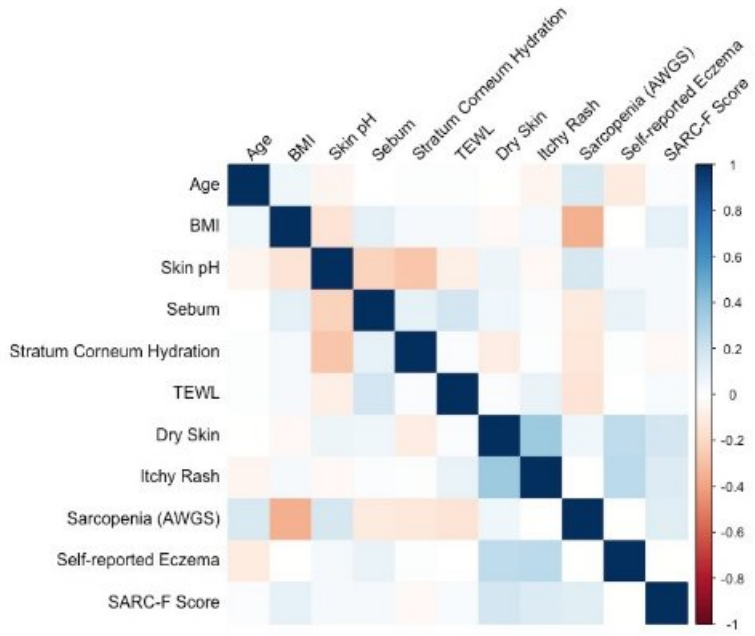

Figure 1: Correlation matrix displaying the relationship between skin parameters and sarcopenia measures

Abstract N°: 2704

leishmania: the other great simulator

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Introduction & Objectives:

Leishmaniasis is a globally distributed chronic disease caused by protozoa of the genus *Leishmania*. It occurs in three forms: cutaneous (most common), mucocutaneous and visceral or kala azar (most severe). Diagnosis is based on detection of amastigotes in clinical specimens, and first-line treatments include pentavalent antimonials and liposomal amphotericin B.

Materials & Methods:

We present two cases of visceral leishmaniasis with cutaneous involvement.

Results:

- Case 1: 78-year-old woman with constitutional syndrome, B symptoms, febrile fever for one month and facial skin lesions. She presented erythematous and hyperkeratotic lesions on the upper lip and nose, an ulcer on the lower lip and erythematous-orange papules in the periocular region. Biopsy confirmed cutaneous leishmaniasis. In addition, PET-CT showed splenomegaly and bone marrow aspirate revealed *Leishmania*, diagnosing concomitant visceral leishmaniasis.
- Case 2: A 49-year-old woman in whom left axillary lymphadenopathy was detected in a follow-up CT scan for another pathology, as well as an erythematous papule on the left forearm. There was no fever, constitutional syndrome or laboratory abnormalities. Core needle puncture of one of the lymphadenopathies and biopsy of the skin lesion revealed lymphadenitis and granulomatous dermatitis with evidence of amastigotes in the cytoplasm of the histiocytes, leading to a diagnosis of visceral leishmaniasis.

Conclusion:

Leishmaniasis is an emerging zoonosis in our environment, and cutaneous manifestations play a key role in the detection of visceral leishmaniasis. Early diagnosis of these lesions may be essential to prevent progression to systemic disease.

Abstract N°: 2719

A Painful Umbilical Nodule: A Rare Cutaneous Manifestation of Endometriosis

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A Painful Umbilical Nodule: A Rare Cutaneous Manifestation of Endometriosis

Introduction & Objectives:

A 38-year-old nulliparous woman presented with a five-month history of a painful, rapidly enlarging umbilical lump, accompanied by worsening umbilical pain during menstruation and heavy, painful periods. She had no prior surgical history and experienced unexplained infertility. Examination revealed a 3×5 cm firm, tender, fixed dermal nodule over the umbilicus. The overlying skin was hyperpigmented with no epidermal change

Materials & Methods:

One case of umbilical endometriosis is reported.

Results:

Ultrasound imaging of the abdomen revealed a hypoechoic lesion in the subumbilical adipose tissue. CT imaging showed a soft tissue lesion in the infraumbilical subcutaneous plane, initially suspected to be a desmoid tumor. The nodule was surgically excised and the histology showed skin with underlying fibrous tissue containing glandular structures surrounded by a cellular stroma in keeping with endometriosis. Further evaluation by the gynecology team, including a transvaginal ultrasound, showed no additional abnormalities.

Conclusion:

Umbilical endometriosis is a rare condition, accounting for only 0.4-4% of endometriosis cases and therefore diagnosis is challenging. It most commonly occurs in women who have had laparoscopic surgery but can also rarely occur in women with no surgical history. Patients usually present with an umbilical mass and cyclical pain or bleeding. Accurate diagnosis relies on correlating clinical presentation with imaging and histopathological findings. This case highlights the importance of considering endometriosis as a differential for women who present with an umbilical mass, particularly those with cyclical symptoms, even in the absence of prior surgical history.

Abstract N°: 2725

Successful “3T therapy” for anti-MDA5 positive dermatomyositis

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Title: Successful “3T therapy” for anti-MDA5 positive dermatomyositis

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Introduction & Objectives: Anti-melanoma differentiation-associated gene 5 (MDA5) antibody-positive dermatomyositis (DM) is frequently associated with rapidly progressive interstitial lung disease (RP-ILD), which carries a high mortality rate of up to 50%. Due to its rarity, no standard treatments have been established. Although immunosuppressive triple therapy with high-dose corticosteroids, tacrolimus, and intravenous cyclophosphamide is recommended, the prognosis remains poor. Recent small-scale studies have reported the efficacy of tofacitinib (TOF), a Janus kinase inhibitor, but long-term data are lacking. This study aims to report the clinical outcomes of a novel combination regimen, “3T therapy” (TOF, tacrolimus, and thalidomide), in patients with early-stage anti-MDA5 positive DM-associated RP-ILD.

Materials & Methods: We retrospectively reviewed 3 cases of early-stage anti-MDA5 positive DM with RP-ILD. Patients received systemic middle-low dose glucocorticoids in combination with TOF (10 mg/day), tacrolimus, and thalidomide (“3T therapy”). Compound sulfamethoxazole was administered for opportunistic infection prophylaxis. Clinical assessments included evaluation of skin lesions, pulmonary function tests, chest computed tomography (CT), and serum ferritin levels. Anti-MDA5 antibody titers were monitored during treatment.

Results: All three patients demonstrated significant improvement in skin rashes, lung function, and CT findings over time. Serum ferritin levels decreased gradually, correlating with clinical improvement. Anti-MDA5 antibody titers, although initially high (up to 1:10,000), did not predict short-term prognosis but may indicate risk of disease flare. Notably, no relapses were observed during a 1-year follow-up in patient 1. The regimen was generally well tolerated; herpes zoster occurred in one case, while no other severe adverse events were reported.

Conclusion: This case series suggests that “3T therapy” (TOF, tacrolimus, and thalidomide) combined with middle-low dose glucocorticoids is a promising treatment option for early-stage anti-MDA5 positive DM-associated RP-ILD. The regimen was effective and well tolerated in our cases, providing durable disease control. Larger prospective studies are warranted to further validate the efficacy and safety of this therapeutic approach.

Abstract N°: 2828

Multicentric Reticulohistiocytosis: A Diagnostic Challenge in Dermatology

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Introduction & Objectives:

Multicentric reticulohistiocytosis (MRH) is a rare systemic granulomatous disorder within the spectrum of non-Langerhans cell histiocytoses. It typically presents with asymptomatic papulonodular lesions, photosensitive micropapular erythema, and erosive polyarthritis. Early recognition is crucial due to its association with systemic diseases, including malignancies. We aim to highlight the diagnostic value of integrated clinical, dermoscopic, radiological, and histopathological findings through a representative case.

Materials & Methods:

We report the case of a 55-year-old woman with a 4-week history of asthenia, generalized arthralgias, and papulonodular lesions on the hands, trunk, and upper limbs. Dermatological examination revealed erythematoviolaceous, shiny papules and nodules forming a “string of pearls” over the lateral fingers. Dermoscopy showed an orange background, arborizing vessels, and brown pigmentation. Imaging studies included PET-CT and hand X-rays. A skin biopsy was performed.

Results:

Radiology revealed erosive arthritis in distal interphalangeal joints and peripheral uptake on PET-CT with no signs of malignancy. Histopathology confirmed MRH, with a dermal infiltrate of histiocytes and multinucleated giant cells positive for PAS, CD68, CD163 and negative for S100, CD1a. The patient responded well to a combination of prednisone, hydroxychloroquine, and methotrexate, achieving marked improvement after six months.

Conclusion:

MRH remains a diagnostic challenge due to its rarity and clinical overlap with dermatomyositis and other autoimmune diseases. The combination of specific clinical features (photosensitive micropapular rash, “string of pearls” nodules) and histopathological markers is essential for diagnosis. Early multidisciplinary intervention can lead to effective disease control and improved prognosis.

Abstract N°: 2832

Cutaneous Manifestations of COVID-19 in Pediatric Patients: A Narrative Review

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Introduction & Objectives: As COVID-19 turned from a relatively small outbreak to a worldwide pandemic overnight, new knowledge emerged about the virus every day. Science and technology were pitted against time, relentlessly learning, creative, building on, then building more strategies to address this serious public health threat. Although respiratory symptoms were often the most evident on physical examination, cutaneous manifestations became more prominent as specific rashes and lesions were recognized in infected individuals. This provides insight into the timing and spread of infection, which is important when considering the pediatric population, who account for 1–5% of all COVID-19 cases.

Materials & Methods: We performed a literature search of multiple medical databases from January 2020 through September 2023 using keywords such as “COVID-19,” “cutaneous manifestations,” and “pediatric”. Following a thorough screening and quality assessment process, 48 studies were initially identified, of which 21 articles were selected for final analysis based on their relevance to confirmed pediatric COVID-19 cases with skin manifestations. We then chose the findings based on lesion morphology, demographic factors, anatomical distribution, and relationship to COVID-19 diagnosis to identify patterns in the literature.

Results: Dermatologic lesions have been correlated with both the general and pediatric population through interactions with the immune system, pro-inflammatory pathways, as well as psychological aggravations. The skin manifestations can be divided into: disease-related, PPE-induced, vaccine-related and rashes due to psychosocial distress of patients. The disease-related manifestations are further classified into different types including maculopapular rash, diffuse urticaria, varicella-like papulovesicular lesions, painful acral purpuric lesions, and most commonly chilblain-like lesions. These “COVID toes” manifested as erythematous or violaceous swelling predominantly of the feet (45.2%) and hands and typically resolved spontaneously within 2-3 weeks. Maculopapular eruptions (32.3%) started usually in the trunk and then spread peripherally. There were urticarial rashes (16.1%), with involvement mostly over the trunk and limbs; vesicular eruptions (8.1%), which looked varicella-like but had preferentially trunk-centered distribution. The most prevalent condition which has a close association with cutaneous manifestations is the Multisystem Inflammatory Syndrome (MIS), which is described by CDC as a “rare but serious condition linked with COVID-19 in which different body parts become inflamed, including the heart, lungs, kidneys, brain, skin, eyes, or gastrointestinal organs”. Notably, there was a demographic disparity in MIS-C, with higher prevalence among Hispanic (40.5%) and Black (33.1%) children than among white (13.2%) populations.

Conclusion: Clinical recognition of COVID-19-associated skin manifestations will help to reach an early diagnosis, even in the presence of minimal or absent respiratory symptoms. Many features distinguished COVID-related dermatological findings from other pediatric conditions including chilblain-like lesions occurring in warm months, unusual distribution patterns, and specific histopathological findings in relation to vascular damage. Future research should address long-term outcomes and evolving presentations with new viral variants.

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Abstract N°: 2979

Atypical Cutaneous Metastasis in Clear Cell Renal Carcinoma

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Introduction & Objectives:

Cutaneous metastases represent an uncommon but clinically relevant manifestation of internal malignancies. Among genitourinary tumors, clear cell renal cell carcinoma (ccRCC) is the most frequently associated with skin involvement. These metastases often present with nonspecific clinical features, mimicking benign or inflammatory dermatoses, and are therefore prone to misdiagnosis. Clinicians must maintain a high index of suspicion when evaluating persistent cutaneous lesions in oncologic patients, especially given the challenging presentations of this entity.

Materials & Methods:

A 73-year-old male patient presented with a persistent lesion on the left dorsal region, initially described as an "infected cyst." The lesion had been present for over six months and did not respond to multiple courses of antibiotic therapy. His past medical history included a radical nephrectomy of the right kidney due to ccRCC, performed two years prior, and ongoing use of Pazopanib, a tyrosine kinase inhibitor prescribed due to the tumor's aggressive behavior and high recurrence risk.

Physical examination revealed a 5 × 4 cm erythematous, firm, non-fluctuant, non-inflammatory tumor on the left dorsolumbar region. The lesion was well-circumscribed and showed no signs of local infection. Dermoscopic evaluation revealed prominent linear branched non-focused vessels, white structureless zones, and superficial scaling.

Soft tissue ultrasound identified a solid, heterogeneous, hypoechoic nodular lesion within the subcutaneous tissue, measuring approximately 5.5 × 4.6 cm. Doppler imaging demonstrated intense intralesional vascularity with a low-resistance arterial flow pattern, raising suspicion of a neoplastic process.

A core needle biopsy was performed. Histopathological analysis showed dermal infiltration by malignant epithelial cells arranged in nests and cords, with clear cytoplasm and prominent nucleoli. Immunohistochemical staining was positive for PAX-8, RCC (renal cell carcinoma marker), and TTF-1. The cells were negative for CK7, CK20, CD34, HSV8, S100, PSA, and CDX2. These findings supported the diagnosis of metastatic carcinoma consistent with a renal origin, specifically metastatic clear cell renal cell carcinoma.

Results:

Cutaneous metastases from ccRCC are rare, occurring in 2.8% to 6.8% of cases, and are usually linked to advanced-stage disease with poor prognosis. Median survival following diagnosis is approximately six months. These metastases generally appear as rapidly enlarging nodules, varying in color from flesh-toned to violaceous or erythematous. Commonly affected sites include the scalp, face, chest, and abdomen.

Atypical presentations may lead to diagnostic delays, particularly when mimicking benign lesions such as cysts, lipomas, or infections. Persistent, non-resolving lesions unresponsive to standard treatment should prompt further investigation, including imaging and histopathological analysis. In this case, the dorsal localization and slow

evolution contributed to the initial misclassification.

Conclusion:

This case underscores the importance of maintaining a high index of suspicion for cutaneous metastases in patients with a history of renal cell carcinoma, particularly when lesions display atypical clinical or dermoscopic features. Early recognition and diagnosis are essential for accurate staging and appropriate management of metastatic disease.

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Abstract N°: 3014

Extensive Tophaceous Gout with Secondary Infection in a Young Male: A Rare Case of Cutaneous Dissemination in Chronic Hyperuricemia

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Introduction & Objectives: Tophaceous gout represents a chronic manifestation of uncontrolled hyperuricemia, commonly occurring in older adults after years of untreated disease. Cutaneous tophus with ulceration and secondary infection is an uncommon presentation, especially in younger individuals. Diagnosis can be challenging in atypical cases, requiring a combination of clinical, histopathological, and radiological approaches. We report a rare case of disseminated tophaceous gout with intradermal lesions and polymicrobial infection in a 35-year-old male with multiple comorbidities. This case highlights the importance of early recognition and comprehensive management of cutaneous gout, particularly in low-resource settings.

Materials & Methods: A 35-year-old Indonesian male presented with year-long progression of painful, firm nodules and ulcerated lesions across his limbs, trunk, and digits. He had a history of uncontrolled diabetes mellitus, hypertension, obesity (96 kg), and dietary habits rich in purines. Physical examination revealed multiple white nodular skin lesions, some ruptured with extrusion of chalky-white material, consistent with monosodium urate (MSU) crystals. Joint stiffness and swelling were noted, particularly in the first metatarsophalangeal joints. Laboratory findings showed severe hyperuricemia (13.1 mg/dL), neutrophilia (96.1%), anemia, and impaired renal function. Swab cultures from ulcer bases revealed *Proteus mirabilis* and *Staphylococcus aureus*. Skin biopsy from the abdominal lesion demonstrated dermal aggregates of needle-shaped urate crystals surrounded by granulomatous inflammation, including multinucleated giant cells and mononuclear infiltrates. Imaging with musculoskeletal ultrasound revealed the “double contour sign” at the MTP joint and hyperechoic soft tissue deposits, confirming urate deposition.

Results: The patient was diagnosed with generalized cutaneous tophaceous gout complicated by secondary bacterial infection and comorbid cardiac and renal dysfunction. He was treated with systemic allopurinol, colchicine, corticosteroids, appropriate antibiotics based on sensitivity testing (ceftriaxone), and supportive care including wound dressing with mupirocin and NaCl 0.9% compresses. A gradual resolution of inflammatory signs, reduced discharge from ulcers, and improvement in general condition was observed after 10 days. No surgical debridement was necessary.

Conclusion: This case illustrates an uncommon presentation of tophaceous gout in a young adult with systemic comorbidities, highlighting the diagnostic and therapeutic complexity of disseminated cutaneous urate deposition. Histopathology and imaging are essential to confirm diagnosis, especially in atypical cases. Early identification and aggressive medical management, even without surgical intervention, can lead to favorable outcomes. In resource-limited settings, integrating clinical suspicion with targeted investigations is crucial for managing severe gout manifestations.

Abstract N°: 3068

“A Wolf in Red Clothing: Carcinoma Erysipeloid in the Postoperative Setting”

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Introduction & Objectives:

Internal malignancies metastases to the skin can manifest in a variety of perplexing ways. 1 to 5% of patients with internal malignancies develop cutaneous metastases. Carcinoma Erysipeloides is a rare form of cutaneous metastasis frequently associated with breast cancer.

Materials & Methods: A 53 yr old female patient came to the OPD with complaints of redness, skin lesions and itching around her left breast since a week. Patient also gives H/O left-side Mastectomy for infiltrating duct carcinoma 2 months ago. On examination, she had diffuse erythema over her left breast, extending up to the neck, axilla with grouped erythematous papulovesicular lesions. It was diagnosed as Irritant Contact Dermatitis and patient was given topical steroids and antihistamines. As the lesions did not respond to the treatment , for further evaluation Biopsy was sent, Needling confirmed the presence of keratin filled milia.

Results: Histological features suggested recurrence at surgical site – Invasive Ductal Carcinoma with Central necrosis and lymphovascular invasion with ?Primary cutaneous adnexal origin. IHC markers showed Positive Her2 and Ki67.

PET-CT reports showed Diffuse FDG uptake with postsurgical changes in left anterior chest wall and Hypermetabolic lymph nodes suspicious for malignancy.

With the above investigation details a final diagnosis of Carcinoma Erysipeloides was made.

Conclusion: Carcinoma Erysipeloides is characterized by erythematous, indurated plaques that mimic infectious erysipelas. In our case it has developed post Modified Radical Mastectomy, with the unique feature of milia embedded within the affected skin. This is highly unusual and has not been widely reported in the literature. This case underscores the need for heightened clinical suspicion when evaluating erythematous lesions in oncology patients and highlights an unusual cutaneous manifestation of CE.

Abstract N°: 3101

Safety and Quality of Life Outcomes in Randomized Controlled Trials of Pharmacologic Treatments for Cutaneous Sarcoidosis: A Systematic Review and Meta-Analysis

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Safety and Quality of Life Outcomes in Randomized Controlled Trials of Pharmacologic Treatments for Cutaneous Sarcoidosis: A Systematic Review and Meta-Analysis

Introduction & Objectives: Cutaneous sarcoidosis is a granulomatous skin disease that may occur independently or as a manifestation of systemic sarcoidosis. While various pharmacologic therapies are used off-label, their effect on patient-reported quality of life (QoL) and safety remains unclear. This meta-analysis aims to systematically evaluate the impact of pharmacologic interventions on QoL and serious adverse events (SAEs) in patients with cutaneous sarcoidosis, based on randomized placebo-controlled trials.

Materials & Methods: A comprehensive literature search was conducted using electronic databases (PubMed, Google Scholar, Cochrane Library) from inception to 01st April 2025, employing the keywords “cutaneous” and “sarcoidosis” or “skin” and “sarcoidosis”. Only studies published in English were included. Eligible studies comprised randomized, double-blind, placebo-controlled trials investigating pharmacologic treatments for cutaneous sarcoidosis and reporting either QoL or SAE outcomes. Data extracted included study characteristics, sample size, duration, patient demographics, interventions, and outcomes. The Cochrane risk-of-bias tool was applied to assess study quality. Due to heterogeneity in QoL instruments (e.g., DLQI, Skindex, Sarcoidosis Questionnaire), a binary outcome was defined as a ≥4-point improvement on any validated scale, based on established minimal clinically important differences. Meta-analyses were performed using random-effects models, with heterogeneity assessed using I^2 statistics.

Results: Three studies (n = 138) contributed QoL data. Among intervention groups, 22 of 40 patients showed improvement versus 12 of 34 in placebo arms (OR = 2.23; 95% CI: 0.87–5.73; P = 0.09). Heterogeneity was low (I^2 = 0%) .Four studies (n = 266) reported SAE data. The incidence of SAEs was identical in both arms (18 events each), yielding a pooled OR of 0.97 (95% CI: 0.48–1.96; P = 0.93). No significant heterogeneity was observed (I^2 = 0%). TNF-α inhibitors and other immunomodulatory agents represented the most commonly evaluated therapeutic classes across studies.

Conclusion: Pharmacologic treatment of cutaneous sarcoidosis may be associated with improved QoL without increasing the risk of serious adverse events. However, the observed QoL benefit did not reach statistical significance, and wide confidence intervals reflect residual uncertainty due to small sample sizes and methodological heterogeneity. These findings highlight the need for adequately powered, high-quality randomized controlled trials with standardized, patient-centered outcomes to inform evidence-based clinical management strategies.

TABLE 1: Quality of Life Improvement (≥4-point reduction)

Study	Total number of patients	Response (# of patients) Intervention	Response (# of patients) Placebo	Odds Ratio [95% CI]
Droitcourt et al.	39	10 (20)	8 (19)	1.38 (0.39, 4.87)
Pariser et al.	15	6 (10)	1 (5)	6.00 (0.48, 75.34)
Redl et al.	20	6 (10)	3 (10)	3.50 (0.55, 22.30)
Total	74	22 (40)	12 (34)	2.23 (0.87, 5.73)

Response defined as ≥4-point improvement on validated QoL scales.
Heterogeneity: $Chi^2 = 1.38$, df = 2 (P = 0.50); $I^2 = 0\%$

TABLE 2: Serious Adverse Events (SAEs)

Study	Total number of patients	SAEs (# of patients) Intervention	SAEs (# of patients) Placebo	Odds Ratio [95% CI]
Judson et al. (Golimumab)	113	7 (55)	9 (58)	0.79 (0.27, 2.30)
Judson et al. (Ustekinumab)	118	10 (60)	9 (58)	1.09 (0.41, 2.91)
Pariser et al.	15	1 (10)	0 (5)	1.74 (0.06, 50.43)
Redl et al.	20	0 (10)	0 (10)	Not estimable
Total	266	18 (135)	18 (131)	0.97 (0.48, 1.96)

SAE = Serious Adverse Event as defined per study protocol.
Heterogeneity: $Chi^2 = 0.30$, df = 2 (P = 0.86); $I^2 = 0\%$

Abstract N°: 3234

Can the Skin Reveal Hidden Diabetes? A Register-Based Study of Dermatophyte Infections and Future Diabetes Risk

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Can the Skin Reveal Hidden Diabetes? A Register-Based Study of Dermatophyte Infections and Future Diabetes Risk

Introduction & Objectives:

Dermatophyte infections affect an estimated 10% of the population, depending on geographic region, and are more prevalent among individuals with type 2 diabetes (T2D). However, it remains unclear whether these infections could serve as early clinical indicators of undiagnosed or developing T2D. This study aimed to investigate whether a positive polymerase chain reaction (PCR) test for dermatophyte infection from the feet (tinea pedis or tinea unguium) is associated with an increased risk of subsequent T2D diagnosis.

Materials & Methods:

This register-based cohort study included 78,752 adults between 2015 and 2021. A total of 19,688 individuals with a positive PCR test for dermatophytes from toenails, toe web spaces, or feet (exposed group) were matched 1:3 by age, sex, and geographic area to 59,064 unexposed individuals. Those with a known diabetes diagnosis prior to testing and individuals under 20 years were excluded. The primary outcome was new-onset T2D after testing. Poisson regression was used to calculate incidence rates and incidence rate ratios (IRRs), adjusted for age, sex, and relevant comorbidities.

Results:

Median age was 49 years (IQR: 43–69) in both groups, and 60.3% were male. The incidence of newly diagnosed T2D was 8.2 (95% CI: 7.79–8.58) per 100 person-years in the exposed group and 8.1 (95% CI: 7.85–8.31) in the unexposed group. The adjusted IRR was 1.01 (95% CI: 0.96–1.07; p = 0.616), indicating no statistically significant association. Subgroup analyses by age and sex yielded similar results. A secondary analysis showed that having three or more fungal PCR tests was not associated with increased risk of developing diabetes (IRR 1.01, 95% CI: 0.71–1.44; p = 0.947). Sensitivity analyses using an alternative diabetes definition, based on two HbA1c measurements ≥48 mmol/mol within one year, supported the primary findings.

Conclusion:

PCR-confirmed dermatophyte infections of the feet were not associated with increased risk of developing T2D. These findings suggest that such infections may not serve as early clinical indicators of undiagnosed diabetes.

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Abstract N°: 3304

malignant atrophic papulosis-degos disease

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Introduction & Objectives:

Degos disease, also known as malignant atrophic papulosis, is a rare multisystem occlusive small vessel vasculopathy of unknown cause. Degos disease can be localised to the skin, in which case it has a good prognosis. Extra cutaneous involvement includes the GI tract, which can lead to intestinal perforation and the central nervous system, causing cerebral thrombosis which are associated with significant morbidity and mortality. Herein, we present a rare case of degos disease.

Materials & Methods and results :

Clinical Course and Diagnostic Findings

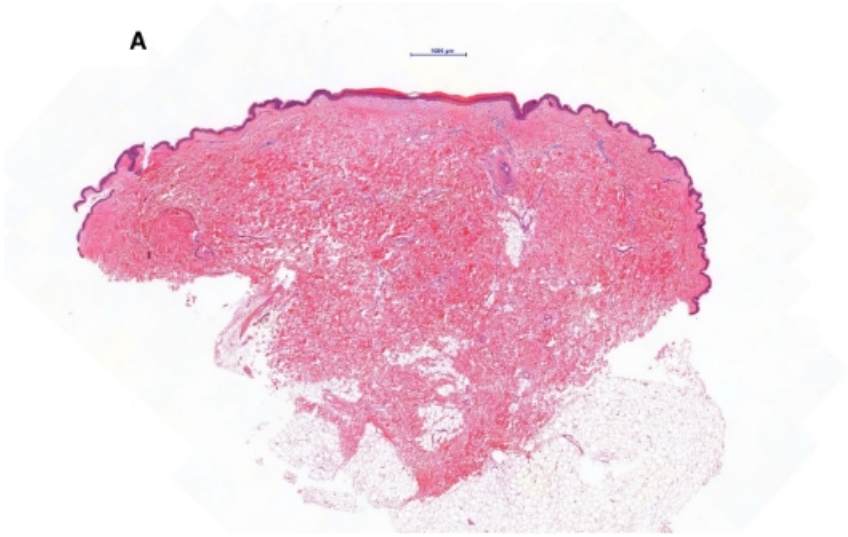
A woman in her 30s presented with pruritic, burning urticarial eruptions that were initially managed with Fexofenadine and Montelukast. Despite this, her symptoms persisted, and the duration of individual lesions exceeding 24 hours raised clinical suspicion for urticarial vasculitis. She developed abdominal pain, diarrhoea and rectal bleed for which gastroenterology opinion was sought. A skin biopsy was therefore performed, and Dapsone was commenced empirically. At a subsequent follow-up, the clinical picture evolved: the patient developed crops of discrete papules distributed over the abdomen and thighs. These lesions featured porcelain-white, atrophic centres with surrounding erythematous rims and telangiectatic borders — features highly suggestive of Degos Disease (malignant atrophic papulosis). Histopathological analysis of these lesions revealed the following (FIGURES A-F):

a. Compact hyperkeratosis overlying flattened epidermis.
b. Perivascular lymphocytic infiltrate in the reticular dermis, involving small-

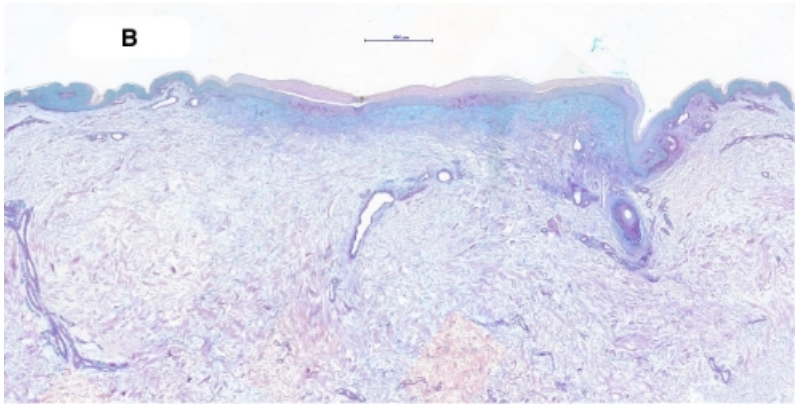
medium calibre mildly-ectatic blood vessels.

c. A narrow band of superficial dermal pallor and homogenization.
d. APBAS staining elucidated prominent mucin deposition within superficial

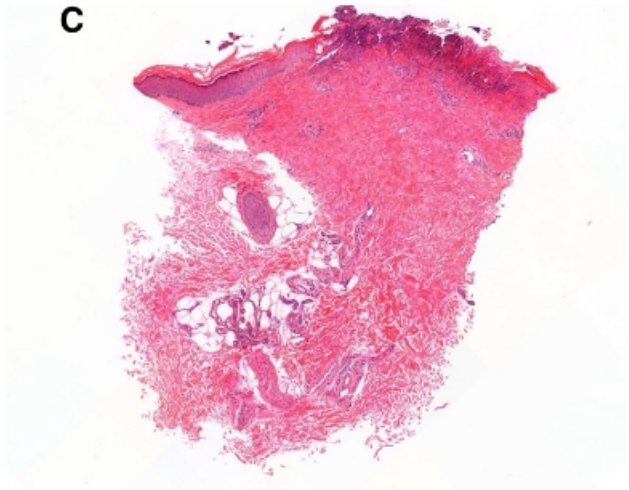
dermal band, and a diminished basement membrane.



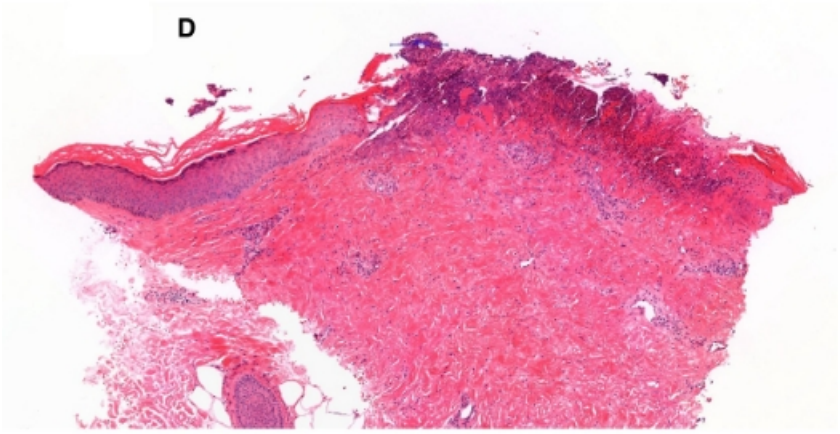
A.Punch biopsy of skin, haematoxylin and eosin stain, ×20 677x343mm



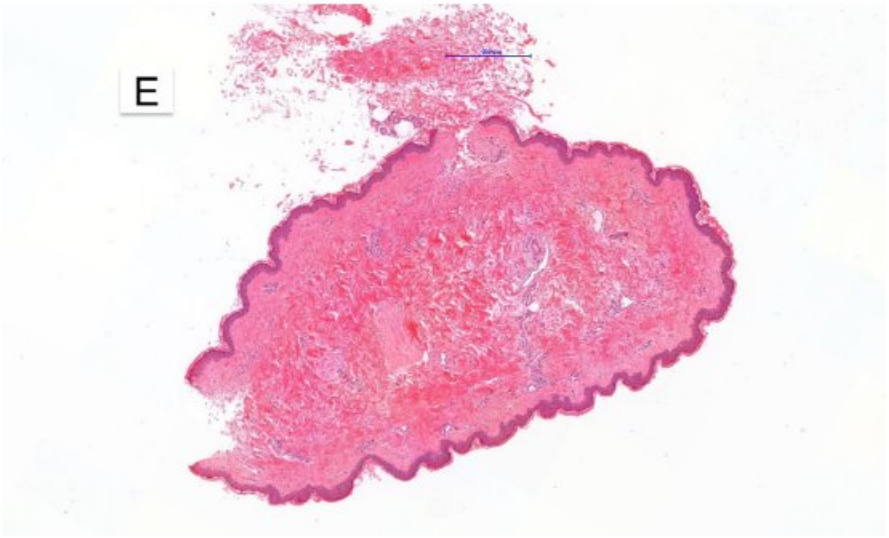
B.Punch biopsy of skin-ABPAS Stain 903x457mm



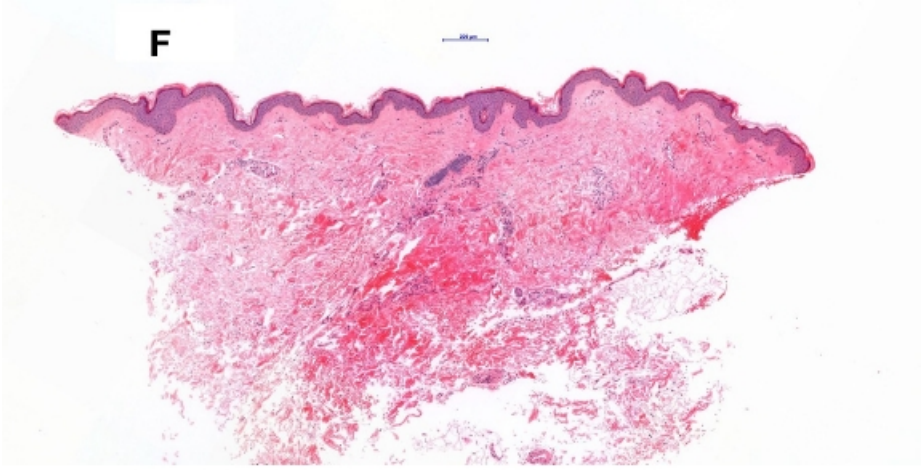
C.Punch biopsy of skin ,haematoxylin and eosin stain, ×20-magnification 1 903x457mm



D.Punch biopsy of skin haematoxylin and eosin stain, ×20 magnification 2 903x457mm



E.Punch biopsy of skin haematoxylin and eosin stain, ×20 magnification 3 903x457mm



F.Punch biopsy of skin haematoxylin and eosin stain, ×20 magnification 4 903x457mm

In the weeks that followed, the patient reported new-onset neurological symptoms. Imaging and clinical assessment confirmed a transient ischemic attack (TIA), indicative of systemic involvement. As a result, Clopidogrel therapy was initiated to address the thrombotic risk associated with systemic Degos Disease.

Conclusion

This case highlights the diagnostic complexity of Degos Disease and underscores the pivotal role dermatologists play in identifying its early cutaneous manifestations, which may lead to serious systemic involvement. Prompt recognition by dermatologists is crucial to enable early intervention and appropriate multidisciplinary

management. Additionally, this case reinforces the necessity for long-term surveillance, as systemic complications can develop even years after the appearance of initial skin lesions. Given the rarity and unpredictable clinical course of Degos Disease, further research is urgently needed to better understand its pathophysiology and to develop effective therapeutic strategies.

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Abstract N°: 3494

Sleep profile of female and male individuals with androgenetic alopecia and its association with thyroid function: an analysis of a representative sample from the EPISONO study

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Introduction & Objectives: Androgenetic alopecia (AGA) is a common condition characterized by the gradual miniaturization of hair follicles, clinically manifested with progressive hair loss and baldness. This condition can significantly impact emotional well-being and quality of life, including sleep quality. The conversion of testosterone to dihydrotestosterone (DHT) by the enzyme 5-alpha-reductase directly impacts the hair follicles and leads to hair thickness. While this hormonal pathway underlying AGA is well-established, the potential connection to thyroid function and its interaction with sleep disturbances warrants further exploration. This study aims to investigate the sleep parameters in individuals with AGA, with an emphasis on potential sex differences, and its association with thyroid hormones.

Materials & Methods: Data from the 4th Edition of the São Paulo Epidemiological Sleep Study (EPISONO) were analyzed. To this study, self-reported AGA, comorbidities, and sleep questionnaires were accessed [Pittsburgh Sleep Quality Index (PSQI), Epworth Somnolence Scale (ESS), Insomnia Severity Index (ISI), and Berlin questionnaire, that measures risk to obstructive sleep apnea (OSA)]. Thyroid hormones were considered: thyroid stimulating hormone (TSH), total and free levothyroxine (T4) and triiodothyronine (T3). For statistical analysis, T-test and Mann-Whitney test were used.

Results: From a total of 769 participants composing the original sample from EPISONO, 81 self-reporting AGA individuals (17 women and 64 men) were included in this study. The mean age was 51.8 years old (56.2 for women and 50.6 for men). Most of men were middle-aged (40 to 59 years-old), while most of women were over 60 years-old (43.8% and 58.8%, respectively). Considering comorbidities, 33.3% reported hypertension (n=7 women; n=20 men); 18.5% reported diabetes (n=4 women; n=11 men); and 11.1% stated thyroid disease (n=5 women; n=4 men). In the sleep questionnaires, women exhibited a significantly higher mean ISI score than men (women 9.8; men 6.2; p=0.017). For ESS, 28 participants had ESS score>10 (hypersomnolence). From the completed PSQI in the AGA-group, 74 individuals presented PSQI score>5 (poor sleep quality). Although not significant, women had a slightly higher PSQI score (women 10.5; men 10.1; p=0.53); and men showed higher ESS total score (women 8.2; men 8.6; p=0.88). In Berlin questionnaire, 34 individuals had risk to OSA (n=9 women; n=25 men). By analyzing TSH, T3, total and free T4 levels with sleep questionnaires, total T4 (p=0.04) and free T4 (p=0.03) were statistically higher in individuals with insomnia symptoms measured by ISI. More advanced age was related to OSA risk (p=0.008).

Conclusion: Individuals with AGA can have compromised sleep quality, with higher risk to specific sleep disorders, such as insomnia, with a particular attention to the women population. Insomnia symptoms related to T4 levels reinforces the importance of investigate thyroid function and sleep disturbance in individuals with AGA.

Support: AFIP, CNPq, FAPESP, and L'Oréal/La Roche-Posay Research Grants.

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Abstract N°: 3518

Granulomatous Dermatitis with Violaceous Nasal Nodules in a 54-Year-Old Female

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Introduction & Objectives:

Granulomatous skin lesions may occur in a wide spectrum of conditions, including infectious, autoimmune, and systemic granulomatous diseases. To describe a diagnostically challenging case of granulomatous dermatitis with facial involvement and systemic lymphadenopathy, highlighting the importance of a multidisciplinary approach in excluding secondary causes and guiding treatment.

Materials & Methods:

Informed consent was given for presentation of the case.

Results:

A 54-year-old female with type 2 diabetes mellitus and hypertension presented with violaceous nodules on the nasal bridge and tip. The lesions had developed insidiously over three years and were non-pruritic and non-tender. Histopathologic examination of a skin biopsy revealed well-formed granulomas with discrete lymphocytes and Langhans giant cells, compatible with sarcoidal granulomas. Special stains for fungal and mycobacteria were negative, tissue mycobacterial PCR was negative, fungal cultures were negative, and stains for mucin and colloidal iron were also negative.

Extensive diagnostic evaluation included:

Laboratory findings: Complete blood count, hepatic and renal function, coagulation profile, thyroid function, serum electrolytes, and urinary calcium — all within normal limits.

Infectious screening: Negative VDRL, HIV, and IGRA (interferon-gamma release assay).

Inflammatory and autoimmune markers: Normal CRP, procalcitonin, complement (C3, C4), immunoglobulin levels, ANA, and ANCA.

Mycotic and opportunistic pathogens: Negative histoplasma urine antigen and serum β-D-glucan.

Ophthalmologic evaluation: No signs of uveitis or ocular involvement.

Imaging: Thoracic CT revealed mediastinal lymphadenopathy with punctiform calcifications. Additional cervical, axillary, abdominal, and retroperitoneal lymph node enlargements were seen, appearing indeterminate but suggestive of benign chronic pathology.

No definitive systemic, infectious, or autoimmune etiology was identified. Based on the clinical presentation, histopathology, and exclusion of secondary causes, a diagnosis of idiopathic granulomatous dermatitis was established. The patient was treated with oral prednisone and hydroxychloroquine, resulting in complete resolution of skin lesions with no recurrence at follow-up.

Conclusion:

This case illustrates the diagnostic complexity of granulomatous skin eruptions, especially when accompanied by non-specific lymphadenopathy and facial involvement. A multidisciplinary work-up is essential to exclude systemic causes. Idiopathic granulomatous dermatitis remains a diagnosis of exclusion, but can respond well to immunomodulatory therapy with corticosteroids and antimalarials such as hydroxychloroquine.

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Abstract N°: 3530

Histiocytoid Sweet Syndrome associated with Chronic Lymphocytic Leukemia

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Introduction & Objectives: Sweet syndrome or Acute febrile neutrophilic dermatosis is a rare skin condition considered a hypersensitivity reaction to various antigens (viruses, bacteria, malignancy, pregnancy). It is tipically manifested with sudden appearance of painful erythematous plaques and nodules, fever, leucocytosis, neutrophilia. Histopapathologicaly presented as diffuse dense infiltrate of mature neutrophils and edema of the papillary dermis in the absence of leococytoclastic vasculitis. Hystiocytoid Sweet syndrome is a rare forme, with histopathological presentation of predominatly mononuclear immature myeloid cells, which have been previously misinterpreted as histiocytes.

Materials & Methods: We present a 68-year-old female who reported sudden pain in the left armpit that occurred after she was chopping wood. Soon after that she developed fever, high body temperature (up to 40), malaise, redness on her hands followed by pain and itching. On clinical examination we found numerous exudative tender violaceous oval and annular plaques with pseudovesicles on patient's neck, hands and legs. Complete blood count showed leukocytosis and lymphocytosis, sedimentation rate and CRP were elevated, while complete biochemical panel were normal. In serum and urine protein electrophoresis, paraprotein was suspected. Urine culture discovered Klebsiella / Enterobacter infection. Serological and immunologic tests (Hepatitis B and C, HIV; Mycoplasma pneumoniae, antinuclear antibodies) were negative. Soft tissue ultrasound showed enlarged lymph nodes in the left armpit. Histopathological finding had characteristic presentation with dense lymphocytic infiltrate, predominantly nodular, partly diffuse between the dermis fiber. Immunohistochemical analysis were positive for CD68 and myeloperoxidase. Blood flow cytometry showed increased absolute number of monoclonal mature B cells, high value of CLL score (Chronic Lymphocytic Leukemia) which led to diagnosis CLL/CD8-CD49d, Score BHLL4. The complete diagnosis of Histiocytoid Sweet Syndrome associated with CLL was done.

Results: We introduced prednisone (0.5mg/kg/day) during 3 weeks, antibiotic for urinary infection, topical corticosteroids. The complete regression of skin lesions was achieved and her hematological disease was stable, with no need for further treatment.

Conclusion: We present the patient as a rare clinical and histopathological form of Sweet's Syndrome – Histiocytoid form. Association of Histiocytoid Sweet's Syndrome with CLL is extremely rare, as we found only one case described in the literature (1).

1. *Bush JW, Wick MR. Cutaneous histiocytoid Sweet syndrome and its relationship to hematological diseases. J Cutan Pathol 2016. doi: 10.1111/cup.12659 John Wiley and Sons. Printed in Singapore*

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Abstract N°: 3533

Epididymo-Orchitis as a Revealing Manifestation of Behçet's Disease

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Introduction & Objectives:

Behçet's disease is a chronic, systemic inflammatory disorder most commonly observed in young individuals from the eastern Mediterranean region. Orogenital ulcers and skin lesions are typically the initial manifestations of the disease, while more severe complications may include ocular, vascular, neurological, and gastrointestinal involvement. Genital involvement in the form of Epididymo-orchitis has been rarely reported.

Herein, we report a rare presentation of Behçet's disease in a young patient, revealed by epididymo-orchitis resistant to antibiotic treatment. This case aims to raise medical awareness of this uncommon manifestation in order to minimize diagnostic delays, prevent severe complications, and preserve the patient's quality of life.

Case report:

A 23-year-old man with no significant medical history was referred to our department for the management of a recently developed genital ulcer, occurring in the context of epididymo-orchitis that was resistant to a one-week course of antibiotic treatment. Laboratory investigations, including urinary cultures and serologies for sexually transmitted infections, were negative.

On physical examination, bilateral epididymo-orchitis was noted, characterized by painful swelling and tenderness of both testicles . A large, deep, and painful ulcer with central necrosis and an eschar, surrounded by a halo of erythema, was observed on the lateral aspect of the left scrotum. Inguinal lymphadenopathy was absent. Additionally, pseudofolliculitis was noted on the upper trunk. The patient was afebrile.

History taking revealed recurrent episodes of oral aphthosis, occurring approximately three times per year over the past two years, along with inflammatory arthralgia. The pathergy test was positive. Clinical and paraclinical evaluations for other systemic involvement revealed no abnormalities.

A diagnosis of Behçet's disease was established, and treatment with colchicine combined with a short course of corticosteroids (1 mg/kg/day) was initiated. All symptoms resolved within a few days, and the patient has remained symptom-free since discontinuation of colchicine, with a 10-month follow-up.

Conclusion:

Behçet's disease should be systematically considered in cases of epididymo-orchitis, particularly when it is resistant to antibiotics or presents as recurrent episodes, especially in regions where the disease is highly prevalent.

Abstract N°: 3565

A Rare Case of Elephantiasic Pretibial Myxedema in a 36-Year-Old Filipino Male

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Introduction & Objectives:

Pretibial myxedema, also known as thyroid dermopathy, is a rare manifestation of autoimmune thyroid disease, seen in 0.5–4.3% of patients with thyrotoxicosis. The elephantiasic variant is the rarest and most severe form, characterized extreme skin thickening, edema, and disfigurement.

Elephantiasis is a chronic dermatologic condition characterized by progressive lymphedema, dermal fibrosis, and papillomatous changes, often resulting in marked cutaneous disfigurement. Although most commonly linked to lymphatic filariasis, similar lymphatic obstruction and edema can also arise from malignancy, trauma, or autoimmune disorders such as pretibial myxedema—potentially leading to diagnostic confusion and inappropriate management.

Materials & Methods:

We report the case of a 36-year-old Filipino male with a known history of Graves' disease and exophthalmos poorly adherent to prescribed methimazole and endocrinology follow-up who presented with a 4-year history of progressively enlarging, firm, hyperpigmented papules and nodules on both lower legs. These lesions gradually coalesced into cobblestone-like plaques. He had sought consultation with multiple physicians and was clinically diagnosed with lymphatic filariasis. As a result, he underwent a 6-month course of doxycycline and was advised to continue treatment with diethylcarbamazine (DEC) and ivermectin; however, he was unable to procure these medications.

Results:

Upon consultation, a 4 mm punch biopsy of the affected skin was done which showed marked dermal edema, separation of collagen bundles, and moderate superficial perivascular lymphocytic infiltrates. Alcian blue staining confirmed significant dermal mucin deposition. Thyroid function tests revealed suppressed TSH with elevated T3 and T4 levels, indicative of poorly controlled hyperthyroidism, while thyroid ultrasound demonstrated diffuse parenchymal changes. Blood film microscopy was negative for microfilariae.

The patient was referred back to endocrinology for optimization of thyroid hormone levels. With improved compliance to antithyroid therapy, a slight reduction in lesion size was observed. Surgical debulking is planned once a euthyroid state is achieved.

Conclusion:

This case underscores the diagnostic challenge posed by the elephantiasic variant of pretibial myxedema, particularly in endemic regions where filarial diseases are more prevalent and may be considered first. Despite the patient's known history of Graves' disease, the cutaneous manifestations were initially misattributed to lymphatic filariasis. This highlights the need to include systemic autoimmune disorders in the differential diagnosis of chronic lymphedema and atypical dermatologic presentations. A comprehensive clinical assessment, supported by histopathologic examination and appropriate endocrine evaluation, is crucial for accurate diagnosis and timely management.

Abstract N°: 3697

Dermatological Signs in Crohn's Disease: A 7-Year Retrospective Analysis

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Introduction & Objectives:

Crohn's disease (CD) is a chronic granulomatous inflammation of the gastrointestinal tract with a multifactorial origin. Mucocutaneous manifestations may precede or accompany the disease. The aim of this study was to identify dermatological signs in patients with CD.

Materials & Methods:

A retrospective study was conducted in the dermatology department of Charles Nicolle Hospital, including patients with confirmed Crohn's disease observed over a 7-year period.

Results:

Twenty-three cases were collected. The mean age was 36 years (range: 4–64), with a male-to-female sex ratio of 0.35.

In six patients, cutaneous involvement preceded the diagnosis of CD. Mucocutaneous manifestations included:

-Reactive dermatoses: oral or genital aphthosis (4 patients), erythema nodosum (1), pyoderma gangrenosum (3), acneiform nodules (1).

-Specific granulomatous lesions: recurrent perineal fistulas (5), macrocheilitis (2), oral and genital ulcers (1), perianal fissures (2), intertrigo of major folds (inguinal, intergluteal, submammary) (4), vulvar edema or penoscrotal lymphedema (3), pseudotags (2), anal margin abscesses (2).

-Iatrogenic skin manifestations: psoriasiform paradoxical reactions (5).

Nutritional deficiency–related lesions: follicular hyperkeratosis (1), eczematous dermatitis (1).

-Other dermatoses: urticarial vasculitis (1), relapsing polychondritis (1).

Conclusion:

Cutaneous lesions in Crohn's disease are diverse and may precede, accompany, or follow gastrointestinal symptoms, with a prevalence estimated at 10–30%.

These manifestations include specific granulomatous lesions, particularly frequent in the perianal area, as seen in our series. Reactive dermatoses, such as erythema nodosum or pyoderma gangrenosum, often evolve independently from digestive symptoms and may be resistant to conventional treatments. Other skin findings may result from nutritional deficiencies related to malabsorption, or from treatment-related adverse effects such as paradoxical psoriasiform eruptions. Inflammatory dermatoses linked by a shared autoimmune or genetic basis may also occur. Given their variety and potential diagnostic value, these skin manifestations require clinical vigilance and underscore the need for close collaboration between gastroenterologists and dermatologists to ensure optimal care for patients with Crohn's disease.

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Abstract N°: 3701

Unmasking Bullous Amyloidosis: Insights from a Systematic Review of 53 Cases

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Introduction & Objectives: Amyloidosis refers to a group of disorders marked by extracellular deposition of misfolded protein fibrils, known as amyloid, which can impair organ function. The most common systemic type, AL (light-chain) amyloidosis, is often associated with plasma cell dyscrasias such as multiple myeloma. Cutaneous involvement is seen in up to 40% of systemic cases, but bullous lesions remain an exceptionally rare and underrecognized manifestation. Characterized by spontaneous hemorrhagic or non-hemorrhagic blisters due to dermal amyloid infiltration, bullous amyloidosis can mimic autoimmune blistering diseases. This study aimed to better characterize this unusual clinical presentation.

Materials & Methods: We conducted a systematic review on PubMed using the keyword "Bullous Amyloidosis," including all case reports and series published up to March 2025. Articles were screened using Rayyan, with duplicates removed. Selection was completed by consensus between two independent reviewers, with a third consulted as needed. A total of 27 studies met inclusion criteria. Extracted data included demographics, clinical features, histopathology, underlying diagnoses, treatment, and outcomes

Results: Fifty-three patients with bullous amyloidosis were identified. Of these, 22 were male and 31 female, with a mean age of 65.1 years (range: 46–85), reflecting a slight female predominance and a typical presentation in older adults. The condition was most often linked to systemic AL amyloidosis, frequently secondary to plasma cell dyscrasias such as IgG κ or IgA κ multiple myeloma. Monoclonal gammopathy and light-chain myelomas (lambda or kappa) were common, often with multiorgan involvement including the skin, mucosa, kidneys, heart, nerves, and gastrointestinal tract. Several hypotheses have been proposed to explain the mechanism of blister formation in bullous amyloidosis, reflecting its multifactorial and non-autoimmune pathogenesis. These are summarized in the table below. Histopathologically, the majority of cases showed subepidermal blistering with deposition of eosinophilic, amorphous material in the dermis. Congo red staining consistently confirmed amyloid deposits, showing characteristic apple-green birefringence under polarized light. In several cases, immunohistochemistry demonstrated λ light-chain restriction, while direct immunofluorescence was typically negative, helping to rule out autoimmune blistering disorders. Bullous lesions frequently served as the first or only sign of systemic disease. Less frequent associations included familial Mediterranean fever with secondary AA amyloidosis, familial amyloid polyneuropathy, localized cutaneous amyloidosis, acquired epidermolysis bullosa dystrophica, solitary pulmonary amyloidoma, and acquired cutis laxa. Treatment approaches for bullous amyloidosis varied widely depending on the extent of systemic involvement and underlying diagnosis.

Conclusion: Bullous amyloidosis is a rare and often misdiagnosed form of systemic amyloid disease, commonly mistaken for autoimmune blistering conditions. Its recognition is essential, as it may be the first indicator of a plasma cell dyscrasia. Given the diagnostic challenges and frequent delays in treatment, this review underscores the need for increased clinical awareness to support earlier diagnosis and appropriate management.

Table: Proposed Mechanisms of Blister Formation in Bullous Amyloidosis

Hypothesis	Description
1. Mechanical weakening at the dermoepidermal junction	Amyloid deposits compromise structural cohesion, resulting in subepidermal or intradermal blistering, often triggered by minimal trauma
2. Vascular fragility due to amyloid angiopathy	Infiltration of blood vessels by amyloid leads to capillary fragility and hemorrhagic bullae; may be aggravated by coagulation abnormalities such as factor X deficiency
3. Altered collagen and elastin metabolism	Amyloid disrupts the normal architecture of dermal connective tissue, decreasing skin resilience and predisposing to blister formation
4. Transepidermal elimination of amyloid	The process of amyloid being expelled through the epidermis may weaken the skin barrier and facilitate blistering
5. Cytotoxicity to keratinocytes	Amyloid fibrils may directly damage keratinocytes, contributing to local epidermal breakdown and blister formation
6. Inflammatory changes in systemic conditions	In disorders like familial Mediterranean fever, systemic inflammation may indirectly promote dermal changes that increase blister susceptibility
7. Submucosal cleavage in mucosal involvement	In mucosal sites, amyloid deposition in the submucosa may weaken tissue planes, leading to cleavage between layers and blister formation

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Abstract N°: 3747

A randomized phase 2 proof-of-concept study to evaluate the efficacy and safety of topical bimiralisib application in patients suffering from actinic keratosis on the face and/or scalp and/or back of hands over a 2 and 4-week treatment period

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[3]TORQUR AG , Research, Basel, Switzerland

Background:

Actinic keratosis (AK) is the most common precancerous skin condition, driven by multiple genetic and molecular alterations. Due to its chronic recurrent course, more effective targeted therapies are required for AK. Bimiralisib, a selective pan-PI3K/mTOR inhibitor, showed well tolerated efficacy in animal models of AK and cutaneous squamous cell carcinoma and high skin penetration indicating its clinical potential.

Methods:

In this multi-center trial, 46 adults (50 years or older) with AK (Olsen grade 1 or 2) on face, scalp, and/or back of hands were assigned in a 1:1 ratio to topical bimiralisib gel 2% once daily for either 2 weeks (Arm A) or 4 weeks (Arm B) as field-directed treatment. Primary outcome was percentage of patients with an Investigator's Global Assessment (IGA) score of 0 (completely cleared) or 1 (partially cleared) at the 4-week follow-up. Secondary outcomes included safety, tolerability, and percentage partial clearance of AK lesions. An optional 8-week treatment extension was offered if at least 50% improvement in lesion size was seen.

Results:

Enrollment is complete with 42 of 46 randomized patients treated with bimiralisib (21 patients per arm). All patients have reached the primary endpoint and received the initial treatment course without dose interruption except one patient who discontinued after 2 weeks due to constraints of the clinical trial setting. Bimiralisib gel 2% led to significant reductions in AK lesions. 52% (Arm A) and 71% (Arm B) of patients achieved an IGA score of 0-1, respectively, with all patients showing some degree of clearance after the initial treatment period. Clearance was seen in Olsen grade 1 and grade 2 AK lesions. Further efficacy sub-analyses are planned.

	No. Pts	Complete Clearance	Partial Clearance	Moderate Clearance	Minimal Clearance	No Change	Percent (complete + partial)
Arm A (2 week)	21	2	9	8	2	0	52.4%
Arm B (4 week)	21	6	9	6	0	0	71.4%

Related adverse events were generally local skin reactions with the vast majority being mild (only three grade 2 events) resolving without intervention. Related adverse events are listed below:

Original Terms (grouped)	Arm A (21 pts)			Arm B (21 pts)		
	Gr 1	Gr 2	Total AEs (pts)	Gr 1	Gr 2	Total (AEs (pts)
Erosion	6	2	8 (6)	4	-	4 (3)
Crusting	5	1	6 (6)	5	-	5 (5)
Erythema (of lesions)	5	-	5 (5)	5	-	5 (5)
Pruritus	2	-	2 (2)	3	-	3 (3)
Itching	-	-	-	1	-	1 (1)
Burning (sensation)	-	-	-	2	-	2 (2)
Flaking/ dryness	1	-	1 (1)	-	-	-
Local skin irritation	1	-	1 (1)	3	-	3 (3)
Scaling	1	-	1 (1)	1	-	1 (1)

A similar safety profile was seen for both 2- and 4-week treatment arms, with no increase in toxicity associated with prolonged treatment. 17 patients entered the optional 8-week extension treatment. Only 4 related adverse events were noted during the extension treatment, with 10 patients completing the extension to date. 6 patients discontinued extension treatment early (4 due to patient decision and 2 due to adverse events - grade 1 recurrent erosion and grade 2 inflammatory response of lesions). The extension treatment showed retreatment is feasible without any significant or new safety concerns. Further improvements of lesions were noted with additional cases of complete clearance.

Conclusions:

Bimiralisib gel 2% demonstrated substantial efficacy in the treatment of AK, both in Olsen grade 1 and grade 2, with a favorable safety profile supporting further clinical development and offering a new option for the treatment of AK. Detailed efficacy, safety (including the extension period), PK and imaging analyses will be presented at the meeting.

Abstract N°: 3776

A rare case of VEXAS syndrome presenting with pyrexia of unknown origin, proximal venous thrombosis, cutaneous manifestation and bilateral proptosis

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Introduction & Objectives: **

A 71 year-old male patient was referred to dermatology during his inpatient admission for a symmetrical maculopapular erythematous to violaceous eruption on bilateral anterior thighs and arms. The rash had a sudden onset of appearance and had persisted for a few weeks. Patient was asymptomatic of the rash. At the time of referral, patient was admitted under general medicine for a two-month history of pyrexia of unknown origin, associated with night sweats and weight loss. During his admission, he also developed a deep vein thrombosis affecting his left upper arm. To ascertain the cause of his presentation, an extensive investigation with blood tests, imaging studies and biopsies was performed.

Materials & Methods:N/A **

Results: **

His blood tests showed iron deficiency, chronic anaemia, borderline leucopenia and elevated CRP. His connective tissue disease screen including ANA, ANCA, PR3 and MPO antibodies as well as lupus anticoagulant antibody screens were normal. His ALP was elevated but the rest of his liver enzymes and bilirubin were normal.

His blood cultures, blood borne viruses and syphilis screen were negative, ruling out an infectious aetiology.

Punch biopsy from his thigh showed features suggestive of either granuloma annulare versus palisading neutrophilic granulomatous dermatitis. His rash resolved less than a month from his dermatology referral without treatment and did not recur since.

He subsequently presented to ophthalmology two months after his admission, with an initial unilateral left sided proptosis which later evolved into bilateral proptosis. His CT and MRI orbit with contrast suggested an inflammatory process. Interestingly, his proptosis self-resolved and did not require corticosteroid therapy.

CT CAP with contrast was normal. However, his NM PET FDG showed increased FDG uptake in the lateral wall of his aortic arch and descending thoracic aorta which were suggestive of vasculitis. There were diffuse increased FDG uptake in his axial skeleton and in the spleen which might represent reactive marrow of a myeloproliferative disorder. Subsequent bone marrow biopsy and serum LDH were normal. **

Conclusion: **

Given the multisystem inflammatory presentation -pyrexia of unknown origin, weight loss, night sweats, transient neutrophilic granulomatous dermatitis, deep vein thrombosis, orbital inflammation and vasculitis of his aorta, genetic testing was performed. This showed UBA1 mutation leading to the unifying diagnosis of VEXAS syndrome.

VEXAS syndrome is an X-linked autoinflammatory condition involving mutation in the UBA1 gene. It affects multiple systems and often presents with multi-organ inflammation with recurrent non-infectious fevers and

constitutional symptoms. Haematological manifestations include macrocytic anaemia,thrombocytopaenia, lymphopenia or unprovoked thrombotic events. Majority of patients have cutaneous manifestations, roughly 60% present with cutaneous manifestations of the disease. Most common types are neutrophilic dermatoses like Sweets syndrome, vasculitis and erythema nodosum, however some cases describe a non-specific maculopapular rash. Ocular involvement is often due to inflammation of ocular structures or surrounding structures such as periorbital/orbital inflammation, uveitis and scleritis. This case of VEXAS syndrome illustrates the importance for a multi-disciplinary team approach to reach a unifying diagnosis and continued management of the patient.

Abstract N°: 3904

Double autoimmune danger: systemic lupus erythematosus and anti-phospholipid syndrome in a young male patient: a case report

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Introduction & Objectives:

Systemic lupus erythematosus (SLE) is an autoimmune disease characterized by multi-system damage mainly affecting the skin, kidneys, lungs, etc. It affects preferentially young women, while its prevalence in males is rarely found, and it is often associated with a more severe prognosis. The association of lupus with anti-phospholipid syndrome (APS) is uncommon.

Materials & Methods:

A 17-year-old male patient, without any medical history, presented with an ulcer on the right leg gradually increased in diameter for 2 months, without any notion of trauma. There was a concomitant appearance of hyperpigmented facial lesions.

Results:

Clinical examination revealed an ulcer on the anterior aspect of the right leg measuring 4 cm, oval, with clear edges, the peripheral pulses were well felt. We noted also, hyperpigmented butterfly-shaped lesions of the face and, cheilitis. The biological assessment revealed hematological involvement, including hemolytic anemia and thrombocytopenia. The immunological tests were positive for anti-double-stranded DNA antibodies and anti-phospholipid antibodies (IgM and IgG). Skin biopsy with direct immunofluorescence confirmed lupus and leukocytoclastic vasculitis. The patient was started on corticosteroid pulse therapy with oral relay and hydroxychloroquine, with significant clinical and biological improvement.

Conclusion:

SLE has a low prevalence in men, leading to a lack of scientific data. The association of SLE and APS is uncommon but potentially severe. Strict and regular monitoring is necessary in order to watch for complications and adapt therapeutic management.

Abstract N°: 3947

Infiltrated Penile Papules as a Cutaneous Marker of Disseminated BCGitis: A Rare Dermatologic Manifestation of Systemic Disease

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Introduction:

Intravesical Bacillus Calmette–Guérin (BCG) therapy is an effective immunotherapy for non-muscle invasive bladder cancer (NMIBC), but it can lead to local and systemic complications. Systemic dissemination of the attenuated *M. bovis* bacillus (BCGitis) is a rare but potentially life-threatening condition. Cutaneous involvement, especially in the form of penile lesions, is exceedingly uncommon and often underrecognized, despite its potential to provide a diagnostic clue in complex systemic illness.

Case Report:

We report the case of a 71-year-old male with a history of high-grade papillary urothelial carcinoma (pT1HG), treated with transurethral resection followed by induction and maintenance intravesical BCG instillations. One week following his last instillation, he developed fever and desorientation. Due to clinical deterioration, with respiratory insufficiency, he was admitted to the intensive care unit (ICU). A CT scan showed bilateral pneumonia with pulmonary diffuse micronodules and hepatomegaly. A provisional diagnosis of disseminated BCGitis was made based on clinical and analytical findings.

During hospitalization, the patient developed multiple erythematous-to-violaceous infiltrated papules on the glans penis. Histopathological examination of a penile skin biopsy revealed non-caseating granulomatous inflammation with Langerhans-type multinucleated giant cells. A liver biopsy performed to evaluate hepatic dysfunction revealed similar granulomatous changes. Ziehl-Neelsen staining was negative for acid-fast bacilli in both specimens. Cultures and PCR for *Mycobacterium tuberculosis* complex were also negative, consistent with the known low sensitivity of these techniques in *M. bovis* infections.

The penile lesions were interpreted as a cutaneous manifestation of systemic BCGitis. Triple anti-tuberculous therapy with rifampicin, isoniazid and ethambutol was initiated, with gradual clinical improvement of systemic symptoms and regression of the penile papules over several weeks.

Conclusion:

Penile lesions secondary to systemic BCGitis are extremely rare and may be overlooked or misattributed to infectious or neoplastic etiologies. In this case, the infiltrated papules emerged after systemic symptoms were already under investigation, serving as a visible cutaneous manifestation of disseminated disease. Biopsy findings mirrored those seen in the liver, supporting the systemic granulomatous nature of the condition. This case highlights the diagnostic value of dermatologic manifestations in complex systemic presentations, which can aid in

the timely diagnosis and management of life-threatening systemic disease. The authors reinforce the importance of considering BCGitis in patients with recent intravesical BCG exposure and multisystemic involvement, even in the absence of microbiologic confirmation.

Abstract N°: 3950

Cutaneous Metastases as the Initial Presentation of Small Cell Lung Cancer – A Case Report

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Introduction: Small cell lung cancer (SCLC) is an aggressive neuroendocrine carcinoma, representing approximately 13% of all newly diagnosed lung cancers. It commonly metastasizes to the brain, liver, adrenal glands, bones, and bone marrow. Cutaneous metastases are rare and typically indicate advanced disease. We report a case of SCLC diagnosed by the presence of multiple metastatic skin lesions.

Case Report: A 51-year-old male, heavy smoker, with a history of chronic obstructive pulmonary disease was referred to the Dermatology department due to multiple painless cutaneous lesions progressively growing over one month. He also reported anorexia in the previous month. Clinical examination revealed indurated masses in the right inguinal region (with central ulceration), right flank and scalp. A skin biopsy was sent for histology and revealed a subcutaneous tumoral cells with minimal cytoplasm, nuclear molding, granular chromatin, high mitotic rate and areas of necrosis. Immunohistochemical analysis was positive for CAM5.2, thyroid transcription factor-1 (TTF-1), CK7, synaptophysin, chromogranin (focal), and CK19 (focal), and negative for CDX2, CK20, and NKX3.1. These findings were consistent with cutaneous metastases of small cell neuroendocrine carcinoma. A CT scan revealed tumoral masses in the right lower and left upper lobes of the lung, multiple bilateral solid pulmonary nodules, pleural tumor implants on the right with extension to the hepatic parenchyma, multiple mediastinal lymphadenopathies and metastases to both adrenal glands and the pancreas. One week after the initial consultation, the patient presented to the emergency department with dyspnea on minimal exertion and a three-day history of cough. The patient was then admitted for management of new-onset pleural effusion. Subsequent staging workup revealed widespread disease, including cerebral metastases. Chemotherapy with etoposide and carboplatin was initiated.

Discussion: Cutaneous metastases from lung cancer are usually detected following diagnosis of the primary tumor. In rarer instances, skin metastases are the first clinical sign of underlying malignancy. The lesions are typically firm painless nodules and may exhibit signs of inflammation or ulceration. Diagnosis is made through histopathological and immunohistochemical analysis of a skin biopsy. In this case, immunohistochemistry played a key role, exhibiting tumor cell positivity for neuroendocrine markers such as synaptophysin, chromogranin and N-CAM. Strong nuclear expression of TTF-1 further supported the diagnosis of a pulmonary primary tumor. Cutaneous metastases should be considered in the differential diagnosis of atypical, rapidly growing skin lesions, particularly in patients with significant smoking history.

Abstract N°: 4000

Cutaneous Clues in Renal Chaos: Untangling Gout from Calcific Mimics

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Introduction & Objectives:

Cutaneous nodules in patients with end-stage renal disease (ESRD) present a significant diagnostic challenge. In the context of chronic hyperuricaemia, tophaceous gout is a frequent consideration. However, overlapping metabolic disturbances—such as secondary hyperparathyroidism and hyperphosphataemia—may lead to dystrophic or metastatic calcifications that mimic or obscure the underlying pathology. Distinguishing between gouty tophi and calcinosis cutis is critical for dermatologists, particularly when histological findings are non-specific.

Materials & Methods:

We report the case of a 52-year-old male with ESRD on dialysis and a longstanding history of gout with destructive arthritis.

Results:

52-year-old male was admitted with respiratory distress and bilateral pleural effusions. Physical examination revealed multiple firm subcutaneous nodules in periarticular areas, ranging from 5 to 40 mm in diameter, with purplish to chalky-white colouration. Some lesions displayed surface ulceration with extrusion of chalk-like material and were associated with synovitis and restricted joint mobility.

Laboratory investigations showed elevated levels of urea (156 mg/dL), creatinine (8.0 mg/dL), phosphorus (8.3 mg/dL), and parathyroid hormone (469.78 pg/mL), alongside decreased calcium (7.0 mg/dL). Histopathological examination revealed amorphous eosinophilic material within the dermis and subcutis, surrounded by fibrosis, without birefringent crystals or inflammatory infiltrates. No vascular calcification or necrosis was observed.

The absence of urate crystals and the altered calcium-phosphate-parathyroid axis raised suspicion of calcinosis cutis or early calciphylaxis. However, the distribution of nodules, destructive joint changes, and prior history supported a diagnosis of tophaceous gout. Dialysis parameters were adjusted, and allopurinol was initiated. Unfortunately, the patient deteriorated and passed away.

Conclusion:

This case illustrates a critical diagnostic intersection between urate and calcium-based cutaneous deposits in patients with ESRD. Tophaceous gout typically presents as chronic periarticular nodules composed of monosodium urate crystals and surrounding granulomatous inflammation. Macroscopically, tophi appear as firm nodules with skin-coloured, yellowish-white, or erythematous tones, occasionally displaying a multilobulated contour. They are often painless to palpation, though they may coexist with chronic synovitis and adjacent joint damage. Ulcerated lesions may drain a characteristic chalky-white substance.

However, in patients with severe disturbances in mineral metabolism, metastatic calcinosis or early calciphylaxis

may closely mimic this presentation. In our patient, the absence of definitive crystals in histology did not exclude the diagnosis of gout, as standard processing often dissolves urate deposits. The combination of clinical features—tophi-like nodules in typical locations, chalky cores, chronic arthritis—and a supportive biochemical profile led to a presumptive diagnosis of tophaceous gout.

This case underscores the importance of integrating clinical, biochemical, and histopathological data when assessing cutaneous deposits in patients with renal disease. It also reinforces the dermatologist's role in recognising atypical cutaneous manifestations of systemic disease, particularly in patients with overlapping inflammatory and metabolic comorbidities.

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Abstract N°: 4191

When the Skin Speaks First: Erythema Gyratum Repens as a Cutaneous Clue to Hidden Lymphoma

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Introduction & Objectives: Erythema Gyratum Repens (EGR) is a rare paraneoplastic dermatosis characterized by rapidly migrating, concentric erythematous bands with a wood-grain appearance. Although it is most frequently associated with lung carcinoma, hematologic malignancies, including lymphomas, have also been reported in less than 5% of cases. We present the case of an 80-year-old man in whom EGR was the first clinical manifestation of an underlying diffuse large B-cell lymphoma (DLBCL), emphasizing the importance of recognizing cutaneous paraneoplastic signs for early cancer detection.

Materials & Methods: The patient, an 80-year-old male, presented with intense pruritus and a two-month history of generalized rash. His past medical history included chronic kidney disease and diabetes mellitus. He reported associated symptoms including significant weight loss (20 kg), persistent diarrhea, and anemia. Dermatological examination revealed polycyclic and serpiginous erythematous lesions with well-defined borders and fine trailing scale, particularly evident on the lower limbs. The lesions were mildly palpable and associated with severe pruritus.

Due to the systemic symptoms and unusual rash, a comprehensive diagnostic workup was initiated. Blood tests showed worsening anemia, neutrophilia, lymphopenia, marked elevation of liver enzymes and total IgE, as well as increased tumor markers. Autoimmune screening was unremarkable. Abdominal ultrasound was negative, while lymph node ultrasound revealed right axillary lymphadenopathy. A total body CT scan confirmed multiple supraclavicular and axillary lymphadenopathies.

A skin biopsy showed a superficial dermal lymphoplasmacytic infiltrate with minimal neutrophilic component and absence of epidermotropism. A subsequent lymph node biopsy confirmed the diagnosis of diffuse large B-cell lymphoma. The temporal correlation, clinical pattern, and histopathological findings supported the diagnosis of EGR.

Results: The cutaneous manifestation of EGR served as an important clinical clue to an underlying malignancy, since they preceded the diagnosis. The dermatologic consultation played a pivotal role in initiating the diagnostic pathway, as the patient's systemic symptoms—including significant weight loss and persistent diarrhea—together with laboratory and imaging findings, prompted a thorough oncologic workup that ultimately led to the diagnosis of DLBCL. The elevation of total IgE, though not commonly described in EGR, may suggest a broader immune dysregulation associated with the paraneoplastic syndrome.

Conclusion: EGR is a rare but striking paraneoplastic dermatosis that may precede or coincide with the diagnosis of an underlying malignancy. Though most commonly associated with lung cancer, it can occasionally be linked to lymphomas, as in this case. Early recognition of EGR should prompt a thorough oncologic work-up, including detailed history, physical examination, laboratory tests (CBC, liver and kidney function, tumor markers), and appropriate imaging studies. The skin can often be the first organ to signal internal disease: the key is knowing when and how to listen.

Abstract N°: 4241

Therapeutic Response to Rituximab in Adult Orbital Xanthogranulomatous Disease: A Case Report

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Title

Therapeutic Response to Rituximab in Adult Orbital Xanthogranulomatous Disease: A Case Report

Introduction & Objectives

Adult Orbital Xanthogranulomatous Disease (AOXD) is a rare non-Langerhans cell histiocytosis that primarily affects periorbital tissues and may extend to other cutaneous or systemic sites. The condition is histopathologically characterized by foamy histiocytes and Touton giant cells within a chronic inflammatory infiltrate [1]. Therapeutic management remains challenging, especially in cases refractory to corticosteroids and conventional immunosuppressants [2].

This report underscores the clinical efficacy of Rituximab in a patient with treatment-resistant AOXD.

Materials & Methods

We report the case of a 28-year-old female with a 10-year history of AOXD who presented with yellow-orange periorbital plaques associated with edema, and infiltrated lesions involving the glabella, temporal areas, and right thigh. Magnetic resonance imaging (MRI) of the brain and orbits with contrast (June 2020) demonstrated subcutaneous soft tissue thickening in the right frontal, periorbital, and malar regions, restricted to the pre-septal compartment of the orbit, with no significant enhancement—an unspecific pattern but consistent with inflammatory infiltrates. Histopathological evaluation revealed a xanthogranulomatous infiltrate rich in lipid-laden histiocytes and Touton giant cells. Immunohistochemistry demonstrated positivity for CD68 and CD163, and negativity for S100 and CD1a, confirming the diagnosis of a non-Langerhans cell histiocytosis.

Previous treatment with systemic corticosteroids (oral prednisone for 10 years) and weekly oral methotrexate (at the maximum tolerated dose for 6 years) yielded only partial disease control and hepatic enzyme elevation. In January 2024, the patient received a first cycle of rituximab (800 mg, administered in four weekly infusions).

Results

Rituximab resulted in marked clinical improvement, including reduced periorbital edema, softening of plaques, and no emergence of new lesions. Laboratory follow-up demonstrated normalization of inflammatory markers and stabilization of hepatic function. Rituximab was well tolerated, allowing for successful corticosteroid withdrawal while maintaining disease control on a low-dose oral methotrexate regimen.

Conclusion

Systemic corticosteroids remain the mainstay of initial treatment for AOXD; however, their long-term use is limited by adverse effects and relapse after tapering [3]. Methotrexate and other steroid-sparing agents have been used with variable efficacy [4]. Rituximab, a monoclonal antibody targeting CD20-positive B cells, has shown therapeutic potential in non-Langerhans histiocytosis, including AOXD, necrobiotic xanthogranuloma, and Erdheim-Chester

disease [5–7]. Its mechanism likely involves modulation of B-cell-driven cytokine networks contributing to histiocytic proliferation.

This case supports the emerging role of rituximab as a corticosteroid-sparing therapeutic option in refractory AOXD. Its favorable clinical response and safety profile warrant further investigation to establish its long-term efficacy and incorporation into treatment algorithms for this rare histiocytic disorder.

Abstract N°: 4272

Avapritinib Durably Improves Cutaneous Involvement of Indolent Systemic Mastocytosis in Patients Treated in the PIONEER Study

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Introduction & Objectives: Indolent systemic mastocytosis (ISM) is a clonal mast cell (MC) disease primarily driven by D816V-mutant *KIT*. ISM is characterized by accumulation and hyperactivation of aberrant MCs in organs including skin. Patients with ISM typically show brown skin lesions as well as other skin symptoms such as pruritus and whealing. Skin findings were characterized in patients with ISM treated with avapritinib, a potent, selective KIT D816V inhibitor, in PIONEER (NCT03731260).

Materials & Methods: PIONEER evaluated the long-term safety and efficacy in 226 patients with ISM who initiated avapritinib 25 mg once daily plus best supportive care. Skin symptoms were evaluated by the ISM-Symptom Assessment Form skin domain score (0–30) and individual skin symptoms (0–10) of spots, itching, and flushing from baseline to 48 and 144 weeks. Changes in skin lesions by photography were captured until 48 weeks.

Results: Mean (standard deviation [SD]) change from baseline in the skin symptom domain was −6.89 (7.11) at Week 48 and −2.48 (2.50), −2.45 (2.82), −1.95 (2.72) for spot severity, itching, and flushing, respectively. At Week 144, the mean (SD) change in skin symptom domain was −8.14 (7.86). Patients with paired photographs (n=51) showed a median percent reduction in lesion surface area in the most affected skin region of −60% after 48 weeks; 82% had lightened skin lesion color. Long-term follow-up (median 3 years, with some patients up to 5 years) demonstrated avapritinib was generally well tolerated with no new safety concerns observed.

Conclusion: Avapritinib provided sustained and durable improvements in skin manifestations of ISM and demonstrated a favorable benefit-risk profile in patients with ISM, highlighting the ability of avapritinib to achieve

long-term disease modification.

Abstract N°: 4361

External physical triggers of systemic sclerosis

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Introduction & Objectives:

Systemic sclerosis (SScl) is a rare autoimmune disease characterized by widespread vascular dysfunction and sclerosis of the skin and internal organs. The pathogenesis is complex and remains incompletely understood; however several environmental triggers have been associated with inducing SScl including infectious and chemical agents, and more infrequently physical injury. Typically, these patients present with bilateral cutaneous. Unilateral progression of SScl is an extremely rare phenomenon. Due to the scarcity of cases, our understanding of the role injury plays in provoking unilateral symptoms of SScl remains limited. With this review of the literature in conjunction with a case presentation, we aim to highlight the potential role of trauma in the pathogenesis of SScl.

Materials & Methods:

A literature search investigating articles that discussed a type of physical trauma (mechanical injury/ immobilization, manual vibration, radiation) as a provoking factor for the onset or progression of SScl was performed in PubMed (Medline). The search yielded 24 articles of which 19 were excluded the following reasons: a) the article does not specify a type of physical trauma as the provoking factor for SScl b) the article focused on other rheumatic or sclerosis disorders or c) it is a non-human study. An additional 7 relevant articles were revealed through literature search and included in this review. Similar methods to identify reports of unilateral presentations of systemic sclerosis which resulted in 2 additional cases resulting in a total of 14 articles reviewed in this meta-analysis.

Results:

We reviewed 12 articles that revealed 29 cases of SScl onset or progression following exposure to physical trauma. Mechanical injury and/or immobilization made up the majority of cases reported (20/29; 68.9%). Of these, musculoskeletal injuries with immobilization by casting (8/20; 40%) was the most common inciting event followed by nerve destruction (6/20; 30%), penetration injuries (3/20; 15%), injections (2/20; 10%), and thermal injuries (1/20; 5%). Of these patients, majority had no prior history of scleroderma or scleroderma symptoms (16/20; 80%). There were 3 cases of SScl developing after chronic exposure to occupational vibration. Additionally, 6 cases reported radiation therapy as a trigger, with majority (5/6; 83.3%) of patients having mild scleroderma-related symptoms exacerbated following exposure to therapy. Of these case, few (4/29; 13.8%) demonstrated unilateral progression of scleroderma and 2 reports outside this review (triggered by cold temperatures and arteriovenous malformation).

Conclusion:

Physical trauma as a provoking factor for SScl is a scarcely reported etiology. The role of trauma as a "triggering event" has been theorized to "unmask" the synthetic capacity of involved fibroblasts via direct blood vessel damage that causes a disturbed local microcirculation and may explain unique asymmetric presentations. Herein, we report a case of unilateral progression of LcSScl after mechanical injury and immobilization supplemented by a review of the literature discussing different types of trauma associated SScl both for clinical interest and to highlight the potential role of external physical injury in the pathogenesis of SScl.

Abstract N°: 4374

Predicting systemic sclerosis autoantibody profiles through dermatological examination: A case series

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Introduction & Objectives:

Systemic sclerosis (SSc) is a rare connective tissue disorder of unknown etiology characterized by visceral fibrosis, microvascular alterations affecting the skin and internal organs, and immune dysregulation with production of diverse autoantibodies. This study aims to characterize the clinical and immunological profile of SSc patients and to determine clinical associations of specific autoantibodies in this population.

Materials & Methods:

A retrospective study was conducted including all patients aged ≥15 years diagnosed with SSc and followed between 2006 and 2025. Diagnosis was established according to either the 2013 ACR-EULAR classification criteria or the 2001 Leroy and Medsger criteria. Clinical manifestations and immunological parameters were analyzed, with statistical associations evaluated using SPSS 17.0 for Windows (Chi-square and logistic regression tests).

Results:

Fifty-two patients were included (mean age 46.7 years) with marked female predominance (M/F ratio: 0,42). Mean diagnostic delay was 2.4 years. Associated autoimmune diseases included Sjögren's syndrome (59%) and systemic lupus erythematosus (38%). Phenotypic distribution showed cutaneous SSc (79%), sine scleroderma (17.3%), and CREST syndrome (3.8%). Cutaneous involvement (94.2%) manifested as scleroderma (85.7%), digital pitting scars (34.7%), telangiectasia (28.5%), hypopigmentation (18.3%), and hyperpigmentation (12.2%). Extracutaneous involvement included gastrointestinal (78.8%), pulmonary (65.4%), cardiac (36.6%), and renal (0.02%) manifestations. Immunological analysis revealed significant associations: skin sclerosis with anti-nucleosome ($p=0.035$) and anti-SSB antibodies ($p=0.024$); telangiectasia with anti-Sm ($p=0.049$); and digital trophic lesions with anti-centromere antibodies ($p=0.018$). No antibody correlated with pigmentary changes. Visceral associations included: gastrointestinal involvement with anti-Sm/RNP ($p=0.038$); pulmonary disease with anti-topoisomerase ($p=0.045$) and anti-SSB ($p=0.02$); rheumatologic manifestations with anti-nucleosome ($p=0.014$) and rheumatoid factor ($p=0.038$); and neurological involvement with anti-dsDNA ($p<0.001$).

Conclusion:

Our study demonstrates significant associations between cutaneous manifestations and autoantibodies in systemic sclerosis. Sclerodactyly strongly correlated with anti-nucleosome ($p=0.035$) and anti-SSB antibodies ($p=0.024$), suggesting their role in skin fibrosis pathogenesis. Telangiectasia showed a specific association with anti-Sm antibodies ($p=0.049$), potentially indicating shared vascular mechanisms. Digital trophic lesions were significantly linked to anti-centromere antibodies ($p=0.018$), reinforcing their known vascular involvement. Notably, pigmentary changes showed no autoantibody correlations, implying distinct pathophysiology. These findings underscore the diagnostic value of dermatological examination in SSc, where skin manifestations may predict specific autoantibody profiles and systemic involvement.

Abstract N°: 4402

Cutaneous sarcoidosis following rituximab therapy for systemic B-cell lymphoma

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Introduction & Objectives: Sarcoidosis is a multisystem disease with cutaneous involvement in 20%–30% of patients. It is rarely complicated with lymphoma, but when it is, the condition is designated as sarcoidosis-lymphoma syndrome. In contrast, rituximab, which is widely used for the treatment of lymphomas of B-cell origin, has been reported to cause sarcoidosis. However, few cases of sarcoidosis with cutaneous involvement following rituximab therapy have been reported.

Materials & Methods: A 72-year-old man with a history of systemic diffuse large B-cell lymphoma was referred to our department with multiple asymptomatic skin nodules and erythematous plaques on his face, forehead, and shoulders. The lesions appeared two months before his first visit and gradually increased in number. Histological examination of the nodules revealed noncaseating epithelial granulomatous infiltration throughout the dermis. No atypical cells were found. Periodic acid-Schiff, Grocott methenamine silver, and Ziehl-Neelsen staining were all negative. Laboratory examinations revealed negative results for interferon-gamma release assays. Angiotensin-converting enzyme levels were within the normal range. Whole-body 18F-FDG positron emission tomography-computed tomography revealed no extracutaneous lesions. Ophthalmological and cardiological examinations did not reveal any abnormalities associated with sarcoidosis. Based on these findings, cutaneous sarcoidosis without systemic involvement was diagnosed. During 14 months before the appearance of skin lesions, the patient was treated with six courses of rituximab-CHOP therapy and three courses of rituximab-DeVIC therapy, which resulted in complete lymphoma remission. After remission, he had been taking rituximab solo therapy every eight weeks as maintenance therapy for six months.

Results: Although his skin lesions were speculated to have been caused by rituximab, he refused to discontinue therapy. Subsequently, the skin lesions gradually enlarged and increased in number, without spontaneous regression. The patient and the hematologist decided to discontinue rituximab therapy six months after the diagnosis of sarcoidosis. The skin lesions began to shrink four months after discontinuation without any treatment for either skin lesions or lymphoma. All skin lesions turned into scars eight months later.

Conclusion: Regression of skin lesions upon discontinuation of rituximab supports the diagnosis of rituximab-induced cutaneous sarcoidosis. Rituximab has been shown to be efficacious in many inflammatory conditions including sarcoidosis. Drug-induced sarcoidosis has rarely been described; however, it constitutes a potential side effect of immunomodulatory medications. Clinicians should be aware that patients receiving rituximab therapy may develop sarcoidosis with skin lesions. In such cases, the recommended course of action is discontinuation of rituximab, thereby protecting patients from unnecessary treatment.

Abstract N°: 4457

Cutaneous Metastases from Breats Cancer, a Single-Center Retrospective Observational Study

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Introduction & Objectives:

Breast cancer is the most common cause of cutaneous metastases. Notably, it exhibits considerable clinical variability. The objectives of this study were to describe the clinical characteristics of cutaneous metastases secondary to breast cancer, to determine the interval between the diagnosis of the primary tumor and the appearance of cutaneous metastases, and to evaluate overall survival based on the location of cutaneous metastases and the presence of visceral metastases.

Materials & Methods:

A retrospective observational study was conducted using the pathological anatomy database from our institution. Patients with histologically confirmed cutaneous metastases originating from breast cancer diagnosed between 1998 and 2025 were selected for analysis.

Results:

A total of 28 patients (26 women and 2 men) were included, with 31 cases of cutaneous metastases identified; 3 patients presented with 2 distinct episodes over time. Infiltrating ductal carcinoma with hormone receptor positivity (HR+) was the most frequently observed histological subtype. The most common clinical presentation was multiple nodules, followed by infiltrated plaques. Atypical presentations were also noted, including lesions mimicking whitlow and toxicoderma.

Metastases were locoregional in 55% of cases and distant in 45%. Patients with distant metastases had lower overall survival; however, the difference was not statistically significant. In most cases, cutaneous metastases were metachronous, with a median latency of 36 months (interquartile range [IQR], 18.5–108 months). In 6 cases, cutaneous metastases were synchronous with the primary tumor, contributing to its diagnosis in 3 of those cases.

Late metastases (defined as occurring ≥10 years after the primary diagnosis) were observed in 6 patients, all with luminal A subtype tumors. Immunohistochemical discrepancies between the primary tumor and cutaneous metastases were identified in 4 cases. While receptor conversion is associated with worse prognosis in some studies, our findings suggest otherwise, potentially due to sample size limitations.

The presence of synchronous or pre-existing visceral metastases was associated with shorter survival compared with subsequent or absent visceral metastases (log-rank test, $P < .001$). Median overall survival after diagnosis of cutaneous metastases was 21 months (IQR, 14–49 months).

Conclusion:

Breast cancer is the leading cause of cutaneous metastases, accounting for approximately 70% of such cases in women. Given the broad clinical spectrum of presentation, clinicians should maintain a high index of suspicion and perform biopsy of suggestive lesions. The possibility of late-onset metastases—occurring even more than a decade after the primary tumor—highlights the importance of long-term follow-up. Additionally, molecular

profiling of cutaneous metastases may provide prognostic and therapeutic insights.

Abstract N°: 4519

Lipoid Necrobiosis: Use of Non-Ablative Fractional Laser (NAFL) in Treatment

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Introduction & Objectives:

Necrobiosis lipoidica (NL) is a chronic granulomatous dermatosis that predominantly affects adult women, particularly those with diabetes mellitus. Although its pathogenesis is not fully understood, it is believed to involve microangiopathy, local hypoxia, and impaired glucose metabolism by fibroblasts, resulting in collagen degeneration. Clinically, NL presents as erythematous plaques with a central atrophic, yellowish area, typically on the pretibial region. The objective of this report is to describe the use of Non-Ablative Fractional Laser (NAFL) as a potential therapeutic option for NL, due to its ability to induce dermal remodeling, stimulate collagen production, and promote neovascularization.

Materials & Methods:

A single female patient with a confirmed diagnosis of necrobiosis lipoidica underwent treatment consisting of monthly sessions of NAFL, totaling eight sessions over eight months. Topical corticosteroids were also used during the treatment period. Clinical assessment was based on visual inspection and comparison of lesion characteristics throughout the treatment.

Results:

The patient, a 36-year-old woman with a history of diabetes, presented with long-standing bilateral plaques on the anterior tibial region, with erythematous borders and central yellowish atrophy accompanied by visible telangiectasias. Following the treatment with NAFL combined with topical corticosteroids, the patient showed progressive improvement. There was a notable reduction in vascular visibility, improved skin texture, and normalization of the erythematous borders to match surrounding skin tones.

Conclusion:

NAFL demonstrated promising results in the treatment of necrobiosis lipoidica in this case. Its ability to stimulate collagen remodeling and influence vascular components may offer a safe and effective therapeutic strategy for patients with chronic, treatment-resistant NL. This case highlights the potential value of laser-based interventions in the management of granulomatous dermatoses when conducted by experienced professionals.

Abstract N°: 4724

Global patterns of common skin diseases: Insights by region and country income from the SkinObservatory Study

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Introduction & Objectives: Skin disease affects a significant proportion of the global population, and the World Health Organisation (WHO) suggests that common skin disease accounts for up to 80% of the global burden of skin disease. Although common skin diseases are associated with low mortality, they often lead to severe morbidity. Understanding the burden of skin disease worldwide and how this varies by region will be critical to informing evidence-based interventions targeted at local needs. The purpose of this study was to identify the most common skin conditions reported from all WHO member states and to evaluate how the burden varies across world region and country income level.

Materials & Methods: The SkinObservatory Study is an online survey of national-level dermatologic leaders across all 194 WHO member states, developed through an iterative process with international experts with a Delphi consensus study. Participants reported the five most prevalent skin conditions, including their data source, and the frequency of common skin conditions is reported. Deidentified data were disaggregated by WHO region and the World Bank Income (WBI) level of each WHO member state.

Results: Launched in August 2024, the SkinObservatory study has captured data from 128 of 194 WHO member states and represents approximately 93% of the global population. Data on common skin disease has been completed by 96.9% of participants (124/128). Overall, the five most common skin diseases reported across all WHO member states were acne (87.1%, 108/124), atopic dermatitis (75.8%), fungal skin disease (55.6%), bacterial skin diseases (46.8%) and psoriasis (43.5%). Acne, fungal skin disease and bacterial skin disease were included in the top five reported common skin conditions in all six WHO regions (Table 1). However, there was variability within WHO regions, which are large and heterogeneous. For example, the most common skin conditions reported in North America (including the United States, Canada and Mexico) included non-melanoma skin cancer and melanoma, which did not rank highly in the rest of the Americas region. Similarly, in Australia and New Zealand, non-melanoma skin cancer and melanoma ranked in the top five most common conditions, unlike the rest of the Western Pacific region. Bacterial skin infections and scabies were among the most frequently reported skin conditions in low- and lower-middle-income countries, whereas psoriasis and non-melanoma skin cancer were more commonly reported in upper-middle- and high-income countries (Table 2). Many countries reported skin disease frequency without a known data source (37/124). When a data source was known, the most common sources were individual experiences (24/124) and hospital medical records (21/124). Notably few countries used data from Ministry of Health or national medical records (10/124).

Conclusion: Common skin disease is not universal across different regions and socioeconomic settings. There is a lack of high-quality global epidemiology and prevalence data on skin disease. We recognise the limitations of self-reported data, collected at one time-point from a small number of leaders in each site, which is distinct from population-based surveillance data. Understanding the burden of common skin disease will inform local skin health priorities and guide targeted and sustainable programmatic action plans at a country and regional level.

Table 1: The five common skin conditions most frequently reported by WHO member states in each WHO region.

	Skin disease-1	Skin disease-2	Skin disease-3	Skin disease-4	Skin disease-5
African Region (AFR)	Acne	Fungal skin disease	Bacterial skin infections	Scabies	Disorders of pigmentation
Eastern Mediterranean Region (EMR)	Acne	Fungal skin disease	Atopic dermatitis	Bacterial skin infections	Psoriasis
European Region (EUR)	Atopic dermatitis	Acne	Psoriasis	Non-melanoma skin cancer	Bacterial skin infections
Western Pacific Region (WPR)	Atopic dermatitis	Psoriasis	Acne	Fungal skin disease	Bacterial skin disease
South-East Asian Region (SEAR)	Fungal skin disease	Acne	Atopic dermatitis	Bacterial skin disease	Psoriasis
Region of the Americas (AMR)	Acne	Atopic dermatitis	Fungal skin disease	Seborrhoeic dermatitis	Bacterial skin disease

Table 2: The five common skin conditions most frequently reported by WHO member states in each World Bank Income level.

	Skin disease-1	Skin disease-2	Skin disease-3	Skin disease-4	Skin disease-5
Low-income Country (LIC)	Acne	Fungal skin disease	Atopic dermatitis	Bacterial skin infections	Scabies
Low-middle-income Country (LMIC)	Acne	Fungal skin disease	Atopic dermatitis	Bacterial skin infections	Scabies
Upper-middle-income Country (UMIC)	Acne	Atopic dermatitis	Fungal skin disease	Psoriasis	Bacterial skin infections
High-income Country (HIC)	Acne	Atopic dermatitis	Psoriasis	Non-melanoma skin cancer	Fungal skin disease

Abstract N°: 4748

Exploring the Associations Between Acne and Disorders of Scalp and Hair: A Cross-Sectional Study

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Introduction & Objectives:

Acne, a common skin condition linked to sebaceous gland activity and inflammation, affects individuals across age groups. While scalp/hair disorders (e.g., dandruff, seborrheic dermatitis, hair thinning) are similarly prevalent and distressing, their relationship with acne remains understudied. This study investigates this association by analyzing subjective scalp/hair symptoms and trichoscopic parameters in different acne groups.

Materials & Methods:

This cross-sectional study involved 1,182 participants who completed a comprehensive questionnaire including scalp and hair disorders. Additionally, trichoscopic parameters were also assessed, such as Lightness (L), Yellow-Blue (B), ITA° (evenness) and Hue .

Chi-square test and Student's t-test were used for group comparisons, and linear and logistic regression analyses were employed to quantify differences in scalp and hair disorders or trichoscopic parameters among various types of acne.

Results:

Characteristic	N = 1,182
Gender	
Man	303/1,182 (25.63%)
Woman	879/1,182 (74.37%)
Age	19.87 (1.76)
Acne	632/1,182 (53.47%)
Scalp symptom	
Scalp itching	634/1,126 (56.31%)
Scalp burning	209/1,109 (18.85%)
Scalp oiliness	858/1,144 (75.00%)
Scalp redness	289/1,088 (26.56%)
Scalp pain	258/1,114 (23.16%)
Diffuse hair loss	334/1,108 (30.14%)
Patchy hair loss	231/1,098 (21.04%)
Frontal hair thinning	524/1,112 (47.12%)
Vertex hair loss	443/1,114 (39.77%)
Scalp hair thinning	556/1,124 (49.47%)
Dandruff	727/1,132 (64.22%)
Severity of scalp (self-assessment)	
Very mild	302/1,182 (25.55%)
Mild	558/1,182 (47.21%)
Moderate-Severe	322/1,182 (27.24%)
Scalp disease	
Seborrheic dermatitis	152/797 (19.07%)
Scalp pruritus	265/911 (29.09%)
Trichoscopic parameters	
Hair midline exposure area (%)	70.73 (4.90)
Mean hair diameter	65.81 (7.23)
Standard deviation of hair diameter	36.85 (3.10)
L(Lightness value 0-100)	58.86 (1.91)
A (red-green value)	10.78 (2.52)
B (yellow-blue value)	10.24 (3.51)
ITA°	67.92 (3.11)
Std eveness	17.58 (5.75)
Std Hue	11.01 (10.18)
Integrated a*	51,311,351.01 (16,019,710.65)

a Note: Qualitative data presented as n/N(%) and quantitative data presented as mean± standard deviation (SD).

Table 1. The baseline characteristics of participants a

For scalp problem severity (self-assessment), the higher the severity of scalp problem, the higher the proportion of acne ($p<0.05$) (Figure 1).

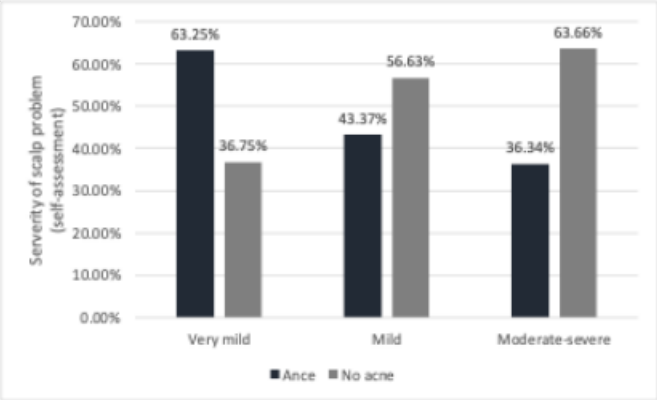

Figure 1. The associations between acne and severity of scalp problem(self-assessment)

Chi-square analysis showed that acne was significantly linked ($p<0.05$) to scalp and hair issues like itching, oiliness, redness, hair thinning, seborrheic dermatitis, and pruritus. People with acne had these problems more often than those without acne (Table 2).

Logistic regression further quantified these associations ($p<0.05$), revealing increased odds of scalp itching (odds ratio (OR) =1.28), oiliness (OR=1.76), redness (OR=1.33), frontal hair thinning (OR=1.29), seborrheic dermatitis (OR=2.27) and scalp pruritus (OR=1.73) among participants with acne (Table 2).

a Data are presented as n/N(%)

Outcome		Acne		OR(95%CI)	p-value
		No	Yes		
Scalp itching	No	244/519 (47.01%)	248/607 (40.86%)	1.28(1.01, 1.63)	0.038
	Yes	275/519 (52.99%)	359/607 (59.14%)		
Scalp oiliness	No	162/527 (30.74%)	124/617 (20.10%)	1.76(1.35, 2.31)	<0.001
	Yes	365/527 (69.26%)	493/617 (79.90%)		
Scalp redness	No	383/501 (76.45%)	416/587 (70.87%)	1.33(1.02, 1.75)	0.038
	Yes	118/501 (23.55%)	171/587 (29.13%)		
Frontal hair thinning	No	289/513 (56.34%)	299/599 (49.92%)	1.29(1.02, 1.64)	0.033
	Yes	224/513 (43.66%)	300/599 (50.08%)		
Seborrheic dermatitis	No	344/389 (88.43%)	301/408 (73.77%)	2.72(1.87, 4.01)	<0.001
	Yes	45/389 (11.57%)	107/408 (26.23%)		
Scalp pruritus	No	333/434 (76.73%)	313/477 (65.62%)	1.73(1.29, 2.32)	<0.001
	Yes	101/434 (23.27%)	164/477 (34.38%)		

Table 2. The associations between acne and disorders of scalp and hair disordersa

Acne was significantly associated with reduced hair diameter and lower ITA° ($p<0.05$), indicating poorer hair quality and increased scalp pigmentation (Table 3).

	Acne		Beta(95%CI)	p-value
	No	Yes		
Hair midline exposure area (%)	70.44(4.95)	70.99(4.85)	0.54(-0.12, 1.2)	0.11
Mean hair diameter	65.28(7.46)	66.27(7.00)	0.99(0.01, 2.0)	0.049
Standard deviation of hair diameter	36.69(3.13)	37.00(3.06)	0.31(-0.11, 0.73)	0.15
L(Lightness value 0-100)	58.90(1.84)	58.82(1.97)	-0.08(-0.33, 0.18)	0.55
A (red-green value)	10.70(2.46)	10.86(2.57)	0.16(-0.18, 0.50)	0.35
B (yellow-blue value)	9.46(3.18)	10.96(3.64)	1.5(1.0, 2.0)	<0.001
ITA°	68.49(3.13)	67.40(2.99)	-1.1(-1.5, -0.68)	<0.001
Std eveness	17.35(5.26)	17.78(6.16)	0.43(-0.33, 1.2)	0.26
Std Hue	11.78(10.12)	10.30(10.19)	-1.5(-2.8, -0.13)	0.032
Integrated a*	50,426,343.37(15, 622,289.09)	52,125,558.04(16, 351,851.65)	1699215(-440,244, 3,838,673)	0.12

a Data are presented as mean(SD); Standard deviation,SD

Table 3. The associations between acne and trichoscopic parametersa

Conclusion:

This study highlights a significant association between acne and scalp hair disorders. Individuals with acne are more likely to report subjective symptoms such as scalp itching, oiliness, and frontal hair thinning, as well as altered trichoscopic parameters, such as lower hair diameter and scalp color metrics. These findings suggest shared inflammatory and sebaceous gland-related mechanisms underlying both acne and scalp conditions. Further research is warranted to elucidate causal pathways and inform integrated treatment approaches targeting both acne and scalp hair disorders.

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Abstract N°: 4783

A possible case of Tysabri (Natalizumab)-induced primary cutaneous diffuse large B-cell lymphoma, leg type

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Introduction & Objectives:

Primary cutaneous diffuse large B-cell lymphoma, leg type, is a rare lymphoma sub-type that tends to present as rapidly growing, solitary or clustered, red or bluish-red skin nodules or tumours located on one or both legs, which can ulcerate, and typically presents in elderly female patients. It is considered to be an intermediate grade lymphoma, with 5-year survival rates ranging from 41% to 73%. We present the first reported case of possible Tysabri (Natalizumab)-induced induced primary cutaneous diffuse large B-cell lymphoma, leg type.

Materials & Methods:

Our patient is 75-year-old lady, with a background of relapsing multiple sclerosis (MS) on Tysabri (Natalizumab) for 13 years, was referred to our tertiary dermatology clinic with a 4-week history of a new, painless nodular lesion on her posterior left leg that had begun to leak a serous fluid. At review 10 days later, her calf nodule was noted to have significantly enlarged to 7cm in diameter, with multiple other similar nodular lesions noted on the same leg. Due to her background long-term immunosuppression and rapidly progressing leg nodules, we were highly suspicious of a lymphoproliferative disorder. Natalizumab promotes activation and pro-inflammatory differentiation of peripheral B cells in multiple sclerosis patients, and was the first monoclonal antibody approved for treatment of relapsing MS. There are no current other reports in the literature of Natalizumab-induced primary cutaneous diffuse large B-cell lymphoma, leg type.

Results:

A diagnostic punch biopsy of a left anterior thigh nodule identified an atypical lymphoid infiltrate in the dermis with subcutaneous tissue involvement, suggestive of diffuse B cell lymphoma, leg type. A staging CT neck, chest, abdomen, pelvis scan identified prominent left common iliac and external iliac nodes, with no evidence of the nodal or solid organ involvement. Her baseline LDH was within normal range. Her Tysabri (Natalizumab) was discontinued on diagnosis and she has underwent standard R-CHOP chemotherapy, which she continues at present.

Conclusion:

Primary cutaneous diffuse large B-cell lymphoma, leg type, is a rare lymphoma sub-type which is mostly limited to the skin at presentation. The development of lymphoproliferative disorders increases with chronic use of immunosuppression, and given our patient’s long-term Tysabri (Natalizumab) usage, we are suspicious this played a role in her developing this disease. It is important all dermatologists are aware of this rare lymphoma sub-type, which presented in our case with normal LDH levels, so that it is quickly identifed and treated, and any contributing immunosuppression is stopped accordingly.

Abstract N°: 4898

Generalized Morphea: Case Report and Clinical Insights

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Generalized Morphea: Case Report and Clinical Insights

Introduction & Objectives:

Generalized morphea is a rare form of localized scleroderma, a chronic autoimmune disease characterized by excessive collagen deposition leading to skin hardening and thickening. Unlike systemic sclerosis, morphea predominantly affects the skin and sometimes the underlying tissues, such as fat and muscle, but rarely involves internal organs. Generalized morphea is diagnosed when more than four lesions are present in at least two distinct anatomic regions.

This case report aims to present a case of generalized morphea, emphasizing its clinical features, diagnostic approach, and the importance of early intervention to prevent severe functional and aesthetic complications.

Materials & Methods:

We present the case of a 38-year-old female with a history of breast fibroadenomas and microcysts, gastroesophageal reflux disease (GERD), and anxiety-depressive disorder. She was admitted to the Dermatovenereology Clinic in Iași for the evaluation of persistent skin lesions that had appeared approximately 12 years earlier. Clinical examination revealed multiple hyperpigmented, mottled, polymorphous, and well-demarcated macules, measuring 5–10 cm, asymptomatic, with a smooth surface and diffuse increased consistency on palpation. The lesions were located on the trunk, upper limbs, and lower limbs. Systemic examination was normal, but limited flexion of both hips was noted. Several investigations and a skin biopsy were performed for diagnostic confirmation.

Results:

Laboratory tests showed an elevated erythrocyte sedimentation rate (ESR), while immunologic tests for anti-nRNP, anti-Scl70, anti-PM-Scl 100, anti-centromere B, anti-dsDNA, anti-histone, anti-Borrelia Burgdorferi IgG, SS-A, SS-B, and ANA antibodies were negative. Complete blood count, serum chemistry, muscle enzymes, and rheumatoid factor levels were within normal limits. Abdominal ultrasound and chest X-ray showed no abnormalities.

Histopathological examination of the skin biopsy revealed a thin epidermis with basal layer hyperpigmentation. The papillary and reticular dermis displayed thickened collagen bundles extending into the hypodermic septa, clearly visualized with van Gieson staining. These collagen fibers enveloped and destroyed hair follicles, displaced sweat glands, and obliterated adjacent adipose tissue. A discrete periadnexal and perivascular lymphoplasmacytic infiltrate was also identified. Based on clinical and histological findings, the diagnosis of generalized morphea was established.

Conclusion:

Generalized morphea, although rare, can have significant impacts on patient quality of life due to extensive skin involvement and potential functional impairment. Early recognition and accurate diagnosis based on clinical features, laboratory investigations, and histopathological confirmation are essential. Initiating therapy early can

prevent irreversible complications such as joint contractures and disfigurement. Regular follow-up and long-term monitoring are important to assess disease progression and treatment response. Increased awareness among healthcare providers is necessary to ensure timely diagnosis and improve patient outcomes in generalized morphea.

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Abstract N°: 4907

Bazex syndrome associated with tonsillar carcinoma: a case report

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Introduction & Objectives:

Bazex syndrome, also known as acrokeratosis paraneoplastica, is a rare, obligate paraneoplastic dermatosis associated with different malignancies, most often squamous cell carcinoma of the upper aerodigestive tract and digestive system, but it can also be associated with other types of carcinoma. Bazex syndrome is characterized by symmetric psoriasiform lesions on acral parts of the body—palms, soles, auricles, and nose—and as the malignancy progresses, the changes can also affect other parts of the skin. The disease most often occurs in men between the ages of 40 and 70. The pathogenesis of the syndrome is unclear. These patients require extensive testing to determine the location of the malignancy.

Materials & Methods:

A 65-year-old man presented with a six-month evolution of changes in the form of symmetric hyperkeratotic redness with yellowish, adherent scales on the palms, fingers, soles, nose, auricles, zygomatic region, elbows, and knees. The nail plates were hyperkeratotic, dystrophic, and yellowish in color. He reported that the changes are pruritic and he experiences chills in the evening. He was treated with systemic antibiotics, local antifungal therapy, and local corticosteroids without improvement. The patient has been a smoker, drinks soda every day, and has a family history of his mother suffering from colon cancer.

Results:

Laboratory tests showed elevated values of liver enzymes, as well as tumor markers Cyfra 21-1 and CEA, while other findings in the blood count, biochemistry, protein electrophoresis, uroporphyrin, and coproporphyrin were normal. Serology tests for hepatitis B and C, and syphilis were negative. Native mycological examination and culture of the skin and nail plates did not reveal a fungal infection. A skin biopsy was performed, revealing a parakeratotic epidermis with acanthosis, without atypical keratinocytes, while a nonspecific inflammatory infiltrate was found in the dermis. Direct immunofluorescence showed deposits of C3 components and fibrinogen in the basement membrane. Findings of bronchoscopy, gastroscopy, colonoscopy, and MSCT of the chest, abdomen, and pelvis were without pathological changes. An MSCT examination of the head and neck revealed a tumoral change in the right tonsil, as well as a pathological conglomerate of lymph nodes in the neck. Laryngoscopy revealed an ulceration in the right tonsil, and a biopsy determined that it was squamous cell carcinoma, grade HG2.

Conclusion:

The presence of symmetrical acral psoriasiform lesions, nail changes, and resistance to conventional treatment should prompt further investigation. Early recognition of the features of Bazex syndrome may lead to earlier

detection of malignancy and improve patient outcomes. This prompted further investigation, ultimately leading to the diagnosis of squamous cell carcinoma of the tonsils. Early recognition of Bazex syndrome may facilitate earlier cancer detection and improve patient outcomes.

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Abstract N°: 4927

Atypical Necrobiotic Xanthogranuloma Without Histological Necrobiosis: A Diagnostic Challenge

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Introduction: Necrobiotic xanthogranuloma (NXG) is a chronic, progressive non-Langerhans cell histiocytosis characterized by yellowish plaques and nodules. It is often associated with paraproteinemia and hematologic malignancies. While necrobiosis is a hallmark histopathological feature, it may occasionally be absent, complicating the diagnosis. We present a diagnostically challenging case of NXG with clinical features typical of the disease but lacking necrobiosis on histology.

Case Report: A 51-year-old male presented with a 6-month history of asymptomatic, dark brown discolorations involving the forehead, periorbital areas, and cheeks.Multiple smooth, yellowish papules were observed bilaterally on the upper and lower eyelids.His medical and family histories were unremarkable, and he was not taking any regular medications.

Laboratory investigations revealed mild leukopenia and neutropenia, elevated LDH levels, while other parameters were within normal ranges. A skin biopsy was performed, and histopathological examination demonstrated a band-like accumulation of pigment-laden histiocytes in the superficial dermis, diffuse infiltration of foamy and eosinophilic granular histiocytes filling the superficial and mid-dermis, and Touton-type giant cells. Immunohistochemistry revealed positivity for CD68 and negativity for S100, Langerin, CD1a, SOX10, and BRAF V600E. Based on these findings, the initial histopathological diagnosis suggested juvenile xanthogranuloma. Further systemic evaluation revealed no bone pain, fever, or weight loss, but the patient reported night sweats. Physical examination was routine, with no evidence of lymphadenopathy or hepatosplenomegaly. Serum protein and immunofixation electrophoresis revealed a gamma spike and an IgG monoclonal band. Additional laboratory tests showed elevated free lambda and kappa light chains, decreased C3 and C4 levels, elevated IgG and IgE, and a mild increase in ESR. A hematology

consultation diagnosed monoclonal gammopathy with undetermined significance (MGUS). Assessment by ophthalmology, endocrinology, and cardiology revealed no systemic involvement.

Discussion: Although necrobiosis is classically described in NXG, literature reports (2007, 2011, 2014) document cases of NXG without this feature, suggesting histological variability. In our patient, the presence of characteristic clinical features, Touton giant cells, foamy histiocytes, paraproteinemia, and exclusion of other diagnoses such as JXG and diffuse normolipemic plane xanthoma (DNPX), supported the diagnosis of NXG despite the absence of necrobiosis. DNPX was considered due to overlapping clinical and histologic findings, but the association with MGUS and eosinophilic cytoplasm-rich histiocytes favored NXG.

Conclusion: This case highlights an atypical presentation of NXG without histological necrobiosis. Accurate diagnosis requires correlation of clinical, histopathological, and hematological findings. Clinicians should recognize that histiocytic disorders may present with variable morphology and overlapping features. Understanding these as a spectrum rather than strictly separated entities may prevent misdiagnosis and ensure appropriate follow-up, particularly given the potential association with hematologic malignancies.

Abstract N°: 4948

Lichen amyloidosis with concurrent atopic dermatitis treated with dupilumab

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Introduction & Objectives:

To present a case of lichen amyloidosis with concurrent atopic dermatitis treated successfully with dupilumab.

Materials & Methods:

Case report.

Results:

A 33-year-old male with skin phototype 5 presented with a long-standing severely pruritic, widespread papular lichenified eruption affecting his forearms, thighs and shins. His past medical history included childhood asthma, acne previously treated with isotretinoin, and vitamin D deficiency. His clinical features were consistent with atopic dermatitis, and histopathology revealed a concurrent diagnosis of lichen amyloidosis, with evidence of pale eosinophilic material in the papillary dermis that stained positive for amyloid on crystal violet. A five-month course of ultraviolet B (UVB) phototherapy coupled with regular topical betamethasone 0.05% alternating with topical tacrolimus 0.1% were effective in relieving the pruritus and flattening most papules. Due to the patient's social circumstances, he was next seen three years later with severe atopic dermatitis and lichen amyloidosis. At this time, he had a Physician Global Assessment (PGA) score of 4, Dermatology Quality of Life Index (DLQI) score of 20, and was commenced on dupilumab. After four months of treatment, the pruritus has completely resolved, with his DLQI score of 0.

Conclusion:

Dupilumab is effective in treating lichen amyloidosis that presents concurrently with atopic dermatitis.

Abstract N°: 5062

Buschke's scleredema; a rare condition that is difficult to manage.

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Introduction & Objectives:

Buschke scleredema, a type of diffuse scleroderma syndrome, is a rare disease characterized by sclerotic edema of the neck and shoulders, which can extend to the rest of the trunk and limbs, but typically spares the extremities.

Observation :

We report a case of Buschke scleroedema in a poorly controlled diabetic patient. The patient, C.O., was a 57-year-old male and obese (weight 96 kg and BMI 32 kg/m^2). He was admitted to a dermatology clinic for a slightly edematous skin induration affecting the upper trunk and neck, which had been progressively developing for over three years without any subjective symptoms, namely: no local pain; no pruritus or burning sensation. During his hospitalization, a complete workup was requested, confirming the clinical findings, and the diagnosis of Buschke scleroedema was made. The patient was placed on colchicine at 1 mg per day, with no results.

Discussion:

Buschke scleredema is a dermal mucinosis of unknown origin, characterized by excess production of collagen and mucin by fibroblasts. [1,2]

The etiopathogenic mechanism is poorly understood and appears to involve processes similar to those of other fibrosing diseases through accumulation of the extracellular matrix. In diabetics, poor glycemic control appears to play a role in promoting skin fibrosis, as it does in diabetic nephropathies and neuropathies, which involve fibrosing processes [6].

There is no effective treatment for Buschke syndrome, and diabetes control does not appear to improve skin lesions. Some satisfactory results have been obtained with cyclophosphamide boluses combined with systemic corticosteroid therapy, PUVA therapy, and cyclosporine. [6]

Intravenous immunoglobulins have been proposed with good results in a few cases.

Conclusion:

Buschke scleredema is a rare condition whose pathophysiology is poorly understood. Its diagnosis is primarily clinical and histological. This rare complication of diabetes can be investigated in certain at-risk patients. Management of Buschke scleredema is often difficult because no effective treatment is available.

Abstract N°: 5154

Rheumatoid nodulitis: report of two cases

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Rheumatoid nodulitis: report of two cases

Introduction & Objectives:

Rheumatoid nodulitis or nodulosis (RN) is a rare extra-articular manifestation of rheumatoid arthritis (RA), characterized by multiple subcutaneous nodules on bony prominences, recurrent joint symptoms, often in the absence of significant synovitis. Due to its atypical presentation, RN may pose a diagnostic challenge, requiring distinction from other nodular conditions. We present two cases of histologically confirmed rheumatoid nodules occurring in the absence of arthritis.

Materials & Methods:

Two cases report study and a bibliographic search

Results:

Case1:
A 55-year-old female with a medical history of diabetes mellitus, hypertension, dyslipidemia, and shoulder tendinitis presented with subcutaneous nodules that had appeared two months prior. On examination, firm, painless, well-defined, and mobile subcutaneous nodules were noted on the dorsum of hands, palms, right wrist, and right elbow. The overlying skin appeared mildly erythematous. At this stage, differential diagnoses such as sarcoidosis, pseudorheumatoid nodules and multicentric reticulohistiocytosis were considered. A biopsy was performed, which confirmed the diagnosis of a rheumatoid nodule, demonstrating fibro-adipose tissue with areas of fibrinoid necrosis encircled by a palisading histiocytic crown. The patient reported no arthralgia and displayed no other associated symptoms. She was treated with intralesional corticosteroids.

Case2: A 61-year-old male with a medical history of diabetes mellitus and gout presented with periarticular nodules located on the left middle finger, left thumb, left knee, and right foot. The nodules were asymptomatic, and the patient denied experiencing any arthralgia. A biopsy of the nodules was conducted, revealing histopathological features consistent with a rheumatoid nodule.

Conclusion:

Rheumatoid nodules are the most common extra-articular manifestation of rheumatoid arthritis characterized by the formation of subcutaneous nodules, commonly located on the hands, elbows, and forearms. These nodules are often linked to severe disease activity.

However, it is important to note that nodules can occur independently of rheumatoid arthritis. This phenomenon affects usually males 30–50 years of age. Although rare, it has been documented in some cases and presents both a diagnostic challenge and a nosological dilemma.

In our patients, despite the nodules' characteristic presentation and location, the absence of arthritis or other signs of systemic disease made the diagnosis challenging. This highlights the importance of considering RN in patients

with isolated subcutaneous nodules, even in the absence of overt joint involvement.

Histopathological examination plays a crucial role in confirming the diagnosis of RN and eliminating differentials. Biopsies of the nodules typically reveal features such as fibrinoid necrosis, mononuclear cell infiltration, and fibrous scarring.

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Abstract N°: 5227

Beyond the subcutaneous tissue: a look from dermatology

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Introduction & Objectives:

In the medical field, there are certain entities and conditions that can pose diagnostic challenges due to their similar clinical presentations. Today, I would like to address you to share my clinical experience and highlight the importance of dermatologists being familiar with the acromioclavicular cyst, an entity that, although generally more associated with traumatology, may also require our attention.

Materials & Methods:

In my clinical practice, I have had the opportunity to see two cases of acromioclavicular cyst. The first case involved a 77-year-old male who came to the Dermatology clinic with an erythematosquamous plaque on the right paramedial region of the back, which was initially treated with photodynamic therapy due to the suspicion of a superficial basal cell carcinoma. After several sessions, the lesion completely disappeared. When we finished examining the patient and he was getting dressed, we noticed a nodular lesion approximately 5 cm in size located on his right shoulder. Upon reviewing the medical history, the patient had a history of acromioclavicular osteoarthritis and an ultrasound that showed findings of a complete rotator cuff tear with an associated acromioclavicular cyst. As a result, the patient was referred to the Traumatology department at our hospital, where a conservative approach and clinical follow-up were decided upon. The second patient was an 85-year-old male who came to our service for a follow-up after the excision of a frontal basal cell carcinoma two months prior. The histopathological study showed complete excision with clear margins, and the scar had a good appearance. During the consultation, we noticed that this patient also had a mass on his left shoulder with a hard, mobile consistency. As in the previous case, the patient was referred to Traumatology, where the diagnosis of acromioclavicular cyst was made. In this case, the patient did not undergo the requested ultrasounds to assess surgical management, and a conservative approach with analgesia and follow-up was decided.

Results:

The acromioclavicular cyst is a benign nodular lesion, generally painless, that occurs in the acromioclavicular area. It is a rare entity, with an incidence estimated at around 1% of all superficial nodular lesions. It is more common in older patients and typically presents as a mass that is usually adherent to deeper tissues. In some cases, the cyst may grow and cause a visible deformity in the affected área. In general, the patients presented a nodular, painless, and asymptomatic lesion in the acromioclavicular region. Interestingly, none of them came to our clinic for this reason; in all cases, it was an incidental finding during the physical examination.

Conclusion:

In conclusion, I believe that although the acromioclavicular cyst is not a common entity in our clinical practice, it is important to consider it in the differential diagnosis of superficial nodular lesions. One reason dermatologists should be aware of the acromioclavicular cyst is that its clinical presentation can be similar to other cutaneous lesions, such as lipomas, abscesses, or benign tumors. This can make its diagnosis more complex and may require

additional tests to confirm it. Furthermore, including it in the diagnostic and therapeutic repertoire of dermatologists can help avoid unnecessary surgical interventions and improve patients' quality of life.

Abstract N°: 5290

Overlapping Systemic Lupus Erythematosus and Lichen Planus in a pediatric patient : More than a coincidence

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Introduction & Objectives:

Lupus lichen is a rare disorder that combines the clinical, histological and immunopathological features of lupus erythematosus and lichen planus. The similarities between these two conditions suggest that they may be the result of a common etiology or pathophysiology. Through this uncommon case of a 12-year-old child diagnosed with overlapping systemic lupus erythematosus and lichen planus, we highlight the clinical, biological and histopathological features that support the coexistence of these two autoimmune conditions, and we discuss the therapeutic challenges.

Materials & Methods:

A comprehensive clinical evaluation was conducted, including dermatological and rheumatologic assessments. Laboratory investigations included ANA, anti-dsDNA, complement levels, and inflammatory markers. A skin biopsy was taken from a representative lesion, and histopathological analysis revealed features consistent with lichen planus with interface dermatitis. Multidisciplinary management was initiated based on clinical, immunological and histopathological findings that confirmed the diagnosis of overlapping systemic lupus erythematosus and lichen planus.

Results:

A 12-year-old child born of a consanguineous marriage presented with pruritic lesions that had been evolving since the age of 7 years old, with a recent appearance of painful oozing lesions on the soles of the feet. Medical history revealed multiple episodes of gingivorrhagia and epistaxis, with no other systemic signs. Clinical examination revealed multiple diffuse pigmented macules all over the skin with a granular appearance on dermoscopy, purplish papules with wickam striae on dermoscopy, and bilateral erosions on the sole of the feet. An endobuccal lichen network and diffuse anonychia were also present. Biopsy revealed lichen planus histological features. Biological results showed pancytopenia with profound thrombocytopenia, positive antinuclear antibodies and anti-DNA antibodies, and C3 and C4 hypocomplementemia. The patient was put on oral corticosteroids and hydroxychloroquine with partial improvement.

Conclusion:

Lupus erythematosus and lichen planus are rarely confused, as they present different clinical and histological aspects. The authenticity of this syndrome has been questioned in some studies, but the growing list of case reports demonstrates the indisputable coexistence of these two diseases. Indeed, this condition may present features of both lichen and lupus in the same skin lesion, just as it may not present typical lesions of either. However, palmoplantar involvement remains characteristic. Biopsy of clinically ambiguous lesions may reveal one or both processes. The course of the disease is characterized by marked chronicity, with no tendency towards spontaneous remission. Therapeutic results reported in the literature are disappointing. Systemic steroids or synthetic antimalarials have been reported to be beneficial in some cases, but ineffective in others.

Abstract N°: 5328

Actinic Granuloma (O'Brien): A Rare and Extensive Presentation With Satisfactory Therapeutic Response

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Introduction & Objectives:

Actinic granuloma, also known as granuloma of O'Brien or elastolytic giant cell granuloma, is a rare chronic granulomatous dermatosis associated with chronic ultraviolet (UV) exposure. It typically manifests on sun-exposed skin as annular plaques with erythematous borders and central clearing. While most cases are localized, extensive presentations involving both photoexposed and non-photoexposed areas are occasionally observed. This report describes a widespread case with favorable therapeutic response and highlights the relevance of recognizing potential metabolic comorbidities.

Materials & Methods:

A 70-year-old female presented with a one-year history of pruritic erythematous papules on the left arm, which evolved into annular lesions. Initial therapy with oral corticosteroids offered temporary relief. Over subsequent months, the lesions gradually spread to the lower limbs, trunk, and abdomen. Medical history included metabolic and psychiatric comorbidities. Clinical examination revealed multiple annular plaques with raised erythematous borders and central hypopigmentation on both sun-exposed and covered areas. The treatment plan included strict photoprotection, systemic hydroxychloroquine (400 mg/day), tapered oral corticosteroids, topical high-potency corticosteroids, and antihistamines for symptom control.

Results:

After 14 months of combined therapy, the patient achieved significant clinical improvement. There was substantial reduction in lesion size, resolution of inflammation, and control of pruritus. No new lesions were noted after the sixth month of follow-up. The disease course appeared to be chronic-relapsing in nature, yet responded well to integrated systemic and topical management.

Conclusion:

This case illustrates a rare, extensive form of actinic granuloma with a successful therapeutic response. It reinforces the need for clinical awareness of atypical presentations and underscores the importance of identifying comorbidities such as diabetes mellitus, which may influence disease progression. Early diagnosis and individualized multimodal treatment can lead to favorable outcomes in this challenging granulomatous condition.

Abstract N°: 5500

Malignancy-Associated Sweet's Syndrome as the Initial Manifestation of Acute Myelomonocytic Leukemia: A Case Report

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Introduction & Objectives:

Sweet's syndrome is an acute febrile neutrophilic dermatosis characterized by the sudden onset of painful, erythematous plaques or nodules, predominantly affecting the upper extremities and face. It may be associated with a variety of underlying conditions and is classified into three categories: classical (idiopathic), malignancy-associated, and drug-induced. Diagnosis is based on clinical and histopathological findings, with a typically rapid response to systemic corticosteroids. Management depends on identification and treatment of the underlying cause. We aim to report a case of this rare syndrome and its successful management.

Materials & Methods:

A 44-year-old female presented to the emergency department with fever, fatigue, myalgia, and a painful erythematous plaque on the right lower limb. Laboratory tests revealed anemia and signs of systemic inflammation. Skin biopsy demonstrated a dense neutrophilic infiltrate in the dermis. Bone marrow examination confirmed a diagnosis of acute myelomonocytic leukemia. Based on clinical, histological, and hematological findings, Sweet's syndrome was diagnosed.

Results:

Systemic corticosteroid therapy with prednisone led to complete resolution of cutaneous lesions within 72 hours, without scarring.

Conclusion:

Although rare, Sweet's syndrome typically shows a favorable response to systemic corticosteroid therapy. Successful treatment depends on accurate diagnosis and identification of any associated systemic disease. The syndrome is often linked to malignancies and may also be drug-induced, making it crucial to treat the underlying condition and discontinue any potential causative medication. Failure to manage the syndrome appropriately may lead to recurrences, particularly in malignancy-associated cases, where relapse of skin lesions may signal recurrence of the primary disease. Early recognition and precise diagnosis are essential for optimal management, particularly by dermatologists and other healthcare professionals.

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Abstract N°: 5523

Papulonodular mucinosis associated with systemic lupus erythematosus: an uncommon clinical presentation that challenges diagnosis

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Introduction & Objectives:

Papulonodular mucinosis (PNM) is a rare cutaneous manifestation of systemic lupus erythematosus (SLE) characterized by mucin accumulation in the reticular dermis. Clinical recognition is challenging and diagnosis requires histopathological confirmation. The objective of this presentation is to describe the clinical, histological and therapeutic features of PNM in SLE, emphasizing its importance through the presentation of a representative case.

Materials & Methods:

A narrative review of current literature on PNM associated with SLE was performed, and a clinical case of a male patient with long-standing SLE who developed atypical cutaneous nodular lesions is presented. Clinical, laboratory and histopathological evaluations were documented and analyzed.

Results:

Case presentation: A 47-year-old male with SLE diagnosed in 2016, positive for fine granular ANA at 1:1280, anti-Ro, anti-Sm, hypocomplementemia (low C3 and C4), mucocutaneous manifestations (diffuse alopecia, discoid lupus on the face and scalp) and hematologic involvement (leukopenia and lymphopenia). He also had vitiligo. At the time of lesion onset, he was receiving mycophenolic acid, hydroxychloroquine and prednisone 5 mg daily. He developed chronic nodular lesions on the upper trunk (back and shoulders), symmetrical, monomorphic, poorly defined, some with annular appearance, up to 5 cm in diameter, asymptomatic and insidious in course. Skin biopsy showed an acanthotic epidermis; the deep dermis demonstrated thickened collagen fibers and a perivascular and periadnexal lymphocytic infiltrate. Alcian blue staining was positive for interstitial mucin deposits, confirming PNM in the context of SLE.Recent labs: ESR 3 mm/h, CRP < 4 mg/L, Hb 16 g/dL, WBC 3.44 × 10^9/L, lymphocytes 0.92 × 10^9/L, normal liver and renal profile. Maintenance therapy was continued with immunosuppressive dose adjustments based on clinical evolution, achieving cutaneous stabilization without systemic progression.

Conclusion:

Papulonodular mucinosis should be considered among the cutaneous manifestations of SLE, particularly when asymptomatic nodules appear in lupus patients. Clinical diagnosis requires high suspicion and histological confirmation by special staining. Early intervention and immunomodulatory therapy, as in this case with combined mycophenolic acid, hydroxychloroquine and corticosteroids, can prevent cutaneous progression and improve patient quality of life. This case highlights the need for a multidisciplinary approach and prolonged follow-up in lupus patients with atypical cutaneous manifestations.

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Abstract N°: 5534

Relapsing Polychondritis: A Case Presenting with Redness and Edema in the Ear

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Introduction:

Relapsing polychondritis (RP) is a rare, progressive inflammatory disease of unknown etiology, of autoimmune origin (1). It targets cartilage tissue in particular, affecting many attachment systems such as the ear, nose, trachea, appendages and structures that can be involved (2). The disease can often expand with recurrent inflammatory attacks, and early diagnosis and appropriate immunosuppressive therapy can prevent progressive tissue damage and serious complications (3). In this case report, a case of RP, which is misdiagnosed as infective chondritis, is presented.

Case report:

A 36-year-old male patient was referred to us by otolaryngology due to ear redness and edema findings and unresponsiveness to antibiotic treatment. He had a voice change complaint that had been ongoing for 5 months and erythema and edema developed in the right ear two weeks after the onset of symptoms, and otolaryngology determined that the patient had sensorineural hearing loss during this period. In the following period, episcleritis, progressive dysphonia and bilateral clavicle deformity were added to the bilateral eyes. Various antibiotics and non-steroidal anti-inflammatory treatments were used for 2 months, and since there was no response, he used systemic methylprednisolone and with this treatment, the erythema and edema in the right ear healed, leaving a permanent deformity in the ear. The patient, who developed erythema and edema in the left ear after the cessation of systemic treatment, applied to us and was diagnosed with RP as a result of the evaluation of anamnesis, physical examination and laboratory results (4). The patient's physical examination revealed bilateral auricular inflammation (erythema and edema), progressive dysphonia, bilateral clavicle deformity, and episcleritis confirmed by ophthalmology. Audiometric evaluation revealed sensorineural hearing loss, laboratory tests revealed elevated CRP and ESR, and the autoantibody panel was negative, and radiological evaluation revealed evidence of inflammatory involvement in the clavicle.

Results:

RP is a potentially life-threatening autoimmune disease that can affect all cartilage structures in the body. The risk of misdiagnosis is high due to its variable clinical presentation due to multiple organ involvement. A multidisciplinary approach is required in the diagnosis and treatment of RP, which is a multisystemic disease. Delay in diagnosis can lead to respiratory and cardiovascular involvement and can be fatal (5). Our case demonstrates that early diagnosis and immunosuppressive treatment play a critical role in preventing disease progression.

Abstract N°: 5538

Trial in progress: A phase 3 randomised study of low-dose intralesional cemiplimab versus primary surgery for patients with early-stage cutaneous squamous cell carcinoma

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[5]Regeneron Pharmaceuticals, Inc., Tarrytown, United States

Introduction & Objectives:

Cemiplimab 350 mg administered intravenously every 3 weeks is approved for the treatment of advanced cutaneous squamous cell carcinoma (CSCC).1 Surgery is the standard of care for early-stage CSCC; however, for patients who prefer non-surgical management of early-stage CSCC, low-dose intralesional (IL) cemiplimab has demonstrated promising clinical activity in a pilot study (NCT03889912).2 The purpose of this study (NCT06585410) was to determine the non-inferiority of IL cemiplimab versus primary surgery, along with its safety, tolerability and efficacy, in patients with early-stage CSCC.

The primary objective of this study is to assess the non-inferiority of IL cemiplimab versus primary surgery by event-free survival. Secondary objectives include safety, tolerability, longest diameter of surgical defect after resection in both arms, and composite complete response in the experimental arm.

Materials & Methods:

In this phase 3, randomised, open-label, multicentre study, approximately 369 patients with early-stage CSCC will be randomised 2:1 to cemiplimab (5 mg IL every week for 6 weeks) versus primary surgery. Key inclusion criteria were patients aged ≥18 years; a histologically confirmed invasive CSCC target lesion ≥1.0–≤2.0 cm (longest diameter) located in the head and neck, hand or pre-tibial surface; adequate performance status; and adequate hepatic, renal and bone marrow function. Key exclusion criteria were target lesion of keratoacanthoma, presence of autoimmune disease requiring treatment with systemic autoimmune suppressants, concurrent or prior solid tumour or haematologic malignancy (except for protocol-allowed exceptions), and a history of solid organ transplant. Patients will be followed for approximately 3 years.

Results:

The study is currently recruiting patients.3 Enrolment is planned at study sites across North America and Australia.

Conclusion:

This study will help establish the potential clinical utility and broader applicability of low-dose IL cemiplimab in early-stage CSCC.

References

\1. Regeneron Pharmaceuticals, Inc. LIBTAYO® (cemiplimab-rwlc) prescribing

information. https://www.regeneron.com/downloads/libtayo_fpi.pdf. Accessed 10 April 2025.

\2. Study of intralesional cemiplimab for adult patients with cutaneous squamous cell carcinoma or basal cell carcinoma. NCT03889912. Accessed 25 February 2025.

\3. Study of intralesional cemiplimab in adult patients with early-stage cutaneous squamous cell carcinoma. NCT06585410. Accessed 25 February 2025.

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Abstract N°: 5655

Pityriasis Rotunda and Systemic Lupus Erythematosus: An Atypical Association

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Introduction: Pityriasis rotunda (PR) is a rare acquired dermatosis, classified as a keratinization disorder. First described by Jean Baptiste Emil Vidal in 1906, about 180 cases have been documented worldwide [1]. It has two variants: type I, more common in Asian and Black adults, is often linked to systemic comorbidities such as diabetes, tuberculosis, leprosy, liver disease, scleroderma, sarcoidosis, and malignancies like gastric and hepatocellular carcinoma; and type II, typically arising before age 40, with familial occurrence and no systemic association [2,3]. This case report presents a rare coexistence of PR and systemic lupus erythematosus (SLE), an association rarely reported.

Case Report: A 48-year-old woman, Fitzpatrick type IV, smoker, with a prior diagnosis of SLE, presented with asymptomatic, well-demarcated, hyperpigmented, scaly macules on the lower limbs for 14 years. Histopathological analysis showed orthokeratosis, mild reduction of the granular layer, superficial perivascular inflammatory infiltrate, and melanophages. Periodic acid–Schiff (PAS) staining was negative for fungal elements. These findings confirmed the diagnosis of PR. Topical treatment with 10% urea and 5% salicylic acid led to gradual clinical improvement.

Discussion: PR is characterized by sharply demarcated, round or oval, scaly lesions of variable size and number. It affects both sexes, with a slight female predominance, mainly between 20 and 45 years, though it may occur from 2 to 87 years of age. It has a heterogeneous distribution, with higher prevalence in Japan, South Africa, the West Indies, and Italy [2,4,5]. Familial cases, reported in 42 individuals, suggest an autosomal dominant inheritance pattern [3].

Its pathogenesis remains unclear. Some authors associate it with decreased expression of structural epidermal proteins like filaggrin and loricrin, compromising the skin barrier and contributing to PR development [1,6]. Clinically, lesions are dry, pink to light brown, and range from 0.5 to 20 cm, mostly on the trunk and proximal limbs.

Diagnosis is clinical and histological. Microscopy typically reveals orthokeratosis, absent or reduced granular layer, moderate hyperkeratosis, follicular plugs, and perivascular lymphohistiocytic infiltrate. Fungal stains are usually negative [2].

There is no standard or consistently effective treatment. In cases related to systemic diseases or malignancy, lesions may regress with control of the underlying condition. Therapies with antifungals, topical corticosteroids, coal tar, salicylic acid, and retinoids have shown limited success. Some reports describe improvement with 10% lactic acid, vitamin A, and etretinate, though evidence is limited. Spontaneous regression is rare [3].

Conclusion: This case underscores a rare association between PR and SLE. It highlights the need to include PR in

the differential diagnosis of hyperpigmented lesions in patients with autoimmune diseases. The case expands the known clinical spectrum of PR and suggests the importance of further studies to explore its pathophysiology and possible immunological links.

Abstract N°: 5713

A retrospective study on clinico-epidemiological, histological, and therapeutic profile in scleromyxedema in Northern India.

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Introduction & Objectives:

Comparative literature evaluating the therapeutic efficacy of different treatment modalities for scleromyxedema remains limited. This study aimed to assess the therapeutic response across various treatment approaches and characterize the clinico-epidemiological profile and treatment response to rituximab in scleromyxedema within the Indian population.

Our objective is to determine the clinico-epidemiological, histological, and therapeutic profile of scleromyxedema patients from Northern India and evaluate treatment responses to various modalities.

Materials & Methods:

A retrospective study was conducted from March 2010 to March 2025 on biopsy-proven scleromyxedema cases with available demographic, clinical data and therapeutic response and relapses. A systematic review of PubMed and Google Scholar was also done until December 2024 to summarize existing literature on therapeutic responses of Bortezomib, Lenalidomide, IVIG, Rituximab and Dexamethasone pulse.

Results:

Eight patients (M:F ratio 1:1.5) were included, with a mean age of onset of 36±2 years. Cutaneous findings included sclerodermoid skin and papular eruptions (100%), doughnut sign (25%), leonine facies (12.5%), and alopecia (25%). Extracutaneous manifestations were present in 87.5%, involving musculoskeletal (25%), respiratory (25%), gastrointestinal (25%), and ocular systems (25%). Thickened collagen bundles(100%), mucin deposition(100%), and fibrosis(87.5%) were seen on histopathology. Treatments included dexamethasone pulse (37.5%), intravenous immunoglobulin (25%), rituximab (25%), and bortezomib-lenalidomide-dexamethasone (12.5%). Complete response rates were observed with all modalities, with rituximab showing a promising remission duration of 2–3 years. Relapse was observed in 50% of cases, notably at 48 to 70 months. Adverse effects included osteoporosis (25%), hypocalcaemia (25%), hyperglycaemia (25%), cataract (12.5%)**.**

Conclusion:

Management of scleromyxedema remains challenging often requiring multidisciplinary approach. Long term systemic therapy is often required to manage relapses. Our study highlights rituximab as a promising induction and maintenance therapy. Further large-scale, prospective studies are warranted to establish standardized treatment protocols.

Abstract N°: 5899

Livedo racemosa as a presentation of antiphospholipid syndrome associated with systemic lupus erythematosus

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Introduction & Objectives: Livedo racemosa (LR) is a variant of livedo characterized by a discontinuous network formed by rings with abrupt interruptions. It typically affects both legs but may also involve the upper limbs or even present in a generalized pattern. We present the case of a young woman with livedo racemosa associated with antiphospholipid syndrome and systemic lupus erythematosus, along with a review of the relevant literature.

Materials & Methods: A 19-year-old woman presented with a one-month history of lesions on her legs, later appearing on her hands, associated with asthenia and Raynaud's phenomenon. On examination, she showed purplish spots on her legs and hands forming a net-like pattern with incomplete branches. A biopsy revealed a thrombus in an arteriole, and blood tests showed low C3 and C4 levels, ANA 1:1280, positive anti-DNA antibodies, and high-titer positive anti-cardiolipin and anti-beta 2 glycoprotein 1 antibodies. A diagnosis of systemic lupus erythematosus (SLE) with secondary antiphospholipid syndrome (APS) was made, and treatment with prednisone and anticoagulation was initiated.

Results: Livedo racemosa (LR) is a variant of livedo characterized by a discontinuous network formed by rings with abrupt interruptions. It typically affects both legs but may also involve the upper limbs or even present in a generalized pattern. Unlike livedo reticularis, LR is always associated with an underlying systemic disorder and necessitates ruling out systemic vasculopathy such as APS, SLE, Sneddon's syndrome, vasculitis, hematologic diseases, and other conditions that may cause obstruction of dermal arteries and arterioles.

Laboratory and histopathological studies are essential for confirming the diagnosis and investigating the etiology. The biopsy should be taken from the pale center of the net (where the arteriolar thrombus is located), not from the purplish branches.

Histologically, a thrombotic pattern, arteriolar wall thickening, and vasculitis may be observed. The most common analytical findings in patients with LR include positive ANA, elevated D-dimer, and positive IgG/IgM anticardiolipin antibodies.

Livedo (both reticularis and racemosa) is the most common cutaneous manifestation of APS, occurring in 70% of patients with SLE and APS. Moreover, LR is associated with a subset of APS patients at higher risk of arterial thrombotic events such as stroke, renal artery stenosis, pregnancy complications, and more.

Conclusion: The presence of livedo racemosa should always prompt investigation of potentially serious systemic vasculopathies, with APS associated with SLE being the most common. A properly performed biopsy from the central pale area of the net, appropriate blood tests, and a thorough medical history focused on autoimmune symptoms and thrombotic events are essential for diagnosis.

Abstract N°: 5927

Erythroderma as the First Manifestation of a Rare Tumour: Case Report

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Introduction & Objectives: Erythroderma is defined as a diffuse erythema involving over 90% of the body surface area, representing a dermatological emergency with a broad and complex differential diagnosis. In elderly patients, neoplastic or paraneoplastic causes — although rare — must be considered, since erythroderma may be the initial manifestation of a malignancy. We report a paraneoplastic erythroderma case, secondary to a rare anterior mediastinal tumour, highlighting the need for thorough investigation to ensure early cancer detection.

Materials & Methods: This is a case report of a 73-year-old woman who developed an insidious onset erythroderma, associated with intense pruritus and progressive generalised scaling. During hospitalisation, she was evaluated by dermatology, thoracic surgery, and oncology. Workup included skin biopsies, laboratory tests, contrast-enhanced thoracic CT, and bronchoscopy.

Results: At the dermatology clinic, the patient reported erythematous, pruritic trunk lesions beginning eight months earlier, with subsequent dissemination throughout the body, and weight loss. A prior biopsy showed eosinophilic lichenoid interface dermatitis, suggestive of a drug reaction. On examination, she was erythrodermic with diffuse scaling, and had a lower limb edema. Upon hospital admission, a new skin biopsy revealed findings of epidermis with regular acanthosis, isolated keratinocyte necrosis, and foci of parakeratosis, suggestive of erythema multiforme. Laboratory results were largely unremarkable except for elevated lactate dehydrogenase. Thoracic CT revealed a large solid mass (11.7 × 7.2 × 8.9 cm) in the anterior mediastinum with calcifications, reduced left lung volume, superior vena cava involvement, and pericardial infiltration, resulting in pericardial effusion. Bronchoscopic biopsy confirmed the diagnosis of malignant thymoma. Surgical resection was ruled out due to local invasion, and palliative chemotherapy was recommended, but declined by the patient and her family. Systemic corticosteroid therapy (prednisone 1 mg/kg/day) combined with antihistamines led to marked clinical improvement in skin symptoms and pruritus. The patient remains stable, without thoracic complaints or disease progression.

Conclusion: Paraneoplastic erythroderma, despite being rare, should be considered in elderly patients presenting with unexplained generalised erythema, particularly with systemic symptoms, such as weight loss. Early identification can prompt oncological investigations and prevent the use of therapies that may obscure or aggravate the underlying malignancy. To our knowledge, few if any cases have described an association between erythroderma and malignant thymoma, suggesting this may be an under-reported presentation. Given the high morbidity and a mortality rate of up to 19% in erythroderma patients — potentially higher when linked to underlying neoplasms, timely diagnosis is crucial for effective management and improved outcomes.

Abstract N°: 5996

Mycosis fungoides with atypical progression in a young patient: case report

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Introduction & Objectives:

Mycosis fungoides (MF) is a rare, indolent form of cutaneous T-cell non-Hodgkin lymphoma (NHL), with prognosis varying by subtype and stage. It typically affects individuals aged 55–60, with a male predominance, and is uncommon in young adults. Clinical manifestations include localized or disseminated macules, plaques, tumors or erythroderma.This report describes an atypical case of MF in a 33-year-old woman with favorable response to localized radiotherapy.

Materials & Methods:

We report the case of a 33-year-old female patient, of mixed race, single, with no known prior comorbidities, who presented with a complaint of a right flank tumor for the past six months. She reported the appearance of diffuse violaceous patches on the trunk and limbs two years prior, followed by a progressively enlarging nodule in the right flank over the past six months, which evolved into a bleeding tumoral lesion. Additional symptoms included night sweats and progressive weight loss of approximately 10 kg over the last three months. She had previously received treatment with itraconazole for the skin lesions, without clinical improvement. On physical examination, the patient presented with an exophytic tumor measuring approximately 10 cm in the right flank, friable, along with hypopigmented patches and infiltrated erythematous plaques diffusely distributed across the trunk and limbs. Significant breast asymmetry was also noted. Following clinical evaluation, the patient was admitted to the hospital for further diagnostic workup. Histopathological analysis of the skin lesions revealed an atypical lymphoid proliferation involving the superficial and mid-dermis, with epidermotropism and intraepidermal microabscesses, findings consistent with a diagnosis of mycosis fungoides. CT scans of the chest, abdomen, and pelvis showed a conglomerate of superficial and deep lymph nodes in the right inguinal region, lymphadenopathy in the right axillary region, and nonspecific pulmonary nodules in the right lower lobe. Peripheral blood involvement was not observed. Following diagnosis, the patient was referred to a specialized center, where she underwent localized radiotherapy targeting the tumoral lesion, resulting in bleeding control and tumor regression. She remains under investigation for the breast findings, with ongoing clinical monitoring and pending evaluation regarding the initiation of systemic therapy.

Results:

Localized radiotherapy was chosen due to the lesion’s extent and bleeding. After two months, complete tumor regression was observed without local recurrence. MF treatment must be individualized, balancing disease activity, adverse effects, comorbidities, and patient preference. Advanced cases often require systemic and skin-directed therapies. Radiotherapy plays a key role by selectively destroying malignant T-cells and may be used alone or with systemic agents. Total skin electron beam therapy (TSEBT) is another option for extensive skin involvement.

Conclusion:

Mycosis fungoides is a rare disease, although it represents the most common type of cutaneous T-cell lymphoma. Its treatment is highly individualized, and radiotherapy stands out as a crucial therapeutic tool in the management

of tumoral-stage mycosis fungoides, offering high response rates, safety, and good tolerability. It can be used both as a curative option for localized lesions and as part of a palliative approach in advanced cases.

Abstract N°: 6044

Albright's Hereditary Osteodystrophy: A Case Series

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Introduction & Objectives:

Albright's hereditary osteodystrophy (AHO) is a rare genetic syndrome characterised by physical features such as short stature, dental anomalies, short digits, obesity, round face and subcutaneous ossifications. It is associated with pseudohypoparathyroidism (PHP) or pseudopseudohypoparathyroidism (PPHP), depending on whether the maternal or paternal allele is involved. We present two paediatric cases of AHO with subcutaneous manifestation as a key finding in the process of diagnosis, underscoring the diagnostic value of this symptoms.

Materials & Methods:

The first case is a 10 month old boy referred to Dermatology for atopic dermatitis and eczema herpeticum. On review, features of obesity and bluish hard subcutaneous nodules on the abdomen, right forearm and right groin were noted, along with an elevated PTH. His high BMI and large head circumference prompted an MRI scan which showed a Chiari 1 malformation that is typical of PHP Ia. This combined with the subcutaneous ossification and genetic testing confirmed the diagnosis of AHO.

The second case is a 16 year old male with a history of psoriasis under the care of the dermatology team. Multiple subcutaneous nodules were noted since the age of 13 and it further progressed over 6 months, covering his left hip, right elbow, right foot and right base of thumb. A biopsy of the lesion on his left hip was taken and was proven to be cutaneous ossification, with no evidence of pilomatrixoma. An X-ray had also showed shortened 3rd and 4th metacarpals. This prompted further investigation which showed the typical GNAS gene deletion of AHO. There was some diagnostic uncertainty due to blood tests showing endocrine abnormalities, and it was concluded that pseudopseudohypoparathyroidism was the underlying diagnosis.

Results:

Both patients were diagnosed with AHO, but with different presentation, severity and endocrine profiles, PHP Ia and PPHP, respectively. However, the subcutaneous ossification was the clinical sign in both cases that prompted further endocrine, biochemical and genetic workup that ultimately led to the diagnosis.

Conclusion:

These cases highlight the variability in presentation of AHO, particularly when there are clinical features that overlap with other conditions. Subcutaneous ossification, which was present in both patients, remains a prominent and consistent feature of AHO and can serve as a critical clue for early diagnosis.

Abstract N°: 6138

When skin speaks: nodular dermatoses unveiling systemic Tuberculosis and Hodgkin Lymphoma

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Introduction and Objectives: Cutaneous manifestations of systemic diseases are crucial diagnostic clues that can precede or accompany internal pathology. Infections such as tuberculosis and malignancies like Hodgkin lymphoma can both present with skin findings, sometimes making diagnosis challenging due to overlapping clinical features. Early identification of these skin signs can lead to a timely and life-saving diagnosis. This report aims to describe a complex clinical case where nodular dermatoses served as a primary manifestation of concomitant systemic tuberculosis and Hodgkin lymphoma, highlighting the importance of integrating dermatological findings into systemic assessment.

Material and Methods: We present the case of a 78-year-old male with a prior history of pulmonary tuberculosis in 2011, who was evaluated in the Dermatology Department due to a two-month history of progressive, painful nodular lesions located on ower extremities and anterior thorax. These lesions had not responded to empirical antibiotic treatments. Patient also reported systemic symptoms, including a chronic cough, night sweats, and intermittent fever. On physical examination, multiple nodular neoformations measuring approximately 1 × 0.8 cm were observed on the posterior aspect of both legs and right infraclavicular region. Nodules exhibited erythematous borders, with central ulceration in some and necrotic crusting in others. Non-tender axillary and supraclavicular lymphadenopathies were also present. Skin and lymph node biopsies were performed. Histopathological analysis revealed two concurrent processes: a diagnosis of mixed-cellularity Hodgkin lymphoma based on the presence of Reed-Sternberg cells and granulomatous infiltrate consistent with a diagnosis of nodular tuberculid. To further delineate systemic involvement, imaging studies and microbiological tests were conducted, which demonstrated active pulmonary tuberculosis and central nervous system infiltration by lymphoma.

Results: The patient was promptly initiated on anti-tuberculosis therapy. A notable improvement was observed in cutaneous lesions, however, the systemic disease progressed. The CNS involvement by Hodgkin lymphoma led to significant clinical deterioration, he unfortunately passed away shortly after the initiation of oncologic evaluation.

Conclusions: This case illustrates the essential role of dermatological examination as a gateway to diagnosing serious systemic illnesses. Nodular dermatoses in elderly patients, particularly when refractory to antibiotics and accompanied by systemic symptoms, should prompt an aggressive diagnostic workup. The coexistence of tuberculosis and Hodgkin lymphoma complicates both clinical presentation and management. Therefore, a multidisciplinary approach is critical for optimal patient care. Recognizing cutaneous signs as potential harbingers of dual systemic pathology is key to improving diagnostic accuracy and therapeutic outcomes.

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Abstract N°: 6156

A case of Amicrobial Pustulosis of Folds associated with Systemic Lupus Erythematosus

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Introduction & Objectives:

Amicrobial pustulosis of folds (APF) is a neutrophilic dermatosis most often affecting young women. It can be post-viral, drug-induced or associated with an autoimmune disease. Herein, we report a case of APF in a woman with lupus.

Results:

A 40-year-old female with a 5-year history of systemic lupus erythematosus, complicated by lupus nephritis and treated with systemic corticosteroids, presented with recurrent erythematous-pustular lesions affecting intertriginous areas over the past year. Dermatological examination revealed erythematous, non-squamous plaques studded with pustules in the axillary, submammary, and inguinal folds. No psoriatic lesions were observed elsewhere. The scalp showed scaly, erosive, non-alopecic patches, without nail or mucosal involvement. Laboratory investigations revealed elevated inflammatory markers, while bacterial cultures from pustules were sterile, supporting the diagnosis of aseptic pustulosis. Histopathological examination of a skin biopsy demonstrated intraepidermal spongiosis with a dermal lymphocytic infiltrate. A diagnosis of amicrobial pustulosis of the folds was established. The patient was initially treated with acitretin; however, due to suboptimal response, colchicine was introduced, resulting in significant clinical improvement.

Dicussion & Conclusion:

Amicrobial pustulosis of the folds (APF) presents a diagnostic challenge, particularly when differentiating it from inverse pustular psoriasis. In our case, the patient had no personal or family history of psoriasis and is a young woman with known lupus, which favored the diagnosis of APF. Clinically, the pustules were localized exclusively to the folds, unlike inverse pustular psoriasis, where pustules or psoriasiform lesions can be found elsewhere. The scalp involvement in this case aligned with the presentations described in the literature for APF, characterized by yellowish, oily, ulcerative, and crusty scales distinct from the dry, whitish, non-ulcerative scales seen in psoriasis. Anatomopathological examination is inconclusive. It can show in both conditions, an intraepidermal spongiosis, acanthosis and parakerathosis. Direct immunofluorescence rarely shows a lupus band which can help confirms AFP. Regarding treatment, Retinoids are effective in both conditions, but other therapeutic alternatives are considered first-line for APF, including systemic corticosteroids alone or in combination with acitretin or dapsone, dapsone alone, colchicine, cimetidine combined with ceftriaxone and vitamin C or zinc sulfate. Cyclosporine or methotrexate for refractory cases. Our patient is currently on a combination of corticosteroids and colchicine, with sustained remission. This case highlights the difficulty in distinguishing between APF and inverse pustular psoriasis, underscoring the need for further research to develop simpler diagnostic tools and improve therapeutic management for these conditions.

Abstract N°: 6204

Massive Vulvar Edema A Rare Consequence of Preeclamsia : A Case Report

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Massive Vulvar Edema A Rare Consequence of Preeclamsia : A Case Report

Introduction & Objectives:

Spontaneous massive vulvar edema is an unusual complication of pregnancy and may be associated with medical conditions such as multiple gestation, diabetes, hypoproteinemia, preeclampsia, tocolytic therapy, vulvovaginitis, and severe anemia. Several other vulvar conditions can closely mimic edema, making differentiation challenging. Massive vulvar edema can interfere with vaginal delivery and has been linked to maternal morbidity in the postpartum period. It presents a diagnostic dilemma and therapeutic challenge for healthcare providers, and a significant source of distress for affected patients. We present the case of a patient with massive vulvar edema who was referred to our department by the obstetrics and gynecology team.

Materials & Methods:

The patient's medical history and records were acquired, and a thorough investigation of literature was performed, using the keywords ' massive vulvar edema' , ' preeclampsia',

Results: A 24-year-old primiparous woman at 37 weeks of gestation presented with massive vulvar edema. Dermatological examination revealed bilateral labial erythema and swelling, more pronounced on the right labium majus, accompanied by a slight increase in local temperature. During pregnancy, blood pressure monitoring showed a maximum measurement of 176/95 mmHg. Routine urinalysis demonstrated proteinuria ("++") without signs of infection, and 24-hour urinary protein excretion was 4 g/24 h. Blood, urine, and wound cultures revealed no bacterial growth. These findings are consistent with a diagnosis of preeclampsia, based on the combination of significant hypertension and proteinuria in the absence of infection.Initial treatment included oral Nifedipine 30 mg and oral Cetirizine Hydrochloride 10 mg, along with the initiation of a salt-free diet. Due to the diagnosis of preeclampsia and the presence of significant vulvar edema, a cesarean section was performed at 37 weeks and 3 days of gestation. On the third postoperative day, the vulvar edema persisted. Topical treatment was initiated with Eau de Goulard solution applied six times daily and Hydrocortisone-17-butyrate cream applied twice daily. Additional supportive measures included bed rest, perineal elevation, and cold compresses.The vulvar edema resolved completely after one week of treatment.

Conclusion:

Massive vulvar edema is a rare but potentially serious complication of pregnancy. Although more frequently linked to conditions such as multiple gestation, diabetes, or hypoproteinemia, its presence in the context of preeclampsia is uncommon and diagnostically challenging. In this case, vulvar edema developed without any infectious cause, ruling out more common etiologies such as urinary tract infection or lymphedema. Given the patient's preeclampsia diagnosis, it is important to consider preeclampsia in the differential diagnosis of vulvar edema.Prompt recognition and appropriate management including blood pressure control and supportive treatment are essential to prevent complications and to ensure the safety of both mother and fetus.

Abstract N°: 6307

A macrocheilitis associated with salivary gland involvement: what diagnosis?

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Introduction & Objectives:

Sarcoidosis is an idiopathic chronic granulomatous disease. Involvement of the oral mucosa is rare.

Sjögren's syndrome (SGS) is a systemic autoimmune disease. Its association with sarcoidosis is very rare. We report the observation of a patient who presented with macrocheilitis associated with salivary gland involvement posing a diagnostic problem.

Materials & Methods:

A 56-year-old woman had macrocheilitis since 2020, associated with nodules on the floor of the mouth for 6 months.

Biological assessment: angiotensin-converting enzyme at 72 U/L (upper limit of normal),

immunological assessment: positive antinuclear antibodies at 1/640; anti-DFS 70 antibodies at 139. IDR to tuberculin: anergy.

Radiological assessment (abdominal ultrasound, chest X-ray, CT TAP, salivary scintigraphy) normal.

Anatomopathological study of the macrocheilitis biopsy: focal lymphocytic sialadenitis grade 4 according to the Chisholm and Mason classification. Biopsy of the sublingual mucosa: tuberculoid granulomatous lesions with grade 3 lymphocytic sialadenitis of Chisholm and Mason. The patient was receiving methotrexate 15 mg/week associated with oral prednisone 0.5 mg/kg/day allowing for partial improvement.

Results:

Oral mucosal sarcoidosis presents as submucosal nodules and lip involvement as macrocheilitis. Salivary gland involvement is classic, often subclinical. The association of SGS with sarcoidosis is well known. The histological involvement of SGS during sarcoidosis is progressive: Initially, it is a massive granulomatous infiltration of the salivary glands, then a specific interstitial scleroinflammatory state. These latter aspects can interfere with the aspects of SGS. Stage 4 of Chisholm occurs before the formation of the sarcoid granuloma, which gives a false appearance of SGS. On the other hand, the lymphocytic infiltrate of authentic SGS may be interspersed with giant epithelial cells. Thus, a labial histology compatible with SGS would be difficult to interpret in a patient with sarcoidosis.

Conclusion:

We report a particular observation due to the association of a tuberculoid sarcoid granuloma of the sublingual glands with an appearance of grade 3 lymphocytic sialadenitis of Chisholm and Mason and a stage 4 sialadenitis of Chisholm and Mason in the accessory salivary glands, suggesting a probable association with SGS.

Abstract N°: 6352

Type I Cryoglobulinemia Unmasked by Skin Involvement: A Diagnostic Challenge

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Introduction & Objectives:

Type I cryoglobulinemia is a rare monoclonal condition, typically associated with lymphoproliferative disorders. While cutaneous signs are common, they are rarely the initial presentation. Identifying the underlying cause is crucial for guiding management.

Cas report : ** A 78-year-old woman with hypertension, diabetes, and coronary artery disease was hospitalized for chronic painful ulcers on the lower limbs, evolving over five months. Examination revealed multiple ulcers with blackish crusts, petechial purpura, reticulated pigmented macules on the legs, livedo racemosa on the upper limbs, acral cyanosis, mechanical arthralgia, and lower limb paresthesia. The patient appeared frail, with marked asthenia and weight loss.

Lab work showed normocytic normochromic anemia (Hb 9.3 g/dL), thrombocytosis (544,000/mm^3), elevated ESR (55 mm/h), CRP (23 mg/L), and high-titer ANA (1:640), but no specific autoantibodies. Viral serologies (HIV, HBV, HCV, syphilis) and immunologic panels (ANCA, anti-DNA, antiphospholipids) were negative. Arterial Doppler revealed calcified arteriopathy without critical ischemia.

Skin biopsy showed leukocytoclastic vasculitis with perivascular infiltrates, leukocytoclasia, erythrocyte extravasation, and microthromboses. Serum testing confirmed type I cryoglobulinemia, but no underlying hematologic malignancy was identified despite extensive workup (no bone marrow biopsy; imaging, immunoelectrophoresis, and tumor markers were normal).

The patient was started on prednisone (20 mg/day) and received regular wound care, with partial clinical improvement.

Discussion :

Type I cryoglobulinemia arises from monoclonal immunoglobulin production, typically linked to disorders like Waldenström's macroglobulinemia, multiple myeloma, or MGUS. It manifests clinically through hyperviscosity and ischemic vascular complications, including purpura, livedo, digital necrosis, Raynaud's, or chronic ulcers—especially on the lower limbs. These lesions result from vascular occlusion by precipitated cryoglobulins, usually without inflammatory vasculitis.

In this case, the presence of leukocytoclastic vasculitis was an atypical finding, as such histological features are classically seen in mixed cryoglobulinemia (types II/III), not in monoclonal type I. This raises the possibility of atypical or overlapping disease forms or a secondary inflammatory response. Importantly, even when no hematologic malignancy is initially evident, ongoing hematologic monitoring is critical, as "idiopathic" or pre-hematologic forms can progress over time.

Conclusion:

This case highlights the importance of considering type I cryoglobulinemia in vascular skin presentations, even in the absence of an identified hematologic disorder. Careful long-term hematologic surveillance is essential to

detect evolving underlying disease.

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Abstract N°: 6514

Cardiometabolic Comorbidities in Psoriasis and Hidradenitis Suppurativa: Insights From a Multicenter Cohort

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Introduction & Objectives: Psoriasis (PSO) and hidradenitis suppurativa (HS) are chronic inflammatory skin diseases associated with systemic inflammation and increased cardiometabolic risk (1,2). Although both conditions are independently linked to cardiovascular (CV) events, comparative data on their respective clinical profiles remain limited. Our study aimed to analyze and compare major cardiometabolic comorbidities between patients with PSO and HS.

Materials & Methods: We set up a multicenter cross-sectional study focusing on adult patients with a diagnosis of PSO or HS, followed from April 2020 to April 2025. Key demographics and clinical data were registered, with a special focus on cardiometabolic comorbidities including hypertension, diabetes mellitus type 2 (DM2), hypercholesterolemia, atrial fibrillation, stroke, arrhythmia and myocardial infarction. Comparisons were performed using independent-samples t-tests or Mann-Whitney U tests. Categorical data were analyzed using Chi-square or Fisher's exact tests as appropriate. Multivariate logistic regression was performed on significant variables and the results were expressed by the Odds Ratio (OR) with the related 95% confidence interval (CI). For all the analysis significance was fixed at 0.05.

Results: A total of 200 patients (100 PSO; 100 HS) was included, with an equal sex distribution: 50.0% female in PSO vs. 52.0% in HS ($p = 0.8876$). PSO patients were older, with a median age of 58.5 years [IQR: 45.0–69.0] compared to 39.0 years [IQR: 27.8–49.2] in HS ($p < 0.0001$). Both diseases showed a comparable disease duration with PSO median duration of 12.5 years [IQR: 4-29] vs 8 years [IQR: 5–18] in HS. HS patients had greater prevalence of obesity (36% vs 21%, $p = 0.005$), smoking habits (62% vs 42% $p=0.007$) and hypercholesterolemia (6% vs 4%, $p= 0.007$). Conversely, PSO patients initially displayed a higher prevalence of hypertension (33% vs. 18%, $p = 0.034$). No significant differences were observed for DM2, stroke, atrial fibrillation, heart failure, arrhythmia or myocardial infarction. After multivariate analysis, an independent role of age ($p<0.001$; OR 1.09; IC: 1.06-1.12), obesity ($p=0.04$; OR: 0.44; IC: 0.20-0.98) and hypercholesterolemia ($p=0.001$; OR: 0.16; IC: 0.04-0.65) was established, while hypertension lost its significance in PSO patients.

Conclusion: Our study pointed out that PSO and HS patients present similar incidence of cardiometabolic comorbidities, with the exception of obesity and hypercholesterolemia which resulted significantly higher in HS patients. These results further emphasize the burden of adipose tissue in the physiopathology of HS, with a putative interplay role mediated by adipokines (3). Conversely, it pointed out that age is a main element in the incidence of cardiometabolic comorbidities, supporting the idea that an early intervention represents a key factor in treating both PSO and HS, thus possibly reducing comorbidities (4,5). A potential next step would be to investigate the average time of onset of CV comorbidities in relation to the initial symptoms of PSO and HS, in order to further explore the potential causal role of the underlying disease in systemic involvement.

\1. doi: 10.1111/ijd.17186.

\2. doi: 10.3892/etm.2021.11075.

\3. doi: 10.1093/bjd/ljac107

\4. doi: 10.1111/bjd.18983.

\5. doi: 10.3109/09546634.2014.880396.

Abstract N°: 6518

From Clinical Suspicion to Histopathological Confirmation: Insights from a Case of Calciphylaxis

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Introduction & Objectives:

Calciphylaxis, also known as calcific uraemic arteriolopathy, is a rare but potentially fatal thrombotic vasculopathy characterised by occlusion of microvessels in the dermis and subcutaneous adipose tissue. It predominantly affects women, with a mean age of onset of 48 years, and is most commonly observed in patients with end-stage renal disease (ESRD). The reported incidence among dialysis patients ranges from 0.04% to 4%. Traditional risk factors include disordered mineral metabolism, secondary hyperparathyroidism, active vitamin D therapy, hyperphosphataemia, and elevated calcium–phosphate product.

Clinically, calciphylaxis typically begins as painful livedo racemosa, which progresses to retiform purpura and ultimately to large areas of ischaemic necrosis. Lesions often localise to areas of increased adiposity such as the lower limbs, trunk, and upper extremities. Arteriolar blood flow reduction is driven by medial calcification, intimal fibrosis, and microthrombi formation affecting dermohypodermic arterioles. The definitive diagnosis requires skin biopsy, which demonstrates medial calcification of dermal or subcutaneous arterioles, fibrointimal hyperplasia, microthrombi, vascular occlusion, and often adjacent tissue necrosis.

Materials & Methods:

We present the case of a 40-year-old woman with dialysis-dependent ESRD and recent supracondylar amputation, who developed painful necrotic skin lesions.

Results:

The patient presented with widespread retiform purpura and extremely painful necrotic plaques on the trunk and upper limbs. Her history included dialysis-dependent ESRD, parathyroidectomy performed 16 years earlier, and recent left supracondylar amputation due to thrombotic complications.

Physical examination revealed disseminated dermatosis involving the entire cutaneous surface of the trunk circumferentially and affecting the upper limbs from the deltoid area to the mid-forearm. Lesions consisted of confluent plaques formed by extensive livedo racemosa, retiform purpura, and necrosis ranging in size from 5×7 cm to 20×10 cm.

Initial differential diagnosis included vasculitis, cryoglobulinaemia, drug-induced vasculopathy, and infection. Laboratory tests revealed: Hb 7.2 g/dL, WBC 33.8×10^9/L, calcium 8.74 mg/dL, phosphate 7.92 mg/dL, PTH 726.3 pg/mL, homocysteine >50 µmol/L. Lupus anticoagulant, ANCA, and wound cultures were negative. CT imaging showed arterial calcifications and a porcelain gallbladder. Skin biopsy revealed medial calcification of subcutaneous vessels, adipocyte necrosis with ghost cell morphology, and dermal ischaemic infarcts. Based on clinical, biochemical, and histopathological correlation, a diagnosis of calciphylaxis was confirmed. Despite dialysis adjustment and initiation of phosphate binders and vitamin D, the patient developed sepsis secondary to skin ulceration and died of septic shock eight days later.

Conclusion:

We present a fatal case of calciphylaxis in a patient with ESRD and secondary hyperparathyroidism. First described by Bryant and White in 1898, the term “calciphylaxis” was coined by Hans Selye in 1962 based on calcium-induced vascular injury models. Misdiagnosis remains common, affecting up to 77% of cases, especially early on when signs may mimic cellulitis or vascular disease. Mortality ranges from 46% to 80%, as reflected in this case. Early recognition is crucial to improving survival and quality of life.

Abstract N°: 6532

Sun exposure is associated with the increase in skin cancer numbers over time: the Trends Of Skin CAncer Numbers In solid organ transplant recipients, TOSCANI longitudinal cohort study

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Introduction & Objectives:

Solid organ transplant recipients (SOTRs) are at markedly increased risk of keratinocyte cancers (KCs) due to long-term immunosuppression, presenting a significant clinical burden. While incidence rates have been widely studied, the total number of KCs per patient better reflects disease burden and management needs. This study aimed to assess trends in the number of KCs among kidney and lung transplant recipients over five years and identify patient-level predictors and modifiable risk factors influencing this burden.

Materials & Methods:

We conducted a retrospective cohort study of SOTRs attending dedicated skin cancer surveillance clinics between 2017 and 2021. Participants provided informed consent for data collection, including medical and transplant history, medication use, and histopathology-confirmed KCs. Baseline questionnaires captured demographic characteristics, sun exposure habits, and sun protection behaviours. Poisson regression was used to assess annual trends and to identify predictors of KC numbers.

Results:

A total of 226 patients were enrolled (121 kidney, 105 lung; 69% male; 36% with >10 years of immunosuppression). Across the cohort, 2384 histologically confirmed KCs were excised. The annual number of KCs increased significantly over time by 9% per year (incidence rate ratio [IRR] = 1.09, p = 0.006), with mean KCs per patient rising from 2.3 in 2017 to 2.9 in 2021. The increase was most pronounced for squamous cell carcinomas (SCCs) and KCs on the head and neck, while basal cell carcinomas (BCCs) and trunk lesions remained stable. Higher outdoor recreational sun exposure was independently associated with increased KC burden (adjusted relative risk = 1.20), whereas reported sun protection practices and chemopreventive use did not significantly modify KC trends.

Conclusion:

SOTRs experience a rising number of keratinocyte cancers over time, particularly SCCs on sun-exposed sites. These findings underscore the growing burden of skin cancer in this vulnerable population and highlight the need for more effective and sustained preventive strategies, including behaviour change and resource planning within

transplant care models.

Abstract N°: 6600

Under the Surface: Unmasking Inflammatory Breast Cancer in the Elderly – A Case Report

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Introduction & Objectives:

Inflammatory breast cancer (IBC), a rare and aggressive subtype of breast cancer, manifests with diffuse skin hardening resembling erysipelas and typically lacks an identifiable mass. Early detection is critical due to its fast progression and unfavorable prognosis. Effective management requires a comprehensive, multidisciplinary strategy aimed at personalized treatment and supportive care, aiming to enhance patient outcomes and quality of life.

Materials & Methods: A single patient was evaluated. Initial assessments included dermoscopy and a potassium hydroxide (KOH) preparation, followed by a punch biopsy. Tissue specimen was processed using Hematoxylin and Eosin (H&E) staining, along with immunohistochemical staining for estrogen receptor (ER), progesterone receptor (PR), and HER2/Neu.

Results:

This report highlights the case of a 75-year-old female with a 7-month history of a slowly growing, warm, tender plaque over the left breast. Breast ultrasound showed no distinct mass on both breasts but with minimal skin thickening on the left breast. She was initially assessed by her primary care physician with Inflammatory Breast Disease, Left; To Consider Mastitis; rule out Malignancy. She was subsequently referred to Dermatology service for further evaluation and management. Upon physical examination, a solitary, well-defined, erythematous, warm, tender, annular plaque with raised borders, topped with scales and crusts, was observed over the left breast. To rule out differential diagnoses and conduct further evaluation, a dermoscopy was performed, revealing a whitish-pink area with irregular dotted vessels and white, round globules. A KOH test was also conducted, which was negative for fungal elements. The patient subsequently underwent a punch biopsy on the plaque over the left breast.

H&E-stained tissue sample from the punch biopsy revealed extensive invasion of the dermis and subcutaneous tissue by strands, groups, and cords of tumor cells, with an interstitial arrangement of tumor cells between collagen bundles (“Indian filing”) prominently observed. There were aggregations of atypical epithelial cells within widely dilated, endothelial-lined spaces and lymphatics; large, atypical, pleomorphic tumor cells with hyperchromatic, round or elongated nuclei; and evidence of perineural invasion. The epidermis appeared relatively spared. Additional immunohistochemical stains for ER, PR, and HER2/Neu were negative.

Chest CT scan showed thickening and fat stranding of the left breast tissue, possibly indicative of an infectious or inflammatory process such as mastitis or a diffuse infiltrative breast neoplasm. Based on these findings, the diagnosis favored Inflammatory Breast Cancer. The patient was referred to the Internal Medicine–Oncology Department for initiation of a Doxorubicin, Cyclophosphamide, and Paclitaxel (AC-T) chemotherapy protocol.

Conclusion:

This case report highlights the identification of cutaneous metastases, particularly those stemming from

inflammatory breast cancer. The diverse skin manifestations can hinder timely diagnosis. Early detection depends on thorough history-taking, physical examination, and histopathological assessment. Treatment involves a collaborative approach, typically including chemotherapy as a pivotal treatment method.

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Abstract N°: 6651

Systemic Amyloidosis with Scleroderma-like Cutaneous Manifestations and Palmoplantar Hyperkeratosis - A Rare and Complex Conundrum

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Introduction & Objectives:

Amyloidosis is a heterogenous disease caused by deposition of insoluble beta-sheet fibrillar amyloid protein aggregates in body tissues. It can be localized cutaneous or, systemic, with the exact incidence of the latter unknown due to it's rarity. Cutaneous manifestations occur in 40% of patients with primary systemic amyloidosis. Herein we present an intriguing case of systemic amyloidosis in a middle-aged gentleman who presented with scleroderma-like skin changes, a rare but recognized manifestation of primary systemic amyloidosis, with fewer than 10 cases reported in literature. Additionally, he exhibited palmoplantar hyperkeratosis, a previously unreported feature of systemic amyloidosis.

Materials & Methods:

A 57-year-old gentleman presented with complaints of paraesthesia over extremities for the past 1.5 years, progressive tightening of skin over hands and feet, hoarseness of voice, and difficulty in swallowing solids over the past year. In the last 2 months, he experienced difficulty in opening his mouth, protruding tongue and swallowing liquids along with a dry cough that had been ongoing for the past month. He was brought to the emergency department with dyspnoea since 1 day. On systemic examination, he was found to have pallor, blood pressure of 80/60 mmHg and scattered wheeze in bilateral lung fields. No organomegaly was noted on per abdomen examination. Cutaneous examination revealed induration of forehead with frontal bossing, macrocheilia, macroglossia, hyperpigmentation over V area of neck, binding down of skin over hands and feet and hyperkeratosis with fissuring and purpuric patches over palms and soles. Few petechial and small ecchymotic lesions were noted over bilateral shins and flanks. The relevant investigations are summarized in the table.

Investigation	Result
Haemoglobin	10.6 g/dL (normal range 14-18 g/dL)
INR (International Normalised Ratio)	1.3 (normal <1.1)
APPT (Activated Partial Thromboplastin Time)	40.3 seconds (normal range 25.1-36.5 seconds)
Urine routine	WBC 8-10/HPF*, RBC 10-12/HPF*, leucocyte esterase 1+, protein 1+ *HPF- high power field
ANA (Antinuclear antibody)	Weakly positive, with coarse granular positivity of chromatin in HEp-2 cells
ANA profile	No elevated autoantibodies
Chest X-ray	Right costophrenic angle blunting
High-resolution computed tomography (HRCT) thorax	• Findings consistent with pulmonary edema • Ruled out interstitial lung disease
2D-Echocardiography	• All 4 chambers were dilated with global severe left ventricular hypokinesia, • Reduced ejection fraction - 20% (normal > 60%) • Moderate tricuspid regurgitation with no significant pulmonary artery hypertension
Skin biopsy	**Amorphous deposits in papillary dermis, vessel wall and subcutis**
Congo Red Stain on skin biopsy	**Positive for apple green birefringence on polarizing microscopy**

Result:

Based on our patient's history and clinical examination, differential diagnosis considered were amyloidosis, systemic sclerosis, scleredema and scleromyxoedema. Investigations revealed anaemia, prolonged INR and APPT. Urinalysis revealed urinary tract infection with proteinuria. Serological markers for systemic sclerosis were negative. High-resolution computed tomography of the thorax ruled out interstitial lung disease. Skin biopsy with Congo red stain confirmed our diagnosis of systemic amyloidosis. Patient was scheduled for serum and urine immunofixation electrophoresis along with serum kappa and lambda free light chain levels and 24-hour urine protein. However, he unfortunately expired due to a cardiac arrest before these tests could be completed.

Conclusion:

Our report highlights a rare and novel cutaneous manifestation of systemic amyloidosis, characterized by scleroderma-like skin thickening and palmoplantar hyperkeratosis. This overlap underscores diagnostic complexity, as systemic amyloidosis and systemic sclerosis can present with similar cutaneous and systemic manifestations, particularly renal. In the absence of specific autoantibodies for systemic sclerosis, a high index of suspicion and early skin biopsy to confirm the diagnosis is critical, given their distinct etiopathogenesis and treatment approach.

Abstract N°: 6705

A Mosaic of Mystery: A Case of Proteus Syndrome in an Adult Male

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Introduction & Objectives:

Proteus Syndrome (PS) is a rare sporadic mosaic overgrowth disorder characterized by a somatic activating mutation in the AKT1 gene leading to an asymmetric proliferation of tissue, particularly the bone, skin, adipose, and nervous tissues. Due to its variable presentation and progressive nature, early recognition and multidisciplinary management are essential.

Materials & Methods:

This highlights the case of a 34-year-old male who presented with asymmetric overgrowth of the first two digits of his right foot since birth. Dermatologic examination revealed multiple linearly arranged macules and patches unilaterally on the left trunk, and a verrucous plaque over the plantar aspect of the enlarged first right toe. All three general criteria for Proteus Syndrome were met: 1) mosaic distribution of lesions, 2) sporadic occurrence of the disease, and 3) progressive course of the disease; and the "Revised Proteus Syndrome Criteria" was used to diagnose the case. Diagnosis requires the fulfillment of the three general criteria and at least one of the following specific criteria (see table 1): Category A, at least 2 criteria from Category B, or three criteria from Category C. Among which, he fulfilled the criteria from Category A (cerebriform connective tissue nevus) and two criteria from Category B (a. linear epidermal nevus, and b. asymmetric, disproportionate overgrowth). **

Results:

A biopsy of the cerebriform plaque over the sole revealed a "Cerebriform Connective Tissue Nevus". Imaging of the right foot showed osseous overgrowth, soft tissue thickening, and an absent second metatarsal and phalanx (from a prior elective digital amputation). Chest CT Scan revealed non-calcified perifissural nodules, subsegmental atelectasis or fibrosis, and early degenerative osseous changes. Abdominal imaging showed hepatomegaly with steatosis, a punctate gallbladder polyp, and diverticulosis. Laboratory tests indicated elevated liver enzymes and dyslipidemia. These clinical and investigative findings met the diagnostic criteria for PS and he was referred to various specialties for further evaluation and management.

Conclusion:

This case highlights the intricacies of diagnosing and managing Proteus Syndrome. A comprehensive multidisciplinary approach is required to administer appropriate treatment, enhance functionality, alleviate the psychological impact, and achieve optimal overall patient outcomes.

Table 1. Modified from Biesecker, L. G. (2006b). The challenges of Proteus syndrome: diagnosis and management. *European Journal of Human Genetics*; *14*(11), 1151– 1157. https://doi.org/10.1038/sj.ejhg.5201638 (4)

Specific criteria categories	
A	Cerebriform connective tissue nevus
B	1. Linear epidermal nevus
	2. Asymmetric, disproportionate overgrowth (one or more of the following)
	a. Limbs
	b. Hyperostosis of the skull
	c. Hyperostosis of the external auditory canal
	d. Megaspondylodysplasia
	e. Viscera (Spleen/thymus)
	3. Specific tumors before the second decade (one of the following)
	a. Bilateral ovarian cystadenoma
	b. Parotid monomorphic adenoma
C	1. Dysregulated adipose tissues
	a. Lipomas
	b. Regional lipohypoplasia
	2. Vascular malformations
	a. Capillary malformations
	b. Venous malformations
	c. Lymphatic malformations
	3. Lung cysts
	4. Facial phenotype (all of the following)
	a. Dolichocephaly
	b. Long face
	c. Down slanting palpebral fissures/or minor ptosis
	d. Low nasal bridge
	e. Wide or anteverted nares
	f. Open mouth at rest

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Abstract N°: 6797

Cutaneous clues to cancer: Paraneoplastic Music Box Spine Keratoderma in a case of Breast Cancer

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Introduction & Objectives:

Spiny keratoderma, is a rare keratinization disorder characterized by multiple, spicule-like keratotic papules predominantly affecting the palms and soles. Due to its rarity, the entity has acquired various names and is often referred as Music box spine keratoderma due to its resemblance to the spines of an antique music box. It can be hereditary or acquired, the latter frequently associated with systemic diseases and malignancies. The recognition of music box spine keratoderma as a potential paraneoplastic dermatosis emphasize the significance of thorough systemic evaluation, particularly in adult-onset cases.

Materials & Methods:

Prior informed written consent was obtained from the patient. We present the case of a 76 years old female, known case of Primary Hypertension, who was diagnosed with HER2-positive Breast cancer in 2022 and received neoadjuvant chemotherapy followed by a modified radical mastectomy. 06 months later, patient developed multiple, asymptomatic spicule-like lesions over left palm, which progressed to involve right palm and bilateral soles over next 01 year. The patient denies history of similar complaints among family members. Dermatological examination revealed multiple, well defined, discrete, yellowish brown, spiny, hyperkeratotic papules measuring 1–2 mm, over bilateral palms and soles with sparing of dorsal aspect. Dermoscopic examination highlighted multiple, yellowish, spine like protrusions with smooth surface, fine scales around the base and no vascularity while intervening skin appeared normal. An incisional skin biopsy was sent from left palm for histopathological analysis.

Results:

Histopathological examination demonstrated marked hyperkeratosis of epidermis with irregular acanthosis, focal parakeratosis and thick underlying granular layer. The dermis showed mild perivascular lymphocytic infiltrate without atypia, granuloma or evidence of malignancy. She undergoes regular malignancy surveillance with no current evidence of recurrence of breast cancer. Based on history, clinical examination and histopathological analysis, a diagnosis of paraneoplastic music box spine keratoderma was made. Patient has been started on 6% Salicylic acid ointment, 12% Urea cream, 0.1% Tretinoin cream and advised mechanical paring.

Conclusion:

The acquired form of spiny keratoderma has been increasingly recognized as a cutaneous marker of internal malignancy, especially in older adults. The clinical hallmark is spicule-like keratotic papules over the palms and soles, resembling the spines of an antique music box, while histopathology is supportive but not pathognomonic. In our case, the temporal association, parallel evolution and rarity indicates a paraneoplastic etiology according to Curth’s criteria. Exact pathogenesis is unknown, but it is hypothesized that tumor-secreted mediators drive localized epidermal hyperproliferation, potentially attributable to upregulation of keratins 6 and 16. Treatment is primarily symptomatic and often unsatisfactory, with topical keratolytics, vitamin D3 analogues, and retinoids. Oral Acitretin has shown efficacy in few cases, but recurrences are common. In acquired cases of spiny keratoderma, a high index of suspicion for underlying neoplasia is warranted and this case underscores the importance of detailed

systemic evaluation and interdisciplinary coordination for early detection and management of hidden malignancies.

Abstract N°: 6869

Calciphylaxis in an early pre-necrotic stage : a rare case report

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Introduction & Objectives:

Calciphylaxis is a rare disease with a poor prognostic that mostly occurs in patients with renal failure. Diagnosis is difficult and skin biopsy is the gold standard diagnostic procedure, although it may aggravate skin lesions.

This syndrome appears to be associated with a phosphocalcic disorders and hyperparathyroidism responsible for mural calcification and occlusion of cutaneous and sub-cutaneous arteries and arterioles.

Sympotoms include hyperalgic and indurated lesions, initially atonic with livedoid borders, that may progress to necrosis. The axial form is the most common (70 to 80% of cases). It affects the fatty areas of the abdomen, pelvis, trunk and the roots of the limbs. The peripheral form affects the lower or upper limbs.

Materials & Methods:

We present a rare case of a patient diagnosed with calciphylaxis in an early pre-necrotic stage

Results:

A 59 years old female patient presented with a medical history of kidney desease since 20 years, hypertension and cardiopathy since 10 years managed with Amlodipine and Vitamin K antagonist, and chronic end-stage renal failure secondary to vascular nephropathy, managed with hemodialysis since 08 years. She was admitted for evaluation of a painful lesions on the lower limbs evolving for one month.

The clinical examination found a patient of Phototype III, poorly defined erythemato-purple patch, indurated and very painful to palpation on the buttocks, both thighs and legs. The dermoscopy showed fine scales, purplish erythematous base, some dotted vessels.

The biological analysis revealed significant abnormalities. Parathyroid hormone (PTH) levels were elevated at 1059 ng/L, accompanied by hypercalcemia (Ca = 107 mg/L), hyperphosphatemia (Phosphorus = 82 mg/L) and an elevated alkaline phosphatase at 140 UI/L. The patient also exhibited normocytic normochromic anemia, with an hemoglobin level of 10 g/dL. Radiological examination was normal.

The histopathological examination showed a normal epidermis, the dermis shows no significant inflammatory infiltrate or mucinous deposits. The hypodermis is the site of multiple calcifications affecting the vascular walls of vessels, accompanied by parietal thickening and a reduction in the vascular lumen. the radiological examination was without abnormalities.

The patient received analgesic treatment with codeine, daily hemodialysis with low-calcium dialysate. Oral or injectable thiosulfate was not administered due to their unavailability. The clinical evolution after 02 months was marked by the extension of the lesions and the appearance of ulceration on the thighs. Given the worsening of clinical symptoms, a parathyroidectomy is planned for our patient.

Conclusion:

Dermatologists must be aware of calciphylaxis, as timely diagnosis and adequate treatment are essential for optimizing patient outcomes. The diagnosis is mainly clinical, supported by histopathological findings when available. A thorough laboratory workup is necessary to evaluate the systemic impact of chronic kidney disease, with special attention to calcium and phosphate levels.

Although calciphylaxis carries a poor prognosis, early diagnosis and a multidisciplinary management approach including pain control, wound care, correction of mineral imbalances, sodium thiosulfate therapy, optimized dialysis and parathyroidectomy can significantly improve quality of life.

Abstract N°: 6976

Recurrent cutaneous abscesses as a manifestation of Bowel-Associated Dermatosis-Arthritis Syndrome (BADAS) in a patient with newly diagnosed Crohn's disease

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Introduction & Objectives:

Bowel-associated dermatosis-arthritis syndrome (BADAS) is a rare neutrophilic dermatosis typically associated with intestinal bypass surgery, but it can also occur in the context of inflammatory bowel disease (IBD). We present a diagnostically challenging case of BADAS as an initial manifestation of previously unrecognized Crohn's disease, highlighting the need for multidisciplinary evaluation in patients with unexplained recurrent cutaneous abscesses and systemic symptoms.

Materials & Methods:

A 73-year-old woman with a history of asthma, persistent atrial fibrillation, hypothyroidism and obesity presented with recurrent episodes of painful, spontaneously draining nodules on the abdomen and extremities over several years. Previous management included surgical excision of some lesions without sustained resolution. Physical examination revealed erythematous-violaceous nodules with purulent discharge. Initial biopsies showed abscess-forming acute inflammation; cultures were negative. Laboratory tests demonstrated iron-deficiency anemia and elevated fecal calprotectin, with normal autoimmune and infectious markers.

Results:

Progressive clinical deterioration, including new-onset diarrhea and polyarthralgia, prompted further investigation. Capsule endoscopy revealed multiple ulcerations and substenotic lesions in the mid-distal ileum, leading to a diagnosis of moderate Crohn's disease. Subsequent MRI and PET-CT demonstrated a 19 mm pancreatic tail lesion with increased metabolic activity, raising strong suspicion of malignancy. Based on these findings, distal pancreatectomy and splenectomy were performed. Histopathological analysis revealed granulomatous abscessing inflammation, fibrosis, and chronic pancreatitis, without evidence of malignancy. The findings were interpreted as possibly related to Crohn's disease-associated systemic inflammation. Treatment with ustekinumab was initiated, along with dapsone for cutaneous symptoms. The constellation of arthralgia, sterile cutaneous abscesses, and underlying IBD was consistent with BADAS.

Conclusion:

This case underscores the importance of considering BADAS in the differential diagnosis of recurrent sterile cutaneous abscesses, especially in patients with undiagnosed IBD. A multidisciplinary approach is crucial for accurate diagnosis and management of systemic neutrophilic dermatoses. Timely identification and targeted therapy can lead to significant clinical improvement.

Abstract N°: 7104

Efficacy and Tolerability of a Ceramide- and NMF-Containing Moisturising Lotion Compared to a Glycerin-Based Lotion in Mature Xerosis

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Introduction & Objectives:

Xerosis, or dry skin, is highly prevalent in older adults, affecting over 50% of those aged 65 and older. Mature xerosis often manifests as a severe form of xerosis, due to intrinsic and extrinsic factors contributing to a decrease in stratum corneum lipids, impaired skin barrier function, and reduced natural moisturising factors (NMF) levels, diminishing water binding capacity. These factors also contribute to pruritus, particularly on the extremities, and are exacerbated by low temperature and humidity. This study assessed the efficacy and tolerability of a moisturiser containing three skin-identical ceramides and NMFs in treating mature xerosis, comparing its performance to a glycerin-based comparator lotion. Data from young, healthy patients served as a reference.

Materials & Methods:

This 4-week controlled clinical study evaluated the efficacy and tolerability of a ceramide- and NMF-containing moisturiser compared to a glycerin-based comparator in adults with mature xerosis (N=76, ages 55-85). A young, healthy control group (N=55, ages 20-35) provided baseline reference data for TEWL, hydration, and ceramides. Subjects with mature xerosis applied the test product to one leg and the comparator to the other leg once daily for four weeks. The treatment group underwent clinical assessments (Overall Dryness Score (ODS) and Specified Symptom Sum Score (SRRC)) by a dermatologist, instrumental measurements (transepidermal water loss (TEWL), hydration, pH), and tape stripping for biomarker analysis at baseline, week 1, 2, and 4. The reference group underwent only baseline assessments. Tolerability was assessed in the mature, treatment group via dermatologist evaluation and subject self-reporting. All Fitzpatrick skin types were represented among the participants.

Results:

At baseline, mature xerotic skin demonstrated 37% lower hydration compared to young, healthy skin. Treatment with the test product resulted in a statistically significant 89.8% increase in hydration from baseline at week 4 ($p<0.001$). This improvement was significantly greater compared to the 61.6% increase observed with the comparator ($p<0.001$). Furthermore, the test product restored skin hydration to levels of young, healthy skin. The test product also significantly reduced the ODS by 72.5% at week 4 ($p<0.001$ vs. baseline), while the comparator reduced ODS by 62.2% ($p<0.001$ vs. baseline). The difference between the test product and comparator in ODS reduction was statistically significant ($p=0.001$). The test product also significantly reduced SRRC by 68.8% at week 4 ($p<0.001$), demonstrating superior efficacy compared to the comparator's 59.8% reduction ($p<0.001$ vs baseline). This difference in SRRC reduction between the test product and comparator was significant ($p<0.05$). Subjects reported no itch or tingling at week 4. Total ceramides increased by 9.8% with the test product compared to the glycerin-based comparator at week 4 ($p \leq 0.05$). The test product maintained skin barrier function as measured by TEWL, whereas the comparator showed a statistically significant worsening of TEWL. Finally, the test product significantly improved skin barrier resilience to tape stripping compared to baseline ($p<0.05$).

Conclusion:

The ceramide- and NMF-containing moisturiser provided significant clinical and subjective improvement in mature xerosis, restored hydration and maintained skin barrier function over 4 weeks compared to a glycerin-based comparator.

Abstract N°: 7111

Scalp necrosis: a misleading presentation of Giant Cell Arteritis

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Introduction & Objectives:

Giant cell arteritis (GCA), also known as Horton's disease, is a granulomatous inflammation of medium and large-sized vessels. The diagnosis is based on suggestive clinical signs and symptoms. Cutaneous involvement, often underrecognized, can lead to delayed diagnosis and management. We report a case of GCA revealed by extensive scalp necrosis.

Case report:

A 79-year-old patient with a history of gastrointestinal stromal tumor treated with imatinib, which was discontinued three years prior, presented with painful and extensive scalp lesions evolving over the past six months. On examination, geographic erosive and necrotic plaques were noted. The lesions circumferentially involved the vertex and both temporal lobes. A diagnosis of necrotizing dermatosis was initially suspected. A skin biopsy revealed a dense and polymorphic dermal inflammatory infiltrate with lymphoid nodules, without granulomas or vasculitis. Blood tests did not show any inflammatory syndrome. Upon further questioning, the patient reported headaches, scalp hyperesthesia, and jaw claudication. GCA was highly suspected. Palpation of the temporal arteries revealed induration with absent pulses. Temporal artery biopsy confirmed the diagnosis, showing features consistent with giant cell arteritis. Ophthalmologic examination was normal. The patient was referred to internal medicine for urgent management.

Conclusion: Giant cell arteritis is the most common vasculitis in the elderly. The diagnosis is usually straightforward when cranial ischemic signs are present. Headaches, jaw claudication, and scalp hyperesthesia are early and suggestive signs. However, cutaneous manifestations rarely reveal GCA. Induration of the temporal arteries and cutaneous nodules along vascular pathways are frequent. Cutaneous and ischemic manifestations are rare and occur late in the disease. They are associated with advanced disease and may lead to severe ophthalmologic complications in one-third of cases. Scalp necrosis often involves the territories supplied by the temporal and occipital arteries, as seen in our case. The differential diagnosis includes necrotizing dermatoses such as necrotizing fasciitis and pyoderma gangrenosum. Skin biopsy is often nonspecific in GCA and may delay the diagnosis. Early diagnosis is crucial and relies on temporal artery biopsy. Management should be urgent, with systemic corticosteroids to slow the ischemic process. However, skin necrosis is irreversible and often requires skin grafting.

Abstract N°: 7139

Facing the Pressure: Unmasking Superior Vena Cava Syndrome

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Introduction & Objectives:

Superior vena cava syndrome (SVCS) is a condition caused by obstruction of central venous flow, with pulmonary neoplasms being its main etiology. Although classically described within the fields of oncology and pulmonology, its initial manifestations can prompt dermatological consultation, especially when it presents as diffuse facial edema mimicking angioedema.

Materials & Methods:

We describe the clinical presentation, diagnostic evaluation, and management of a patient with superior vena cava syndrome initially assessed in dermatology for presumed angioedema. Clinical data were obtained through direct patient examination and review of medical records. Relevant laboratory tests and imaging studies were analyzed to establish the underlying cause. The case is reported in accordance with institutional ethical standards, ensuring patient confidentiality.

Results:

We present the case of a 68-year-old man with no relevant medical history who presented to dermatology with progressive facial and eyelid edema. An initial suspicion of angioedema led to treatment in primary care with antihistamines and systemic corticosteroids, without improvement. Due to persistence of the condition, the patient attended the emergency department at our center, where subtle thoracic collateral circulation was noted. A chest X-ray was requested, revealing a mass in the right lung apex.

The dermatologist plays a key role in the early recognition of cutaneous manifestations of systemic diseases. In this case, the initial consultation for facial edema highlighted the importance of differentiating allergic angioedema from an underlying vascular cause. The absence of pruritus, bilateral involvement, and refractoriness to antihistamine treatment should raise suspicion for possible venous obstruction, particularly in at-risk patients.

Conclusion:

SVCS can present to dermatology with a clinical picture suggestive of angioedema. Recognizing warning signs such as persistent edema, bilateral involvement, and the presence of collateral circulation is crucial for early diagnosis and timely referral, avoiding delays in oncological management.

Abstract N°: 7182

Chronic non-healing ulcer in the inguinal region: Langerhans cell histiocytosis

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Introduction & Objectives: Langerhans cell histiocytosis (LCH) is a clonal proliferative disorder characterized by the infiltration of one or more organs by abnormal Langerhans cells. Although most frequently diagnosed in children between the ages of 1 and 3 years, LCH is rare in adults, with an estimated incidence of 1–2 cases per million. While single-organ involvement is the typical presentation; multiple organ systems—including the lungs, bones, pituitary gland, skin, and liver— may also be affected. Clinically, LCH can mimic conditions such as seborrheic dermatitis, folliculitis, or intertrigo. Herein, we report a case of adult-onset LCH in a patient with a history of long-standing diabetes mellitus, gingival granulomas, and chronic, non-healing ulcers in the inguinal region.

Materials & Methods: A 48-year-old male presented with a recurrent genital ulcer that had persisted for one year. Previous treatments for presumed *tinea cruris* were unsuccessful. His medical history was notable for multiple biopsies and resections of an oral tumoral mass, which ultimately led to a diagnosis of Langerhans cell histiocytosis (LCH), however, he had remained under observation without active treatment. A prior PET-CT scan demonstrated mild fluorodeoxyglucose (FDG) uptake in the mandible, ribs, and iliac bone. Dermatological examination revealed a 5 cm exophytic, ulcerated plaque in the bilateral inguinal region. A punch biopsy confirmed the diagnosis of LCH. A follow-up PET-CT scan showed increased FDG uptake in the inguinal region and distal femur. The patient was referred to hematology and oncology for further evaluation and management.

Results: LCH in adults presents with a heterogeneous clinical spectrum, ranging from isolated osseous lesions to aggressive multisystem involvement. Osseous manifestations occur in approximately 80% of cases, with a prevalence of 30–50% among adults, most commonly affecting the skull, chest wall, vertebrae, and jaw. In present case, mandibular involvement was evident, correlating with chronic dental symptoms. Cutaneous involvement may manifest as ulcers, nodules, or plaques, and can precede systemic symptoms by months or even years.

Therapeutic strategies are determined by extent and severity of disease involvement. Localized forms of LCH may undergo spontaneous regression or respond favorably to topical therapies, surgical excision, or localized radiotherapy. Treatment options for localized disease include observation, topical nitrogen mustard, psoralen plus ultraviolet A therapy, intralesional corticosteroids or interferon, and radiotherapy. In contrast, multisystem disease typically requires systemic chemotherapy, with first-line agents including vinblastine or etoposide. Refractory or relapsed cases may necessitate combination chemotherapy regimens.

Conclusion: This case highlights the importance of reconsidering the diagnosis in patients with chronic, non-healing ulcers that fail to respond to standard treatments. A thorough diagnostic workup —including histopathological evaluation and advanced imaging —is essential to exclude alternative etiologies, alternative causes such as inflammatory, infectious, metabolic, or neoplastic conditions. Recognizing LCH as a potential underlying cause of genital ulcers is critical for achieving a timely diagnosis and implementing appropriate therapeutic interventions.

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Abstract N°: 7242

Pyostomatitis vegetans: a rare manifestation of ulcerative colitis

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Pyostomatitis vegetans: a rare manifestation of ulcerative colitis

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Introduction & Objectives:

Pyostomatitis vegetans (PV) is a rare dermatological condition usually classified as a neutophilic dermatosis. It is associated with chronic inflammatory bowel disease (IBD) in 75 percent of cases. Its diagnosis is often unrecognized due to its atypical presentation, which delays its management.

We report the case of a patient with ulcerative colitis presenting this association; that aims to clarify the clinical, histolopathological characterisctics of PV and explore its role in the broader spectrum of chronic inflammatory bowel disease manifestations.

Materials & Methods:

A 31-year-old woman treated for hemorrhagic rectocolitis for 1 year and treated with salazopyrine 1g *3 /d for 1 week, presented with lesions of the oral mucosa that had been evolving for 4 days. Examination revealed linear fibrinous erosions covered with a whitish exudate mimicking “snail tracks” of the gums, hard palate and mucosal sides of the lips;

Biopsies showed an abundant intraepithelial infiltrate of neutrophils with microabscesses, with no signs of malignancy. Direct immunofluorescence was negative, and mycological samples were sterile. The overall picture was consistent with Pyostomatitis Vegetans. Digestive exploration by rectosigmoidoscopy was in favor of relapsing UC. Oral corticosteroid therapy at a dosage of 1mg/kg/d was instituted, along with symptomatic measures based on ABX solution.

Results:

The evolution was favorable, with regression of lesions one week later.

Conclusion:

Although rare, vegetative pyostomatitis is a specific mucosal manifestation with high diagnostic value. The diagnosis should be made in the presence of a characteristic clinical presentation in the context of chronic inflammatory bowel disease. Close collaboration between dermatologists, gastroenterologists and pathologists is essential for early diagnosis and effective management, thus improving the patient’s prognosis.

Abstract N°: 7298

When genital ulceration mimics carcinoma : An unusual presentation of Behçet's Disease

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Introduction & Objectives: Behçet's disease is a rare systemic vasculitis of unknown etiology, characterized by mucocutaneous, ocular, articular, neurological, and/or gastrointestinal involvement. Genital ulcers are a major diagnostic criterion. When they present as large ulcers or extensive tissue loss, they can mimic other pathologies, complicating and delaying the diagnosis.

Materials & Methods: We report the case of a 39-year-old married woman, primigravida and primiparous, followed for psychiatric disorders, admitted for a destructive tissue loss of the left labia majora associated with a painful giant ulcer (3 cm in diameter) located in the perineal region at 12:35 on the vulvar clock face. The lesion had been evolving for four months despite various topical treatments. Examination revealed no leucorrhea, bleeding, or digestive symptoms. Hypopigmented scars, including one measuring 2 cm, suggested prior ulcerations. History revealed occasional oral aphthae and recurrent genital ulcers for the past eight years, resolving spontaneously. A first biopsy in 2021 was non-specific. Due to persistent lesions, a second biopsy was performed and showed a leukocytoclastic vasculitis consistent with Behçet's disease. Viral serologies (Human Immunodeficiency Virus, Epstein-Barr Virus, Cytomegalovirus, Hepatitis B Virus, Hepatitis C Virus) and syphilis screening (Treponema pallidum hemagglutination assay–Venereal Disease Research Laboratory test) were negative. No ophthalmological, articular, neurological, or digestive involvement was found.

Results: The main differential diagnoses included squamous cell carcinoma, Crohn's disease, and pyoderma gangrenosum. Histology ruled out neoplasia. The absence of gastrointestinal symptoms and non-granulomatous histology excluded Crohn's disease. Pyoderma gangrenosum was deemed unlikely due to the chronicity of the genital aphthosis. A pathergy test was performed and returned positive—an important diagnostic element. Additionally, the patient reported a family history of Behçet's disease; her brother had been diagnosed previously. These findings reinforced clinical suspicion. The vascular histology, history of recurrent oral and genital ulcers, and absence of infectious causes support a diagnosis of Behçet's disease according to the International Criteria for Behçet's Disease.

Conclusion: This case illustrates an atypical presentation of Behçet's disease, revealed by vulvar tissue loss and a painful giant ulcer. It highlights the importance of a thorough diagnostic approach based on medical history, clinical examination, histology, exclusion of differential diagnoses, and specific tests such as the pathergy test, to enable early and appropriate management.

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Abstract N°: 7343

A Rare Case of Lucio's Phenomenon in Western Canada

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Introduction & Objectives:

Leprosy, despite being declared "eliminated" by the World Health Organization in 2000, remains a significant health challenge in endemic regions. Global reports show over 200,000 new cases since 2017, with India, Brazil, and Indonesia accounting for the majority. Lucio's phenomenon, a rare vascular necrotic reaction associated with lepromatous leprosy, is particularly challenging to diagnose, especially in non-endemic regions. This case report discusses a rare instance of Lucio's phenomenon in Canada.

Materials & Methods:

A retrospective review of a single adult case was conducted, including clinical history, physical examination findings, diagnostic workup, treatment course, and outcomes. Diagnostic methods included histopathology, Fite staining, direct immunofluorescence, and polymerase chain reaction (PCR) for species identification. Multidisciplinary input from dermatology, infectious diseases, and rheumatology was incorporated. Therapeutic interventions and clinical responses were documented over a 24-month period.

Results:

A 77-year-old South Asian male presented with widespread retiform purpura, ulcerations, and necrosis on the limbs. He had a significant travel history to India and a medical background including hypothyroidism and stroke. Initial laboratory tests revealed positive autoimmune markers, including antinuclear antibody, anti-Jo1 antibody, rheumatoid factor and pANCA (MPO-positive). A skin biopsy showed granulomatous dermatitis with acid-fast bacilli, and PCR testing confirmed Mycobacterium leprae. The positive rheumatological markers suggested a potential diagnosis of ANCA-vasculitis but ultimately, the diagnosis of lepromatous leprosy with Lucio's phenomenon was made. The patient was treated with a 24-month multi-drug therapy regimen, including clofazimine, rifampin, dapsone, and prednisone. Significant improvement was observed, with no new symptoms or lesions.

Conclusion:

Leprosy remains a significant health challenge in endemic regions and is still observed in non-endemic areas. This case report highlights a rare instance of lepromatous leprosy with Lucio's phenomenon in Canada. In conjunction with Infectious Diseases and a positive PCR result for Mycobacterium leprae, we were able to arrive at the correct diagnosis. However, mycobacterial infections, such as leprosy, can present with clinical signs and laboratory findings suggestive of autoimmune rheumatologic diseases, posing significant diagnostic challenges.The infection was likely misdiagnosed multiple times due to the rarity of leprosy in non-endemic regions, demonstrating the critical role of a multidisciplinary approach in the accurate diagnosis and treatment of this infection.

Abstract N°: 7433

Treatment of Xanthelasma Palpebrarum Using Trichloroacetic Acid 80%

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Introduction & Objectives:

We sought to analyze the effectiveness, recurrence, safety, and patient satisfaction rates following xanthelasma palpebrarum (XP) treatment with trichloroacetic acid (TCA) 80%. Although TCA is a commonly used treatment option, the studies investigating TCA application had small sample sizes, used varying concentrations, or had short follow-up times.

Materials & Methods:

This was a retrospective review of patients treated with TCA 80% for XP between January 2012 and August 2022. A prospective telephone questionnaire was administered to the same patient population to evaluate recurrence, patient satisfaction, and side effects.

Results:

In total, 77 patients were included in this retrospective review. Most patients received one treatment (n=38; 49.4%) and had XP located bilaterally (n=59; 76.6%) on either the lower eyelids only (n=18; 23.4%) or both the upper and lower eyelids (n=18; 23.4%). Following treatment, 94.2 percent (n=49) of patients expressed satisfaction and 97.2 percent (n=70) displayed a clinician-reported improvement in XP. In the prospective patient questionnaire, the reoccurrence of XP was self-reported in 24.7 percent (n=19) of all patients. The adverse events, reported by the clinician during the retrospective review and the patient during the prospective questionnaire, included erythema (n=2; 2.6%), hyperpigmentation (n=4; 5.2%), hypopigmentation (n=3; 3.9%), and scarring (n=2; 2.6%).

Conclusion:

XP has a strong likelihood of recurrence. TCA 80% as a treatment exhibited a high degree of patient satisfaction that was sustained long-term compared to other TCA concentrations. The patients perceived nominal side effects, minimal invasiveness, and reduced risk of further cosmetic disfiguration. TCA 80% for XP management should be considered as a treatment option due to high patient satisfaction, mild side effects, low cost, and long-term cosmetic results.

Abstract N°: 7505

Inflammatory plaques on the arms and back as a diagnostic clue in refractory autoimmune encephalitis.

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Introduction & Objectives:

Systemic lupus erythematosus (SLE) is a systemic autoimmune disease that can affect multiple organs throughout the human body, with lupus encephalitis representing one of its most severe complications.SLE may manifest with specific lesions characteristic of cutaneous lupus erythematosus, but it has also been associated with nonspecific lesions such as reactive granulomatous dermatitis, which may also occur in other systemic inflammatory diseases.

Materials & Methods:

We present a clinical case in which the histopathological evaluation of cutaneous lesions consistent with interstitial granulomatous dermatitis and cutaneous lupus erythematosus enabled the diagnosis of SLE as the underlying cause of refractory autoimmune encephalitis.

Results:

A 39-year-old woman with no significant past medical history developed a clinical presentation characterized by cutaneous lesions, fever, myalgias, and muscle weakness. Initially, the lesions responded well to systemic corticosteroids; however, they recurred, this time accompanied by neurological symptoms including disorientation and cognitive decline, with a fulminant progression to generalized tonic-clonic status epilepticus requiring admission to the intensive care unit for two months. After excluding other differential diagnoses, autoimmune encephalitis was suspected. Laboratory tests revealed positive antinuclear antibodies (ANA) at a titer of 1:640, while the remaining autoimmune panel—including anti-dsDNA antibodies and a comprehensive panel for autoimmune encephalitis—was negative. Hematological, biochemical, and microbiological studies were unremarkable. Given the suspected diagnosis, high-dose intravenous methylprednisolone, immunoglobulins, and rituximab were administered, alongside combination antiepileptic therapy. Cyclophosphamide was subsequently introduced, leading to acceptable control of the neurological symptoms. The patient was later referred to outpatient dermatology for persistent erythematous inflammatory plaques on the arms and back. Skin biopsy revealed vacuolar alteration of the basal layer of the epidermis with occasional necrotic keratinocytes at the dermoepidermal junction and melanophages in the papillary dermis. A dermal inflammatory infiltrate was observed with perivascular and periappendageal distribution, predominantly composed of plasmacytoid dendritic cells and interstitial mucin. Additionally, aggregates of histiocytes surrounding collagen bundles were identified in the dermis. Direct immunofluorescence testing was negative. A diagnosis of cutaneous lupus erythematosus and interstitial granulomatous dermatitis was established, confirming SLE as the underlying cause of autoimmune encephalitis. Hydroxychloroquine 200 mg daily was added to the ongoing cyclophosphamide treatment, resulting in complete resolution of the cutaneous manifestations and no recurrence of neurological symptoms. The patient is currently not receiving any anticonvulsant therapy.

Conclusion:

Interstitial granulomatous dermatitis is a reactive granulomatous dermatosis associated with various systemic diseases, including systemic lupus erythematosus (SLE). The histopathological evaluation of cutaneous lesions in patients with suspected SLE can be highly valuable and may, in certain cases, facilitate a definitive diagnosis.

Abstract N°: 7616

Urticaria-like vasculitis in drug-induced antineutrophil cytoplasmic antibody (ANCA)-positive vasculitis and lupus-like syndrome

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Introduction & Objectives:

Idiopathic and drug-induced autoimmune diseases can be very similar. We compared clinical and serological profile of patients with idiopathic antineutrophil cytoplasmic antibody (ANCA)-vasculitis (IAV) with antithyroid drug (ATD)-induced ANCA-positive patients.

Materials & Methods:

We compared clinical and serological features of 56 patients with IAV (29 granulomatosis with polyangiitis - GPA, 23 microscopic polyangiitis and 4 eosinophilic granulomatosis with polyangiitis - EGPA) with 17 ANCA-positive patients receiving ATD (13 propylthiouracil and 4 methimazole), diagnosed and treated from 2005 to 2024. We determined antinuclear antibodies (ANA) by IIF; ANCA profile (MPO, PR3, lactoferrin, CTG, elastase, bactericidal/permeability-increasing protein), anticardiolipin antibodies (aCL) by ELISA, and cryoglobulins by precipitation. C3 and C4 were measured by nephelometry.

Results:

Of 17 ATD-treated patients, 4 had drug-induced ANCA vasculitis (3 MPA and one GPA), while 12 had lupus-like disease (LLD). ATD-induced ANCA-positive patients more frequently had cutaneous manifestations (11/17) than ISV (14/56) ($p<0.01$), but less frequently had arthritis, renal and neurological manifestations ($p<0.01$). 7/17 patients with ATD-induced disease had urticaria-like vasculitis ($p<0.01$) and 6/17 had purpura ($p<0.01$). ATD-induced LLS patients more frequently had polyspecific ANCA (anti-MPO, anti-elastase and anti-PR3 were most commonly detected) ($p<0.01$). We have found association between decreased C4, presence of ANA, aCL and cryoglobulins with urticaria-like vasculitis in patients with ATD-induced LLS. Idiopathic ANCA-positive vasculitis patients had a more severe course in comparison with ATD-induced ANCA-positive diseases.

Conclusion:

Different serological profiles can help in the differential diagnosis and adequate therapeutic approach to ANCA-positive ATD-treated patients with symptoms of systemic disease. Urticaria-like vasculitis associated with polyspecific ANCA, ANA, low complement and cryoglobulins are useful markers in the differential diagnosis between IAV and ATD-induced LLS.

Abstract N°: 7625

A rare case of NXP-2 Dermatomyositis with respiratory manifestations in an adult

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Introduction & Objectives:

Dermatomyositis is an idiopathic inflammatory myopathy characterised by a spectrum of cutaneous manifestations and could be associated with muscle weakness and potential internal organ involvement. Various autoantibodies are associated with specific clinical phenotypes. Among these, anti-NXP-2 autoantibodies are rare in adults.

We report a case of dermatomyositis with positive anti-NXP-2 antibodies and interstitial lung disease.

Materials & Methods:

A 51-year-old female presented to the medical team with peri-ocular swelling and a progressive rash over the extensor surface of the arms. She had associated pain and swelling of the small joints in her hands. She denied any systemic symptoms at this time. Her past medical history included poorly controlled Type 1 Diabetes, pernicious anaemia and a previous DVT. Clinical examination revealed mild swelling of the eyelid and thickening of the flexor tendons in the hands. She was treated initially for suspected psoriatic arthritis with oral steroids under Rheumatology based on ultrasound findings of active inflammation in the hands and wrists. Symptoms improved with oral steroids, although this presented the challenge of hyperglycaemia in the context of poorly controlled diabetes requiring monitoring by the Diabetes team. She later presented due to bilateral lower limb swelling with tenderness and progressive skin changes on reduced doses of steroids prompting dermatological review. On examination she had erythematous scaly papules and plaques affecting the periocular area, upper chest, extensor aspect of both forearms, dorsum of both hands including fingers and the lateral aspect of both thighs and knees. She also had evidence of jagged cuticles, dilated looped capillaries on dermoscopy and erythematous scaly plaques affecting the palmar aspect of both hands. She revealed recent-onset exertional shortness of breath and later developed proximal muscle weakness.

Results:

Laboratory tests showed positive anti-nuclear antibody (1/640). Creatinine Kinase was normal at 33 U/L. Extended myositis panel revealed positive antibodies. MRI of the lower leg showed no evidence of myositis however CT chest abdomen pelvis to rule out malignancy demonstrated features consistent with an organising pneumonia pattern of interstitial lung disease. Considering the CT findings, she was referred to Respiratory and the diagnosis of anti-NXP-2 dermatomyositis related interstitial lung disease was concluded. Mycophenolate was initiated as a steroid-sparing agent and her treatment response is under review with a plan to consider Rituximab if this treatment fails.

Conclusion:

This case illustrates a rare presentation of anti-NXP-2 positive dermatomyositis in an adult, complicated by interstitial lung disease. Anti-NXP-2 antibody positivity is uncommon in adult's with dermatomyositis, and is associated with a distinct phenotype characterised by muscle weakness, dysphagia, subcutaneous oedema and increased risk of malignancy. This case highlights the importance of accurate serological testing and

multidisciplinary evaluation which is essential to prevent delays in diagnosis and management of this rare dermatomyositis subtype.

Abstract N°: 7716

"A Tangled Web of Skin and System: Kyrle's Disease in the Dialysis Patient"

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Introduction & Objectives: Kyrle's disease (KD), first described as hyperkeratosis follicularis et parafollicularis in cutem penetrans, is a rare acquired perforating dermatosis, most commonly observed in patients with systemic conditions such as advanced chronic kidney disease, diabetes mellitus, liver dysfunction, congestive heart failure, and disorders of vitamin A metabolism. Characterized by transepithelial elimination of keratotic material, KD presents with intensely pruritic, hyperkeratotic papules or nodules featuring central plugs.

Materials & Methods: We report the case of a 58-year-old male with advanced chronic kidney disease on long-term hemodialysis and multiple associated comorbidities, referred to dermatology for evaluation and management of persistent, pruritic skin lesions.

Results: The patient, with a known history of stage G5 chronic kidney disease on hemodialysis since 2006, as well as essential hypertension (grade III), NYHA class II heart failure, and chronic hepatitis C, was referred to our clinic for evaluation of long-standing, pruritic dermatoses. The skin condition had begun insidiously in 2018, initially involving the lower legs and demonstrating periods of partial remission. Over time, the lesions recurred and gradually extended to the torso, upper limbs, face, and scapular regions, with the patient reporting minimal relief from previously attempted topical therapies. Chronic pruritus had a considerable impact on his quality of life, especially given the burden of his comorbid conditions. Clinical examination revealed multiple discrete and confluent hyperpigmented, dome-shaped papules and nodules with central keratotic plugs, characteristic of KD. These were widely distributed across the trunk, extremities, face, and scapular areas. Many lesions were excoriated and lichenified due to chronic scratching. Marked onychodystrophy was also observed, including nail pitting, longitudinal ridging, onycholysis, and nail fragility. A comprehensive dermatological and laboratory evaluation was performed, including skin biopsy, whose findings were consistent with KD. Due to the refractory and extensive nature of the dermatosis, treatment involved high-potency keratolytic emollients (urea-based), narrowband UVB phototherapy sessions, and systemic therapies for the patient's comorbid conditions. This multidisciplinary approach resulted in partial clinical improvement, with a noticeable reduction in pruritus, stabilization of lesion progression, and absence of secondary infection.

Conclusion: KD represents more than a dermatologic curiosity—it is a visible manifestation of deep systemic dysregulation. Its occurrence in dialysis-dependent patients demands vigilance and a holistic view of the patient's health landscape. This case underscores the importance of early dermatologic referral in patients with end-stage renal failure presenting with pruritic eruptions, not only for diagnosis but also for the initiation of tailored, symptom-relieving therapies. Beyond its clinical complexity, this case underscores the value of interdisciplinary collaboration—uniting dermatology, nephrology, and internal medicine—to manage the delicate therapeutic balance required by patients with overlapping chronic pathologies. While a definitive cure may be elusive, coordinated care can yield meaningful improvements in symptom control, lesion stability, and overall patient quality of life.

Abstract N°: 7803

When Eczema Turns Out to Be Myopathy: The Unexpected Diagnosis of Explosive Dermatomyositis with CPK Levels above 20,000 UI/L in a young adult woman

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Introduction & Objectives:

Dermatomyositis (DM) is a rare autoimmune inflammatory myopathy, with clinical heterogeneity that makes diagnosis particularly challenging, especially in the absence of clear muscle manifestations from the onset. In young adults, forms initially presenting with cutaneous or atypical extradermatologic manifestations are prone to significant diagnostic delay. We report the remarkable case of a 22-year-old patient whose DM presented insidiously, with an initially misleading cutaneous involvement, followed by a dramatic increase in CPK (> 20,000 UI/L), highlighting the importance of early detection despite an incomplete presentation.

Materials & Methods:

A 23-year-old woman with no significant medical history initially consulted for pruritic eyelid erythema, mistakenly diagnosed as eczema, and treated for several months without improvement. Later, she presented with digestive symptoms, and biological tests revealed acute hepatic cytolysis (ASAT: 742 UI/L; ALAT: 308 UI/L), with no obvious infectious or toxic cause and no abnormality on ultrasound. The evolution was marked three weeks later by the appearance of facial edema, photosensitivity, arthralgia, and rapidly progressive proximal muscle weakness, leading to specialized exploration. A complete dermatological examination, capillaroscopy, and further biological, immunological, electromyographic, and muscular histological investigations were performed.

Results:

Dermatological examination revealed heliotrope erythema, Gottron's papules, flagellate erythema of the trunk, the manicure sign and late-stage scleroform changes on capillaroscopy, without Raynaud's phenomenon. The biological work-up revealed a massive increase in CPK to 20,940 UI/L (x125 the normal), accompanied by elevated aldolases (124 U/L). Immunological testing showed positive anti-Mi-2a antibodies (typically associated with a good prognosis) and anti-SAE1 antibodies (often linked to extensive cutaneous involvement), a rare mixed profile. EMG was suggestive of active myopathy, and muscle biopsy confirmed inflammatory myositis. The paraneoplastic screening was strictly normal. The patient was treated with prednisone (1 mg/kg/day), weekly methotrexate (12.5 mg), supplementation, and rehydration. Evolution was marked by rapid improvement of symptoms, muscle recovery, and complete normalization of enzymes within one month.

Conclusion:

This case illustrates dermatomyositis in a young adult with an initially misleading presentation, marked by isolated cutaneous involvement followed by a digestive syndrome. The progression to severe muscular involvement, with an unusually high elevation of CPK above 20,000 UI/L, constitutes an atypical feature outside of pure necrotizing forms. The presence of anti-Mi-2a and anti-SAE1 antibodies supports the hypothesis of a mixed phenotype. Hepatic cytolysis, although non-specific, could reflect either active myopathy or an immune-mediated hepatic involvement, as sometimes described. Thus, this case underscores the importance of high vigilance in the face of partial clinical presentations, particularly in young adults, in order to initiate early treatment and prevent severe functional complications.

Abstract N°: 7865

Eruptive Bullous Porokeratosis in a Patient with Complex Autoimmuneand Metabolic Comorbidities: A Rare Case Presentation

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Introduction & Objectives: Bullous porokeratosis (BPK), a rare clinical variant of porokeratosis, poses diagnostic challenges due to its mimicry of autoimmune blistering disorders. We report a novel case of eruptive BPK in a patient with multi-system comorbidities, underscoring the interplay of immune dysregulation and metabolic factors in its pathogenesis.

Case presentation: A 59-year-old woman with SLE, Hodgkin lymphoma (in remission), T2DM, and hypertension developed recurrent bullous eruptions. Initial arm lesions resolved with superpotent topical corticosteroids but recurred 7 months later, disseminating to the torso and limbs. Examination revealed non-pruritic, non-tense bullae (≤1.5 cm) and hydroxychloroquine-associated hyperpigmented patches. Histopathology demonstrated cornoid lamella and subepidermal blistering, confirming BPK.

Discussion: This case expands BPK's clinical spectrum, presenting without peripheral edema—a previously reported hallmark. Immunologic dysregulation (SLE, lymphoma) and metabolic dysfunction (T2DM) may drive atypical manifestations. Histopathology remains critical to distinguish BPK from autoimmune blistering diseases. The partial response to corticosteroids highlights therapeutic challenges in comorbid patients, necessitating alternative strategies.

Conclusion: We present a rare eruptive BPK in an immunocompromised host, emphasizing histopathology's role in diagnosing atypical bullous eruptions. Further research is needed to elucidate triggers and optimize management in complex cases.

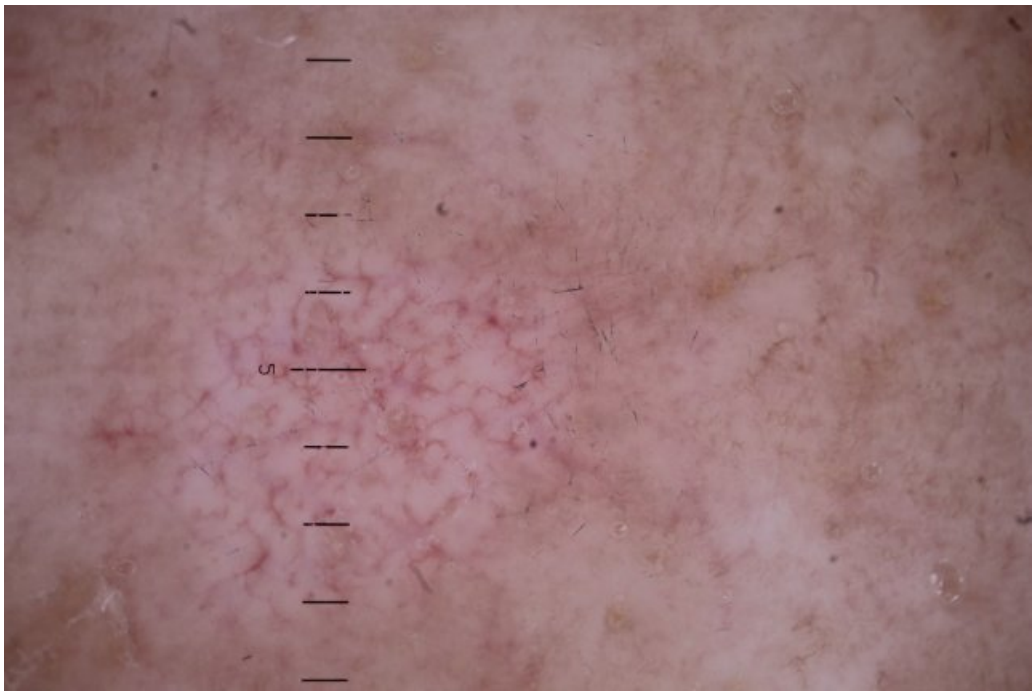
Hyperpigmentation is consistent with hydroxychloroquine-associated skin changes. This case broadens the spectrum of bullous porokeratosis presentations and emphasizes the need for histological confirmation in atypical bullous eruptions.

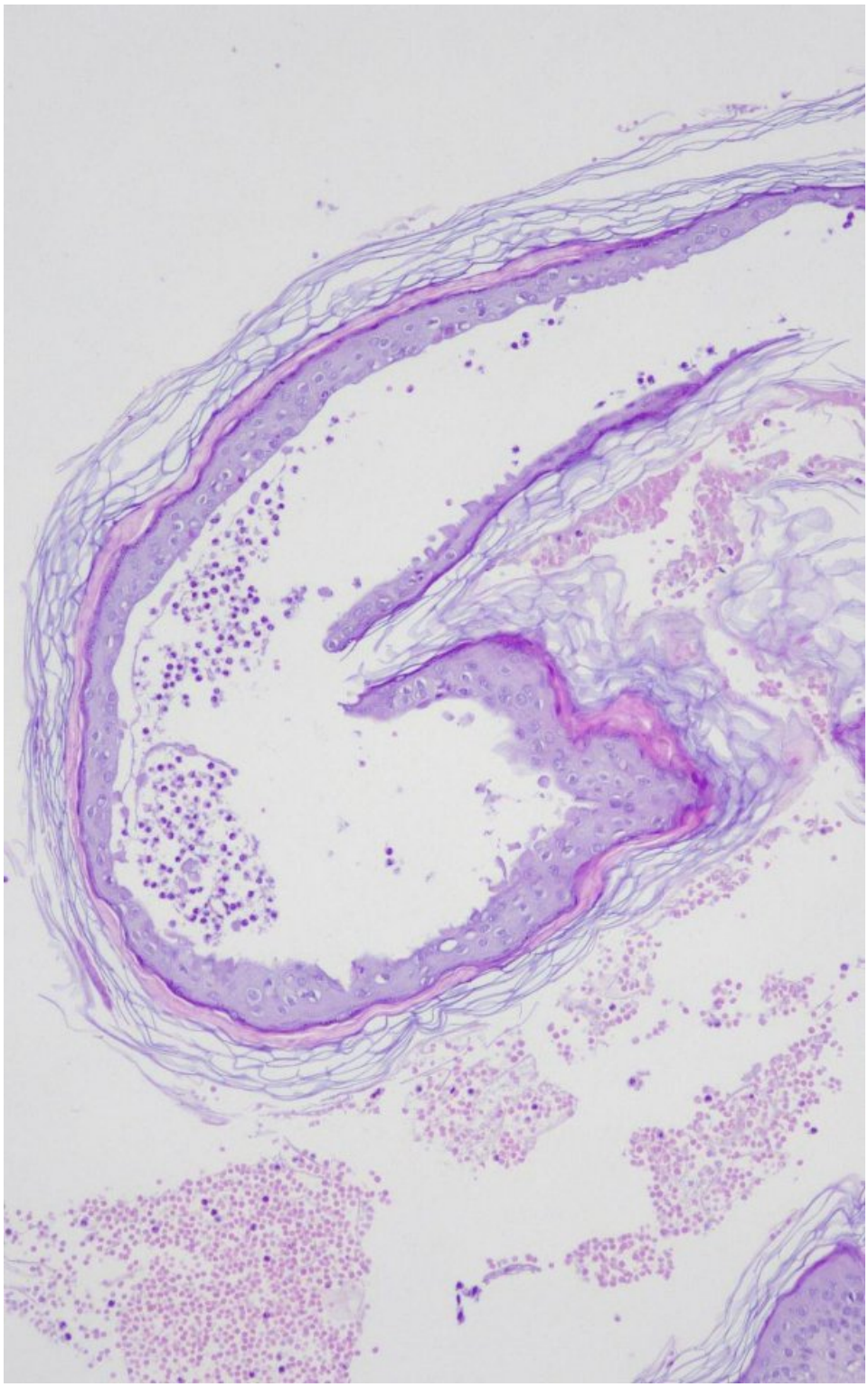
References

1. Shoimer I, et al. Eruptive disseminated porokeratosis: a new classification system. J Am Acad Dermatol. 2014.

2. Ellis M, et al. A Rare Case of Bullous Eruptive Disseminated Porokeratosis. Henry Ford Health System. 2019.

3. Jallouli M, et al. Hydroxychloroquine-induced hyperpigmentation in SLE. Int J Dermatol. 2012.





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Abstract N°: 7975

Inflammatory Bowel Disease as a Cutaneous Carcinogenic Amplifier: An Analysis of Gut-Skin Axis Dysregulation and Immune-Mediated Oncogenesis in Cutaneous Squamous Cell Carcinoma

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Introduction & Objectives:

Cutaneous squamous cell carcinoma (cSCC) is a malignant neoplasm of keratinizing epidermal cells arising from the squamous layer of the epidermis. Immunosuppression, chronic skin inflammation, arsenic exposure, and ultraviolet radiation are major risk factors for cSCC, which most often develops on the face, scalp, ears, and dorsum of the hands. Chronic inflammation—mediated by dysregulated cytokines such as TNF-α, IL-6, and IFN-γ—promotes oxidative stress, DNA damage, and tumorigenesis. We sought to quantify the association between inflammatory bowel disease (IBD) and cSCC, test the hypothesis that systemic gut inflammation and its treatments amplify cutaneous carcinogenesis, and highlight implications for interdisciplinary surveillance.

Materials & Methods:

In this retrospective case-control study using the NIH All of Us Research Program database, we identified individuals with cSCC (SNOMED 254651007 or ICD-10 C44.92) and matched them 1:4 to controls via nearest-neighbor propensity-score matching on sex, age, race/ethnicity, income, education, and smoking status. Participants with missing data were excluded. Univariate and multivariate logistic-regression models calculated odds ratios (ORs) and 95% confidence intervals (CIs) for celiac disease, Crohn's disease, irritable bowel syndrome (IBS), and ulcerative colitis (UC). Fisher's exact test and unpaired t-test compared categorical and continuous variables, respectively. Statistical significance was set at $P < 0.05$.

Results:

We included 3,755 cSCC cases (mean age 75.8 years; 90.8% White; 48.6% annual income ≥ 50 000 USD; 63.1% college graduates) and 15,020 matched controls. In univariate analyses, celiac disease (OR 2.06; CI 1.45–2.92), Crohn's disease (OR 2.17; CI 1.70–2.77), IBS (OR 1.76; CI 1.54–2.00), and UC (OR 2.26; CI 1.76–2.90) were each significantly associated with cSCC (all $P < 0.01$). After adjustment for covariates, associations remained: celiac disease (OR 1.60; CI 1.13–2.23), Crohn's disease (OR 2.25; CI 1.75–2.88), IBS (OR 1.43; CI 1.26–1.63), and UC (OR 1.99; CI 1.55–2.53) (all $P < 0.01$).

Conclusion:

IBD and related disorders confer a two-fold increased risk of cSCC, supporting a model in which chronic gut inflammation, thiopurine-derived photosensitization, and TNF-α inhibition potentiate cutaneous carcinogenesis. These findings underscore the need for dermatology–gastroenterology collaboration to develop tailored skin-cancer surveillance and to investigate alternative IBD therapies that mitigate SCC risk.

Abstract N°: 7983

Unmasking Pellagra: The Combined Role of Malabsorption and Isoniazid Therapy

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Introduction & Objectives:

Pellagra is a rare but potentially fatal nutritional disorder caused by niacin (vitamin B3) deficiency, classically presenting with dermatitis, diarrhea, and dementia. While uncommon in developed countries, secondary forms of pellagra may occur due to malabsorption or drug-induced interference with niacin metabolism. Isoniazid, an anti-tuberculosis agent, is known to inhibit niacin absorption and conversion from tryptophan. Here, we present a case of pellagra in a patient with prior ileal resection, where isoniazid treatment likely exacerbated the underlying malabsorption and unmasked the deficiency. The aim of this report is to highlight a rare but significant adverse effect of isoniazid and to underline the importance of clinical recognition.

Materials & Methods:

A 48-year-old male with a history of rheumatoid arthritis, dilated cardiomyopathy, and ileal resection presented with scaly, erythematous rashes over photoexposed areas, along with chronic diarrhea and memory impairment. The patient had lost approximately 20 kg post-resection. One year prior, he had received isoniazid and rifampin for suspected joint tuberculosis following olecranon bursitis surgery. Dermatological examination revealed sharply demarcated erythematous plaques on the face, neck, and hands. Laboratory investigations showed normocytic anemia and ANA positivity (1:100), with normal renal, hepatic, and metabolic workup. Skin biopsy was consistent with pellagra. Based on clinical features and history, niacin deficiency was suspected, and oral niacin therapy was initiated at 300 mg/day.

Results:

Marked clinical improvement was observed within five days of niacin treatment, supporting the diagnosis of pellagra. Neuropsychiatric symptoms improved in parallel. No recurrence was noted after the continuation of nicotinamide and supportive therapy, including dietary optimization and vitamin supplementation. This rapid response confirmed the diagnosis of drug-exacerbated pellagra secondary to malabsorption.

Conclusion:

Pellagra should be considered in patients presenting with photo-distributed rash and neuro-gastrointestinal symptoms, especially in the context of malabsorption or isoniazid exposure. Early recognition and treatment are critical to avoid irreversible complications. This case illustrates the diagnostic value of a detailed history and highlights the potential for common medications to unmask underlying nutritional deficiencies.

Abstract N°: 8032

Bowel-Associated Dermatosis-Arthritis Syndrome (BADAS) Following Bariatric Surgery: A Diagnostic Challenge in the Era of Obesity

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Introduction & Objectives:

Obesity, often termed the "21st-century epidemic," has led to a surge in bariatric surgeries worldwide. While these procedures offer significant benefits, they can also result in rare complications. Bowel-Associated Dermatosis-Arthritis Syndrome (BADAS) is a neutrophilic dermatosis characterized by flu-like symptoms, arthritis, and distinctive skin lesions. Initially linked exclusively to bariatric surgery, BADAS is now recognized in various gastrointestinal conditions.

Materials & Methods:

We report a 54-year-old male who developed symmetric polyarthritis one year post-bilio-intestinal bypass surgery. Initially diagnosed with psoriatic arthritis, he was treated with methotrexate and golimumab. Subsequently, he presented with flu-like symptoms and papulopustular lesions on his forearms, armpits, abdomen, and thighs. Histological examination revealed papillary dermal edema with dense, perivascular neutrophilic infiltration confined to the upper dermis. A diagnosis of BADAS was established. Treatment with cyclic tetracycline provided temporary relief, with skin lesions subsiding slowly over several years.

Results:

BADAS remains underrecognized, often misdiagnosed due to its overlapping features with other dermatological conditions like hidradenitis suppurativa and psoriasis. The pathogenesis is believed to involve bacterial overgrowth in the bypassed intestinal segment, leading to immune complex formation and complement activation. This case underscores the importance of considering BADAS in patients presenting with compatible symptoms post-bariatric surgery.

Conclusion:

As obesity rates continue to climb, leading to increased bariatric interventions, clinicians must remain vigilant for rare complications like BADAS. Early recognition and appropriate management are crucial to prevent prolonged morbidity.

Abstract N°: 8086

Cutaneous lupus erythematosus: a detailed clinical, immunological and therapeutic review of a series of 151 cases

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Introduction & Objectives:

Lupus erythematosus (LE) is a multifactorial autoimmune disease, with cutaneous manifestations in up to 85% of cases. These dermatological signs are diverse and often precede systemic involvement. Early recognition is crucial for guiding treatment and preventing complications. The objective of this study is to describe the clinical, immunological, and therapeutic characteristics of patients with cutaneous lupus erythematosus (CLE), and to assess the risk of systemic progression.

Materials & Methods:

We conducted a retrospective study over seven years (January 2018 to March 2025), including all patients diagnosed with cutaneous lupus erythematosus (CLE) in a dermatology department. CLE subtypes were defined based on clinical and histopathological findings. Data collected included age, sex, CLE subtype, immunological profile, systemic involvement, treatments received, and clinical outcomes. Systemic lupus erythematosus (SLE) was diagnosed according to the 2019 ACR/EULAR criteria.

Results:

Over a seven-year period (January 2018 to March 2025), we conducted a retrospective study of 151 patients diagnosed with cutaneous lupus erythematosus (CLE). Patient age ranged from 5 to 76 years (mean age of 44.3 years), and a female predominance of 89.1%. Based on a comparative analysis of clinical features and histopathological findings, the identified CLE subtypes included chronic CLE (CCLE) (66.9%), subacute CLE (SCLE) (15.2%), and acute CLE (ACLE) (9.3%). Less frequent forms included lupus panniculitis (4.6%), lupus tumidus (2.0%), and bullous lupus erythematosus (1.3%). A unique case combining lupus tumidus with panniculitis was also observed (0.7%), an association rarely reported in the literature and underscoring the clinical polymorphism of CLE.

Systemic lupus erythematosus (SLE) was diagnosed in 26.2%. Among these, progression to SLE occurred in 18.8% of chronic CLE and 71.4% of acute CLE cases. Laboratory abnormalities included ESR/CRP dissociation in 28.7%, hematologic involvement in 7.9%, and positive proteinuria in 4.1%. ANA positivity was observed in 39.3% of patients and anti-dsDNA antibodies in 29.3%. Signs suggestive of thrombotic vasculopathy were found in 2% of cases, linked to severe systemic involvement.

All patients received photoprotection and antimalarials as first-line treatment. Localized lesions were treated with topical corticosteroids, and in refractory cases, calcineurin inhibitors were used instead. Oral corticosteroids were prescribed for systemic disease, with immunosuppressants added in refractory or renal forms. Complete remission of skin lesions was achieved in 59% of cases.

Conclusion:

CLE exhibits significant clinical heterogeneity and variable risk of systemic progression, particularly in ACLE. Early

identification of high-risk profiles—such as positive anti-dsDNA, hematologic or renal involvement, and thrombotic vasculopathy—is essential. Individualized treatment based on severity and systemic involvement improves long-term outcomes.

Abstract N°: 8317

An Unusual Case of Antisynthetase Syndrome in a Lupus Patient: A Diagnostic Trap with Dermatomyositis-Like Presentation

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Introduction & Objectives:

Antisynthetase syndrome (ASS) is a rare autoimmune entity within the spectrum of idiopathic inflammatory myopathies, defined by the presence of anti-aminoacyl-tRNA synthetase antibodies—most commonly anti-Jo1. While typically associated with a clinical triad (myositis, polyarthritis, interstitial lung disease), its presentation may be incomplete or overlap with other connective tissue diseases. The overlap between ASS and systemic lupus erythematosus (SLE) is exceedingly rare and poses a major diagnostic challenge. We report a unique case of antisynthetase syndrome revealed in a patient with pre-existing lupus, initially suspected of having dermatomyositis, highlighting the diagnostic complexity of inflammatory myopathies within the context of established connective tissue disease.

Materials & Methods:

A 40-year-old woman with a history of systemic lupus erythematosus (SLE) since 2012 under corticosteroid therapy, complicated by steroid-induced osteoporosis and diabetes, was hospitalized in 2024 for suspected mixed connective tissue disease. Her symptoms began several months prior with facial edema, arthralgia, myalgia, and a painful parotid nodule. Clinical examination revealed malar erythema, facial swelling, violaceous eyelid rash, periungual erythema with positive “manicure sign”, multiple scarring alopecia plaques, proximal muscle weakness (shoulder girdle), and tender cervical nodules. Given the dermatomyositis-like presentation, an extensive diagnostic work-up combining labs, imaging, EMG, and muscle biopsy was initiated.

Results:

Investigations showed moderate elevation of CPK (560 IU/L), a myogenic pattern on EMG, and nonspecific inflammatory myopathy on muscle biopsy. Dermatomyositis-specific antibodies (Mi-2, TIF1γ, MDA5…) were negative, while anti-Jo1 and anti-Ro52 antibodies were strongly positive. Thoracic CT revealed ground-glass opacities and consolidations consistent with cryptogenic organizing pneumonia. Cervical lymph node biopsy revealed caseating necrosis without evidence of active tuberculosis. The diagnosis of antisynthetase syndrome was established based on the triad of confirmed myositis (clinical, EMG, histological), interstitial lung disease, and strong anti-Jo1/Ro52 antibody positivity. The pre-existing lupus context initially led to a misdiagnosis of dermatomyositis within a mixed connective tissue disease. The patient was treated with high-dose corticosteroids and methotrexate, with favorable clinical outcome.

Conclusion:

This case highlights a rare and diagnostically challenging overlap between lupus and antisynthetase syndrome, revealed through a misleading dermatomyositis-like presentation. It underscores the importance of a rigorous and updated diagnostic approach, including early testing for myositis-specific antibodies when inflammatory myopathy is suspected. Early identification of antisynthetase antibodies enables accurate diagnosis and appropriate treatment, preventing diagnostic delays and potentially severe pulmonary complications. This case emphasizes the value of differential diagnosis in complex connective tissue disorders.

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Abstract N°: 8329

Dermatological Emergencies: Knowledge and Perception Among Medical Interns in Emergency Departments

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Introduction & Objectives:

Dermatological emergencies are common in emergency departments and can be life-threatening. Despite the visible nature of skin signs, non-dermatologists, especially medical interns, often lack the training to assess severity and manage these conditions. This study aimed to evaluate the knowledge, diagnostic challenges, and training needs of medical interns facing dermatological emergencies.

Materials & Methods:

A prospective study was conducted during March 2025. A 16-item structured and anonymous questionnaire was distributed to medical interns rotating in emergency departments across two hospitals. The questionnaire explored multiple dimensions: demographic characteristics, exposure to dermatological education, frequency and types of dermatological emergencies encountered, self-reported diagnostic confidence, therapeutic decisions, and perceived gaps in training.

Results:

A total of 132 medical interns completed the survey, with a mean age of 24.5 years. Among them, only 23.4% had received dermatology training during their medical studies, and for the vast majority, this training consisted of theoretical lectures without any clinical exposure. Despite this, nearly all interns reported encountering between one and five dermatological emergencies per week during their emergency department shifts.

Erysipelas and cellulitis were the most frequently reported, mentioned by 86% of respondents. Drug-induced eruptions (41%) and angioedema (36.4%) were also commonly cited, reflecting their importance in acute care settings. Acute urticaria was reported by 29% of interns. Less frequently observed were bullous dermatoses and severe acute pruritus, each identified by 18.2% of participants.

Diagnostic uncertainty was reported by 61% of respondents, with difficulty particularly high in distinguishing between benign and severe presentations, especially when patients exhibited systemic signs such as fever, hypotension, altered mental status, or rapid lesion progression. Several interns admitted to relying on internet searches or specialist to guide decision-making.

Therapeutic strategies were mainly symptomatic, with empirical use of antihistamines, antibiotics, and topical corticosteroids being the most commonly prescribed treatments. In cases perceived as severe, 92% of interns systematically referred patients for dermatological evaluation without delay.

Importantly, 97% of participants expressed a strong need for practical and visual training modules, simulation-based learning, and standardized emergency protocols.

Conclusion:

This study reveals significant gaps in the management of dermatological emergencies among medical interns. Despite frequent exposure, diagnostic uncertainty is common, and training is often lacking. Strengthening dermatology education in emergency settings is essential to improve early recognition and patient care.

Abstract N°: 8392

Environmental and Neighborhood Predictors of Systemic Sclerosis Incidence: A Population-Based Machine Learning Study

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Introduction & Objectives:

Systemic sclerosis (SSc) is a chronic autoimmune connective tissue disease marked by immune dysregulation, vasculopathy, and progressive fibrosis of the skin and internal organs. It carries high morbidity and mortality. In a recent Quebec population-based study, we reported rising age- and sex-standardized incidence (ASIR) and prevalence rates of SSc from 1996 to 2019, with the greatest crude incidence increase observed in children. Spatial analyses showed marked regional variation in ASIR, despite smoothing, suggesting a role for environmental and neighborhood-level influences. This study aimed to identify key predictors of SSc incidence across Quebec neighborhoods using machine learning (ML) applied to population-level health and environmental data.

Materials & Methods:

Incident SSc cases were identified from Quebec health administrative data (1996–2019) using validated ICD-9/10 codes. ASIRs were calculated for 418 geographic sub-units (forward sortation areas [FSAs]; 3-digit postal code) over six four-year periods, generating 2,508 subunit–period observations. Neighborhood-level predictors (>400 variables) were obtained from the Canadian Urban Environmental Health Research Consortium (CANUE), including air/light/noise pollution, built environment, climate, UV radiation, and socioeconomic/marginalization indices. ASIR was the outcome variable. ML algorithms (eXtreme Gradient Boosting or XGBoost, Ordinary Least Squares [OLS], Ridge Regression, and Decision Trees)—were evaluated using 5-fold cross-validation. Feature importance for these ML models was assessed using SHapley Additive exPlanations (SHAP).

Results:

The overall ASIR was 4.14 per 100,000 person-years (95% CI: 4.05–4.24), higher in females (6.61; 95% CI: 6.45–6.78) than males (1.63; 95% CI: 1.55–1.72). XGBoost outperformed the rest of the models, with test RMSEs of 0.63–1.18 not exceeding the standard deviations (SDs) of ASIR of 1.14–4.21 (RMSE/SD: 0.15–0.50). Ridge Regression and Decision Trees showed moderate performance (RMSE/SD ≥0.40 and ≥0.32), while OLS yielded the least accurate test performance (≥0.50). Of 121 predictors, eleven explained over 70% of total XGBoost model gain, including precipitation (rain-day count, rain-event duration), snowfall frequency, heatwave length, greenness (NDVI at 100–500 m), night-time light brightness, summerautumn wildfire-smoke $PM_{2.5}$, and neighborhood deprivation and dependency indices. Future work will include parsimonious models to refine top predictors,

supported by variable importance plots (VIPs), partial dependence plots (PDPs), and adjusted odds ratios (aORs) to assess association direction and magnitude. A spatiotemporal Bayesian model is also under development to evaluate residual spatial effects not captured by existing models.

Conclusion: ** In this population-based study, we identified environmental and neighborhood-level features associated with geographic variation in SSc incidence across Quebec. ML models highlighted climate variability, greenness, air pollution, night-time light, and socioeconomic deprivation as potential contributors to regional disparities. While causality cannot be inferred, these findings support further investigation into environmental influences on SSc and may guide future hypothesis-driven and public health studies.

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Abstract N°: 8416

A Pyoderma Gangrenosum revealing splenic abscesses

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Introduction & Objectives: Pyoderma gangrenosum is a neutrophilic dermatosis characterized by aseptic skin ulcerations and can indicate an underlying systemic disease. Extracutaneous manifestations of pyoderma gangrenosum and other neutrophilic dermatoses are rare, with pulmonary involvement being the most frequent. In this report, we present the case of a patient with pyoderma gangrenosum associated with splenic abscesses.

Materials & Methods: An 81-year-old hypertensive patient under treatment was hospitalized for multiple lower limb ulcerations. Initially, he presented with pustules on the right foot and both thighs, which progressed to painful ulcers in the context of general deterioration and unquantified fever. Examination revealed multiple ulcerations (five in total), located on the lower third of the right leg and above both popliteal fossae, of varying sizes, with the largest measuring 10×11 cm. The ulcers had a fibrinous and occasionally granulating base, with elevated and violaceous borders, and were painful and bled upon contact.

Biological tests revealed an inflammatory syndrome with leukocytosis at 15,300 (85% neutrophils), CRP at 168 mg/L, and a polyclonal increase in gamma globulins. The superficial microbiological sample was negative. Histology showed a subcorneal pustule in the epidermis with mild spongiosis. The dermis contained a very dense inflammatory infiltrate composed exclusively of neutrophils, forming a true abscess (figure 1).

Abdominal CT scan revealed fluid-filled splenic lesions, one of which was subcapsular, with the largest measuring 23×19 mm (figure 2). MRI showed diffusion restriction in all intra-splenic and subcapsular collections, suggesting splenic abscesses.

The diagnosis of pyoderma gangrenosum with splenic abscesses was made. The patient was started on oral corticosteroid therapy at 1 mg/kg/day, resulting in good clinical improvement, re-epithelialization of the ulcers, and resolution of the inflammatory syndrome, with CRP decreasing to 1.2 mg/L. A follow-up CT scan showed sequelae.

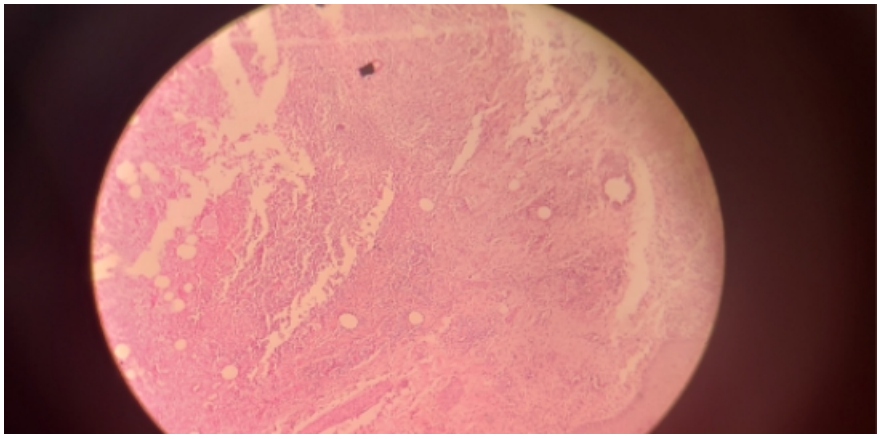

Figure 1: The dermis exhibits a very dense inflammatory infiltrate composed exclusively of neutrophils, forming a true abscess.

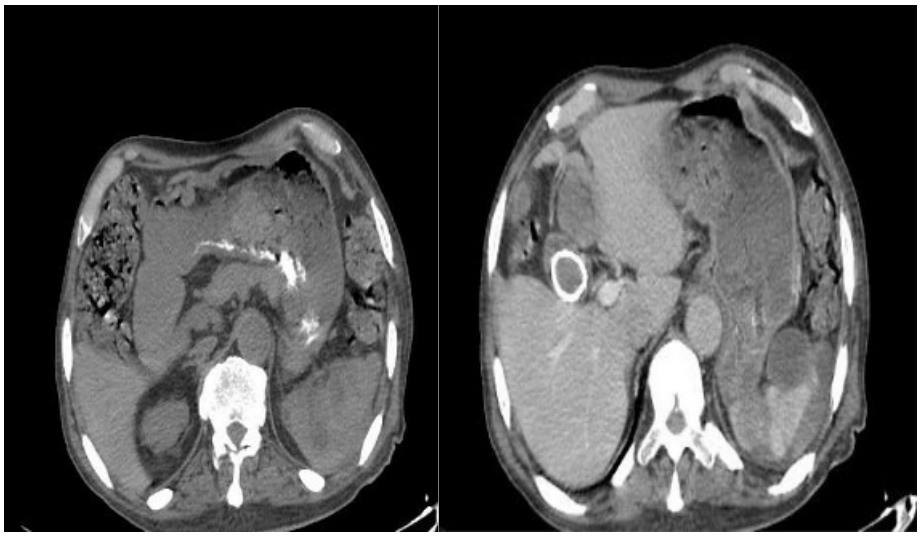

Figure 2: Axial section of an abdominal CT scan without (A) and following contrast injection in the portal phase with axial slices (B) demonstrating intrasplenic and subcapsular hypodense collections, some encapsulated and others not, with liquid density and thickened, enhanced wall, suggestive of splenic abscesses, Noted gallbladder stones

Results: Extracutaneous localizations of pyoderma gangrenosum are rare. Several organs can be affected, but isolated pulmonary involvement is the most frequent. Other visceral localizations have been reported, particularly multiple intra-abdominal ones, including hepatic, splenic, pancreatic, and lymph node abscesses, as well as extra-abdominal ones. When visceral involvement precedes cutaneous lesions, the diagnosis is difficult, as the clinical presentation may mimic an infection. In our case, splenic involvement occurred simultaneously with the cutaneous lesions.

Conclusion: Splenic involvement in pyoderma gangrenosum is a very rare association, with only a few cases of aseptic splenic abscesses reported in the literature. Our case represents the ninth case of splenic involvement without any significant underlying systemic disease.

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Abstract N°: 8442

When a recently introduced drug in rheumatoid arthritis opens a dermatological Pandora's box

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Introduction & Objectives: Cutaneous manifestations in autoimmune rheumatic diseases pose a diagnostic and therapeutic challenge, especially when clinical features overlap or are drug-induced. Although leflunomide is widely used for rheumatoid arthritis, it has rarely been linked to autoimmune conditions such as subacute cutaneous lupus erythematosus and polymyositis, but also lichenoid drug reactions, hypersensitivity reactions, DRESS (drug reaction with eosinophilia and systemic symptoms) syndrome and toxic epidermal necrolysis.

Materials & Methods: We report a case of a 68-year-old female patient with seropositive rheumatoid arthritis who developed complex dermatological manifestations suggestive of an overlap syndrome or adverse drug reaction. She also had a long-standing history of chronic prurigo, managed for approximately 20 years with antihistamine therapy and topical treatment combining gentamicin and corticosteroids.

Results: The patient was initially treated with methotrexate which was discontinued due to gastrointestinal side effects. Sulfasalazine (SSZ) and chloroquine were introduced as alternative therapies. The patient independently discontinued csDMARDs and did not attend follow-up appointments for three years. She returned with a clinical relapse of RA, prompting the initiation of leflunomide and the reintroduction of SSZ. A few months later, she developed newly formed erythematous-squamous lesions on the trunk and both extremities, accompanied by pruritus. At the follow-up visit, leflunomide was discontinued. Dermatological examination revealed disseminated nodules covered with central crusts and erythematous lichenified plaques. On the hands, lichenified lesions were observed along with occasional erosions and hyperkeratotic fingertips. The initial skin biopsy revealed lichenoid dermatitis, which could be consistent with a collagenosis (such as systemic lupus erythematosus or dermatomyositis). A second skin biopsy showed interface dermatitis, which may correspond to SLE or a drug-induced reaction. Hydroxychloroquine was then initiated. Due to accompanying symptoms including increased hair loss, livid papules, erythematous lesions above the metacarpophalangeal and proximal interphalangeal joints, and rhagades on the fingertips, an underlying connective tissue disease was suspected. Immunological testing showed ANA positivity and MI-2β antibodies, with normal complement and CK levels. Porphyrins in 24-hour urine, BP180 and BP 230 were all negative. Cutaneous lesions were treated with topical corticosteroids without clinical improvement. To exclude Ashy dermatitis, patch testing for a standard allergen series was performed and returned negative. In addition to topical therapy, a second-generation oral retinoid, acitretin, was introduced at 30 mg/day. The patient remains under rheumatological and dermatological follow-up, with no improvement in cutaneous lesions and no new clinical manifestations to support a definitive diagnosis of collagenosis.

Conclusion: In patients with RA presenting with new-onset cutaneous manifestations, a broad differential including adverse drug reactions, overlap syndromes, and secondary autoimmune phenomena should be considered. It remains uncertain whether the cutaneous changes were triggered by leflunomide or represent the onset of a distinct autoimmune condition unrelated to the patient's prior diagnoses.

Abstract N°: 8476

Exosomes as Emerging Biomarkers in Inflammatory and Oncological Skin Disorders: A Systematic Review of Current Evidence and Clinical Implications

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Introduction & Objectives:

Exosomes, nanosized extracellular vesicles secreted by cells, have shown significant potential as biomarkers due to their ability to reflect pathophysiological states through their cargo of nucleic acids and proteins. This systematic review aims to analyze published studies on exosome-derived biomarkers for dermatological diseases, focusing on diagnostic accuracy, disease correlation, and therapeutic potential.

Materials & Methods:

This systematic review was conducted according to PRISMA guidelines. Eligible studies included original research articles investigating exosome-derived biomarkers in dermatological diseases. The inclusion criteria encompassed human studies, availability of diagnostic and/or prognostic outcomes, and the use of validated exosome isolation methods. Two independent reviewers performed data extraction and quality assessment using the Newcastle-Ottawa Scale for observational studies and the QUADAS-2 tool for diagnostic accuracy studies.

Results:

The studies melanoma, psoriasis, vitiligo, oral lichen planus, and dermatomyositis. The most widely used exosome isolation methods were size-exclusion chromatography, ultracentrifugation, and immunocapture. Exosome particle sizes ranged from 30 nm to 270 nm, with consistent detection of exosomal markers such as CD9, CD63, TSG101, and flotillin-2.

In melanoma, exosomal connexin 43 demonstrated prognostic value, with an AUC of 0.78 for predicting 5-year overall survival and disease-free survival. Downregulation of connexin 43 levels was significantly associated with advanced-stage tumors ($P < 0.001$). In psoriasis, miR-625-3p in keratinocyte-derived exosomes showed strong diagnostic performance, with an AUC of 0.9515 and significant correlations with PASI and BSA scores ($P < 0.05$). In vitiligo, plasma-derived exosomal miR-1469 was significantly upregulated ($P < 0.05$) and was implicated in impaired NK cell regulation via the CD122/IFN-γ signaling pathway. In oral lichen planus, circulating exosomes enhanced T-cell proliferation and migration, with exosomal IL-2 and IFN-γ levels correlating with disease severity ($P < 0.05$). In dermatomyositis, complement and coagulation pathway proteins, such as C1QB and VWF, were significantly elevated in plasma-derived exosomes and correlated with CRP, ESR, and platelet count ($P < 0.05$).

Several studies demonstrated changes in exosomal miRNA and protein levels pre- and post-treatment. For example, miR-625-3p levels decreased significantly after treatment in psoriasis responders, while connexin 43 levels remained stable in melanoma patients with localized disease.

Conclusion:

Exosomes exhibit significant potential as diagnostic and prognostic biomarkers for dermatological diseases. Their ability to reflect immune dysregulation and disease progression, as demonstrated in melanoma, vitiligo, and psoriasis, supports their use as non-invasive biomarkers. However, standardization of isolation methods and large-

scale validation studies are needed to enhance clinical applicability.

Abstract N°: 8497

The Enigma of Erythema Induratum of Bazin: Diagnosis and Management

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Introduction & Objectives:

Erythema induratum of Bazin (EIB) is a rare, chronic nodular vasculitis primarily affecting the posterior lower legs of middle-aged women. Although historically linked to tuberculosis, a significant proportion of contemporary cases present without evidence of mycobacterial infection. EIB likely arises from a delayed hypersensitivity reaction to various antigens, including Mycobacterium tuberculosis and potentially others. Clinically, it presents as recurrent, painful, red-purple subcutaneous nodules on the lower legs that can ulcerate and heal with scarring, with reccurence over time. Histopathologically, EIB is characterized by predominantly lobular panniculitis with granulomatous inflammation, fat necrosis, and vasculitis, often demonstrating multinucleated giant cells and epithelioid granulomas. Diagnosis involves clinical evaluation, tissue biopsy, and excluding other conditions. While tuberculosis is often suspected, direct evidence is usually lacking, requiring clinicopathological correlation and supportive tests (such as positive interferon-gamma release assays). Treatment varies depending on the suspected cause and may include supportive care, anti-inflammatories, and anti-tuberculous drugs. Further research is needed to clarify the triggers and optimal treatment for this complex skin condition.

Materials & Methods:

A 39-year-old male with a known history of untreated arterial hypertension was evaluated in our Dermatology department for painful nodules on his lower legs that had been developing over the past two years. Laboratory investigations demonstrated a notable inflammatory response and mild hepatic cytolysis. Screening for viral hepatitis and parasitic infections yielded negative results. The patient’s angiotensin-converting enzyme level was within the normal range.

Results:

Following a wedge biopsy, the histopathology report showed suppurative granulomatous lobular panniculitis. Cultures for fungi and mycobacteria, and GeneXpert for Mycobacterium tuberculosis, were negative. Despite a positive Quantiferon-TB assay, active tuberculosis was ruled out by a pulmonologist. The patient was started on isoniazid, which effectively controlled the disease initially. However, a relapse occurred after six months. Subsequent treatment with intralesional triamcinolone in the new lesions yielded only a partial response. Due to the continued development of new lesions, dapsone was considered as adjunctive therapy, but the patient declined this treatment due to the lack of strong evidence supporting its use in this situation.

Conclusion:

Erythema induratum of Bazin, while uncommon, continues to be a diagnostic challenge in everyday practice, especially in countries with a significant tuberculosis burden. Its clinical and histological features often overlap with other panniculitides and nodular vasculitides. Management is tailored to the presumed underlying cause and can include supportive measures, anti-inflammatory agents, and anti-tuberculous treatment when indicated. A

deeper understanding of the diverse triggers and optimal therapeutic strategies for this enigmatic dermatological entity necessitates further investigation.

Abstract N°: 8661

Cutaneous Involvement in Sarcoidosis: A Retrospective Monocentric Study

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Introduction & Objectives:

Sarcoidosis is a systemic granulomatous disease of unknown etiology. In 80% of cases, cutaneous involvement may be the initial manifestation of the disease or occur alongside other systemic abnormalities. Skin lesions play a major diagnostic role due to their accessibility for biopsy. This study aims to describe the epidemiological and clinical profile of cutaneous sarcoidosis and identify predictive factors of mediastino-pulmonary involvement in patients followed in our department over a 32-year period

Materials & Methods:

We conducted a retrospective single-center study from January 1993 to February 2025, including patients hospitalized in our department for cutaneous sarcoidosis, confirmed by histopathology.

Results:

A total of 64 patients were included, with a mean age of 50.5 years (range: 11–74). The female-to-male sex ratio (F/M) was 2.6 (46/18). Among them, 29.7% had at least one cardiovascular comorbidity, with hypertension (14.1%) and diabetes (21.9%) being the most frequent. The predominant symptoms were exertional dyspnea (21.8%) and inflammatory arthralgia (17.2%). Xerostomia and/or xerophthalmia were reported in 5 cases (7.8%).

Specific skin manifestations were categorized as follows: small-nodular sarcoidosis (50%), large-nodular sarcoidosis (20.3%), dermohypodermal lesions (12.5%), plaque-type sarcoidosis (23.4%), scar sarcoidosis (7.8%), and lupus pernio (7.8%). The face was the most common location, observed in 43 patients (67.2%). Non-specific cutaneous manifestations included erythema nodosum (8 patients), granulomatosis of the labial mucosa (4 cases), and scarring alopecia (3 cases). Isolated skin involvement was observed in 61% of cases.

Mediastino-pulmonary involvement was the most frequent extracutaneous manifestation, present in 46.8% of patients. Pulmonary involvement was associated with advanced age (*p* = 0.004) and was significantly more frequent in female patients with arthritis (*p* = 0.009), respiratory disorders (*p* < 0.001), and visceral involvement (*p* < 0.001).

Conclusion:

Our results suggest the existence of multiple clinical phenotypes of sarcoidosis. Further large-scale studies are needed to guide precision therapeutic management.

Abstract N°: 8672

Pyoderma Gangrenosum Associated with Parathyroid Carcinoma: A Rare Case Report

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Introduction & Objectives

Pyoderma gangrenosum (PG) is a rare neutrophilic dermatosis often characterized by painful, rapidly progressing ulcers with undermined violaceous borders, typically located on the lower limbs. In approximately 50% of cases, PG is associated with underlying systemic conditions, such as inflammatory bowel diseases, hematologic malignancies, or solid tumors. However, its association with parathyroid carcinoma has not been previously described. This case aims to report a rare presentation of PG in a patient with parathyroid carcinoma, highlighting the importance of investigating atypical systemic associations.

Materials & Methods

A 33-year-old female with a history of chronic leg ulcers, clinically consistent with PG, was admitted due to methotrexate toxicity after mistakenly taking the medication daily. On admission, she presented with mucous-bloody diarrhea, new painful ulcerated papules on the neck, and pancytopenia. The condition rapidly progressed to febrile neutropenia, hemodynamic instability, and hypoxemia. A thoracic CT angiography revealed extensive bilateral pulmonary embolism. The patient was transferred to the intensive care unit and treated with thrombolysis using alteplase, resulting in clinical recovery and cardiac function improvement. Upon return to the general ward, a 4 cm nodule was noted in the left parathyroid region. Laboratory tests revealed hypercalcemia (serum calcium 14 mg/dL) and elevated parathyroid hormone (PTH) levels (700 pg/mL), raising suspicion for primary hyperparathyroidism due to parathyroid carcinoma. Surgical excision was indicated and is currently pending.

Results

The patient presented with PG in the setting of a previously undiagnosed parathyroid carcinoma. While PG is frequently linked to systemic disease, particularly inflammatory and neoplastic disorders, this appears to be the first reported case associating PG with parathyroid carcinoma. The case reinforces the hypothesis that PG may represent a paraneoplastic manifestation and highlights the need for a thorough systemic investigation, especially in atypical or refractory presentations.

Conclusion

This case illustrates a novel association between PG and parathyroid carcinoma. Awareness of rare systemic triggers is essential for appropriate diagnostic workup and management of PG. Further reports and studies are needed to better understand the underlying pathophysiological mechanisms linking PG to solid organ malignancies.

Abstract N°: 8789

Clinical and Biological Insights into Discoid Lupus Erythematosus: A 10-Year Bicentric Study

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Introduction & Objectives:

Discoid lupus erythematosus (DLE) is the most common form of chronic cutaneous lupus erythematosus (CCLE). The objective of our study was to describe the clinical, dermoscopic, histopathological, biological, and evolutionary characteristics of patients followed for DLE.

Materials & Methods:

We conducted a retrospective, descriptive, and analytical bicentric study of patients followed for DLE between 2013 and 2023 at Charles Nicolle and La Rabta Hospitals. Diagnostic criteria for systemic lupus erythematosus (SLE) were identified according to the ACR 1997, SLICC 2012, and ACR/EULAR 2019 criteria.

Results:

We included 87 patients, with a male/female sex ratio of 0.34 and a median age of 46 years. Four patients had an associated chilblain lupus and 2 had an associated lupus panniculitis. Fifteen patients had personal histories of autoimmune diseases. The median affected skin surface was 5%, with a predominant location on the face (91%), followed by the scalp (45%).

Clinical manifestations included erythematous-squamous plaques (68.4%), telangiectatic borders (31%), atrophy (83%) and dyschromia (74%). Cicatricial alopecic plaques were observed in 44% of patients. Dermoscopically, the most frequent signs were white scales (53%), erythematous structureless areas (60%), and telangiectasias (100%). Non-specific skin lesions were more frequent in patients with associated SLE.

Histology revealed epidermal atrophy (50%), hyperkeratosis with corneal plugs (46%), interface dermatitis (92%), lymphocytic inflammatory infiltrate was present (95%). Regarding biology, 21% of patients presented with leukopenia, thrombocytopenia, and/or hemolytic anemia. Laboratory tests showed an elevated erythrocyte sedimentation rate in 36% of patients, elevated gamma globulins in 11%, and positive antinuclear antibodies in 30% of cases. Anti-DNA and anti-Smith antibodies were positive in 20% and 6% of cases, respectively, and antiphospholipid antibodies were present in 6% of patients. Direct immunofluorescence showed a lupus band in 47% of cases.

SLE was diagnosed in 24%, 32%, and 21% of patients according to ACR-1997, SLICC-2012, and EULAR-2019, respectively. The most common systemic manifestations included osteoarticular involvement (40%), general condition impairment (20%), renal involvement (7%), cardiovascular (20%), pleuropulmonary (5%), and neuropsychiatric (7%) manifestations.

The prescribed treatments included topical corticosteroids (94%), topical tacrolimus (7%), synthetic antimalarials (73%) and oral corticosteroids (19%). The treatment response was favorable in 96% of patients with disease control. However, 55% of patients retained cutaneous, mucosal, and adnexal sequelae, while 45% achieved healing without sequelae.

Conclusion:

DLE had a frequent association with SLE in our study. While treatment is generally effective, long-term sequelae remain a concern. Early diagnosis and comprehensive management are crucial to improving outcomes.

Abstract N°: 8799

Factors Associated with Systemic Lupus Erythematosus in Patients with Chronic Cutaneous Lupus: A Bicentric Study

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Introduction & Objectives:

Chronic cutaneous lupus erythematosus (CCLE) is a form of cutaneous lupus that may occur in isolation or be associated with systemic lupus erythematosus (SLE). Identifying the clinical and biological factors associated with the development of SLE in these patients is essential for early diagnosis and optimal management. This study aimed to analyze the factors associated with SLE in patients with CCLE by applying the ACR 1997, SLICC 2012, and ACR/EULAR 2019 classification criteria.

Materials & Methods:

We conducted a retrospective, descriptive, and analytical study including 95 patients followed for CCLE between 2013 and 2023 at La Rabta and Charles Nicolle hospitals. Clinical, dermoscopic, histopathological, and biological data were collected. The association with SLE was determined according to the three main classification criteria. A univariate analysis identified factors associated with SLE, followed by a multivariate logistic regression analysis to determine independent factors.

Results:

Among the 95 included patients, 24% met the ACR-1997 criteria, 32% met the SLICC-2012 criteria, and 21% met the ACR/EULAR-2019 criteria for SLE. Univariate analysis identified several factors significantly associated with SLE, including female sex, younger age, general health deterioration, extensive skin involvement, the presence of leg ulcers, Raynaud’s phenomenon, diffuse non-scarring alopecia, cytopenia, gamma globulin abnormalities, and the positivity of antinuclear and anti-DNA antibodies.

Multivariate analysis confirmed that asthenia, general health deterioration, arthralgia, cytopenia, increased erythrocyte sedimentation rate (ESR), and positive antinuclear antibodies were independent factors associated with SLE according to the ACR 1997 criteria. According to the SLICC 2012 criteria, independent factors included female sex, arthralgia, extensive skin involvement, cytopenia, gamma globulin abnormalities, and positive antinuclear antibodies. Finally, according to the ACR/EULAR 2019 criteria, only arthralgia, increased ESR, and positive antinuclear antibodies were significantly associated with SLE.

Conclusion:

The association between CCLE and SLE remains poorly understood but appears to result from a complex interaction of genetic, environmental, and immunological factors. Our results confirm the importance of certain clinical and biological parameters in assessing the risk of SLE development in CCLE patients. The variability of associated factors depending on the classification criteria highlights the need for a multidimensional approach in evaluating these patients.

Our study highlights several clinical and biological factors associated with the development of SLE in patients with CCLE. Identifying these factors allows for optimized follow-up and management of at-risk patients, helping to prevent systemic complications and rationalize unnecessary additional testing in patients with a low risk of

systemic involvement.

Abstract N°: 8806

Assessing Systemic Lupus Prevalence in Chronic Cutaneous Lupus: A Comparison of Three Classification Criteria

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Introduction & Objectives:

Chronic cutaneous lupus erythematosus (CCLE) is the most common form of cutaneous lupus and may be associated with systemic lupus erythematosus (SLE). Several classification criteria have been used to diagnose SLE. The objective of our study was to assess the prevalence of SLE according to the three main classification criteria (ACR 1997, SLICC 2012, and ACR/EULAR 2019) in patients with CCLE.

Materials & Methods:

We conducted a retrospective, descriptive and analytical, bicentric longitudinal study including patients followed for CCLE between 2013 and 2023 at La Rabta and Charles Nicolle hospitals. Clinical, dermoscopic, histopathological, and biological data were collected. The classification criteria were applied to each patient to determine the association with SLE.

Results:

A total of 95 patients were included, with a sex ratio (M/F) of 0.34 and a mean age of 47±15 years. Among the study population, 23 patients (24%) met the SLE classification criteria according to ACR 1997, 30 (32%) according to SLICC 2012, and 20 (21%) according to ACR/EULAR 2019. Severe systemic involvement was rare among our patients: pericarditis (n=4), glomerulonephritis (n=7), renal failure (n=2), and peripheral neuropathy (n=2).

Conclusion:

Variability in the prevalence of SLE across studies can be attributed to several factors, including differences in patient populations, study designs, classification criteria used, and follow-up duration. Our results confirm that the SLICC 2012 criteria have the highest sensitivity for diagnosing SLE but lower specificity. This can be explained by several factors: the inclusion of non-scarring diffuse alopecia, modifications to the arthritis criterion, different weighting of immunological criteria, and the inclusion of the direct Coombs test.

Furthermore, our study highlights that some patients classified as having SLE according to the SLICC and ACR 1997 criteria had normal antinuclear antibodies (ANA), excluding them from the ACR/EULAR 2019 classification. The lowest association rate between CCLE and SLE was observed with the ACR/EULAR 2019 criteria, consistent with previous studies. This may be due to the hierarchical approach of this classification, considering only the highest-weighted criterion within each domain rather than all criteria.

Severe systemic involvement was rare among our patients. These findings align with the observations of some authors who report that patients with chronic cutaneous lupus erythematosus (CCLE) tend to develop SLE with a favorable prognosis, rarely associated with severe systemic complications.

Our study is the first to assess SLE prevalence in CCLE using three classification criteria, highlighting the superior accuracy of ACR/EULAR 2019. Our findings confirm that SLE associated with CCLE has a favorable prognosis with rare severe systemic involvement, emphasizing the importance of precise classification for optimal diagnosis and

management.

Abstract N°: 8887

Fatal disseminated herpes zoster associated with methotrexate-induced immunosuppression

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Introduction & Objectives:

We present the case of a 63-year-old woman who was admitted due to an extensive necrotic plaque affecting the mandibular region, cervical region, upper back, shoulder and anterior thorax on the right side, with zosteriform distribution. Multiple vesicular and papulonecrotic lesions were present and spread throughout the body surface. The patient revealed a personal history of rheumatologic joint disease, which had been treated for years with compounded methotrexate. However, it is possible that the weekly dose of the medication was inadvertently excessive, as suggested by the case history. In addition, she was taking carbamazepine due to a previous history of suspected epileptic seizures. The exuberant skin condition was accompanied clinically by drowsiness and, on laboratory testing, by anemia and lymphopenia in the blood count upon admission. Several differential diagnoses were considered, including cutaneous necrosis secondary to methotrexate toxicity, chronic lymphocytic leukemia or angioimmunoblastic T-cell lymphoma complicated by necrotic herpes zoster, purpura fulminans associated with protein C or S deficiency and disseminated herpes zoster secondary to immunosuppression from methotrexate use. A skin biopsy was performed, which revealed findings consistent with herpesvirus infection. A peripheral blood test revealed hypogammaglobulinemia on immunoglobulin electrophoresis along with a positive result for varicella-zoster virus detected by polymerase chain reaction (PCR). Unfortunately, the patient's condition worsened, requiring hemodialysis and resulting in a reduced level of consciousness. Cranial tomography revealed cerebral hemorrhage in a region tipically affected by vasculitis associated with herpetic meningoencephalitis. The patient unfortunately died despite receiving intravenous antiviral therapy at dose sufficient for central nervous system involvement from the time of admission. This case highlights an atypical, severe and exuberant presentation of disseminated herpes zoster associated with methotrexate use.

Materials & Methods:

The method involves the case presentation as e-poster after data collection

Results:

Conclusion: