

**Abstract N°: 13****Zoonotic and Anthropophilic *Trichophyton mentagrophytes* complex infection in human: an update and narrative review**

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Introduction & Objectives:

Trichophyton mentagrophytes complex comprises dermatophytes responsible for common superficial fungal infections affecting keratinized tissues. Recent shifts in taxonomy and increasing antifungal resistance—necessitate updated understanding of this fungal complex. This narrative review provides a comprehensive update on the taxonomy, morphology, virulence, host immune response, and clinical genotyping of the *T. mentagrophytes* complex, with a focus on zoonotic and anthropophilic infections in humans.

Materials & Methods:

A comprehensive literature search was conducted across PubMed and Scopus using MeSH terms and relevant keywords related to *T. mentagrophytes*, *T. interdigitale*, and *T. indotineae*. Eligible English-language publications up to March 2025—including original research, case reports, reviews, and guidelines—were included.

Results:

The *T. mentagrophytes* complex includes several genotypes with distinct transmission profiles. Genotypes III/III* are primarily zoonotic; genotype VII is sexually transmitted, especially in MSM populations; genotype VIII (*T. indotineae*) is anthropophilic and associated with terbinafine resistance. Infection involves keratinocyte adhesion, enzymatic skin barrier degradation, and activation of proinflammatory cytokines and antimicrobial peptides. Both innate and adaptive immunity, particularly Th1 and Th17 responses, are critical for fungal clearance, while chronic infections are associated with impaired T-cell function and skewed Th2 responses.

Conclusion:

Emerging genotypes and drug resistance within the *T. mentagrophytes* complex pose increasing clinical challenges. Awareness of transmission patterns, immune evasion mechanisms, and resistance profiles is essential for accurate diagnosis and effective management of dermatophytoses.





Abstract N°: 27

Leprosy: a great imitator in tropical regions

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Leprosy: a great imitator in tropical regions

Introduction & Objectives:

Leprosy, or Hansen's disease, is a chronic infectious granulomatous disease caused by *Mycobacterium leprae* and *Mycobacterium lepromatosis*, acid-fast bacilli with a tropism for reticuloendothelial cells and peripheral nerves. Due to its multisystemic nature, leprosy can mimic many rheumatologic diseases, posing a diagnostic challenge for clinicians, particularly in endemic regions.

Objectives:

1. **Share the case of a patient with lepromatous leprosy who had been misdiagnosed as having SLE**
2. **Propose a comparative table of clinical and laboratory findings of SLE and Hansen's disease**
3. **Familiarize clinicians from other countries with cutaneous manifestations of leprosy**

Materials & Methods:

We present the case of a 47-year-old female from Colombia, diagnosed with systemic lupus erythematosus (SLE) two years prior, with an ANA titer of 1:320 and 11 points on the EULAR/ACR classification criteria for SLE. She was treated with hydroxychloroquine, prednisone, and azathioprine, and had received cyclophosphamide and rituximab multiple times without clinical improvement. She presented with a 3-day history of fatigue, arthralgia, leg weakness, and erythematous infiltrated plaques on her cheeks and earlobes. An active SLE flare was initially suspected.

Results:

Electromyography revealed demyelinating sensorimotor polyneuropathy, and laboratory results were within normal limits (including ANA titers, SLE-specific antibodies, C3, and C4). A skin biopsy of the cheek lesion was performed. Slit skin smear and histopathology confirmed multibacillary (MB) leprosy. A review of previous skin biopsies confirmed the patient had been misdiagnosed with SLE. Immunosuppressants were discontinued, and multi-drug therapy for MB leprosy was initiated.

Conclusion:

Leprosy is a neglected tropical disease that, if left undiagnosed and untreated, can cause progressive and permanent sequelae. In its multibacillary form, leprosy can mimic SLE, and physicians should consider this possibility before making a definitive diagnosis of SLE.



**Abstract N°: 40****External validation of the WHO skin NTDs App's artificial intelligence algorithms for diagnosing leprosy and leprosy reactions**

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Introduction and objective: Leprosy presents various clinical forms, ranging from hypochromic patches in paucibacillary forms to multiple nodules and infiltrations in multibacillary forms. This disease can also present specific skin lesions associated with leprosy reactions, which can challenge even experienced clinicians. Delayed recognition leads to delayed diagnosis, increasing the risk of permanent disabilities that severely affect the quality of life of affected individuals. Leprosy is considered one of the Skin Neglected Tropical Diseases (Skin NTDs), a group of diseases characterized by skin lesions. To enhance diagnostic accuracy and assist healthcare providers, especially in resource-limited settings where proper training may be lacking, the WHO launched the Skin NTDs app in 2023, beta version utilizing artificial intelligence (AI) to support the identification of these conditions as an educational tool. This study represents the first external validation of the WHO algorithm for leprosy identification.

The primary objective of this study is to evaluate (test) the accuracy of the WHO Skin NTDs app's AI algorithms in identifying leprosy and leprosy reactions within the Top-5 diseases displayed by the algorithm. Specific goals include assessing sensitivity (recall), comparing AI-generated possible diagnoses with gold-standard clinical diagnoses, and identifying error patterns to improve the algorithm's performance.

Material & Methods: This validation study utilized a dataset of 439 anonymized clinical images from confirmed leprosy patients, collected between 1996 and 2024. The dataset included images of leprosy lesions (all forms of Ridley-Joplin Classification) for which the AI had been trained and leprosy reactions (T1R and ENL), and Lucio's Phenomenon, for which the AI had not been largely trained. The AI algorithms' performance was evaluated by comparing the Top-5 where leprosy would appear with expert-validated clinical and/or laboratory diagnoses, focusing on sensitivity and F1-score. Error patterns, including false positives and false negatives, were also analyzed.

Results: The AI algorithm demonstrated an overall sensitivity of 72% for the Top-5, with higher sensitivity for leprosy lesions (87.19%) compared to leprosy reactions (69.64%). The F1- score was 93.16% for leprosy lesions and 82.11% for leprosy reactions.

Conclusion: This study confirms the potential of the WHO Skin NTDs app's AI algorithms as an educational tool to identify leprosy, showing high sensitivity for leprosy lesions but highlighting challenges in identifying leprosy reactions. The app holds promise as a clinical decision support tool for healthcare providers in resource-limited settings, improving patient care and disease management. Further refinement of the AI model is needed for more accurate identification of leprosy reactions.



**Abstract N°: 49****Superficial dermatophyte skin infections, a new great imitator**Muhsin Al Dhalimi¹¹University of Kufa, College of Medicine, Dermatology, Najaf, Iraq**Introduction & Objectives:**

In recent years, there has been an increase in the incidence of superficial fungal infections associated with increasing evidence of their resistance to antifungal drugs. Different clinical presentations have been recorded.

The Objective is to evaluate the peculiar skin presentations of the superficial dermatophyte infections and identify the causative fungal species by direct microscopic examination and mycological culture.

Materials & Methods:

The study was conducted over a one-year period and included patients of both sexes and different age, recruited from the outpatient clinic at Al-Sader Hospital in Al-Najaf city. Scrapings were taken from skin, hair, and nails. Collected samples were subjected to KOH 10% to detect fungal elements. Additionally, mycological cultures were performed using Dextrose Sabouraud Agar (DSA) incubated at room temperature for 1 to 6 weeks, then examining the samples microscopically to identify fungi at the species level.

Results:

Among 233 patients with proved superficial fungal infections, 27 patients presented with peculiar presentations that mimic alopecia areata, psoriasis, dermatitis, rosacea, systemic lupus erythematosus, lymphoma and lichen planus. The majority of patients (85.0%) presented with a non/ minimal inflammatory type. *Trichophyton rubrum* was the most commonly found, accounting for thirty-three cases (45.8%), this was followed by *Epidermophyton floccosum* (26.3%) and *Trichophyton mentagrophytes* (16.7%). The majority of tinea corporis cases were caused by *Trichophyton rubrum*, while tinea cruris cases were mostly caused by *Epidermophyton floccosum*. It was noted that most cases of *Trichophyton rubrum* and *Epidermophyton floccosum* presented with a non/ minimal inflammatory character.

Conclusion:

There is a great increase in the incidence of superficial fungal infections with a tendency for bizzare presentations.





Abstract N°: 74

emergomycosis: a twisted tale of the toxic trio

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Introduction & Objectives:

Emergomycosis is an emerging opportunistic fungal infection among individuals living with HIV, with cases reported in North America, Europe, Asia and Africa.

First reported in 1998 (on histology from 1994), South Africa has the highest number of reported cases worldwide, with 68 documented cases in the literature

Clinical features, as well as histological and fungal culture features greatly overlap with other deep fungal infections, most commonly *Histoplasma capsulatum*, making PCR the gold standard for diagnosis.

With a 50% mortality rate, awareness needs to be raised around Emergomycosis, allowing for early diagnosis and treatment.

Materials & Methods:

We present a 38 year old female patient of black African descent, referred from Internal Medicine under whom she was admitted for fever of unknown origin.

During her tumultuous 2 month admission, she was first diagnosed with an adverse drug reaction secondary to antibiotics she had received for a pneumonia 3 weeks prior. With associated clinical signs and blood findings, this diagnosis was further strengthened by a skin biopsy in keeping with this diagnosis.

Following treatment of the above the patient improved but soon developed a new rash on her face suggestive of a papular mucinosis, prompting another biopsy.

Given the improvement of her symptoms and negative work up for opportunistic infections, the patient was started on ARV's. A week later the patient developed an acute change in clinical picture. Her facial rash became worse, with regard to size, number and clinical appearance and a new rash developed on her upper torso. Assessment of her skin was in keeping with a suspected deep fungal infection, and the concern for unmasking histoplasmosis IRIS was raised.

Results:

Histology findings on the facial lesions biopsied prior to ARV initiation were expedited and found to show fungal spores on special stains, in keeping with *Histoplasma capsulatum*. In light of these findings, the first biopsy done at the beginning of the patients admission, which was concluded to be in keeping with an adverse drug reaction, was reviewed with special stains which showed the same fungal spores mentioned above. The biopsy of the new rash that developed after ARV initiation also showed fungal spores.

Positive fungal cultures were sent for PCR, confirming the diagnosis of *Emergomyces africanus*.

Thus all of the patients presentations, originally misdiagnosed as pneumonia, an adverse drug reaction and papular muconosis were all secondary to *Emergomyces africanus*, with the eventual development of unmasking

Emergomyces africanus IRIS which helped clinch the diagnosis.

This patient thus exhibited 3 distinct macroscopic skin pathologies from Emergomyces africanus during her 2 month admission.

Conclusion:

HIV is still a heavy burden in developing countries, leading to unnecessarily high morbidity and mortality. Emergomyces africanus has been recognised as an emerging AIDS defining opportunistic infection with poor outcomes.

Owing to the lack of awareness of this new dimorphic fungus, its wide array of clinical presentations, the difficulty of differentiating it from other deep fungal infections clinically and on histology, Emergomyces africanus continues to ravage the immunocompromised community.

Through sharing of this case and educating dermatologists, we hope to ensure earlier detection and diagnosis of this infection, improving outcomes of this vulnerable population.

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Abstract N°: 101

PECULIARITIES of HUMORAL IMMUNITY in CASES of INFILTRATIVE-SUPPURATIVE TRICHOPHYTIA in CHILDRENIndirakhon Samarkhodjaeva*¹, Шахноза Мавлянова¹¹Republican centr dermatology and cosmetology , Dermatotoxicology, Tashkent , Uzbekistan

Introduction & Objectives: Fungal infections, particularly those caused by dermatomycetes, have become increasingly common in children, emphasizing the growing significance of dermatomycology. The primary objective of this study was to explore the specific characteristics of the humoral immune response in children with infiltrative-suppurative trichophytia (IST). Specifically, the study focused on assessing the levels of secretory IgA (sIgA), total IgA, IgE, and IgG antibodies against *Candida albicans*.

Materials & Methods:

This study included 60 children diagnosed with IST, aged 2–18 years (35 boys and 25 girls). Clinical, microbiological, mycological, and immunological analyses were conducted. The enzyme-linked immunosorbent assay (ELISA) was used to measure sIgA, total IgA, specific IgG antibodies against *Candida albicans*, and total IgE. A control group consisting of 30 healthy children was also included for comparison.

Results: The ELISA results revealed a significant increase in the levels of sIgA (7.6 ± 0.5 mg/ml) and total IgA (7.4 ± 0.4 mg/ml) in the IST group compared to the control group ($P < 0.05$). Specific IgG to *Candida albicans* was elevated by 10.6 times (0.8 ± 0.2 pg/ml vs. 0.07 ± 0.03 pg/ml, $P < 0.001$). Mycological analysis showed a higher colonization rate of *Candida albicans* in fecal samples (over 2×10^3 CFU/g) compared to controls ($P < 0.05$). Additionally, total IgE levels were significantly higher in the IST group (205 ± 8.2 IU/ml vs. 63.2 ± 1.4 IU/ml, $P < 0.05$).

Conclusion: Children with infiltrative-suppurative trichophytia exhibit a humoral immune response characterized by immunological hyperreactivity, including elevated levels of IgA and IgE. This response is influenced not only by *Trichophyton* and *Staphylococcus* infections, but also by *Candida albicans*, leading to sensitization and secondary immune deficiency.



**Abstract N°: 131****Erythema Nodosum Leprosum: A disease in disguise**Vaishali Nahata¹¹Belle Skin Care & Laser Clinic, Dermatology, Nashik, India

Introduction & Objectives: Erythema nodosum leprosum (ENL), also known as type 2 immunologic reaction or Lepra reaction, is an immunologic complication of leprosy. ENL presents with painful subcutaneous nodules, vesicles, pustules, or ulcers. ENL is a systemic reaction that includes fever, neuritis, and involvement of other organs. This report describes ENL as the initial presentation of Borderline lepromatous leprosy (BLL), without prior lepromatous symptoms, skin findings, or treatment. This presentation is uncommon, as ENL typically occurs after treatment for LL or borderline lepromatous leprosy (BL).

Materials & Methods: A 31 year old male patient presented with multiple painful nodules and plaques on body since 3 weeks. The lesions were more on trunk and upper part of lower extremity. Plaque on the abdomen was ulcerated. Looking at the lesions following differentials were thought of:

- \1. Papulonecrotic Tuberculid
- \2. Lichenoid Drug reaction.

On systemic examination patient was febrile. Inguinal lymphadenitis was noted.

Results: On investigations: Hemogram with ESR showed Leucocytosis, however ESR was normal.

X ray chest was normal and Mantoux test was normal.

A skin biopsy was done from one of the nodule which showed nodular granulomatous inflammation centered around neurovascular bundles of superficial and deep dermis. The granuloma consists of foamy macrophages and lymphocytes. Occasional neutrophils dot the granulomas accompanied by scant nuclear dust & fibrin. The dermoepidermal junction is spared by the granulomatous infiltrate.

The Findings were consistent with Erythema Nodosum leprosum.

The patient was re-examined and on neurologic exam demonstrated diminished grip strength in the left upper extremity and decreased sensation to pinprick and light touch in both upper and lower extremity. Slit skin smear was done from three sites (one ear lobe and two from active lesions). It showed multiple acid fast bacilli suggestive of *Mycobacterium leprae*. Thus, a diagnosis of Borderline Lepromatous leprosy with Erythema nodosum leprosum was made.

Patient was started on MDT for MB which included oral Dapsone (100mg) and clofazimine (50mg) daily and oral Rifampicin (600mg) and Clofazimine (300mg) once a month. Oral Thalidomide (100mg) was given thrice a day for controlling the reaction. Patient responded to it and lesions started decreasing.

Conclusion: ENL is a debilitating complication of *M. leprae* infection. ENL should be considered for a patient who presents with episodic cutaneous findings in association with fever, lymphadenitis, and neuritis. Although immunologic reactions including ENL can manifest before treatment and even before diagnosis of the underlying leprosy subtype. Early diagnosis and treatment can limit transmission of disease and permanent disability.



**Abstract N°: 198****A Rare Case of Periocular *Dirofilaria Repens* Infestation in a Patient with Chronic Spontaneous Urticaria**

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Introduction:

Chronic spontaneous urticaria (CSU) is defined by the presence of recurrent wheals, angioedema, or both, persisting for more than six weeks without an identifiable precipitating trigger. Affecting approximately 1–2% of the general population, CSU is usually self-limiting, with an average duration of two to five years. Although the precise etiology remains unclear, various infectious agents, including bacteria, viruses, and, in rare cases, parasites, have been implicated in pathogenesis of CSU.

Case Presentation:

A 39-year-old woman presented upon a dermatological examination with a two-month history of recurrent generalized urticaria, occasionally accompanied by facial angioedema. The patient was unable to identify any specific triggers associated with symptom onset and her medical history was unremarkable. She resided in an urban area, had no pet exposure, and had not traveled in the preceding months. Initial management included a quadruple dose of second-generation H1-antihistamines daily. Additionally, the patient was instructed to maintain a urticaria activity score (UAS7) to systematically monitor disease symptoms. Despite adherence to this regimen, follow-up UAS7 assessments revealed persistent daily urticarial eruptions, although the angioedema had resolved. An extensive diagnostic workup failed to identify any underlying cause for her CSU. Given the persistence of symptoms, omalizumab initiation was planned if the condition remained refractory. At the subsequent follow-up, due to ongoing symptoms, omalizumab 300 mg was added to existing treatment regimen. Shortly thereafter, the patient developed persistent periocular discomfort and pruritus, with a progressive foreign body sensation. A subcutaneous nodule in the lower right eyelid migrated superiorly, prompting urgent ophthalmological evaluation. Clinical examination confirmed a subcutaneous foreign body, which was surgically extracted under local anesthesia. The removed organism was a mobile, whitish, worm-like structure measuring 11.5 cm in length and 0.2 cm in thickness. Microbiological analysis identified it as *Dirofilaria repens*. To exclude systemic involvement, chest X-ray and laboratory tests were performed, yielding normal results. Prophylactic therapy was initiated by an infectious disease specialist, consisting of a single dose of albendazole 16 mg and doxycycline 100 mg administered twice daily for five days. Omalizumab therapy was temporarily suspended for the duration of the aforementioned therapy. Despite surgical removal, antiparasitic treatment, and continued quadruple-dose antihistamine therapy, intermittent urticarial eruptions persisted during subsequent follow-up visits.

Conclusion:

This case underscores the potential, yet underrecognized, role of *Dirofilaria repens* infestation as a trigger for CSU, particularly in endemic regions. Although a direct causal relationship remains unproven, these findings highlight the importance of a multidisciplinary diagnostic approach and warrant further research into the contribution of parasitic infections to the pathogenesis of CSU.



**Abstract N°: 199****Clinical Characteristics and Antibiotic Susceptibility of *Staphylococcus aureus*-Infected Dermatoses.**

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Introduction & Objectives:

Methicillin-resistant *Staphylococcus aureus* (MRSA) poses significant treatment challenges, particularly in community settings. Despite its growing prevalence, data on *S. aureus*-associated infected dermatoses (ID) in outpatient dermatology clinics remain limited. This study aims to assess the clinical characteristics, microbiological profiles, antibiotic resistance patterns, and treatment outcomes of *S. aureus*-associated ID in an outpatient dermatology clinic in Heraklion, Greece.

Materials & Methods:

A prospective observational study was conducted from January 2023 to January 2025. Consecutive adult patients with clinically diagnosed infected dermatoses (ID) and microbiologically confirmed *S. aureus* infection were recruited. Demographic, clinical, and treatment data were recorded. Skin swabs were collected, cultured, and analyzed for antimicrobial susceptibility following Clinical and Laboratory Standards Institute (CLSI) guidelines. Statistical analyses were performed using IBM SPSS Statistics (Version 25.0) to evaluate associations between clinical and microbiological findings.

Results:

A total of 68 patients were included, with a mean age of 46.7 years (SD $\pm$ 25.1). MRSA was identified in 22.1% (15/68) of cases and was significantly associated with female gender ($p = 0.014$). The most common clinical diagnoses included eczema (35.3%), folliculitis (19.1%), and hidradenitis suppurativa (10.3%). Resistance rates were highest for benzylpenicillin (81.8%), levofloxacin (54.9%), and erythromycin (39.4%). Resistance to fusidic acid, clindamycin, mupirocin, and tetracycline was observed in 38.2%, 20.6%, 16.9%, and 10.3% of isolates, respectively. Other pathogens, including *Pseudomonas aeruginosa* and *Escherichia coli*, were identified in 27.9% of cases. Systemic antibiotic therapy was more frequently administered to patients with oxacillin-resistant *S. aureus* ($p = 0.039$). Among all patients, 16.2% were immunosuppressed, receiving medications such as oral prednisolone (45.4%), methotrexate (27.3%), azathioprine (18.2%), and mycophenolate mofetil (9.1%). Treatment regimens included topical fusidic acid (27.9%), mupirocin (16.2%), and clindamycin (8.8%), while systemic therapy involved oral doxycycline (14.7%), amoxicillin/clavulanic acid (13.2%), and cefuroxime axetil (10.3%). Despite the high prevalence of antimicrobial resistance, all patients achieved clinical cure.

Conclusion:

This study highlights the significant burden of MRSA in outpatient dermatology settings and underscores the necessity for local antimicrobial resistance surveillance. The findings emphasize the importance of informed empirical antibiotic selection to optimize treatment strategies for *S. aureus*-associated ID and improve patient outcomes. Future research should focus on long-term monitoring of resistance trends and evaluating novel therapeutic approaches for managing *S. aureus* infections in dermatology clinics.

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Abstract N°: 282

Disseminated Herpes Zoster Mimicking Monkeypox in Patient with History of Chemotherapy: A Case ReportWinawati Eka Putri^{1, 2}, Indah Purnamasari³, Pramita Ariyanti⁴, Zahrudin Ahmad⁵, Adelia Wulandari Karim⁶¹Universitas Nahdlatul Ulama Surabaya, Faculty of Medicine, Department of Dermatology and Venereology, Surabaya, Indonesia²Rumah Sakit Islam Surabaya - Jemursari, Department of Dermatology and Venereology, Surabaya, Indonesia³Rumah Sakit Islam Surabaya - A. Yani, Department of Dermatology and Venereology, Surabaya, Indonesia⁴St. Vincentius A Paulo Catholic Hospital, Department of Dermatology and Venereology, Surabaya, Indonesia⁵RSUD DAHA HUSADA, Department of Dermatology and Venereology, Kediri, Indonesia⁶RS EMC Sentul, Department of Dermatology and Venereology, Surabaya, Indonesia

Introduction & Objectives: Disseminated herpes zoster is diagnosed when 20 or more blisters develop within a week of the initial skin symptoms of typical herpes zoster. This condition is rare and predominantly affects immunocompromised individuals, including elderly patients, those with malignancies, HIV infections, or those undergoing chemotherapy. The increasing prevalence of monkeypox has made differentiating between these two conditions clinically challenging. We present a case of disseminated herpes zoster initially suspected as monkeypox due to its widespread vesiculobullous lesions.

Materials & Methods: A 56-year-old male with a history of chemotherapy presented to the emergency department with multiple vesiculobullous lesions, some crusted, distributed across his body for the past five days. These symptoms were accompanied by cervical lymphadenopathy. Due to the clinical similarity to monkeypox, a PCR test was performed to detect monkeypox virus (MPXV) DNA. The patient was treated with oral valacyclovir, neurotropic vitamins, salicylic powder, and topical fusidic acid.

Results: The PCR test for MPXV was negative. The patient's skin lesions improved within 10 days without complications.

Conclusion: This case highlights the importance of considering disseminated herpes zoster in immunosuppressed patients presenting with widespread vesiculobullous lesions, particularly in the context of differential diagnosis with monkeypox. Early recognition and appropriate antiviral therapy are essential to prevent complications and ensure optimal patient outcomes.



**Abstract N°: 303****Cutaneous Leishmaniasis in a Patient with Crohn Disease: Report of a Case with Diagnostic Challenges**

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Introduction & Objectives: Cutaneous leishmaniasis is a vector-borne disease transmitted mainly by sandflies. Localized disease manifests with papules, plaques, or nodules. Immunosuppression is a well-established risk factor for infection. Here we present the case of a plaque located on the right elbow of a Crohn disease patient, diagnosed as cutaneous leishmaniasis.

Materials & Methods: 24-year-old male presented to our department with a verrucous plaque on the extensor aspect of the right elbow. It had multiple erythematous projections, some parts of which were covered with yellow crusts. There were several thrombosed vascular structures on the plaque. The well-defined borders were mildly hyperemic. The length was 10 cm, and the width was 5 cm. It started four years ago as a small pimple, then it enlarged indolently. It did not improve with topical steroids, intralesional steroids or oral antibiotics. The patient also had familial mediterranean fever, juvenile rheumatoid arthritis, hypothyroidism and glaucoma. He was taking adalimumab 80 mg/week for one and half years, and mesalazine to control Crohn disease.

Results: Both incisional and punch biopsies were obtained with preliminary differential diagnoses of pyoderma gangrenosum, mycobacterial infection, deep mycosis, cutaneous Crohn disease, and pyodermatitis vegetans. Histology showed epidermal ulceration with granulomatous inflammation in the dermis. PAS stain and EZN stain did not show any microorganism. Cultures for mycobacteria and Leishmania were obtained with a 4 mm punch. Both cultures were negative. Meanwhile, 8 more plaques with similar characteristics developed on the face of the patient. The patient did not have a travel history to an endemic region for leishmaniasis; however, due to clinical suspicion, 10 ml saline was injected from multiple points into the margin of the plaque and then immediately withdrawn. Less than 1 ml of sample was obtained, and Leishmania tropicalis amastigotes were observed. The diagnosis was confirmed with polymerase chain reaction. The patient was admitted for further investigation and treatment.

Conclusion: Crohn disease may exhibit various extraintestinal manifestations. In addition to the dermatologic findings associated with the disease itself, treatment of Crohn disease might also predispose the patient to several skin disorders. Cutaneous leishmaniasis has been reported recently in a Crohn patient taking infliximab, azathioprine and mesalazine. Similarly, our patient had been managed with a TNF inhibitor taken in different doses for eight years. Our case developed multiple plaques at a distant site from the first lesion, probably indicating that the infection was transmitted by autoinoculation. This route of transmission was reported in the literature; however, the association of autoinoculation risk and immunosuppression is yet to be elucidated. Furthermore, our case demonstrates an example of a diagnostic challenge, and it proves that clinical suspicion is crucial for diagnosis, since the histopathology may show inconclusive findings and microbiologic examination of one specimen might be inadequate. Conclusively, cutaneous leishmaniasis should be kept in mind as a possible entity in patients presenting with solitary, resistant, verrucous plaques.

**Abstract N°: 328****efficacy and safety of voriconazole vs itraconazole; a randomized, prospective, comparative, open label clinical trial**

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Objectives:

Objectives: To compare the efficacy and safety of voriconazole versus itraconazole in the treatment of tinea corporis and cruris.

Introduction

Cutaneous fungal infections are emerging as difficult to treat problem in many areas of world especially developing countries. Antifungal resistance is on rise due to emergence of resistant strains along with long duration of treatment and sub therapeutic dosage of antifungal drugs. This study aims to compare traditional oral antifungal drug; itraconazole with newer drug voriconazole to establish efficacy and safety.

Materials & Methods:

This randomized, comparative, open label clinical trial was conducted at Dermatology outpatient department, Khawaja Muhammad Safdar Medical College and Allama Iqbal Memorial Teaching Hospital, Sialkot, Pakistan, from 01st July 2023 to 30th June 2024 over a period of 1 year. Patients of both genders in age range of 18 to 65 years with clinical diagnosis of dermatophytosis were enrolled in the study after taking informed consent. Sample size of 262 was calculated and were subdivided into group A (131) receiving voriconazole and group B (131) itraconazole. Group A was given oral voriconazole 400 mg twice on day 1, followed by 200 mg twice daily for 4 weeks. Group B was given oral itraconazole 100 mg twice daily for 4 weeks. Patients were assessed every 2 weeks for resolution of disease and side effects.

Results:

Out of 262 patients, 65 (24.8%) were males and 197 (75.2%) females. Mean age of the patients was 33.63 ± 10.64 years. 118 (45%) patients had tinea corporis, 97 (37%) tinea cruris and 47 (17.9%) had both tinea corporis and cruris. 45.4% were new cases, 42% belonged to recurrent infection and 12.6% had resistant disease. In group A, 89(33.9%) patients had excellent response while only 3 did not respond to treatment. In group B, 128(48.8%) patients had either excellent or good response to medication. In voriconazole group, 13 patients experienced troublesome photophobia and 25 had headache while only one patient had elevated transaminases. Sixteen patients discontinued treatment either due to photophobia or headache due to voriconazole. In group B, 7 patients had mild gastrointestinal upset and all patients completed treatment duration.

The Chi square test for comparison of efficacy between two groups has p value of 0.001 which is statistically significant.

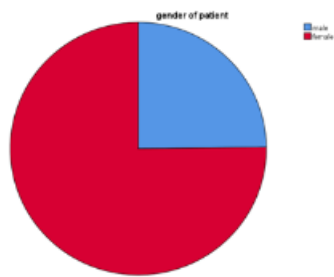


Figure 1: Gender distribution of patients

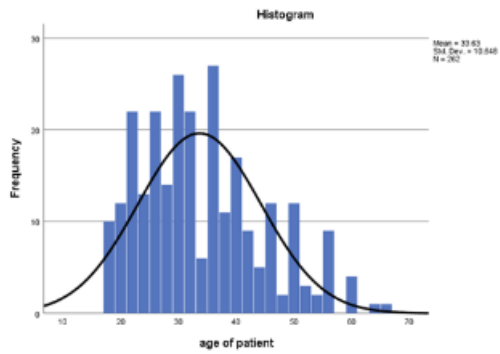


Figure 2: distribution of age of patients

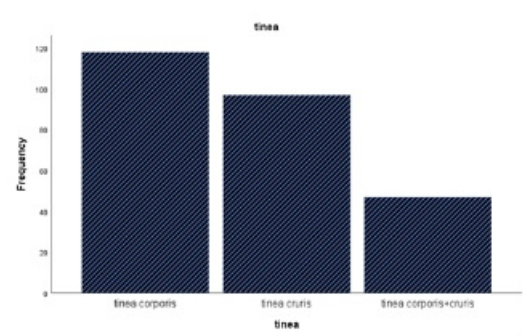


Figure 3: distribution of morphological types of tinea

	Frequency	Percent	Cumulative Percent
new case	119	45.4	45.4
Recurrent	110	42.0	87.4
Resistant	33	12.6	100.0
Total	262	100.0	

Figure 4: frequency of severity of tinea

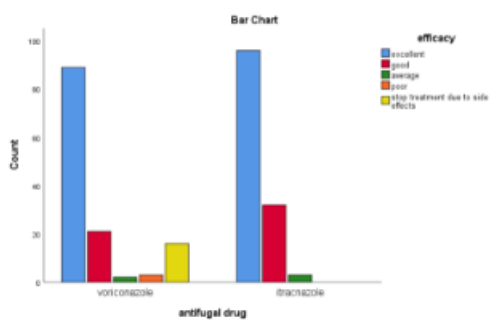


Figure 5: efficacy distribution of group A & B

		Photophobia	Headache	GI symptoms	Jaundice	1,2,3	Total
Antifungal drug	voriconazole	13	25	6	1	6	131
	itraconazole	0	3	7	0	0	131
Total		13	28	13	1	6	262

Figure 6: frequency of adverse effects

Conclusion:

Itraconazole was found superior to voriconazole in the treatment of dermatophytic infections in terms of clinical resolution of lesions, adverse effect profile, patients' tolerance to medication and cost effectiveness. Voriconazole is also effective but should be reserved for resistant and recurrent cases of tinea infection.

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Abstract N°: 330
Factors associated with the outcome of cryotherapy in the management of warts

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Introduction & Objectives:

Viral warts constitute a worldwide health problem. Although several treatments including cryotherapy have been recommended for warts, the effect of patient's own characteristics on treatment outcome has not been sufficiently investigated. The aim of this study was to explore the demographic, clinical and lifestyle factors influencing the response of warts to cryotherapy.

Materials & Methods:

147 patients attending the dermatology clinic of Farshchian hospital (Hamadan, west of Iran) between January 2019 and March 2020 for treatment of warts were included in the study. The patients had previously received no treatment for their warts. Patients' demographics, the number and location of warts and the disease duration were recorded. Data regarding lifestyle habits (smoking and alcohol consumption) and pregnancy status were also recorded. A patient was considered a responder if his/her warts disappeared completely within 6 cryotherapy sessions, with no wart relapse for at least one month after the last session. Univariable and multivariable logistic regression analyses were applied to assess the association between explanatory variables and outcome variable (response to cryotherapy).

Results:

Of 147 patients, 39 (26.5%) were non-responders and the remaining 108 patients (73.5%) were responders. Multivariable logistic regression analysis revealed that pregnancy was significantly associated with non-

response to treatment (OR = 29.103; 95% CI = 3.462, 244.651; p = 0.002). No significant association was found between other variables and response to cryotherapy.

Conclusion:

Pregnancy is associated with elevated odds of having treatment-resistant warts. This association may be explained by the altered maternal immune responses during pregnancy.

**Abstract N°: 363****Dermoscopic evaluation of a case of successfully treated Kerion**Rohit Kothari, MD¹¹Buckinghamshire Healthcare NHS trust, Dermatology, Amersham, United Kingdom

Introduction: The data on dermoscopy of Kerion is extremely scarce. A negative dermoscopy may be observed in up to 30% of tinea capitis patients and it is common (~75% patients) to get only crusts on dermoscopy of Kerion. No follow-up dermoscopy data is available in the literature.

Case: A 4-year old boy was brought with a history of an erythematous boggy swelling over the right side of his scalp associated with hair loss, recurrent pustules, pain, and itching. He had received multiple courses of oral antibiotics without any significant relief. Dermoscopy revealed a diffuse erythematous background, areas of hair loss, yellowish-white crusts and scales, pustule, broken hairs, and erosion. A pus-swab and scraping from the lesion didn't show any organism. Culture of the plucked hair sample was suggestive of *Trichophyton verrucosum*. He was diagnosed as Kerion and started on 1% terbinafine cream and oral terbinafine 125 mg (based on his weight) for six weeks. A follow-up post-treatment revealed complete clearance of the infection; however, there was associated scarring and hair loss. Dermoscopy revealed significant resolution of the erythematous background which was replaced by a predominant brownish background, multiple regrowing hairs, adnexal openings, and scarring alopecia with mild patchy erythema. There was complete resolution of pustule, crusts, scales, and erosion on dermoscopy after the treatment.

Conclusion: A follow-up dermoscopy is an important tool in assessing the treatment response in this serious infection. The disappearance of erythema, pustule, crusts, scales, and erosion signified an adequate treatment response in our patient.





Abstract N°: 381

Emergomycosis: a twisted tale of the toxic trio

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Introduction & Objectives:

Emergomycosis is an emerging opportunistic fungal infection among individuals living with HIV, with cases reported in North America, Europe, Asia and Africa.

First reported in 1998 (on histology from 1994), South Africa has the highest number of reported cases worldwide, with 68 documented cases in the literature

Clinical features, as well as histological and fungal culture features greatly overlap with other deep fungal infections, most commonly *Histoplasma capsulatum*, making PCR the gold standard for diagnosis.

With a 50% mortality rate, awareness needs to be raised around Emergomycosis, allowing for early diagnosis and treatment.

Materials & Methods:

We present a 38 year old female patient of black African descent, referred from Internal Medicine under whom she was admitted for fever of unknown origin.

During her tumultuous 2 month admission, she was first diagnosed with an adverse drug reaction secondary to antibiotics she had received for a pneumonia 3 weeks prior. With associated clinical signs and blood findings, this diagnosis was further strengthened by a skin biopsy in keeping with this diagnosis.

Following treatment of the above the patient improved but soon developed a new rash on her face suggestive of a papular mucinosis, prompting another biopsy.

Given the improvement of her symptoms and negative work up for opportunistic infections, the patient was started on ARV's. A week later the patient developed an acute change in clinical picture. Her facial rash became worse, with regard to size, number and clinical appearance and a new rash developed on her upper torso. Assessment of her skin was in keeping with a suspected deep fungal infection, and the concern for unmasking histoplasmosis IRIS was raised.

Results:

Histology findings on the facial lesions biopsied prior to ARV initiation were expedited and found to show fungal spores on special stains, in keeping with *Histoplasma capsulatum*. In light of these findings, the first biopsy done at the beginning of the patients admission, which was concluded to be in keeping with an adverse drug reaction, was reviewed with special stains which showed the same fungal spores mentioned above. The biopsy of the new rash that developed after ARV initiation also showed fungal spores.

Positive fungal cultures were sent for PCR, confirming the diagnosis of *Emergomyces africanus*.

Thus all of the patients presentations, originally misdiagnosed as pneumonia, an adverse drug reaction and papular muconosis were all secondary to *Emergomyces africanus*, with the eventual development of unmasking

Emergomycetes africanus IRIS which helped clinch the diagnosis.

This patient thus exhibited 3 distinct macroscopic skin pathologies from Emergomycetes africanus during her 2 month admission.

Conclusion:

HIV is still a heavy burden in developing countries, leading to unnecessarily high morbidity and mortality. Emergomycetes africanus has been recognised as an emerging AIDs defining opportunistic infection with poor outcomes.

Owing to the lack of awareness of this new dimorphic fungus, it's wide array of clinical presentations, the difficulty of differentiating it from other deep fungal infections clinically and on histology, Emergomycetes africanus continues to ravage the immunocompromised community.

Through sharing of this case and educating dermatologists, we hope to ensure earlier detection and diagnosis of this infection, improving outcomes of this vulnerable population.

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**Abstract N°: 438****Epidemiological and Clinical Features of Mycetomas in Tunisia: Insights from a 49-Year Study**Nouredine Litaïem¹, Malek Akid¹, Faten Zeglaoui¹¹University of Tunis El Manar, Tunis**Introduction & Objectives:**

Mycetomas are chronic infections of the subcutaneous tissues, characterized by the formation of grains resulting from invasion by exogenous fungal or actinomycotic agents. These infections are primarily endemic in tropical and subtropical regions, where environmental conditions favor their development. In Tunisia, mycetomas remain exceptional, making their recognition and management challenging.

Materials & Methods:

We conducted a retrospective study over 49 years (January 1976 – March 2025), including all patients who presented with fistulized swellings with grain discharge at the dermatology department of Charles-Nicoll Hospital in Tunis. The analysis was based on clinical, histological, and biological criteria.

Results:

The diagnosis of mycetoma was confirmed in 17 patients (mean age: 34.7 years) based on clinical, histological, and biological criteria. The average disease duration was 11.29 years. The causal pathogen was identified in 10 cases (4 actinomycotic and 6 fungal). The grains were black in 4 cases, white in 7 cases, and yellow in 2 cases. Actinomycotic species included *Actinomadura madurae* (2 cases) and *Streptomyces somaliensis* (2 cases), while fungal species included *Madurella mycetomatis* (4 cases) and *Pseudallescheria boydii* (2 cases). Lesions were exclusively localized to the feet in 15 patients, 11 of whom had a rural background, and 4 reported a history of prior microtrauma. One patient had an extrapodal location, presenting with bifocal involvement of the face and perineum. Bone involvement was observed in 11 patients, manifesting as osteitis (8 cases) or demineralization (2 cases). Antibiotic therapy was administered to 13 patients (cotrimoxazole/ampicillin in 4 cases, cotrimoxazole/amoxicillin in 1 case, and cotrimoxazole/dapsone in 1 case). Fungal mycetomas were treated with oral antifungals, including ketoconazole (200 mg/day) in 5 cases, itraconazole (400 mg/day) in 1 case, and terbinafine (500 mg/day) in 1 case. Surgery was required in 7 of the 11 patients with bone involvement. The outcome was favorable in 10 cases, while 3 patients were lost to follow-up.

Conclusion:

In Tunisia, mycetomas are rare and often underdiagnosed, leading to significant diagnostic delays and late management. This delay contributes to the progression of severe forms requiring prolonged treatment and, in some cases, mutilating surgical procedures, particularly in cases with bone involvement. The functional and aesthetic impact can be considerable, with significant psychological and socio-economic repercussions. Improving early diagnosis and access to appropriate antifungal and antibiotic treatments could help reduce complications and optimize patient outcomes.





Abstract N°: 493

Dual Cutaneous Tuberculids in Polyresistant Tuberculous Lymphadenitis: A Rare and Challenging Coexistence

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Introduction & Objectives:

Tuberculids are a rare group of cutaneous hypersensitivity reactions to *Mycobacterium tuberculosis* antigens, typically occurring in individuals with a competent immune system. Papulonecrotic tuberculid (PNT) presents as necrotizing papules, while erythema induratum (EI) manifests as chronic nodular vasculitis primarily affecting the lower limbs. Their simultaneous occurrence in a single patient is exceedingly rare, especially in the setting of polyresistant tuberculosis. Tuberculous lymphadenitis (TBL), the most common extrapulmonary manifestation of tuberculosis (TB), poses additional management challenges, particularly when associated with drug resistance.

Objectives: discuss the clinical presentation, histopathological findings, and treatment approach for dual cutaneous tuberculids and polyresistant TBL in a treatment naïve individual

Materials & Methods:

This is a case report on the occurrence of two distinct types of cutaneous tuberculids in a single patient with TBL and polyresistance to anti-tuberculous therapy (ATT).

Results:

A 34-year-old male presented with a painless cervical swelling persisting for three years, preceded by low-grade fever in the evenings and significant weight loss. He also developed erythematous, raised lesions on the trunk with central ulceration that appeared in crops and resolved within a week. HIV serology was negative.

Clinical and dermatological examination

- Firm, lobulated, matted cervical lymph node mass (7 cm) on the right side.
- Multiple discrete and confluent dull-red infiltrated papules with central necrosis and ulceration on the extremities
- Indurated plaques with central ulceration on the shins.

Histopathological findings from:

- Papulonecrotic lesion (trunk): aggregates of epithelioid histiocytes, langhans giant cells, necrotizing granulomas, and focal ulceration, consistent with papulonecrotic tuberculid.
- Indurated plaque (shin): deep dermal granulomas, necrotizing panniculitis, and septolobular necrotizing granulomatous inflammation, suggestive of erythema induratum.
- Cervical lymph node: necrotizing granulomatous inflammation, confirming tuberculous lymphadenitis.

Microbiological and drug susceptibility testing proved resistance to Streptomycin and Isoniazid, while retaining susceptibility to Rifampicin, Pyrazinamide, and Ethambutol. A final diagnosis of polyresistant tuberculous lymphadenitis with concurrent PNT and EI was established. The patient was initiated on Rifampicin (600 mg/day), Ethambutol (1200 mg/day), Levofloxacin (1 g/day), and Pyridoxine (10 mg/day). During six months of follow-up, complete resolution of cutaneous lesions was observed, with partial regression of cervical node. He was advised to continue ATT for a total of nine months and follow-up.

Conclusion:

This case highlights the rare co-occurrence of PNT and EI in a patient with polyresistant tuberculous lymphadenitis. The distinct clinicopathological features emphasize the importance of early diagnosis and recognition of cutaneous tuberculids, which can serve as important indicators of underlying systemic TB. Polyresistance in extrapulmonary TB presents a therapeutic challenge, making targeted ATT essential for optimal patient outcomes. Clinicians should maintain a high index of suspicion for cutaneous TB, particularly in endemic areas, to facilitate timely intervention and disease control.

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**Abstract N°: 519****Validation of Dermatophytosis Severity Score(DSS) in steroid modified tinea – A novel method in assessing the severity of dermatophytosis.**

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²Father Muller Medical college, Dermatology, Resident, Mangalore, India

Introduction & Objectives:

Steroid Modified Tinea or Tinea incognito is a form of dermatophytosis with modified clinical features due to topical or systemic corticosteroid use, leading to a rise in recalcitrant dermatophytosis in most of the developing country. Tinea incognito although used as a synonym to steroid modified, it also includes other immunomodulatory drugs like Tacrolimus.

Objectives: To assess the clinical severity of steroid modified tinea using a novel tool, dermatophytosis severity score. (DSS).

Culture and identification of fungi through MALDI-TOF technique.

Materials & Methods: A cross-sectional study was conducted on 100 patients presenting with tinea incognito in our outpatient department. Severity was assessed using DSS, which considered erythema, scaling, raised borders, and nail involvement. The diagnosis was confirmed through KOH examination, culture, and identification.

Results: Among 120 patients, a slight male predominance was observed, with most patients belonging to the working class. DSS scores indicated mild (<5) in 4 patients, moderate to severe (5-10) in 18, and >10 in 98. After 2 weeks of treatment, 15 patients had severe score, moderate in 36 and mild in 69. Eczema-like conditions were the most prevalent clinical manifestation. There were steroid induced skin lesions like Atrophy, Striae, Hypopigmentation and Telangiectasia. also Clobetasol propionate was the most commonly used topical steroid (76 cases), followed by betamethasone dipropionate (13). Trichophyton mentagrophytes was the predominant fungal isolate. KOH examination and culture were positive in 85 and 78 cases respectively. Most of the patients received these steroids as a combination cream mainly dispensed by Pharmacists.

Conclusion: This study underscores the dangers of unsupervised topical steroid use, which exacerbates disease severity, prolongs treatment duration, and increases resistance. It highlights the need for greater awareness regarding the risks of self-medication with topical steroids. Strict vigilance and implementation of legal interference is required to combat this global threat of steroid misuse.





Abstract N°: 538

Comparing emollient use with topical luliconazole (azole) in the maintenance of remission of chronic and recurrent dermatophytosis. An open-label, randomized prospective active-controlled non-inferiority study

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¹All India Institute of Medical Sciences, Rajkot (AIIMS Rajkot), DERMATOLOGY, VENEREOLOGY & LEPROLOGY, Rajkot, India

Introduction & Objectives:

Background:

Despite continuing the topical or systemic therapy after clinical cure, many patients report recurrence of tinea lesions in due course. The chronicity of dermatophytosis is a major challenge to the dermatologists to manage patients nowadays

Objective:

To assess the efficacy of emollient in the remission maintenance of chronic and recurrent dermatophytosis

Materials & Methods:

In this randomized open-label study with the intention to treat, 80 patients with chronic recurrent dermatophytosis were randomized into two groups, where both groups were treated adequately for 6 weeks, followed by continuation of topical azole in group A and topical emollient in group B for 6 weeks. Clinical remission was determined by disappearance signs and symptoms of tinea lesions with or without hyperpigmentation. Physician and patient global assessment scores were evaluated every 2 weeks for 6 weeks to assess remission maintenance.

Results:

A total of 80 patients of chronic and recurrent dermatophytosis were assessed for remission maintenance. The recurrence of disease occurred in 20 patients overall, wherein 7 patients (17.5%) in group A and 13 patients (32.5%) in group B at the end of the study (18 weeks); however, the difference between the two groups was not statistically significant ($p = .121$). The mean physician global assessment scores of group A and group B at 12 weeks were 4.45 ± 0.74 and 4.15 ± 0.92 , 4.43 ± 0.90 and 4.10 ± 0.98 at 14 weeks, 4.0 ± 1.32 and 3.98 ± 1.23 at 16 weeks, 3.85 ± 1.44 and 3.90 ± 1.35 at 18 weeks, respectively. The mean patient global assessment scores of group A and group B were 4.65 ± 0.62 and 4.25 ± 0.87 at 12 weeks, 4.40 ± 0.87 and 4.17 ± 0.98 at 14 weeks, 4.18 ± 1.15 and 4.12 ± 1.30 at 16 weeks and 3.97 ± 1.33 and 3.90 ± 1.51 at 18 weeks.

Conclusion:

The present study concluded that the efficacy of emollient was not inferior to topical luliconazole for maintaining remission in chronic and recurrent dermatophytosis



**Abstract N°: 563****Persistence of Leprosy Granuloma After 12 Years of Multidrug Therapy: A Rare Case Report**Shama Naaz^{*1}¹C K Birla Hospital, Dermatology, Gurugram, India**Introduction & Objectives:**

Leprosy is a chronic infectious disease commonly caused by *Mycobacterium leprae*, that primarily affects the skin and peripheral nerves. Leprosy has been considered curable after the introduction of multi-drug therapy (MDT). While MDT is highly effective in eliminating viable bacilli, histopathological changes may persist post-treatment, raising questions regarding long-term tissue response and immunological memory. We present a case of a 33-year-old male diagnosed with lepromatous leprosy, who completed 12 months of multibacillary multi-drug therapy (MB-MDT) 13 years ago and was considered clinically cured, but histopathology of the old, healed lesions showed multiple granulomas. This case highlights the significance of post-treatment monitoring for leprosy patients, emphasizing the importance of histopathological and immunological evaluation in clinically cured cases.

Case report:

A 33-year-old male, previously diagnosed with lepromatous leprosy, successfully completed 12 months of MB-MDT in 2011. He presented to our outpatient department (OPD) with multiple old, healed lesions over the upper limbs, lower limbs, and trunk. He reported no new sensory loss, no new lesions, and no history of fever. Clinical examination revealed multiple atrophic scars with mild erythema in some areas, but no signs suggestive of active leprosy or Type 1 or Type 2 lepra reactions. A slit skin smear was negative for acid-fast bacilli, ruling out bacterial persistence. Histopathological examination of a skin biopsy revealed granulomas composed of vacuolated macrophages with lymphocytic infiltration, consistent with a residual immune response rather than active infection. Fite-Faraco staining did not detect any acid-fast bacilli, further supporting the absence of viable *M. leprae*.

Discussion:

Leprosy is considered clinically cured when patients become bacteriologically negative and demonstrate no signs of disease activity. However, histopathological remnants of granulomas, inflammatory infiltrates, and tissue remodeling may persist, as seen in prior studies where granulomatous changes persisted in a subset of patients despite bacterial clearance. The presence of vacuolated macrophages with lymphocytic infiltration likely represents a regressing immune response rather than relapse. Such findings emphasize the need for long-term dermatological and histopathological follow-up to differentiate between true relapse and post-treatment residual changes.

Conclusion:

This case underscores the importance of post-treatment surveillance in MB leprosy patients, even in the absence of clinical symptoms suggestive of relapse. Persistent histological changes do not necessarily indicate active infection, but careful monitoring is required to differentiate between residual immune response and true disease reactivation. Future research should focus on understanding long-term immune-mediated changes post-MDT and their implications in leprosy management.





Abstract N°: 619

Erbium-YAG Laser treatment for recalcitrant warts: a retrospective analysis

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Introduction & Objectives:

Introduction : Viral warts are the result of keratinocyte infection caused by the human papillomavirus (HPV), usually represent as benign growths of epithelial tissue. Those afflicted often experience a notable decline in their quality of life due to these lesions, which can also lead to functional issues and physical discomfort. Laser technology has introduced novel approaches in treating viral warts, especially ablative lasers such as CO₂ and Erbium-YAG (Er:YAG) lasers.

Er:YAG laser gained recognition as a safe and effective method for addressing viral warts. Nevertheless, different recurrence rates have been reported in medical literature following treatment using Er:YAG laser, ranging from 24% to 71%

Objectives : To evaluate the recurrence rate and the risk factors that might affect it following successful treatment of warts using an Er:YAG laser.

Materials & Methods:

A retrospective chart review analysis of all 245 patients who underwent an Er:YAG laser wart removal between January 2019 and July 2023 was conducted. The main outcomes measures were response rate and number of sessions required to get complete clearance.

Results:

There was an overall complete resolution rate of 71.6% at 12 months follow-up. Four parameters were found to affect the response rate: the number of sessions until complete response, duration of the wart present before the laser treatment, smoking, and periungual wart location.

Conclusion:

Er:YAG laser is an effective method for treating recalcitrant warts, different risk factors were proven to effect its efficacy.



**Abstract N°: 676****Lewandowsky rosaceiform eruption: unmasking tuberculosis amidst rosacea mimicry**

Erika Zúñiga Ramírez^{*1}, Fernando Galván Fernando¹, Diana Abarca Duque¹, Valerie Dafne Alcantara Ramirez¹, Diana Valeria Guerrero Hernández¹, Salvador Gutierrez¹

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Introduction & Objectives:

Cutaneous tuberculosis (TB) is a chronic infectious disease caused by *Mycobacterium tuberculosis*. Nodular facial tuberculid, or Lewandowsky's rosaceiform eruption, is a rare variant of cutaneous tuberculosis, representing less than 1% of all cases. Misdiagnosis can lead to delayed treatment and potential complications. It represents a paucibacillary form of the disease, where the lesions are not inhabited by the mycobacterium. This case describes a patient with Lewandowsky's rosaceiform tuberculid, highlighting the importance of proper differential diagnosis to optimize therapeutic approaches in these rare presentations.

Materials & Methods:

A 47-year-old male presented with pruritic erythematous lesions on his face. Dermatoses was localized to the head, affecting the frontal region, dorsum of the nose, and bilateral malar region. It was characterized by multiple semicircular papules, 2 to 5 mm in diameter, erythematous, smooth, with well-defined borders, and pruritic. The lesions had been present for 6 months. Initially diagnosed as rosacea, treatment with a calcineurin inhibitor and topical antiparasitic was indicated, without improvement. A skin biopsy revealed an adnexal and periadnexal lymphohistiocytic infiltrate, with the presence of eosinophilic necrotic material in the center and tuberculoid granuloma formation. A diagnostic protocol for systemic tuberculosis was performed with purified protein derivative (PPD), which was positive at 72 hours with an induration of 34 mm, a positive interferon-gamma release assay (IGRA); sputum acid-fast bacillus (AFB), GeneXpert, and chest X-ray showed no alterations. A diagnosis of nodular facial tuberculid was made based on clinicopathological correlation of the biopsy and positive laboratory studies. Antituberculous therapy was initiated with an intensive phase for 2 months and a maintenance phase for 9 months. Lesion clearance was observed from the first month of treatment.

Results:

Lewandowsky's rosaceiform tuberculid arises from hypersensitivity to *M. tuberculosis* due to prior exposure and high levels of immunity. Clinically, the disease has a predilection for the face, manifesting as erythematous or yellowish, translucent, millimeter-sized nodules or papules, with a rapid course and recurrent outbreaks. The definitive diagnosis of this infection is difficult to make as it is a paucibacillary form of the disease; the usual methods of identifying the causative mycobacterium have limited detection capability, making histological differentiation crucial. Only 28% of TB cases are associated with systemic TB. Treatment is based on anti-tuberculosis drugs, with the same regimen as for systemic tuberculosis.

Conclusion:

Nodular facial tuberculid is a rare and particularly complex entity to diagnose, requiring high clinical suspicion, as it presents similarity with other more common dermatoses; in addition, it is not always possible to detect a primary infectious focus. Therefore, accurate clinicopathological integration and biochemical testing are essential for assertive clinical diagnosis and timely patient treatment leading to successful resolution of lesions.

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Abstract N°: 687

Unmasking the Unexpected: Genital and Mucosal Manifestations of Leishmaniasis – A Diagnostic ChallengeSara Catano^{*1}, Juan Ochoa², Claudia Arenas³, Juan Orozco⁴, Samuel Morales³, Karol Blanco³¹Pontificia Universidad Javeriana, Dermatology, Bogotá, Colombia²Fundación Universitaria Sanitas, Dermatology, Bogotá, Colombia³Centro Dermatológico Federico Lleras Acosta, Dermatology, Bogotá, Colombia⁴Pontificia Universidad Javeriana, Dermatology, Bogotá, Colombia

Introduction & Objectives: Mucocutaneous leishmaniasis (MCL) is a rare but severe form of leishmaniasis primarily affecting the nasal, oropharyngeal, and laryngeal mucosa. While cutaneous and mucosal involvement is well-documented, cases including **penile mucosa** are exceptionally rare and pose a significant diagnostic challenge. Such cases are often misdiagnosed as sexually transmitted infections (STIs) or autoimmune diseases, leading to delayed treatment and severe complications. Early detection and appropriate management are crucial to preventing disfiguring sequelae. This report presents a highly unusual case of MCL with nasal, oral, and **penile involvement**, emphasizing the diagnostic and therapeutic challenges.

Materials & Methods: A 48-year-old male from an endemic region presented with a five-year history of progressive nasal obstruction, recurrent expectoration, and ulcerative lesions on the hard palate and lips. Over the past year, he developed infiltrated erythematous-violaceous plaques with ill-defined borders, superficial erosions, and serohematic crusts on the nasal dorsum, upper lip, and cheeks, leading to progressive nasal collapse with a characteristic deformity. The oral mucosa exhibited multiple exophytic, vegetative plaques with irregular surfaces on the soft palate and oropharynx. **Most notably, the glans penis displayed three well-demarcated infiltrated ulcers with an erythematous base, an extremely rare manifestation of MCL.**

Two biopsies were performed—one from the nasal mucosa and another from the genital lesion—both revealing nodular granulomatous inflammation rich in plasma cells. Histopathological findings confirmed MCL. Immunofluorescence antibody testing for Leishmania was negative. The patient had a history of cutaneous leishmaniasis 20 years earlier but did not receive adequate treatment. He remained asymptomatic for 15 years until the current presentation.

Results: The histopathological examination of nasal mucosa and penile lesion biopsies revealed nodular granulomatous inflammation with plasma cells and amastigotes within macrophages, confirming MCL. The patient was treated with systemic pentavalent antimonials, showing significant clinical improvement, with regression of mucosal and **genital lesions**.

Conclusion: This case represents an **extraordinarily rare** presentation of **MCL involving penile mucosa** highlighting the need for increased clinical suspicion in endemic regions. Genital lesions may mimic syphilitic chancres, herpes simplex, or inflammatory dermatoses, leading to misdiagnosis and treatment delays. The unusual involvement of penile mucosa further complicates the clinical picture and underscores the importance of thorough evaluation, including biopsy and molecular testing. **Early diagnosis and prompt treatment are crucial** to preventing disfiguring complications. Greater awareness among dermatologists and infectious disease specialists is necessary to improve early recognition and outcomes for these **highly atypical** presentations.



Abstract N°: 728

De Novo Histoid Type Lepromatous Leprosy in a 40-Year-Old PatientJaymee Quindara¹, Maritess Macaraeg¹¹Philippines, Dermatology, Dagupan City, Philippines

Introduction & Objectives: Leprosy, often referred to as “the great mimicker,” presents with a diverse range of clinical manifestations, complicating diagnosis. Histoid leprosy, a rare variant, exhibits distinct features that diverge significantly from classic lepromatous leprosy. Despite a notable decline in global leprosy cases due to effective multidrug therapy, the disease persists in many regions, with rare instances of histoid leprosy remaining. This is critical, as patients with histoid leprosy can serve as silent reservoirs of bacilli, heightening the risk of transmission and resistance to standard treatments.

Materials & Methods: We present a case of a 40-year-old male patient with a 7-month history of multiple erythematous to flesh-colored, well-demarcated, soft, hypoesthetic nodules primarily located on the trunk, back, and extremities. He had no prior history of leprosy. Dermoscopy revealed rim hyperpigmentation, linear blood vessels, and yellow-orange structureless areas. A 4.0 mm skin punch biopsy demonstrated atrophic epidermis, dense mixed cellular infiltrates of foamy, epithelioid, and spindle-shaped histiocytes, along with numerous lymphocytes in the superficial and deep dermis extending into the subcutaneous tissue, and collagen trapping. Fite-Faraco staining indicated a Bacillary Index of 6+ with globi formation, leading to a diagnosis of multibacillary lepromatous leprosy, histoid type. The patient was treated with a 24-month multidrug therapy (MB-MDT) regimen. At the three-month follow-up, there was a significant reduction in the size and number of lesions, with no new lesions observed.

Results: Histoid leprosy is a distinctive variant often seen in patients with a history of brief sulfone therapy, dapsone monotherapy, or those who relapse. It can clinically mimic various conditions, including xanthoma, neurofibroma, dermatofibroma, and reticulohistiocytosis. Dermoscopic findings typically align with granulomatous skin conditions, while histopathology reveals epidermal atrophy and characteristic histiocyte patterns. This case underscores the rarity of histoid leprosy and the necessity for ongoing vigilance in leprosy management. Although there is no formal consensus on the treatment of histoid leprosy, this case illustrates that standard MB-MDT can lead to significant clinical improvement.

Conclusion: This case highlights the importance of recognizing histoid leprosy as a rare but significant variant of leprosy especially in Public Health. Continued awareness and vigilance are essential for early diagnosis and management, as patients with histoid leprosy may pose a risk for transmission and treatment resistance.



**Abstract N°: 772****MRI Findings in Sporotrichoid Leishmaniasis: Fascial and Lymphatic Dissemination in Disease Evolution**Gokhan Okan*¹, Mustafa Ozates²¹Istanbul Aydin University, Dermatology, Istanbul, Türkiye²HSM Radiology Center, Radiology, Istanbul, Türkiye

Introduction: Sporotrichoid leishmaniasis is a rare and atypical form of cutaneous leishmaniasis that occurs due to the direct extension of the parasite into the subcutaneous tissue or its dissemination via hematogenous and lymphatic routes.

Case: A 29-year-old Uzbek female patient presented to the dermatology clinic with an ulcerated, inflammatory nodular skin lesion on her right arm, persisting for two months. Her medical history revealed a history of an insect bite during a trip to Uzbekistan. Dermatological examination showed ulcerated, nodular lesion on the right arm. Histopathological evaluation showed intense inflammatory infiltrates; however, no *Leishmania* bodies were detected. PCR analysis confirmed the diagnosis of *Leishmania major*.

Due to limited access to Glucantime and the unavailability of Mefloquine in Turkey, treatment with Itraconazole (200 mg/day for 2 months) and topical Imiquimod (3 times per week for 3 months) was initiated. However, after three months, the disease progressed to a sporotrichoid form (Figure 1). MRI findings revealed intense edema at the posteromedial aspect of the distal right arm, adjacent to the elbow joint, along with lymphadenopathy. Axillary lymphadenopathy was also noted (Figure 2).

The treatment regimen was switched to liposomal amphotericin B.

Result: Treatment with 3 mg/kg/day liposomal amphotericin B resulted in the regression of the lesions.

Conclusion: Sporotrichoid leishmaniasis can present with atypical deep tissue involvement, including fascial and lymphatic dissemination. Early diagnosis and appropriate treatment are crucial to managing the progression of the disease.



**Abstract N°: 831****Coccidioidomycosis Presenting with Acute Change in Mental Status and Skin Lesions in an Immunocompetent Patient**

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Introduction & Objectives:

Coccidioidomycosis, also known as Valley fever, is a fungal infection caused by the dimorphic fungi *Coccidioides immitis* and *Coccidioides posadasii*. Endemic to certain regions—particularly the southwestern United States—it presents with a wide clinical spectrum, ranging from mild respiratory symptoms to severe disseminated disease affecting the skin, central nervous system, and bones. While disseminated coccidioidomycosis is more common in immunocompromised individuals, it can also affect immunocompetent patients.

Case Report:

A 71-year-old male presented to the dermatology clinic with acute-on-chronic confusion, lethargy, and a rapidly evolving fungating mass on the nasal tip, along with erythematous, heme-crusting papules on the chest and back. He also reported right periocular pain and tingling. Given the acute mental status changes and concern for disseminated infection, multiple skin biopsies and wound cultures were obtained. The patient was referred to the emergency department for expedited evaluation. Histopathology revealed pseudoepitheliomatous hyperplasia, granulomatous inflammation with giant cells, and fungal spherules consistent with *Coccidioides*, confirmed across multiple biopsy sites. Direct immunofluorescence was negative. Imaging revealed mediastinal lymphadenopathy, pulmonary consolidations, and an occipital brain lesion with edema. CSF testing showed positive *Coccidioides* antibody, indicating CNS involvement. He was diagnosed with disseminated coccidioidomycosis and initiated on oral fluconazole 800 mg daily for three months. The patient experienced marked improvement in both mental status and cutaneous lesions.

Discussion:

Coccidioidomycosis is acquired via inhalation of arthroconidia released from soil in endemic areas such as California's Central Valley and the southwestern U.S. While most cases remain asymptomatic or present as self-limited respiratory illness, approximately 1% progress to disseminated disease. Dissemination typically affects the skin, bones, joints, and central nervous system and is more frequently observed in individuals who are immunosuppressed, pregnant, elderly, or of certain ethnic backgrounds.

However, this case illustrates that disseminated coccidioidomycosis can occur even in immunocompetent individuals, challenging the conventional clinical assumption that dissemination is largely restricted to high-risk populations. The absence of known risk factors in this patient may have delayed recognition of the systemic nature of his illness. His rapidly evolving cutaneous lesions, particularly the fungating nasal mass and heme-crusting papules, served as crucial early signs of deeper infection.

Early dermatologic assessment and biopsy played a pivotal role in guiding the diagnosis. Continued dermatologic follow-up is essential, particularly to monitor post-inflammatory changes and ensure complete resolution.

Conclusion:

This case highlights the critical role of dermatologists in identifying early cutaneous clues to systemic fungal

infections, even in patients without classic risk factors. Dermatologic findings may be the first and only external sign of a potentially life-threatening internal disease. Clinicians should maintain a high index of suspicion for disseminated fungal infections regardless of immune status, especially when confronted with rapidly evolving or atypical skin lesions.

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**Abstract N°: 873****Persistence of Hansen's Disease in Northern Mexico: A Statistical Analysis from an Endemic Referral Center in the Post-Elimination Era**

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Introduction & Objectives:

Hansen's disease (HD), a neglected tropical disease, was officially eliminated as a public health problem globally by 2000 (defined as <1 case per 10,000 inhabitants) according to the World Health Organization (WHO). Despite this milestone, over 200,000 new cases are reported annually in over 120 countries, particularly in Southeast Asia and Africa. In Mexico, 300 prevalent cases were documented in 2023, distributed across 18 states, reflecting ongoing endemicity. The objective of this study was to analyze epidemiological trends of HD in a referral center in Northern Mexico between 2007 and 2023, highlighting demographic features, clinical variants, treatment status, relapse incidence, and cases requiring treatment for drug resistance.

Materials & Methods:

A retrospective analysis was conducted of all patients diagnosed and treated for HD at our Hansen's Clinic from 2007 to 2023. Variables analyzed included age, sex, clinical classification, treatment status, resistance management, and geographic distribution. Newly diagnosed cases from 2024 and 2025 were also reviewed. Descriptive statistics were used.

Results:

A total of 131 HD cases were registered (M:F ratio 1.3:1), predominantly affecting individuals aged 58–68 years (26.7%) and ≥69 years (25.2%). Most cases originated from the state of Nuevo León (94.6%). The lepromatous form (LL) accounted for 77% of cases, followed by tuberculoid (LT, 10%), borderline (LI, 7%), diffuse (LD, 5%), and histioid (LH, 1%) forms. Annual case numbers ranged from 3 to 20, with a peak in 2015. Currently, 15 patients remain under active treatment, including 12 multibacillary cases and one case receiving therapy for drug resistance. Additionally, 29 patients are under post-treatment surveillance and 77 have completed monitoring. Notably, 4 new relapse cases were identified in 2024–2025, all with LL subtype and prior diagnoses between 1998–2019.

Conclusion:

Despite WHO's declaration of HD elimination as a public health problem, endemic regions in Mexico continue to face a sustained burden of Hansen's disease, predominantly lepromatous type, with relapses, multibacillary cases, and the emergence of drug resistance. These findings highlight the gap between global targets and local realities, underscoring the need for continued surveillance, specialized care, and public health efforts to address persistent foci and resistance challenges in "post-elimination" countries.





Abstract N°: 878

Early congenital syphilis: a case series

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Introduction & Objectives:

Congenital syphilis has been re-emerging in the past few years. According to the Centers for Disease Control in 2019, there were a total of 1,870 cases, with national rate of 48.5% per 100,000 live births, with a 477% rate increased compared to 2012. In the Philippines, there is no current data on the incidence of congenital syphilis. Low economic status, poor prenatal care, inadequate treatment, and unsafe sexual practices increases the risk of infection which can also result to infection during gestation.

Materials & Methods:

We described 3 cases of newborn infants born preterm via normal spontaneous vaginal delivery to young mothers, ages ranging from 19 to 22 years old, with inadequate prenatal care, early coitarche, and multiple sexual partners with little to no use of contraception. At birth, the first and second cases presented with generalized flaccid bullous lesions, some with beginning desquamation. The third case presented with generalized desquamating plaques. All mothers and infants were reactive for syphilis treponemal tests and non-treponemal tests. Baseline titers of rapid plasma reagin (RPR) were done for case 1 and case 3 for monitoring of effectivity of treatment. All patients were treated with intravenous aqueous Penicillin G with good outcome except for the second case who died at 32 hours of life due to acute respiratory failure secondary to neonatal pneumonia.

Results:

All 3 infants were born prematurely with the second case dying of acute respiratory failure, and the last case having low birth weight. Clinical manifestation is variable, the most common being fever, organomegaly, lymphadenopathies, pneumonitis, snuffles and mucocutaneous lesions. The typical skin finding in early congenital syphilis is a symmetrical copper-red maculopapular eruption that affects the hands and feet. Rarely, it can present with vesicubullous lesions at birth, termed pemphigus syphiliticus, which commonly presents on the palms and soles, but can be generalized, as seen in the first 2 cases, and the last case presenting with desquamating plaques which can be difficult to diagnose. Diagnostics include treponemal and non-treponemal tests, or through direct visualization of the spirochete, such as in skin punch biopsies. It is recommended by CDC that screening for syphilis should be included in prenatal care and should be done during the first visit. Neonates born to seropositive mothers should also be tested even if asymptomatic. A negative titer does not exclude the diagnosis congenital syphilis.

Penicillin G is still the most effective antibiotic and is given at 50,000mg/kg/dose every 12 hours for 7 days then every 8 hours if treatment goes beyond 7 days until 10-14 days. Ideally, seropositive mothers should be treated to avoid unwanted long-term sequelae. After completion of treatment, serial nontreponemal serological test to monitor decreasing titers and should be done at 3 months, 6 months and at 12 months of age or until titers become negative as a marker for successful treatment.

Conclusion:

Congenital syphilis is a re-emerging but preventable and treatable disease. It is of utmost importance that

mothers receive adequate prenatal care, screening, and treatment during pregnancy. A careful history facilitates early diagnosis and treatment. Close follow-up is important, and counselling of the mothers is crucial for future pregnancies.

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Abstract N°: 916

Tinea Imbricata: a diagnosis to consider for an annular dermatosis

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Introduction & Objectives:

Tinea imbricata is a rare fungal infection caused by *Trichophyton concentricum*, characterized by figured skin lesions. Its distribution is geographically limited. This case highlights the clinical, epidemiological, and mycological aspects of this unusual infection. To our knowledge, it is the first reported case in Morocco.

Materials & Methods:

We report the case of a 34-year-old man, residing in Morocco, of Pakistani origin, with no significant medical history or animal contact. He reports similar lesions in two family members in Pakistan. He had an annular, pruritic, scaly lesion on his left inner thigh for 4 months, initially treated with topical corticosteroids, which worsened and spread.

Dermatological examination revealed: Erythematous, concentric, well-defined lesions on the inner thighs with fine white scales, and erythematous, scaly papules in the inguinal area.

The suspected clinical diagnosis was an atypical dermatophyte infection, and mycological testing confirmed *Trichophyton concentricum*. Treatment with local and oral terbinafine (250 mg) for 4 weeks showed improvement by the second week.

Results:

Tinea imbricata is a rare superficial mycosis caused by the anthropophilic dermatophyte *Trichophyton concentricum*. It is mainly found in regions like Oceania, Southeast Asia and Central and South America, with cases among immigrants, suggesting that travel and immigration may play a role.

There are no established statistics on it in Morocco.

Transmission is human-to-human, affecting both sexes and all ages, typically acquired in childhood.

Predisposing factors include hot and humid climates, poor hygiene, skin microbiota and genetic and immunological factors. Only a few cases have been reported outside endemic areas despite a prolonged cohabitation, as in the case with the patient's spouse, suggesting a potential genetic predisposition.

Diagnosis is clinical, based on the finding of a pruritic, concentric, annular, or lamellar lesions with scaly borders that can generalize. The use of topical corticosteroids may mislead the diagnosis. Lesions often affect the trunk, limbs, and face, sparing nails, palms, soles, and hair. It is highly contagious due to the scales rich in arthrospores. *Trichophyton concentricum* grows slowly, forming cream colonies with a smooth, waxy, wrinkled surface. Microscopy shows irregular, branched hyphae.

Lesions may evolve chronically, with risks of post-inflammatory dyschromia and lichenoid changes.

The treatment of choice is oral antifungals, such as terbinafine (250 mg) or griseofulvin (1000 mg daily) for 4 weeks. Topical antifungals and keratolytics may be added. Spontaneous improvement is rare, and relapses are

common, especially in genetically predisposed individuals.

Conclusion:

Concentric lesions present a diagnostic challenge. Despite its geographic limitations, *Tinea imbricata* should be considered. This case underscores the importance of diagnostic vigilance and appropriate therapy to prevent exacerbation under unsuitable treatment.

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**Abstract N°: 1024****Management of complications following leprosy : a 60 year old story**

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Introduction & Objectives:

Leprosy is a chronic, granulomatous disease caused by *Mycobacterium leprae*. Multidrug therapy (MDT) for leprosy has been a huge global success.

However, if leprosy is left untreated or treatment is delayed, it can cause progressive and permanent damage to tissues and nerves, leading to skin sores, ulcerations, physical deformities, severe disfigurements, and disabilities. As a result, leprosy is a major cause of preventable disability. Physical impairment associated with leprosy is usually secondary to nerve damage resulting from the chronic granulomatous inflammation due to *Mycobacterium leprae*.

Case:

An 81-year-old male patient presented with ulcer on his left hand and right foot. His complaints had been present for about 1 year. It was learned that the patient was diagnosed with leprosy 60 years ago, received 6 months of dapsone treatment, and various complications developed in the 10 years following the treatment. When our patient came to us, he had been left untreated for 10 years because the leprosy hospital in his city had closed due to a lack of cases. In the dermatological examination, lagophthalmos in both eyes, corneal opacity, total destruction of bulbus oculi, total destruction and flexion contracture of the finger joints, a 2 cm ulcer on the palmar side of the left hand, and autoamputations of the toes were observed. Education was provided to the patient with neuropathy symptoms and deep neuropathic ulcers. It was explained how to protect their feet and hands, which do not have a sense of pain, from mechanical, thermal, and chemical traumas. During each check-up, the feet and hands were examined. Regular foot care-hygiene, appropriate shoes, and insoles prevented the formation of new ulcers. Due to foul-smelling discharge and pain from the ulcer on the right foot, an MRI examination was requested, and after consulting with infectious diseases, systemic antibiotic treatment was started according to the antibiogram results. For the non-epithelialized ulcer on the hand, a plastic surgery consultation was obtained, and gentle debridement was performed for wound care. Antiseptic solution and topical antibiotics were added to the treatment.

Results:

A study has shown that the cumulative probability of progression (worsening) of the physical disability (PD) grade of people treated and bacteriologically cured of leprosy increases with time. After 10 years this probability was 30%. Preventing disability is one of the priorities of the Global Leprosy Strategy. New deformities continue to develop in certain forms of leprosy despite therapy. A deformity plays a major role in stigma associated with leprosy. Treatment of leprosy case doesn't end with completion of multi-drug chemotherapy. Long-term & regular follow up of patients who have been released from treatment is required. On the other hand, any delay in starting treatment increases the risk of PD developing in the post-release period. For this reason, disability prevention measures including regular medical review of the former patients are recommended to continue after the completion of the MDT treatment. For this, primary care would need to be restructured to ensure the provision of standardized and quality services post-release from treatment.

Conclusion:

Since leprosy complications affect many systems, they should be treated with a multidisciplinary approach. More importantly, to prevent the development of complications, leprosy patients should be regularly monitored.

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**Abstract N°: 1078****Beyond the surface: Unlocking enhanced antifungal efficacy through comparison between luliconazole alone and luliconazole with salicylic acid peel synergy in dermatophytosis.**

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Introduction & Objectives: Superficial dermatophytosis has high recurrence rates, necessitating the need for newer, more cost-effective, and better-tolerated treatment modalities.

The primary objective of this study is to undertake a comparative evaluation of the efficacy and safety profiles between the use of luliconazole 1% cream alone and the combination therapy of luliconazole 1% cream with 30% salicylic acid peel in superficial dermatophytosis.

Materials & Methods: This interventional, prospective, comparative follow-up study enrolled 320 patients with superficial dermatophytosis, divided into two groups: Group 1 (n=160) received luliconazole 1% cream alone, while Group 2 (n=160) received combination therapy with 30% salicylic acid peel and luliconazole 1% cream. This clinical trial enrolled immunocompetent adults (≥ 18 years) at a tertiary dermatological center. Following stratified randomization, subjects received treatment according to either group 1 or 2 for four consecutive weeks. Mycological verification was performed using the cellophane tape KOH mount technique. The salicylic acid (30% w/v) was compounded by dissolving salicylic acid crystals in propylene glycol, with standardized application limited to 3g per session. Luliconazole 1% cream was advised twice daily with centrifugal application extending 1cm beyond lesion margins, clinical assessments utilizing validated PASI scoring methodology and standardized photographic documentation were conducted at baseline and study endpoint. Structured weekly evaluations monitored therapeutic response and adverse events throughout the intervention period, with final assessment conducted at one-month post-treatment to evaluate sustained efficacy.

Results: The combination therapy demonstrated superior clinical efficacy with significantly greater PASI score reductions ($p < 0.01$). High-magnitude improvements (PASI reduction 2.6-3.0) were achieved in 25.7% of Group 2 patients compared to only 2.1% in Group 1. Furthermore, Group 2 showed rapid resolution of hyperkeratotic plaques after a single application and complete alleviation of pruritus, while Group 1 patients frequently reported persistent itching.

Adverse events in the combination therapy group included transient burning sensation during peel application (27.1%), isolated cases of irritant dermatitis (1.4%), maceration (0.7%), and hyperpigmentation (0.7%). However, the overall safety profile was comparable between groups ($p = 0.07$).

This study demonstrates that combination therapy with chemical peel and luliconazole provides faster resolution of lesions, superior symptomatic relief, and significantly greater clinical improvement compared to luliconazole monotherapy, while maintaining an acceptable safety profile. These findings suggest that the combination approach represents an optimal therapeutic strategy for managing hyperkeratotic dermatologic lesions, particularly in patients with extensive involvement or recalcitrant disease.

Conclusion: This study reveals compelling evidence for the superior efficacy of combining 30% salicylic acid peel with luliconazole 1% cream in treating superficial dermatophytosis, demonstrating significant advantages in several key areas: Lesion reduction, safety profile, pruritus relief, accelerated recovery, providing important clinical implications, potentially reshaping treatment protocols for superficial dermatophytosis. **



**Abstract N°: 1101****Immunological Pathways Underlying Exaggerated HPV Growth in Immunosuppressed Patients**

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Introduction & Objectives:

HPV (Human Papillomavirus) is a virus with more than 200 known subtypes, some of which are associated with the development of warts and malignant neoplasms, including cancers of the cervix, penis, anus, and throat. In immunosuppressed individuals, immune surveillance fails due to dysfunction in cellular signaling pathways resulting in accelerated and persistent wart growth and a higher rate of malignant transformation. This study aims to present two cases of giant warts (>2.5 cm), discussing the mechanisms involved in pathogenesis, such as alterations in signaling pathways and immune surveillance in immunosuppressed patients using drugs like mycophenolate (in transplant recipients) and immunobiologics such as Guselkumab for psoriasis in the paraneoplastic context.

Case 1: An 82-year-old woman with a diagnosis of grade II leiomyosarcoma in the liver, psoriasis, and psoriatic arthritis, treated with Guselkumab (100 mg every 4 weeks), presented with accelerated growth of a 3x3 cm verrucous lesion on her left thigh, present for 3 months. **Case 2:** A 52-year-old woman who underwent a kidney transplant in 2013, using prednisone (5 mg/day), mycophenolate (1 g/day) and tacrolimus (1 mg/day), presented with a 4x4 cm verrucous lesion on her left hallux for 2 years, causing itching, pain, paresthesia and destruction of the nail plate, along with smaller lesions on other toes.

Materials & Methods: This study presents two clinical cases of giant warts in the context of immunosuppression, causing clinically significant lesions requiring early and effective intervention to reduce the potential for malignancy. The methods followed standard guidelines for the management of HPV-induced warts, including patient selection, diagnostic tests (anamnesis, physical examination, dermatoscopy, and histopathology), assessment of treatment response, and clinical follow-up.

Results: The literature strongly supports the correlation between immunosuppression and the accelerated growth of HPV-induced warts, as well as increased malignant transformation. Organ transplant recipients treated with immunosuppressors, as mycophenolate, have a higher incidence of HPV and an increased risk of persistent warts. The failure in immune surveillance, the reduction in immune responses (particularly T and NK cells), the direct effect of immunosuppressive drugs, and the disruption of the tumor microenvironment in paraneoplasia contribute to the dysfunction of cellular signaling pathways such as TGF- β and Notch, which regulate keratinocyte proliferation and wart development. These factors explain the inability of the immune system to control HPV, resulting in more persistent infections and uncontrolled wart growth.

Conclusion: Immunosuppressive drugs like mycophenolate significantly increase the risk of accelerated wart growth in HPV-infected individuals by suppressing immune responses, allowing latent infections to reactivate and promoting viral replication. Disruption of cellular pathways such as TGF- β and Notch facilitates uncontrolled growth of infected keratinocytes. Immunosuppressed patients, particularly those with organ transplants or malignant neoplasms, are at higher risk of developing persistent HPV-related lesions that may progress to carcinomas. These findings emphasize the importance of monitoring HPV infections in immunosuppressed patients to reduce the risk of wart formation and associated complications.





Abstract N°: 1156

“Tropical Verrucous Syndrome: When Two Lightning Strikes Hit the Same Place”.

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Introduction & Objectives: Tropical verrucous syndrome (TVS) comprises chronic granulomatous infections endemic to tropical areas, often linked to insect bites or trauma. We describe the clinical approach that led to the simultaneous diagnosis of two rare tropical entities in an immunocompetent patient.

Materials & Methods: A 58 year old Colombian male developed an erythematous, ulcerated nasal nodule expanding to both nasal cavities and the upper lip, alongside a similar lesion on his right foot. The condition arose after jungle work in Puerto Rubiales, Meta. He denied trauma or insect bites but recalled a similar, self-resolving arm lesion four years prior.

Physical examination revealed an extensive ulcerated, verrucous plaque with irregular borders on the nose and upper lip, with mucosal erosions. The right foot showed a large exophytic verrucous plaque with ulcerations and a granulomatous base. Initial differential diagnoses included TVS.

Histopathology of the upper lip showed nodular dermatitis with dense lymphoplasmacytic inflammation and amastigotes confirming leishmaniasis, on the other hand the foot lesion revealed nodular dermatitis with similar inflammation but no amastigotes. Special stains (PAS and Grocott) suggested dematiaceous fungi, leading to the diagnosis of and chromoblastomycosis.

Results: Subcutaneous Verrucous Tropical Diseases (SVT), also known as PLECT syndrome (Paracoccidioidomycosis, Leishmaniasis, Lobomycosis, Sporotrichosis, Chromoblastomycosis, and Cutaneous Tuberculosis), are chronic granulomatous infections prevalent in tropical regions and classified by the WHO as neglected tropical diseases.

Mucocutaneous Leishmaniasis (MCL) is caused by *Leishmania* spp, transmitted via *Lutzomyia* sandflies. Over 12 million cases globally, with Colombia as a major endemic area. Risk factors include agricultural work and poor sanitary conditions, as seen in this patient. MCL presents as firm, well-defined infiltrative lesions that may ulcerate. While mucosal involvement can develop months to years after primary infection, it may also appear synchronously. Diagnosis requires amastigote identification, and treatment includes pentavalent antimonials or amphotericin B in special populations (pregnancy and HIV patients).

Chromoblastomycosis (CBM) is a deep fungal infection caused by dematiaceous fungi, primarily *Fonsecaea pedrosoi*. It affects middle-aged male farmers through direct inoculation of contaminated plant material. The disease manifests as verrucous nodules and plaques, with potential lymphatic or hematogenous spread. Though most cases are reported in the Brazilian Amazon, CBM is also documented in Argentina, Venezuela, and Colombia. Diagnosis is based on clinical history, direct examination, culture, and histopathology, which reveals Medlar bodies (pigmented fungal cells). Treatment is challenging, requiring prolonged therapy with itraconazole, terbinafine, flucytosine, or adjunctive methods like thermotherapy, curettage, electrodesiccation, or cryosurgery.

Conclusion: This case highlights the rare coexistence of MCL and CBM, emphasizing the need for comprehensive histopathological evaluation in tropical endemic areas. Clinicians should maintain a high suspicion for co-

infections when evaluating chronic verrucous and ulcerated lesions.

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Abstract N°: 1223

Co-presentation of chickenpox and multifocal Herpes zoster in an immunocompetent child: A case report

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Introduction & Objectives:

Herpes Zoster is a viral vesicular rash caused by the reactivation of latent varicella-zoster virus (VZV). The pediatric multifocal form is rare. We report a case of simultaneous varicella and multifocal Herpes zoster in a child with no prior maternal or postnatal exposure.

Observation:

A 14-year-old patient with no significant medical history, vaccinated against varicella one year prior, presented to the emergency department with a painful vesicular eruption in the L1 and L2 dermatomes, along with two painful clear bullae evolving for 4 days, consistent with herpes zoster. This was associated with vesicular lesions with umbilication on the face and scalp, indicative of varicella, appearing simultaneously without any signs of visceral involvement.

To exclude immunodeficiency conditions and other diseases, a biological assessment was performed during hospitalization. HIV, syphilis, and hepatitis B and C serologies returned negative, and the rest of the investigations were unremarkable.

The patient was treated with Valaciclovir 20mg/kg/dose 3 times daily for 7 days, a second-level analgesic, and daily antiseptic baths.

The progression was marked by drying of the lesions and the appearance of erosions covered by crusts.

Discussion:

Epidemics of concurrent varicella and Herpes Zoster in children have not been extensively studied. Here, we describe a rare case in an immunocompetent vaccinated child, with no prior known contact with VZV.

The umbilicated vesicles on the face were diagnosed as varicella, while those in a dermatomal distribution were classified as Herpes zoster. This association has been described in Asia for genotype J. Understanding the pathogenesis and molecular triggers of concomitant varicella and Herpes Zoster will provide more useful insights for treatment.

Furthermore, between 0.7 and 2.1/100,000 vaccinated individuals have developed a shingles-like eruption at the injection site, involving underlying peripheral neurons. This association likely implicates the live attenuated vaccine in immunocompetent individuals.

Conclusion:

Further studies should focus on the relationship between clinical presentation and VZV genotype groups, providing valuable guidance for clinicians in diagnosis.

A strong suspicion should be raised when a patient develops a shingles-like rash one year after vaccination, and

prompt treatment with acyclovir should be initiated.

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**Abstract N°: 1249****A Rare Manifestation of Syphilis: Malignant Lues – Case Report**

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Introduction & Objectives:

Malignant syphilis (lues maligna) is a rare and severe variant of secondary syphilis, characterized by ulceronecrotic skin lesions and systemic involvement. Its incidence is unknown, but it has been increasingly reported in immunocompromised patients, particularly those with HIV. The first documented case was described in 1988 in an HIV-positive patient, and since then, most cases have been observed in young HIV-infected males. This form of syphilis is highly aggressive, often misdiagnosed due to its atypical presentation, leading to delayed treatment and increased morbidity.

Materials & Methods:

We report the case of a 69-year-old female from Guadalajara, Mexico, with a history of social neglect and no known chronic degenerative diseases. She presented with a profound constitutional syndrome, including severe weight loss (approximately 40 kg in two months), leading to hospitalization under geriatric care. Laboratory tests confirmed concurrent HIV and hepatitis C infections.

On physical examination, the patient exhibited a disseminated dermatosis involving the face, upper and lower extremities, with a predilection for the frontotemporal region, left knee, anterior right tibial region, and soft palate. The lesions were characterized by multiple necrotic ulcers of varying sizes, covered with eschar, featuring irregular and, in some cases, undermined borders. The lesions were asymptomatic but showed a chronic evolution.

Results:

Given the unusual dermatological presentation, a punch biopsy was performed, along with a VDRL test, both confirming the diagnosis of malignant syphilis. The patient was started on appropriate antibiotic therapy, along with antiretroviral treatment for HIV.

Conclusion:

This case highlights the clinical complexity of malignant syphilis, emphasizing the need for early recognition and prompt treatment to prevent severe complications. The atypical presentation in an elderly female patient reinforces the notion that syphilis should be considered in a broad range of differential diagnoses, especially in immunocompromised individuals.

Given the increasing prevalence of syphilis worldwide, particularly among HIV-positive individuals, physicians should be aware of its diverse clinical manifestations. Early diagnosis through serological and histopathological evaluation is essential, as timely treatment with penicillin remains highly effective. Furthermore, this case underscores the importance of comprehensive STI screening in vulnerable populations, particularly in those with concurrent HIV infection.

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Abstract N°: 1330
Unusual Mycosis in a Metabolic Disorder: *Aureobasidium pullulans* and *Tinea Unguium* in a Hypothyroid Patient

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Introduction & Objectives:

Tinea unguium (onychomycosis) is a superficial fungal infection of the nail plate, typically caused by dermatophytes, leading to nail discoloration, thickening, and deformation. However, non-dermatophytic molds (NDMs) can also be rare causative agents. *Aureobasidium pullulans* is an environmental fungus known for its industrial and biotechnological applications, yet it has been reported as an opportunistic pathogen in immunocompromised individuals.

Materials & Methods:

Case: A 57-year-old female patient presented to the dermatology clinic with a 7-month history of nail discoloration in her right great toe. Her medical history included cerebrovascular aneurysm, gastroesophageal reflux disease (GERD), gastritis, tuberculosis, hypothyroidism, and a past COVID-19 infection. Additionally, her family history revealed that a first-degree relative had passed away due to lung cancer. The patient was currently taking levothyroxine sodium (100 mcg/day), acetylsalicylic acid (150 mg/day), and sodium alginate + sodium bicarbonate for GERD treatment.

Dermatological examination revealed a hyperkeratotic, yellow-brown discolored, thickened, and dystrophic nail plate on the right great toe and left second fingernail. A nail sample was obtained and examined using potassium hydroxide (KOH) microscopy and fungal culture. Culture results confirmed the presence of *Aureobasidium pullulans*, leading to the diagnosis of tinea unguium.

The patient was treated with the following antifungal regimen: itraconazole 200 mg/day (oral), ciclopirox nail lacquer (80 mg/g), and a 40% urea-containing topical emulsion. After six weeks of treatment, clinical evaluation showed marked regression of the lesion, improvement in the nail structure, and symptomatic relief.

Results:

Aureobasidium pullulans is a dematiaceous, yeast-like fungus with a global distribution, commonly found as a saprophyte on various substrates, including soil, rocks, wood, and household dust. It can colonize human hair and skin and has been implicated in various opportunistic infections, particularly in immunocompromised individuals. Reported infections include skin and soft tissue infections, meningitis, peritonitis, and fungemia.

The pathogenicity of *A. pullulans* in nail infections is not fully understood. Its ability to produce melanin may contribute to its virulence by providing resistance to environmental stresses and host immune responses. Its polymorphic nature, allowing it to exist in yeast-like and filamentous forms, may facilitate tissue invasion and persistence.

Diagnosis of NDM-related onychomycosis requires careful interpretation of laboratory results. Contamination is a concern, so repeated isolation and correlation with clinical findings are essential to confirm pathogenicity. Molecular diagnostic techniques, such as internal transcribed spacer (ITS) sequencing, have been employed to accurately identify *A. pullulans* in clinical specimens.

Conclusion:

Treatment of *A. pullulans*-associated tinea unguium is challenging due to limited data on antifungal susceptibility. Itraconazole and ciclopirox have been used with varying success. In this case, a combination of oral itraconazole and topical ciclopirox, along with urea-containing emollients, resulted in clinical improvement. Further studies are needed to establish standardized treatment protocols for NDM-induced onychomycosis.

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Abstract N°: 1401

Annular eyebrow plaque: an entity to recognize

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Introduction & Objectives:

Eye-brow ringworm is a rare fungal infection, often unrecognized or under-diagnosed. Trichoscopy can improve diagnostic accuracy by highlighting specific signs useful for therapeutic orientation.

Materials & Methods:

We report here the clinical and trichoscopic manifestations of a case of tinea fascei affecting the eyebrow in a child.

Results:

An 8-year-old girl was referred for evaluation of a solitary annular erythematous plaque of the left eyebrow evolving over the past three months. No contact with animals was reported. Moderate hair loss in the affected area was noted, without pruritus or systemic symptoms.

Initial treatment with moderate-potency topical corticosteroids had been prescribed by her doctor, without clinical improvement. Physical examination exhibited a well-demarcated, annular erythematous plaque in the left frontal region, with an active, raised border with central clearing and fine scaling, along with a localized alopecia of the eyebrow with broken hairs within the lesion.

Trichoscopy of the lesion showed a pink background, brown-red globules, non-pigmented vellus hairs, scales and dotted vessels. On the left eyebrow we found zigzag hairs, corkscrew hair, comma hair, broken hair, black dots, morse-like hair and exclamation hair. The right eyebrow and the scalp were normal.

Mycological culture showed the presence of *Microsporum audouinii*, diagnosing tinea. The patient was treated with oral and topical griseofulvin for three months with a good improvement and full regrowth of the eyebrow. Follow-up trichoscopy revealed no signs of parasitism, attesting to resolution of the infection.

Conclusion:

Tinea faciei is a relatively uncommon dermatophyte infection that causes atypical clinical symptoms, affecting non bearded areas of the face. *Microsporum audouinii* is an anthropophilic dermatophyte developing outside the hair shaft, a type of hair damage known as ectothrix. This dermatophyte has resurged recently, mostly in prepubertal children manifesting by specific clinical and trichoscopic signs, such as comma and corkscrew hairs. Furthermore, Barcode hairs, which were present in our case, have only been observed in ectothrix infection, and have recently been reported as a novel dermoscopic feature specific for follicular fungal infection of the scalp and eyebrows. Periocular ringworm is often misdiagnosed, patients wrongly treated for at least one other condition, including eczema, herpes simplex virus and cellulitis, before the correct diagnosis is made. This case highlights the importance of trichoscopic diagnosis, particularly in isolated forms or those associated with skin involvement. Topical glucocorticoid treatment can change the lesion's clinical appearance and develop tinea incognito with vellus hair involvement, which spreads the infection to the follicles. It is crucial to note that topical antifungal

treatment alone is often insufficient. For effective management, a combined topical and oral antifungal approach is required, griseofulvin being the first-line treatment and the most effective for *Miscrosporum* species.

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**Abstract N°: 1419****Crusted Scabies in a patient with Primary Immunodeficiency treated with topical thiabendazole**

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Introduction: This crusted scabies is a rare and severe presentation of scabies which configures a large amount of mite all over the skin, caused by *Sarcoptes scabiei hominis*. The crusted scabies is most common seen in patients with primary or acquired immunodeficiency, hematology malignancy, chronic use of corticoids or cognitive deficits. The absence of cellular response against the parasite has been notice as the pathogenesis of the disease.

Case report: Male, 18-years-old, student, living in São Paulo, Brazil, phenotype II. Seek for a physician because of scaly erythematous plaques up to 4 months, that appeared after a hospitalization for pneumonia treatment, on investigation of primary immunodeficiency. The lesions were slightly itchy, although were localized all over the body, including genitals and face. On the dermatological exam, observed excoriated erythematous plaques with hematic surface. On axillaries region whitening plaques was furfuraceous desquamation. On plantar palm region there were discreet hyperkeratosis with desquamation. The diagnoses of crusted scabies were given by the clinical suspicious and scraped of the lesions to direct parasitological exam. Was chosen thiabendazole as topic intervention and Ivermectin as oral treatment, once the combined therapy was indicated **Conclusion:** The super infection of *Sarcoptes scabiei hominis* seen on the crusted scabies the combined therapy is indicated, differently of the common scabies. The chosen therapy with topic thiabendazole was given because the patient in question was immunosuppressed and has a sensibly skin. As a conclusion, after one month of follow up, the patient returns to the service without skin lesions and no more symptoms.





Abstract N°: 1430

Actinomadura pelletieri mycetoma in Mexico: a case report of a rare species

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Actinomadura pelletieri mycetoma in Mexico: a case report of a rare species

Introduction & Objectives: Mycetoma is a chronic granulomatous disease. In Mexico, the primary etiology involves actinomycetes, with *Nocardia brasiliensis* being predominant, followed by *A. madurae*.^{1,2} Within this genus, *A. pelletieri* is rare cause of mycetoma in Mexico, which is why we present a clinical case reported in the western part.

Materials & Methods/ case presentation: A 70-year-old male presented with a 35-year history with an embedded tick on the dorsum of his left foot. 2 years later he developed a lesion with a hard, whitish discharge, and spontaneous cicatrization. He received 3 years of unspecified treatment in the United States and underwent unsuccessful surgery.

On the right foot dorsum, he presented multiple firm, erythematoviolaceous nodules, of 1 cm with two draining sinuses. Direct microscopy of exudate with Lugol demonstrated red, fragmented grains, diameter of 300 µm. The grains showed no growth on Sabouraud dextrose agar after 30 days.

Molecular analysis was performed, PCR amplification and nucleotide sequencing of a fragment of the *NOC3/NOC4 (kat N)* gene. It demonstrated homology with *Actinomadura pelletieri*. A radiography revealed evidence of radiolucency of the midfoot and toes. Treatment was initiated with trimethoprim-sulfamethoxazole (TMP/SMX) 160/800 mg every 12 hours, resulting in clinical improvement after 9 months.

Results/discussion: Actinomycetoma is prevalent in tropical and subtropical regions.^{3,4} In Mexico, 3933 cases were reported in 2013, with an average of 73 new per year.⁵ *A. pelletieri* is rarely reported in our country; the first case is from Nuevo León.⁶ Based on literature review, we identified 15 published cases in Mexico, however the majority lacked description of clinical-epidemiological data.

A focused literature review identified 15 published cases of *A. pelletieri* isolation in Mexico. One case, described by Barrón-Tapia et al.⁶, involved the right foot and demonstrated an adequate response to TMP/SMX. While López-Martínez et al.⁵ mentioned 11 cases, specific clinic-epidemiological details were not provided. Bonifaz et al.² reported a two cases where molecular techniques confirmed the species. Similarly, the single case reported by Cárdenas de la Garza et al.⁷ lacked a description of epidemiological data.

On direct examination with potassium hydroxide or Lugol, *A. pelletieri* shows grains ranging from 60-300 µm, coral-red color and a bilobed shape.⁷ In culture, colonies develop in 20-30 days, displaying a coral-red color, moist and cerebriform appearance and soft consistency.¹¹ Radiological studies are recommended due to their osteophilic capacity.⁹

TMP-SMX is the first-line treatment.⁷ In the reported case of Barrón-Tapia et al.⁶ it presented favorable response with this treatment and dapsone for 1 year. In our patient, the initial poor therapeutic response could be

attributed to a sub-optimal dosage that failed to destroy the grains, or to a poor therapeutic adherence during the treatment period.¹⁰

Conclusion: The infrequent occurrence of *A. pelletieri* as a mycetoma cause in Mexico complicates prompt diagnosis with standard methods. This delay can result in advanced disease with extensive bone involvement and substantial morbidity, highlighting the urgent need for improved diagnostic technologies for early and reliable pathogen identification to facilitate timely and targeted treatment.

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**Abstract N°: 1437****TCR sequencing for TB-IGRA in *Mycobacterium* infections**Huaibo Zhao¹, Degang YANG^{*1}

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Introduction & Objectives:

More than 2 billion people (approximately 25% of the world's population) have latent tuberculosis infection (LTBI). 85% to 90% of newly diagnosed active TB is due to progression from LTBI, with an annual risk of progression of 0.1%. Interferon-gamma release assay (IGRA), the current gold standard for LTBI diagnosis, has drawbacks such as complicated operation, long assay duration, and limited sample transportability over long distances.

Mycobacterium marinum infection is known to yield positive IGRA results, with its value significantly decreasing or turning negative 2 - 6 months post-treatment. Thus, this study innovatively selected *M. marinum*-infected cases with IGRA(+) as the subjects and employed high-throughput single-cell sequencing technology for a self-control study before and after treatment. The aim was to investigate the TCR sequence characteristics related to IGRA(+) and seek a potential alternative to IGRA.

Materials & Methods:

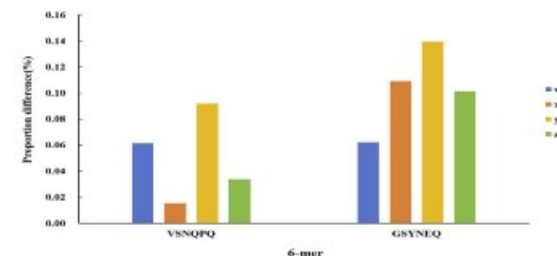
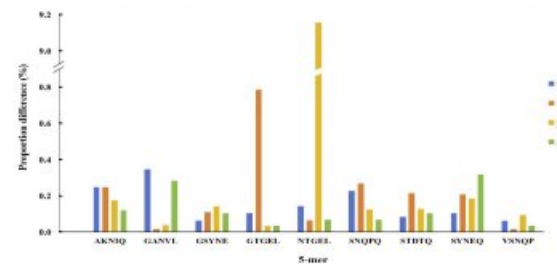
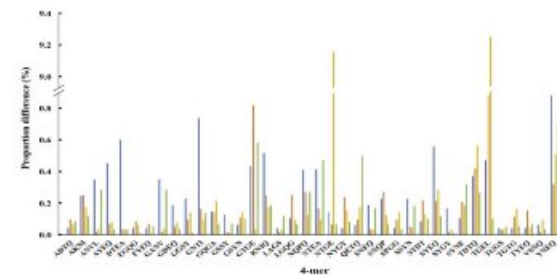
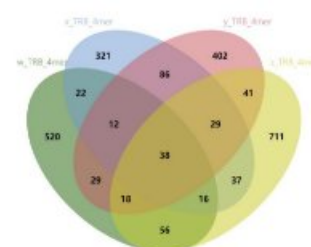
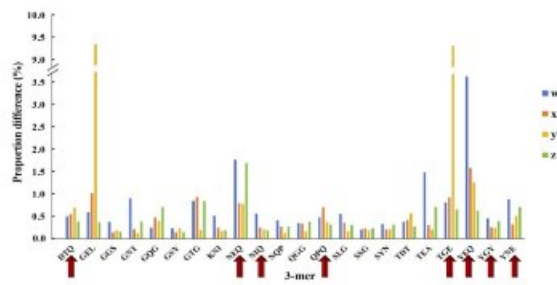
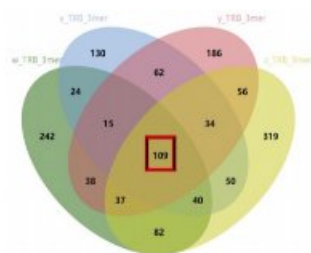
Patients clinically diagnosed with *M. marinum* infection and positive TB-IGRA were enrolled (n = 4). Whole blood was collected pre- and post-treatment at suitable IGRA values. PBMCs were isolated and underwent single-cell TCR immune-bank sequencing. After data processing, clonotype identification was done using the k-mer algorithm. The focus was on clonotypes with reduced percentages post-treatment, analyzed at three levels: clonotype, short sequence, and gene fragment type.

Results:

The TRB CDR3-IMGT 107-116 sequences of the four patients were analyzed by the k-mer approach. Several short TRB sequences with significant percentage discrepancies among the patients were identified, including "YEQ", "NEQ", "TGE", "YNEQ", "KNIQ", "SYNEQ", "AKNIQ", and "GSYNEQ". At the single-cell level, by computing the proportional differences of V/J genes and V-J pairs in the positively differentiated clones of the four patients, gene fragments including TRBV5-1, TRBV20-1, TRAV13-1, TRAV17, TRBJ2-1, TRBJ2-7, and TRAJ49 were identified. Among them, the TRBV5-1-TRBJ2-1 and TRAV13-1 -TRAJ29 pairs might be related to TB-IGRA(+), which could facilitate the development of alternative IGRA detection methods.

Conclusion:

Through the k-mer algorithm-based comparative analysis of single-cell TCR immune-bank sequencing data from four patients, multiple short sequences like "YEQ", "NEQ", "TGE", "YNEQ", "KNIQ", "SYNEQ", "AKNIQ", and "GSYNEQ" in the TRB CDR3 region were found potentially associated with TB-IGRA(+). Future validation could involve designing a fluorescence probe PCR assay to substitute the IGRA assay.



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Abstract N°: 1470
Reddish-black dots as a diagnostic clue in dermatoscopy of chromoblastomycosis: a case report

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Introduction

Chromoblastomycosis is a chronic mycotic infection of the skin and subcutaneous tissue caused by dematiaceous fungi endemic to tropical and subtropical areas. The fungi usually invade cutaneous tissue through an inoculation site (more frequently by traumatic skin penetration), resulting in slow-growing verrucous plaques. Commonly isolated fungal species are *Fonsecaea*, *Phialophora* and *Cladophialophora* spp. Dermatoscopy is non-invasive tool that can aid in the diagnosis of this condition.

Case Report:

We present the case of a male Costa-Rican 78-year-old patient, with known history of hypertension and chronic kidney disease, who presented to the dermatology clinic with a lesion in the dorsum of his left hand that appeared 8 years before. He worked in agriculture, and informed that the lesion started after trauma with the thorn of a palm tree. It began as a small erythematous slow-growing papule with associated pruritus.

At physical examination, an erythematous hyperkeratotic plaque with scaling, crust, and satellite lesions was identified in the lateral aspect of the dorsum of his left hand. Dermatoscopic examination revealed a reddish pink background with whitish scales, yellow-white crust, and multiple round vessels. The areas with crust presented hemorrhage and reddish-black dots.

Routine laboratories evidenced no abnormalities. A biopsy was performed, reporting granulomatous dermatitis and documenting the presence of fungi. A fungal culture identified the presence of *Fonsecaea monophora*.

The patient was treated with itraconazole 200 mg twice a day and cryotherapy with great response so far.

Conclusion:

Dermatoscopic findings in chromoblastomycosis have only been described in a few case reports. Previous cases documented the presense of pink and white areas in the rough areas of the clinical lesion. Reddish-black dots have also been frequently described, which are presumed to represent the transepidermal elimination of inflammatory cells, fungal elements, and hemorrhage. Yellow-orange structures corresponding to granulomas may also be seen, such as those described in other granulomatous disorders. Polymorphic vessels, scales and crusts can also be found.

Our patient presented most of the findings previously described. We believe the presence of reddish-black dots and hemorrhage are an important clue to the diagnosis, as they have been found in most of the reported cases, and are not frequently found in other diseases.

Dermoscopy is a non-invasive tool that can be helpful for diagnosing this entity and other infrequent infectious pathologies. A detailed description of dermoscopic findings in these diseases may lead to an easier diagnosis in

the future.

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**Abstract N°: 1476****Features of the course and clinical picture in patients with parvovirus infection in childhood and adulthood after the covid 19 pandemic**

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Introduction & Objectives: After the COVID-19 pandemic, there is an increase of cases of parvovirus infection, both in children and adults. Some differences in the clinical features of the disease depending on the age have been described, so the aim of our study was to detail the clinical features of parvovirus infection in children and adults.

Materials & Methods: 118 patients (67 adults and 51 children) with parvovirus infection confirmed by PCR (DNA Parvovirus B19), who were undergoing inpatient treatment in infectious disease departments in Moscow were included in this study.

Results: A comparative analysis of the clinical symptoms data in children and adults showed significant differences. Among children, there were 63.3% boys, among adults - 37.2% men ($p = 0.004$). The duration of hospital stay differed slightly and averaged 5 days in adults, 4 days in children ($p < 0.001$). In children, the most common clinical manifestations were conjunctivitis (81.6%) and nasal congestion (81.6%), while in adults only in 18.8% and 20.3% of cases, respectively ($p < 0.001$). In the majority of cases, patients in both groups had skin rashes (children - in 93.9%, adults - in 82.6%). The share of maculopapular rashes in children accounted for 57.1%, in adults - 66.7%; hemorrhagic lesions were noted in 8.2% of children and in 15.9% of adults, punctate and petechial rash was observed mostly in children - in 24.5% and in 4.1% of adults ($p < 0.001$). Differences in rash localization were found: rash was noted on the skin of the trunk more often in children - in 67.3% of cases, in adults - in 47.6%; on the legs - in 69.4% of children and in 65.2% of adults; rashes were more often recorded on the arms in children - in 75.5%, in adults this localization was affected in 45.6%; on the face in children - in 42.9%, in adults - in 35.3%; rash on the palms was noted more often in adults (26.1%) than in children (14.3%), lesions on the feet were noted equally in both age groups - in 14.3% and 14.5%, respectively. In the anogenital area, rashes were noted in all children (100%) and in 7.2% of adults. In 36.7% of children, there was a slapped cheek symptom, while in adults this symptom was absent ($p < 0.001$). In 6.1% of children and in 31.9% of adults, itching was reported ($p < 0.001$).

Thrombocytopenia was observed in 10.2% of children and in 42% of adults ($p < 0.001$), an increase in CRP was noted 2 times more often in adults (83%). It is noteworthy that in 43.5% of cases in adults, the disease proceeded with complications, while in children frequency of complications was significantly lower (14.3% of cases).

Conclusion: After the COVID-19 pandemic, parvovirus infection began to be registered more often in both adults and children, characterized by differences in clinical manifestations, which explains the need for alertness regarding this disease when conducting differential diagnostics and choosing therapeutic tactics.



**Abstract N°: 1519****The struggle of an adolescent with leprosy**

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Introduction & Objectives: Leprosy is one of the neglected tropical diseases and its prevalence in children and adolescent is a marker of continuous transmission of bacteria in the community. Apart from this epidemiological significance the morbidity caused by this bacteria in adolescent age group is a matter of concern. In this series five cases of leprosy in adolescents are discussed with emphasis on its long term morbidity.

Materials & Methods: Data was retrieved from the electronic data base for** cases of leprosy affecting the age group 10-19 years from January 2024 to March 2025. Their demographic profile, details about clinical spectrum, treatment given and investigations were recorded. Clinical photographs were available with proper informed consent were also retrieved

Results: Total 5 cases with age range of 10-19 years presented with leprosy in last 15 months. All the patients were male with the duration of illness ranging from 6 months to 2 years. Four cases were of BLHD (borderline lepromatous Hansen diseases) and one case was of PNHD (pure neuritic Hansen disease). All four cases of BLHD had multiple infiltrated papules, nodules, plaques, nerve thickening and sensory loss. Among these 5 patients four had facial disfigurement (all BLHD), four had grade 2 deformity, two were anemic, one had proteinuria, two were in type 2 reaction (one bullous type) and one was in type 1 reaction. Acid Fast bacilli was positive in biopsy and slit skin smear in 4 patients (BLHD). Nerve thickening was significant in BLHD group, maximum in cubital tunnel to a range of max area 37mm² and max diameter 10 mm as measured by ultrasonography. All patients were started on MB-MDT (as per WHO guidelines) along with treatment of reaction and rehabilitation exercises as required. Four out of 5 patients also had school dropout because of the disease.

Conclusion: Leprosy a chronic infectious disorder is still very much prevalent in our population and affecting the growing age group causes significant physical and functional lifelong disability. These patients not only suffer from social stigma, they may have life long complications like facial disfigurement, permanent weakness of hand and foot, nephropathy. Ongoing complications like reactions, medications side effects easily hampers their growing and learning age. Targeted approach towards children and adolescent leprosy will definitely help in reducing permanent disability in this age group.



**Abstract N°: 1683****Isolated scabious nodule: An unrecognized clue to scabies without evident skin lesions**Najat Chebbawi¹, hanane rachadi¹, fatimazahra elfatoiki¹, fouzia hali¹, soumiya chiheb¹¹1 Rue des Hopitaux, Department of dermatology-venereology, CHU IBN ROCHD, CASABLANCA, Casablanca, Morocco**Isolated scabious nodule: An unrecognized clue to scabies without evident skin lesions****Introduction & Objectives:**

Scabies is a contagious skin condition caused by the mite *Sarcoptes scabiei*, typically presenting with intense pruritus and characteristic cutaneous lesions. Among these manifestations, the scabious nodule, although less common, represents an atypical presentation requiring careful clinical attention. This report aims to highlight the importance of recognizing isolated scabious nodules as potential indicators of scabies, even in the absence of other typical skin lesions, emphasizing their diagnostic significance in unusual anatomical regions.

Materials & Methods: A 32-year-old male patient with no significant medical history presented with itchy nodules localized on the glans penis, evolving over two months, associated with generalized pruritus but without evident skin lesions. Clinical examination and patient history were collected, focusing on symptomatology, lesion characteristics, family history, and pruritic areas. Skin scraping with microscopic examination was conducted to confirm the presence of *Sarcoptes scabiei* mites and eggs.

Case report :

Clinical examination revealed a single firm, reddish nodule approximately 3 cm in diameter, with well-defined borders and a smooth surface on the prepuce, without secondary infection. Despite generalized pruritus and suggestive family history, no additional scabietic lesions (wrists, interdigital spaces) were found. Skin scraping confirmed the presence of *Sarcoptes scabiei* mites and eggs microscopically. The patient was treated with topical benzyl benzoate over the entire body, including genital regions, and oral antihistamines for symptomatic relief. Household contacts received preventive treatment and hygiene measures were recommended.

Conclusion:

This case underscores the importance of including scabies in the differential diagnosis of isolated cutaneous nodules, even in atypical locations and without typical lesions. Early recognition and appropriate treatment are essential in reducing transmission risk, managing persistent pruritus, and improving patient quality of life.



**Abstract N°: 1742****Thighs wide shut: An eosinophilic mass masquerading as malignancy in basidiobolomycosis**Claudine Howard-James^{*1}, Gregg Murray¹, Kevin Molloy¹¹Tallaght University Hospital, Dermatology, Dublin, Ireland**Introduction & Objectives:**

A healthy 24-year-old male presented with a two-month history of a rapidly enlarging painful mass on his left anterior thigh. Travel history was notable for migration to Ireland from Pakistan in the last year. On examination he had a large mobile plaque with superficial pustulation and erosions. Regional lymphadenopathy was palpable, but there were no other skin lesions or systemic features.

Materials & Methods:

Due to clinical appearances, the initial differential diagnosis was soft tissue sarcoma. MRI demonstrated a large (12.3cm x 3.6cm x 12cm) subcutaneous enhancing superficial soft tissue mass overlying the quadriceps. PET-CT scan confirmed the mass was heterogeneously FDG-avid with FDG-avid left groin lymph nodes. He had a leucocytosis with peripheral eosinophilia, raised ESR (93) and CRP (173). Viral serology for HIV, HCV and HTLV was negative, with positive hepatitis B serology indicating previous infection. *Borrelia burgdorferi* IgG, quantiferon, beta-d-glucan, Ascaris, Hydatid, Strongyloides and Bartonella serology were negative.

Results:

Full-thickness skin biopsy revealed extensive dermal and subcutaneous granulomatous inflammation with marked eosinophilic infiltrate. PAS, Giemsa and Gram stains showed no evidence of micro-organisms. Mycobacterial direct microscopy was negative. A fungal species was seen on culture and *Basidiobolus* spp was detected on 18S PCR from tissue. He was diagnosed with basidiobolomycosis and commenced on itraconazole 200mg twice daily, and is exhibiting good clinical response.

Conclusion:

Basidiobolomycosis is a rare deep fungal infection caused by *Basidiobolus ranarum*, endemic in rural areas of tropical and subtropical countries. It typically produces a chronic painless subcutaneous infection affecting the thigh or buttocks of immunocompetent individuals. It presents as a well-circumscribed, fluctuant, firm subcutaneous swelling on an extremity that enlarges over months. Lymph nodes are not usually involved. This case is unusual due to lymph node involvement and associated pain, mimicking malignancy both clinically and radiologically. The diagnostic delay highlights the challenges of recognising basidiobolomycosis in non-endemic regions.



**Abstract N°: 1778****Co-occurrence of Varicella and Tinea Capitis in an 8-year-old child: A diagnostic challenge**Najat Chebbawi¹, fatimazahra elfatoiki¹, fouzia hali¹, soumiya chiheb¹¹1 Rue des Hopitaux, Department of dermatology-venereology, CHU IBN ROCHD, CASABLANCA, Casablanca, Morocco**Co-occurrence of Varicella and Tinea Capitis in an 8-year-old child: A diagnostic challenge****Introduction & Objectives:**

Varicella, caused by the varicella-zoster virus (VZV), is a common viral infection characterized by diffuse pruritic vesicular eruptions, typically benign in children. Tinea capitis, a contagious dermatophytosis primarily affecting prepubertal children, results from dermatophytes such as *Trichophyton tonsurans* or *Microsporum canis*. Although rare, the simultaneous occurrence of these infections can complicate clinical assessment and delay appropriate treatment. This case highlights the importance of thorough diagnostic evaluation in atypical pediatric skin eruptions.

Case Report:

An 8-year-old boy, unvaccinated against varicella with no significant medical history, presented with a three-day history of febrile, itchy skin eruption. Clinical examination revealed a generalized papulovesicular eruption with umbilicated lesions, some crusted, predominantly located on the trunk, limbs, and face. The scalp examination showed multiple rounded alopecic, erythematous, scaly plaques, occasionally crusted and tender on palpation, with perifollicular pustules. Dermoscopic examination revealed dystrophic, broken hairs characterized by “exclamation mark” and “black dot” signs, suggesting tinea capitis. Direct microscopy and fungal culture confirmed *Trichophyton tonsurans* infection. The diagnosis of concurrent active varicella and tinea capitis was established. Management included systemic antifungal therapy with oral griseofulvin (20 mg/kg/day) for six weeks, topical antiseptic care for varicella lesions, and monitoring for secondary bacterial infection. Clinical improvement was noted, with resolution of scalp lesions within three weeks and complete healing of varicella lesions by day fifteen.

Discussion:

This case emphasizes the diagnostic complexity in pediatric dermatology when two infectious conditions coexist. Varicella-related scalp lesions may be misinterpreted as crusted varicella lesions, potentially delaying tinea diagnosis. The increasing incidence of *T. tonsurans* infections in Europe and diagnostic challenges posed by atypical presentations are well documented. Dermoscopy, recommended as a first-line diagnostic tool for inflammatory alopecia, significantly facilitated rapid diagnosis in this case. Systemic antifungal therapy is crucial for hair involvement, and stringent hygiene measures combined with family education are necessary to prevent transmission.

Conclusion:

This report illustrates the rare overlapping of varicella and tinea capitis, emphasizing the necessity for thorough dermatological examination, including scalp assessment, even during acute viral illnesses. Dermoscopy proves valuable in diagnosing pediatric mycological infections, highlighting the importance of avoiding attribution of all skin lesions to a single etiology without mycological confirmation. Clinicians should broaden their diagnostic

approach in similar clinical scenarios, particularly during epidemic periods or in community settings.

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Abstract N°: 1889

Retrospective Analysis of Erysipelas in 71 Patients: Confirmation of Known Risk Factors, Seasonal Patterns, and Treatment Outcomes

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Introduction & Objectives:

Erysipelas is an acute bacterial cutaneous infection usually restricted to the dermis, with prominent lymphatic involvement and often accompanied by fever and systemic toxicity. Clinically, it is distinguished from other forms of cutaneous infection by the clear elevation and demarcation of the affected skin compared to the uninvolved areas, together with its bright red colour (Stevens et al., 2016)¹. Although commonly described with its characteristic facial involvement of the butterfly area, nowadays the disease manifests itself most often on the lower limbs, usually associated with a disruption of the cutaneous barrier (such as an open wound or cutaneous dermatoses), lymphoedema, venous insufficiency and high BMI (Dupuy et al., 1999)², demonstrating a peak incidence during the summer months (Sočan et al., 2018)³

This retrospective study evaluates 71 patients diagnosed with erysipelas to assess risk factors, seasonal distribution and diagnostic and treatment modalities, aiming to compare findings with existing literature.

Materials & Methods:

Medical records of 71 patients diagnosed with erysipelas between October 2023 and August 2024 at ANRegiomed Klinik Dinkelsbühl hospital were reviewed. Data collected included demographics, site of lesion, diagnostic and treatment regimens, length of stay, comorbidities, month of hospitalization as well as bacterial culture results where applicable. Descriptive statistics and basic comparative analyses were used.

Results:

The majority of patients were older adults, with a mean age of 68,4 years and a median age of 68 years. High BMI and cardiovascular disease were prevalent among cases, representing 63,4% of cases. In every case the infection was localised on the inferior limbs. A significant proportion of infections occurred during the warmer months, amounting to 42,3% of cases. Most patients responded well to standard penicillin and β -lactam-based antibiotic therapy, with the 80,3% achieving full resolution without complications.

Conclusion:

This retrospective study confirms well-established findings in the literature, especially regarding patient-related risk factors, seasonal incidence, and effective treatment approaches.

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**Abstract N°: 2038****Utility of acetic acid in Goldman-Fox syndrome: A case series**

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Introduction & Objectives:

Goldman fox syndrome (GFS) or Green nail syndrome (GNS) is a rare infective condition of nail caused by *Pseudomonas* species characterised clinically by a triad of greenish discoloration of nail plate, proximal paronychia and distal onycholysis. This condition is important clinically and epidemiologically as it carries a substantial risk of serious pseudomonas infection outbreak in the community from an infected caregiver. Here we describe a series of 11 patients of GFS who presented with chief complaint of greenish discoloration of nail.

Materials & Methods:

All patients presenting with greenish discoloration of nails were thoroughly evaluated. After detailed history taking, clinical, dermoscopic and microbiological examination, a final diagnosis of GNS was established. All cases were treated with acetic acid soaks prepared from household vinegar. One patient was additionally treated in combination with tobramycin eyedrops.

Results:

We encountered 11 cases (5 males, 6 females) of GNS over a period of 18 months. Their age ranged from 16 to 67 years. Two** cases had a past history of diabetes mellitus, 3 had history of chronic wet work and one case was a nursing officer by profession. All patients presented with chief complaint of greenish discoloration of nail, color of affected nails varied from yellowish-green to greenish-black. Duration of symptoms varied from 2 weeks to 3 months. 8 patients had affection of single nail. 7 patients had affection of finger nails while remaining had affection of toenails. Dermoscopy revealed green aurora sign in 4, distal onycholysis in 9 and subungual hyperkeratosis in 6 cases.

Bacterial culture demonstrated growth of *Pseudomonas aeruginosa* in only 2 cases. Fungal culture resulted in growth of *Candida* species in another 3 cases. We treated all these cases with acetic acid soaks prepared from household vinegar in 1:4 dilution with water. One patient (case 1) was additionally treated in combination with tobramycin (0.3%) eyedrops in view of multiple risk factors including uncontrolled diabetes mellitus and engagement in chronic wet work. Improvement was seen in 7 (63.3%) cases. The response was noticed as early as two weeks with fading of green color and treatment was continued upto 12 weeks. Spontaneous avulsion followed by subsequent growth of normal nail was noted at 12 weeks follow-up.

Conclusion:

GFS is a potentially dangerous condition with a risk of community spread of life-threatening infections. Use of acetic acid soaks is a safe, inexpensive and effective therapy for treatment of GFS with no risk of systemic adverse effects. Its antifungal activity is of added benefit in co-existent fungal infection. We recommend availability of pharmaceutical preparation of 1-2% acetic acid lotions and nail lacquers which may be directly utilized for such patients.



**Abstract N°: 2127****An Unexpected Diagnosis: Disseminated Bullous Dermatitis Revealing Hansen's Disease**

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Introduction & Objectives:

We report the case of a 38-year-old man from Brazil, with no known medical history, who presented to the emergency department with a 2-week history of fever, myalgia, arthralgia, and a newly developed painful dermatosis, along with a 15 kg weight loss over the past year. Clinical examination revealed leonine facies with supraciliary madarosis, widespread erythematous painful papules and nodules, hemorrhagic blisters, erosions, hepatomegaly, and palpable lymphadenopathy. Given the polymorphic presentation, a broad differential was considered, including cutaneous lymphoproliferative disease, bullous Sweet syndrome, Hansen's disease, and other mycobacterial infections.

Materials & Methods:

Laboratory tests showed anemia, leukocytosis, hyperferritinemia, an elevated C-reactive protein (31.5 mg/dL), and a negative Interferon Gamma Release Assay. Skin biopsy revealed lymphohistiocytic nodules in the dermis with associated edema, numerous neutrophils without vasculitis, and alcohol-acid resistant bacilli arranged in globi. Bacilli were also identified in a lymph smear and an inguinal lymph node biopsy. PCR testing was positive for *Mycobacterium* spp., supporting the diagnosis.

Results:

The patient was diagnosed with Hansen's disease (leprosy) complicated by erythema nodosum leprosum, including bullous lesions. A multidrug antileprosy treatment regimen and immunosuppressive therapy were initiated, leading to significant clinical improvement.

Conclusion:

Although erythema nodosum leprosum is a common immunological complication of Hansen's disease, bullous forms with systemic involvement are rare. In Europe, cases of leprosy are uncommon and mostly imported. Prompt recognition is essential for timely initiation of antimicrobial and immunosuppressive therapy. Accurate diagnosis and exclusion of other differentials, such as lymphoproliferative and autoimmune conditions, are critical for proper management.





Abstract N°: 2135

Trichophyton indotineae. A new pathogen to be aware of

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Introduction & Objectives: *Trichophyton indotineae*, formerly *T. mentagrophytes* genotype VIII, is a recently identified dermatophyte with presumed origin in India, Australia, Iran, and Oman. It has spread beyond Asia through travel and migration. This fungus is associated with virulent clinical behavior and resistance to terbinafine. Its identification requires molecular techniques not routinely available, posing a diagnostic and public health challenge. We describe the first Spanish series of patients infected with *T. indotineae* to raise awareness of its diagnosis and treatment.

Materials & Methods: Diagnosis was based on skin scale cultures on Sabouraud dextrose agar with chloramphenicol, gentamicin, and cycloheximide. Plates were incubated at 30 °C for four weeks and monitored biweekly. Dermatophyte-like colonies were examined microscopically. Cottony isolates with a yellowish to cream reverse and MALDI-TOF spectra matching *T. interdigitale* were sent to the National Microbiology Center (ISCIII) for ITS sequencing confirmation. Antifungal susceptibility testing was not feasible.

Results: We report 15 cases of *T. indotineae* infection in Barcelona between 2022 and 2024. The mean age was 30 years (range 11–48), with nine males and six females. Eight patients were from Bangladesh, three from Pakistan, one from India, and one from Nepal. All but one had lesions at multiple sites (trunk, limbs, groin, nails, buttocks), and three had facial involvement. Diagnosis delay reached up to 10 years. Four cases were linked to household transmission, and nine patients had recently visited their countries of origin. Treatment regimens varied (see Table 1). All but one patient treated solely with topical agents showed no response. Most patients underwent multiple therapies, though treatment duration and adherence were inconsistently documented. Nearly all remain under treatment, limiting outcome analysis.

Conclusion: Only one case of *T. indotineae* infection had been reported in Spain prior to this series, suggesting underrecognition of this pathogen. Its resistance to terbinafine 250 mg/day and the lack of diagnostic tools in routine labs present major challenges. Given its status as the leading cause of dermatophytosis in India and the increasing number of imported cases in Europe, early suspicion is critical. In widespread tinea from endemic regions, itraconazole (100–200 mg/day) or higher-dose terbinafine (250 mg twice/day) should be considered when susceptibility data are unavailable.



**Abstract N°: 2183****Purpuric Targetoid Eruption in a Patient with Febrile Neutropenia: The Role of Dermatology in Critical Care**

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Introduction & Objectives:

We report the case of a 76-year-old male with newly diagnosed diffuse large B-cell lymphoma (DLBCL), admitted to the Hematology ward to undergo R-CHOP chemotherapy with curative intent. During hospitalization, the patient developed febrile neutropenia and a respiratory infection. The infection rapidly progressed to septic shock, accompanied by new cutaneous findings. These developments raised important concerns regarding infection control, adequacy of antimicrobial therapy, and the potential role of dermatologic evaluation in guiding clinical decision-making.

Materials & Methods:

Amidst evolving multiorgan failure, Dermatology was consulted for an acute dermatosis affecting the left hemithorax and flank, with a three-day evolution. Clinical examination revealed five well-demarcated, annular purpuric plaques with central induration and peripheral macular rims—targetoid in configuration, without ulceration or desquamation. Skin biopsies were obtained from both the central and peripheral areas of the lesions for histopathological analysis, microbiological culture, and immunophenotyping. Based on the suspected diagnosis of fungal septic emboli, prompt escalation to liposomal amphotericin B was recommended.

Results:

Despite ongoing broad-spectrum antimicrobial therapy (ceftazidime/avibactam, linezolid, aztreonam, and fluconazole), the infection remained refractory, and multiorgan failure ensued. Given the severely limited prognosis based on the hematologic malignancy and uncontrolled infectious process, escalation of care was not undertaken following a multidisciplinary discussion. Despite recommendation for broadening of antifungal coverage, the patient ultimately died shortly thereafter from refractory septic shock. Histopathological examination confirmed extensive septic cutaneous emboli, and PCR analysis identified *Mucorales fungi*. A definitive diagnosis of mucormycosis was ultimately established, likely in the context of a pulmonary infection with hematogenous dissemination and cutaneous involvement.

Conclusion:

This case underscores the critical role of dermatologists in recognizing systemic disease through cutaneous manifestations, particularly in immunocompromised and critically ill patients. Prompt dermatologic evaluation may uncover key diagnostic clues that could influence both investigation and management. In this case, the identification of a distinctive purpuric eruption raised suspicion for fungal septic emboli, prompting targeted biopsy and the recommendation to escalate antifungal therapy. Although antifungal treatment was not intensified due to the patient's deteriorating clinical status, earlier recognition of the skin findings might have altered the

disease trajectory and prognosis. Dermatologists remain essential contributors to multidisciplinary care, capable of impacting outcomes even in complex, late-stage clinical scenarios.

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**Abstract N°: 2244****Clinical and Laboratory Characteristics of Trichophyton Indotineae Infection in a National Tertiary Dermatology Centre**Hui Xin See Tow^{*1}, Cheryl Ma², Kuan Ling Yee², Jiun Yit Pan²¹National University of Singapore, Singapore, Singapore²National Skin Centre, Singapore, Singapore**Introduction & Objectives:**

Dermatophytosis is a common fungal infection of the superficial layer of skin, and has been reported to have increased in incidence since 2016. *Trichophyton indotineae* (*T. indotineae*), is an emerging fungal strain that causes extensive treatment-resistant fungal infections. Recently, Singapore reported its first case of terbinafine-resistant dermatophytosis caused by *T. indotineae*. Previously, dermatophytosis was often treated effectively with topical antifungals. However, the recent recalcitrant fungal infections have necessitated prolonged courses of multiple oral antifungals. Diagnosis of *T. indotineae* in routine laboratories is challenging as Internal Transcribed Spacer (ITS) DNA sequence analysis is the gold standard, which is costly and unavailable in most clinical laboratories. Conventional fungal culture is less accurate for diagnosing *T. indotineae* due to the morphologic similarity to *T. mentagrophytes* and *T. interdigitale*.

Materials & Methods:

A retrospective review of all patients with a diagnosis of *T. indotineae* from January 2024 to March 2025 was conducted at the National Skin Centre, Singapore, a national tertiary dermatology referral centre.

Regarding the response outcome of patients, the following definitions are used:

- Complete response was defined as being 100% cleared of *T. indotineae*
- Almost complete response was defined as being more than 90% cleared with minimal residual active lesions
- Partial response was defined as having an improvement but still having active lesions
- Minimal response was defined as having less than 10% of lesions cleared
- No improvement was defined as having no response at all.

Results:

The records of 38 patients who were diagnosed to have *T. indotineae* by culture were included in the analysis. Patients' age ranged from 20-70, with a mean of 37.9. Majority of patients were not immunosuppressed. Among the patients, nine reported contact history and eight patients had significant travel history. For treatment response, seven (18.4%) patients had complete response with total resolution of skin rash, four (10.5%) had almost complete response, with near total resolution of rash, and minimal remnant involvement, and 24 (63.2%) patients had partial response (Table 1). 36 patients were treated with oral antifungal medications, while two patients declined oral antifungals. Regarding relapses, nine patients had no relapses to date. 22 patients had improvement but experienced frequent relapses once antifungals were discontinued, and were still on active treatment. Mean duration of oral antifungal treatment was 10.6 weeks. Among patients without relapses, treatment included varied combinations of oral terbinafine, itraconazole and griseofulvin (Table 2).

Conclusion:

In this study, we report the largest cohort of patients with *T. indotineae* infection in Singapore to date. Patients were predominantly young, with common sites of involvement being the groin and buttocks, and the majority were not immunocompromised. Considering the increasing resistance of *T. indotineae* to oral antifungals, we propose using distinct culture morphology features to aid its identification when advanced molecular diagnostics are unavailable. Additionally, prolonged treatment with oral antifungals can be considered as a treatment regime for *T. indotineae* dermatophytosis. Further studies are needed to establish standardized diagnostic and treatment guidelines for *T. indotineae*.

Relapses	Treatment Outcome				
	Complete (%)	Almost Complete (%)	Partial (%)	Defaulted (%)	Total (%)
On Treatment		1 (2.6)	21 (55.3)		22 (57.9)
Cleared	6 (15.8)	2 (5.3)	1 (2.6)		9 (23.7)
Defaulted	1 (2.6)	1 (2.6)	2 (5.3)	3 (7.9)	7 (18.4)
Total (%)	7 (18.4)	4 (10.5)	24 (63.2)	3 (7.9)	

Table 1: Relapses in Relation to Initial Treatment Outcome

Patient ID	Age, Sex	Immuno-suppressive conditions	Contact History	Duration of symptoms prior to first visit (months)	Body sites affected	Topical treatment	Oral antifungals	Duration of oral antifungals	Nature of Treatment	Response
1	21, M	NI	NI	4	Buttocks	Topical azoles	Itraconazole 200mg/day Terbinafine 250mg 5 weeks (on)	5 weeks	Continuous	Complete
2	25, M	NI	NI	6	Groin, Buttocks, Thunk, Back	Terbinafine, azoles	Terbinafine 1 month, 5 pulses Itraconazole	6 months	Continuous	Complete
3	51, M	NI	Yes (wife)	3	Groin, neck	Selsun, miconazole	Terbinafine 10 days, Griseofulvin 6 weeks, pulsed Itraconazole 200mg 2 weeks (bd)	3 months (had previous treatment)	Intermittent	Complete
4	70, F	NI	NI	84	Groin, Body	Miconazole, clotrimazole	Terbinafine 2 weeks	2 weeks	Continuous	Complete
5	27, M	NI	NI	6	Body, Back, Groin	Topical azoles	Itraconazole 2 months	2 months	Continuous	Complete
6	60, M	NI	NI	9	Body, Back, Groin	Clotrimazole, ketoconazole cream, shampoo	Terbinafine 2 weeks, griseofulvin 90 days, Itraconazole 100mg 2 weeks (twice daily)	4 months	Continuous	Complete
7	22, M	NI	NI	3	Back	Topical azoles	Itraconazole 1 week, Terbinafine 2 weeks	3 weeks	Continuous	Almost complete
8	33, F	NI	NI	4	Buttocks, Thighs	Topical azoles	Griseofulvin 500mg on x3m, Terbinafine 250mg for 2 weeks (on)	5 weeks	Continuous	Almost complete
9	53, F	NI	Yes (multiple generations)	3	Face, Abdomen, Groin, Limbs, Buttocks	Topical antifungals, steroids	Terbinafine	2 weeks	Continuous	Partial

Table 2: Treatment Among Patients Without Relapses

Characteristics	<i>T. mentagrophytes</i>	<i>T. interdigitale</i>	<i>T. indotineae</i>
Phenotype			
Colony Morphology	Flat, cream to white colour, velvety surface with a deep reddish-brown pigmentation. Granular; expanding, cottony to powdery colonies on Sabouraud dextrose agar (SDA) culture	White, cotton-like, powdery-like; velvety surface with a deep reddish-brown pigmentation; expanding, cottony to powdery colonies on Sabouraud dextrose agar (SDA) culture	Flat, white colour, suede-like surface, velvety surface with a deep reddish-brown pigmentation. Granular; expanding, cottony to powdery colonies on Sabouraud dextrose agar (SDA) culture After increased incubation, there is chlamydospores in string which differentiates <i>T. indotineae</i> from <i>T. mentagrophytes</i>
Colony Morphology (Reverse Pigment)	Brown ochre to pale brown pigmentation	Brown ochre pigmentation	Pale brown to yellow orange pigmentation
Tween-80 Opacity Test (lipolytic activity)	Positive or weakly positive (95%); higher lipolytic activity due to its abundance in human scalp with a high level of sebum	Positive (100%); indistinguishable from <i>T. mentagrophytes</i> . No significant difference was found between <i>T. interdigitale</i> and <i>T. mentagrophytes</i> ($p > 0.05$) for lipolytic activity, whereas their difference between <i>T. indotineae</i> was found significant ($p < 0.01$)	Positive or weakly positive (76%); significantly different from <i>T. mentagrophytes</i> and <i>T. interdigitale</i> (which were indistinguishable)
Hair Perforation	Positive (92.5%)	Positive (100%)	Weakly positive or negative (27.08%); lesser with <i>T. indotineae</i> as compared to others
Urea Hydrolysis	Positive and weakly positive (75%)	Positive and weakly positive (67.2%)	Positive and weakly positive (27.1%); different from <i>T. mentagrophytes</i> and <i>T. interdigitale</i>
Keratin azure test	Positive or weakly positive result : 68.51%	Positive (95.24%)	Positive or weakly positive result (85.1%) The difference between <i>T. interdigitale</i> on the one hand and <i>T. mentagrophytes</i> and <i>T. indotineae</i> on the other was statistically significant ($p < 0.01$).
Genotype			
ITS Genotype	III, III', IV, V, VII, IX, XII, XIV, XV, XVI, XVII, XIX, XX, XXI, XXII, XXIII, XXIV, XXV, XXVI, XXVII, XXVIII	I, II, X, XI, XII	VIII
High Mobility Group (HMG) alpha-box genes-mating type (MAT) genes	MAT1-2 (ITS Type VII, IX) Both MAT1-1 and MAT1-2 (ITS type III, IV) MAT1-1-1 : MAT1-2-1 (0 : 70) $p < 0.01$	MAT1-2 Both MAT1-1 and MAT1-2 MAT1-1-1 : MAT1-2-1 (14 : 25) $p < 0.01$	MAT1-2
Squalene epoxidase (SQLE) Gene Point Variant			Point variants F397L, L303S, or A448T

Table 3: Differences Between Trichophyton Species




Abstract N°: 2274
Craters on the back of the hands: Blastomycosis-Like Pyoderma

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Introduction & Objectives:

Blastomycosis-like pyoderma is a rare cutaneous entity resulting from an exaggerated chronic inflammatory reaction triggered by a bacterial skin infection. It presents as vegetative tumors with purulent fistulous tracts, typically in immunocompromised individuals, although it can also occur in immunocompetent patients.

Materials & Methods:

Case report and literature review

Results:

An 80-year-old woman, with no significant medical history, was referred to Dermatology due to a lesion on the dorsum of her left hand that had evolved over two months, characterized by slow but progressive growth. Upon physical examination, a tumor-like, exophytic, and erythematous plaque measuring 5 centimeters was observed on the dorsum of the left hand, with multiple surface openings and spontaneous drainage of purulent material through them. An incisional biopsy was performed, and samples were sent for histopathological study, mycobacterial analysis, and microbiological culture of fungi and bacteria. Additionally, a sample of the purulent exudate was collected and sent to microbiology. Given the suspicion of infectious disease, antibiotic treatment was initiated with oral cephalexin and topical betamethasone/gentamicin/tolnaftate/clioquinol. The histopathological examination of the skin fragment revealed severe elastosis and phenomena of fistulization or formation of epidermal cysts, along with acute inflammation, focal abscess formation, and chronic inflammation, as well as a foreign body-type giant cell reaction. No changes suggestive of malignancy were observed in the studied sections. Gram, Grocott, PAS, and Ziehl-Neelsen stains were negative. Fungal and bacterial cultures from the skin sample were negative; however, the culture of the purulent exudate was positive for *Staphylococcus aureus*. Upon follow-up, significant improvement of the cutaneous lesion was noted with the instituted treatment. Therefore, based on the histopathological characteristics, culture results, and improvement with antibiotic therapy, a diagnosis of blastomycosis-like pyoderma was concluded.

Conclusion:

Blastomycosis-like pyoderma is a rare bacterial skin infection characterized by the presence of vegetative skin lesions with multiple pustules and fistulous tracts. The most frequently involved pathogens include *S. aureus*, *S. beta-hemolytic*., *P. aeruginosa*, *Proteus mirabilis*, *E. coli* and *C. albicans*, with the first being the most common. Predisposing factors include states of immunocompromise such as alcoholism, malnutrition, HIV, and diabetes mellitus. In rare cases, as presented here, it occurs in immunocompetent individuals. In 1979, Su et al. proposed six

diagnostic criteria for this entity: 1. Verrucous plaques with elevated borders and multiple pustules. 2. Histological evidence of pseudoepitheliomatous hyperplasia with abscesses. 3. Identification of bacteria in skin cultures. 4. Negative cultures for fungi and mycobacteria. 5. Negative fungal serologies. 6. Blood levels of iodine and bromine within range. The differential diagnosis should include pyoderma gangrenosum, vegetative pemphigus, chromoblastomycosis, sporotrichosis, coccidioidomycosis and bromoderma vegetans. Unlike what occurs in blastomycosis-like pyoderma, the infiltrate in pyoderma gangrenosum is characterized as being sterile. The usual treatment is systemic antibiotic therapy directed against the causative microorganism.

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**Abstract N°: 2295****the Fungus Behind the Mask: Sporotrichosis Mimicking Cutaneous Carcinoma**

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Introduction & Objectives:

Sporotrichosis is a chronic granulomatous fungal infection most commonly caused by traumatic inoculation of *Sporothrix schenckii* species. It typically affects individuals with occupational exposure to plant matter, such as gardeners, agricultural workers, and florists. Clinically, it presents in three forms: fixed cutaneous, lymphocutaneous, and disseminated. This case aims to emphasize the importance of considering sporotrichosis in the differential diagnosis of verrucous skin lesions that mimic malignancy.

Materials & Methods:

We report the case of a 69-year-old male with an 8-month history of a progressively enlarging, occasionally bleeding, asymptomatic lesion on the left forearm. An initial skin biopsy reported moderately differentiated invasive squamous cell carcinoma, prompting referral for oncologic surgical management. However, due to clinical inconsistencies, a comprehensive medical history was taken, followed by repeat biopsy and fungal culture to investigate the possibility of a verrucous tropical syndrome.

Results:

Histopathological examination and fungal culture confirmed a diagnosis of sporotrichosis. The patient was treated with oral antifungal therapy, which led to complete resolution of the lesion without surgical intervention.

Conclusion:

This case underscores the need to include sporotrichosis in the differential diagnosis of verrucous skin lesions, particularly those with atypical clinical features for squamous cell carcinoma. Thorough patient history and confirmatory diagnostic testing are critical to ensuring accurate diagnosis and appropriate treatment.



**Abstract N°: 2302****“Disseminated Leishmaniasis: Diagnostic Clues from the New World”**

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Introduction and Objectives

Disseminated leishmaniasis (DL) belongs to a heterogeneous group of diseases caused by protozoa of the genus *Leishmania* (1). It is defined as the presence of 10 or more polymorphic lesions (acneiform, papular, nodular, and/or ulcerated), located in two or more different areas of the body (e.g., head, trunk, arms, and legs) (2). Although DL has been reported in various countries in Latin America and the Old World, most cases have been described in Brazil and are predominantly caused by *Leishmania (Viannia) braziliensis* (3).

The objective of this case report is to illustrate a typical presentation of DL in an endemic region of Colombia, highlighting clinical, histopathological, and epidemiological findings.

Materials and Methods

We describe the case of a 37-year-old male patient from an endemic region, who presented with a 7-month history of an erythematous lesion on the right earlobe that progressed to central ulceration after an insect bite. Three months later, multiple papular lesions developed on the trunk and both upper and lower limbs. Three direct smear examinations from the earlobe (performed on 24.08.2024) were negative. A first skin biopsy of the right earlobe on 09.10.2024 revealed acute suppurative and granulomatous lymphohistioplasmacytic nodular dermatitis. A second biopsy was performed on 02.01.2025 and showed nodular dermatitis with suppurative foci, pseudoepitheliomatous hyperplasia, and ulceration.

Results

This case represents a classic presentation of DL, beginning with involvement of the earlobe—known as “chiclero’s ulcer”—a manifestation more frequently seen in the New World than in the Old World (4). The disease subsequently disseminated to multiple regions of the body, with lesions displaying varied morphologies. This condition is of high clinical relevance due to its association with mucosal involvement and a high rate of treatment failure with agents such as meglumine antimoniate. Notably, treatment failure rates have risen from 10% to over 50% in the past four decades (3).

Risk factors associated with DL include age ≥ 20 years, male sex, agricultural occupation (2), and alcohol consumption (5); the patient in this case met three of these criteria. Additionally, the case is remarkable for three negative direct exams and histopathology showing granulomatous nodular dermatitis without visible amastigotes—a finding compatible with DL, where the parasitic load is often minimal, unlike in diffuse cutaneous leishmaniasis (1).

Conclusion

This case underscores the importance of recognizing disseminated forms of leishmaniasis in endemic regions like Colombia, especially given the broad clinical spectrum of the disease in Latin America. Accurate diagnosis can be

challenging due to the low parasitic burden; therefore, clinicians should maintain a high index of suspicion in appropriate epidemiological contexts.

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**Abstract N°: 2317****Is the Cost of Treatments a Barrier to Recovery? A Comparative Study of Scabies Treatment Outcomes Before and After the Introduction of Free Medication**

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Introduction & Objectives:

In many healthcare systems, scabies treatment has traditionally not been provided free of charge, potentially limiting access and adherence. Recently, some Italian regions have introduced free treatment policies for individuals affected by the virus and their close contacts. This study aimed to assess the epidemiological impact of such a policy in our metropolitan area and to evaluate whether alleviating treatment cost influenced therapeutic outcomes.

Materials & Methods:

We conducted an ambispective observational study that combined retrospective data (January 2024–October 2024) with prospective monitoring (January 2020–July 2025). Monthly scabies cases were compared with Holt–Winters exponential smoothing forecasts to assess the epidemiological impact of the intervention. Clinical outcomes were also evaluated before and after the introduction of the free treatment policy

Results

The analysis showed that the expected trend, based on Holt–Winters forecasts, indicated a progressive increase in scabies incidence. In contrast, the observed number of cases declined after the introduction of the free treatment policy in late October 2024, consistently remaining below the projected values. These findings suggest that removing economic barriers contributed to reversing the rising trend and improving disease control at the population level.

Conclusion

Free access to scabies medication is an effective public health intervention, supporting international recommendations for universal treatment in high-burden settings. While cost alone is not the primary driver of treatment failure, eliminating financial barriers can enhance equity and help reverse incidence trends. Measures such as patient education and systematic contact tracing remain essential to sustain long-term disease control.





Abstract N°: 2387

A Five-Year Review of Cutaneous Leishmaniasis Cases and the Rare Need for Systemic Treatment: A Case ReportSueda Sanli Arikan^{*1}, Hilal Kul¹, Asya Almila Can¹, Bugra Burc Dagtas¹, Duygu Yamen¹, Ayse Esra Koku Aksu¹¹University of Health Sciences Istanbul Training and Research Hospital, Dermatology, Istanbul, Türkiye

Introduction & Objectives: We have recently observed a relative increase in cutaneous leishmaniasis (CL) cases in our clinical practice, which is located in a non-endemic region of Türkiye. The majority of cases are managed with local treatments, rarely, systemic therapy is required. This study retrospectively reviews our five-year experience with CL cases and presents a representative case that required systemic intervention.

Materials & Methods: A retrospective review was conducted of patients diagnosed with CL at our clinic between May 2020 and May 2025. Additionally, a single case requiring systemic treatment is presented in detail.

Results: In our clinic, between May 2020 and May 2025, a total of 17 patients were diagnosed with CL, with a mean age of 28.4 years. Of the 17 patients, 8 (47%) were diagnosed using Tzanck smear, and 9 (53%) through histopathological examination. One patient did not receive antimonial treatment as the entire lesion was removed by excisional biopsy, and two patients did not return for follow-up. Among the 12 patients who received local treatment, the lesions completely healed after an average of 18 doses of intralesional meglumine antimoniate injections. Systemic treatment was deemed necessary in two patients due to resistance to local treatment and multiple large lesions, the latter being the case presented below.

A 58-year-old male patient presented with six non-healing ulcerative lesions on the neck, both arms, and the right leg, persisting for one month. He had a history of travel to Afghanistan and reported insect bites. Leishmania infection was strongly suspected, and a Tzanck smear confirmed the presence of amastigotes (Figure 1). Due to number, size and sporotrichoid distribution, systemic therapy was initiated. A 20-day intramuscular meglumine antimoniate therapy was planned for the patient. The calculated daily dose was 10 mg/kg, corresponding to a total of 10 mL of injection daily, with 5 mL administered to each gluteal area. No cardiac side effects were observed. On the 5th day, pancreatic enzyme levels showed a mild elevation (2.3x the upper limit of normal), but in the absence of clinical symptoms, treatment was continued without modification. On the 13th day, treatment was briefly paused for one week due to pain at the injection site; no sign of necrosis, abscess or secondary infection detected. After 15 injections, the lesions showed significant improvement, leaving residual scarring (Figure 2).

Conclusion: Most cases of leishmaniasis can be managed with intralesional injections, an area in which we have considerable experience (Figure 3). However, when indicated, systemic treatment should be initiated. Potential serious side effects, such as cardiac arrhythmia and pancreatitis, make patient selection and treatment follow-up critical. High-volume intramuscular administration may lead to injection site complications. In this regard, sodium stibogluconate, which is also approved for intravascular use, may be a preferable alternative to meglumine antimoniate.

This case represents an example of a widespread cutaneous leishmaniasis case that rarely requires systemic treatment, highlighting the importance of careful monitoring.



Abstract N°: 2408

Cydnidae (Burrowing Bug) Pigmentation in a Non-Acral Site: Clinical and Dermoscopic Features

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Introduction & Objectives:

Cydnidae (burrowing bugs) in the order Hemiptera have morphological adaptations for digging and release an odorous defensive secretion, which can cause pigmented macules on human skin, especially during the rainy season. Here we report an unusual case due to the involvement of an uncommon body site.

Materials & Methods:

An otherwise healthy 24-year-old female presented with sudden-onset, asymptomatic, multiple tiny brown spots on the left gluteal region that had developed one week ago. The onset of lesions was observed after a seaside stay during the summer vacation. There was no history of associated preceding trauma, drug intake, or any contact with chemicals.

Results:

On examination, multiple discrete, irregularly shaped brownish-black macules with streaky ends, measuring 2-6 mm in diameter, resembling lentigines were observed on the left gluteal region. Other mucocutaneous sites were uninvolved. The patient stated that there had been no changes in the color or texture of the lesions from their initial appearance to the time of the current assessment. The macules were non-blanching upon pressure and remained unaffected when attempts were made to remove them using alcohol, soap, or water.** Dermoscopy demonstrated pigmentation exhibiting both linear structures and irregular, bizarre-shaped patterns. The pigmented structures exhibited a superficial “stuck-on” appearance. The lesions disappeared in a week without any intervention.

Considering the patient’s history, along with clinical and dermoscopic evaluations, the diagnosis was consistent with Cydnidae (Burrowing Bug) Pigmentation.

Conclusion:

Cydnidae, also known as burrowing bugs, belong to the order *Hemiptera* and are characterized by morphological adaptations that facilitate digging. These insects burrow into the soil to feed on plants, making them less frequently encountered. The odorous secretion released from specialized glands serves as a defense mechanism; however, upon contact with human skin, it can induce pigmented macules. Patients, particularly during the rainy season, present with the sudden onset of asymptomatic pigmented spots. The lesions typically resolve spontaneously within 1–2 weeks without the need for treatment. Similar to other arthropod-induced pigmentation, these lesions predominantly affect acral areas; however, involvement of the abdomen, back, and chest has also been documented.

Lesions range from oval to irregular in shape, measuring from pinpoint size to a few millimeters. They may appear as isolated spots or in grouped formations with streaky, tapering ends and usually develop within minutes of contact with the insect’s fluid following accidental crushing. They closely resemble lentigines, particularly on exposed areas. Acral melanoma, melanocytic nevi, petechiae, and exogenous pigmentation from chemical exposure can be excluded based on the patient’s history. Recognizing this rare underlying cause of pigmentation

is crucial for easing patient concerns and avoiding unnecessary diagnostic tests or treatments.

While most reported cases in the literature affect the palms and soles, occurrences in rare anatomical sites, as observed in our case, have also been documented. It is essential for clinicians to be aware of atypical localizations.

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**Abstract N°: 2463****Sporotrichosis Masquerading as a Verrucous Squamous Cell Carcinoma – A Diagnostic Challenge**Ying Shan Cheung¹, Kong Bing Tan¹, Adeline Mei Yen Yong¹, Peter Goon¹¹National University Hospital (NUH) - Singapore, Singapore, Singapore**Introduction & Objectives:**

Sporotrichosis is a subcutaneous fungal infection caused by *Sporothrix schenckii*, known for its diverse clinical manifestations, including nodular lymphangitis, fixed cutaneous lesions, and less commonly, pulmonary, osteoarticular, or disseminated forms. We report a case involving a verrucous plaque initially suspected to be squamous cell carcinoma, which was ultimately diagnosed as cutaneous sporotrichosis.

Materials & Methods:**Results:**

A 62-year-old male presented to the dermatology clinic with a lesion on his left shin that had been gradually enlarging over the past six months. The lesion began as a small scab and progressively increased in size and irregularity. Clinical examination revealed a well-demarcated, 5 × 7 cm raised verrucous plaque with central crusting and peripheral scaling. Differential diagnoses included verrucous squamous cell carcinoma (SCC), cutaneous tuberculosis, and atypical pyoderma gangrenosum. A skin punch biopsy was performed, and fungal culture confirmed the presence of *Sporothrix schenckii*. The patient was treated with oral itraconazole 100 mg twice daily for three months, resulting in interval improvement of the lesion.

Conclusion:

Sporotrichosis can present with various cutaneous morphologies, often misleading clinicians. Verrucous lesions are rare but have been reported, particularly in immunocompetent individuals with prolonged infection. Pseudoepitheliomatous hyperplasia on histopathology can mimic SCC, making fungal stains and cultures critical for diagnosis.





Abstract N°: 2489

Hyalohyphomycosis caused by *Diaporthe phaseolorum* in a Renal Transplant Recipient with Systemic AL Amyloidosis: A Rare Case Report

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Introduction & Objectives:

Hyalohyphomycosis refers to opportunistic infections caused by non-pigmented filamentous fungi. Human infections with *Diaporthe phaseolorum*, a known plant pathogen, are exceptionally rare. This case report describes a cutaneous hyalohyphomycosis in an immunocompromised patient with multiple risk factors, including a history of renal transplantation and systemic amyloid light-chain (AL) amyloidosis.

Case Presentation:

A 71-year-old Thai male with a history of renal transplantation for end-stage renal disease and a recent diagnosis of AL amyloidosis with renal involvement presented with a progressively enlarging, non-tender mass on his left leg. The lesion had initially developed following minor trauma two years prior and had worsened after a blunt injury from a plant leaf two months before presentation. He was receiving immunosuppressive therapy consisting of mycophenolate mofetil, prednisone, tacrolimus, and cyclophosphamide.**

On physical examination, multiple lobulated, skin-colored nodules measuring 6 × 4 cm were observed on the anterior aspect of the left leg. An incisional biopsy revealed pseudocarcinomatous epidermal hyperplasia with dense suppurative granulomatous inflammation, containing multinucleated giant cells, septate hyphae, and round fungal elements. Periodic acid–Schiff (PAS) and Grocott's methenamine silver (GMS) staining highlighted numerous hyaline hyphae. Molecular identification via 18S rDNA sequencing from both tissue and culture confirmed the presence of *Diaporthe phaseolorum*. No evidence of systemic dissemination was found. The patient was treated with oral itraconazole at a dose of 400 mg/day and demonstrated a good clinical response.

Conclusion:

This is the first reported case of cutaneous hyalohyphomycosis caused by *Diaporthe phaseolorum* in a renal transplant recipient with AL amyloidosis. Clinicians should maintain a high index of suspicion for uncommon fungal infections in immunocompromised patients presenting with atypical skin lesions, particularly in endemic regions or following trauma.



**Abstract N°: 2551****Efficacy and safety of terbinafine and itraconazole monotherapy in conventional and increased doses and in combination in dermatophytosis**Afsana Nahid¹¹Dhaka Medical College, Dermatology and Venereology, Dhaka, Bangladesh

Introduction & Objectives: Dermatophytosis is a public health problem globally, affecting 20–25% of the world's population. During the last decade, there has been an uncontrolled increase in dermatophytosis with atypical presentations in Bangladesh, with difficult-to-treat cases. The treatment guidelines given in the standard books for commonly prescribed systemic antifungals no longer seem valid today and frequently result in treatment failures and relapses. So, prolonged treatment durations, higher doses, and systemic antifungal combinations are empirically prescribed by clinicians. The present study is designed to evaluate the efficacy and safety of the most commonly prescribed drugs, oral terbinafine and itraconazole, in conventional and increased doses and combination therapy in the treatment of dermatophytosis.

Materials & Methods: This randomized parallel group trial was conducted at the Department of Dermatology and Venereology of a government tertiary care hospital from January to June of 2023 per the Ethical Review Committee of that hospital and the Helsinki Declaration of 2013 with the registration number NCT05881980 by clinicaltrials.gov. Patients with tinea corporis, tinea cruris, or tinea faciei, or any combination of these conditions, from 18 to 60 years of age, with microscopic confirmation of dermatophytosis were enrolled. One hundred and fifty patients were randomly allocated to five treatment groups (T1, I1, T+I, T2 & I2). T1 & I1 received conventional doses of terbinafine & Itraconazole, respectively. T+I cases received terbinafine and itraconazole combination in conventional doses. T2 & I2 received a double dose of terbinafine and itraconazole, respectively. Patients were evaluated for the severity of clinical parameters (itching, erythema, and scaling), using a four-point scale ranging from 0 to 3 with a total symptom score of 0 to 9. Follow-up was done every 2 weeks up to a maximum of 8 weeks. Improvement in overall clinical assessment was assessed by the Physician Global Assessment (PGA) score and graded as I (1–25% improvement), II (26–50% improvement), III (51–75% improvement), and IV (76–100% improvement). The outcome was measured as cure, partial clinical response, and complete failure. All adverse events (AEs) were assessed, and laboratory measurements were taken at each visit.

Results: Most participants fell within the 18–30 age group, and the combination of T. corporis & T. cruris was the most common clinical type. The majority of all groups showed severe scoring of erythema, scaling, and pruritus at baseline. For all groups, symptom score improvement is highly significant at the 8th week compared to baseline. I2 has the highest cure rate (96.30%). then T+I (89.70%), then I1 (83.30%). The failure rate is high in T1 (51.90%) and T2 (51.90%). Across all follow-ups, the reported unpleasant effects were relatively low. Serum creatinine and SGPT levels were within normal ranges throughout the study.

Conclusion: The sudden increase in the number of treatment failure dermatophytosis in Bangladesh is of major concern. Antifungals no longer seem to work like they used to. Itraconazole is the most effective antifungal drug against dermatophytes. Longer duration of treatment is required for complete cure of the disease. Use of higher doses of both terbinafine and itraconazole or a combination does not seem to have any additional benefit. Adverse effects were scattered and minimal, suggesting a wide acceptability of all treatments.





Abstract N°: 2589

Histioid Leprosy: A rare form of multibacillary Hansen's Disease

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Introduction and Objectives

Histioid leprosy (HL) is a rare variant of lepromatous leprosy (LL), clinically characterized by papulonodular lesions on the extremities and face. It is a highly bacilliferous form with distinctive histopathological features that differentiate it from classical LL. Accurate identification is critical, as its elevated *Mycobacterium leprae* burden poses a significant public health risk. Diagnosis, however, can be challenging due to its resemblance to fibrohistiocytic disorders.

Materials and Methods

We report the case of a 41-year-old migrant woman in Colombia with a six-year history of asymptomatic papular lesions on her left leg, progressing to scattered nodules. She denied any close contacts with dermatological symptoms or peripheral neuropathy. Physical examination revealed exophytic, euochromic to pale pink nodules on the face, earlobes, back, buttocks, and extremities (up to 15 mm), along with erythematous-violaceous infiltrated papules and plaques on the trunk, sparing deep folds.

Skin biopsy demonstrated dermal proliferation of epithelioid and spindle-shaped histiocytes, accompanied by epidermal atrophy and an Unna band, without foamy cells or globi. Fite-Faraco staining revealed abundant acid-fast bacilli (AFB), with a bacillary index (BI) of 4.5 on the Ridley-Jopling scale, confirming the diagnosis of HL. Multibacillary multidrug therapy (MDT) was initiated, and significant clinical improvement was observed after five months. Given the high BI, a 24-month treatment course was recommended.

Results

HL accounts for approximately 1.2% of all leprosy cases and 8.7% of LL cases. Its pathophysiology remains incompletely understood. Early reports associated HL with irregular treatment or monotherapy, suggesting the emergence of resistant *M. leprae* strains. Clinically, HL presents with painless, smooth, globular papules and nodules, predominantly on the upper limbs. Histopathologically, it is distinguished by spindle-shaped histiocytes arranged in storiform or nodular patterns, absence of foamy cells or globi, and associated epidermal atrophy.

The spindle morphology may result from the interaction between infected macrophages and extracellular matrix components. Cellular proliferation is often well-circumscribed and surrounded by a collagen pseudocapsule, indicating a hyperactive yet ineffective local immune response. Immunohistochemistry demonstrates CD68+ expression, supporting the phagocytic origin of the histiocytic component. Due to its clinical and histological overlap with conditions such as neurofibromatosis type 1 or fibrohistiocytic tumors, AFB staining is essential for definitive diagnosis. Early recognition of HL is crucial due to its high infectivity. MDT remains the treatment of choice, with extended therapy (24 months) recommended to ensure adequate control of the bacillary load.

Conclusion

HL is a rare but highly infectious form of LL requiring prompt and accurate diagnosis to avoid mismanagement and limit community transmission. This case underscores the importance of recognizing its distinct clinical and

histopathological characteristics and implementing timely, extended multidrug therapy to achieve effective disease control.

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**Abstract N°: 2597****Visceral Leishmaniasis Secondary to *Leishmania mexicana*: A Rare Case Report from Mexico**

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Introduction & Objectives:

Leishmaniasis is a chronic infectious disease caused by flagellated protozoa of the genus *Leishmania*, obligate intracellular parasites, with over 20 pathogenic species identified. It is estimated that each year, 50,000 to 90,000 new cases of visceral leishmaniasis (VL) occur globally, though only 25% to 45% are reported to the WHO. Its clinical significance lies in its high mortality: while timely treatment reduces death rates to around 7%, without treatment, mortality can rise up to 95%.

Materials & Methods:

A 72-year-old male, rural resident of Campeche, Mexico, dedicated to farming (corn and beans), initially developed localized cutaneous leishmaniasis, presenting as a single retroauricular lesion. He was treated with intramuscular meglumine antimoniate (1.5 g for one month) with partial improvement. Four months later, he developed disseminated cutaneous involvement with multiple nodules and ulcerated nodules on the face, trunk, and limbs, along with fever, fatigue, weight loss of 14 kg over two months, and asthenia. Skin biopsy showed an acute lymphoplasmacytic infiltrate with abundant histiocytes and intracellular amastigotes, confirmed by PCR as *Leishmania mexicana*. Viral panel was negative. Laboratory tests revealed elevated cholestatic liver enzymes. Contrast-enhanced abdominal CT showed a liver lesion in segment II and splenomegaly. Due to suspected visceral involvement with hepatic-splenic compromise, treatment with IV liposomal amphotericin B (20 mg/kg) was started in four weekly doses, resulting in marked clinical improvement, lesion reduction, and normalization of liver enzymes.

Results:

The patient responded well to treatment, with decreased number and size of lesions, resolution of systemic symptoms, and improvement in general condition. There were no new lesions during follow-up, and complete healing of the previously affected areas was observed. The case was confirmed as visceral leishmaniasis by *L. mexicana* through molecular diagnosis.

Conclusion:

The clinical presentation of VL is usually nonspecific, including fever, hepatosplenomegaly, weight loss, lymphadenopathy, and pancytopenia, sometimes with or without skin involvement. In this case, visceral involvement was secondary to *L. mexicana*, a species geographically distributed in Mexico, Central and South America, commonly associated with solitary or multiple ulcerated cutaneous lesions, rarely involving systemic spread. It is the causative agent of 'chiclero ulcer', which resolves spontaneously in 80% of cases within 3 to 4 months. To date, only two cases of VL due to *L. mexicana* have been reported—one in Mexico (2000) and another in Colombia (2011), while *L. donovani* remains the most frequent cause. This case emphasizes the importance of PCR for species identification. Although treatment is not species-specific, liposomal amphotericin B remains the first-line drug due to higher efficacy and lower toxicity compared to amphotericin B deoxycholate.





Abstract N°: 2609

Efficacy of Methylene Blue Mediated Photodynamic Therapy for Multiple Common Warts Using Intralesional and Topical Application

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Introduction & Objectives:

Common warts are benign epidermal lesions, caused by human papillomavirus (HPV). Methylene blue mediated photodynamic therapy (MB-PDT) is a non-invasive treatment modality with potential for wart clearance. This study aimed to evaluate the overall efficacy of a combined approach utilizing both intralesional and topical application of methylene blue (MB) followed by red light irradiation in the treatment of multiple common warts.

To assess the clinical efficacy of MB-PDT, employing both intralesional injection and topical application of the photosensitizer, followed by red light irradiation, in achieving complete clearance of multiple common warts in a cohort of 30 patients.

Materials & Methods:

Thirty patients with multiple clinically diagnosed common warts were enrolled in this study. Each patient received five weekly treatment sessions. During each session, a 0.1% methylene blue solution was injected intralesionally into each wart, immediately followed by topical application of a 1% methylene blue gel on the surface of the same warts. Subsequently, all treated warts in each patient were irradiated with red light (Omega Light, 630 nm, 80 J/cm²) for 10 minutes. The primary outcome measure was the percentage of improvement in size and diameter of wart at the end of the five treatment sessions and at a 6-month follow-up. Secondary outcome measures included, patient-reported pain during treatment, and the incidence of adverse effects.

Results:

Following the five weekly treatment sessions, a significant percentage of treated warts demonstrated variant clinical clearance (from 20 % to 70 % improvement). Patient-reported pain was generally mild and primarily associated with the intralesional injection, subsiding quickly after the procedure. The treatment was well-tolerated, with minimal adverse effects observed, mainly consisting of localized mild erythema and transient hyperpigmentation at the treatment sites. At the 6-month follow-up, no recurrence in improved lesions.

Conclusion:

The combined approach of intralesional injection followed by topical application of methylene blue, activated by red light photodynamic therapy, demonstrates promising efficacy in the treatment of multiple common warts. This treatment protocol with minimal side effects can be optimized and combined with other modalities of wart therapy to maximize its results. Further studies with larger cohorts and comparative arms are warranted to optimize treatment parameters and further evaluate the long-term outcomes of this combined MB-PDT strategy for common warts.





Abstract N°: 2620

Chronic Rhinosinusal Mucormycosis with Secondary Cutaneous Involvement in a Patient with Ataxia-Telangiectasia Syndrome: A Case Report

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¹University of Monterrey, Dermatology, Monterrey

Introduction & Objectives:

Mucormycosis is a rare and aggressive opportunistic fungal infection caused by fungi of the order Mucorales, typically affecting immunocompromised patients. The chronic form is less frequent and often underrecognized due to its indolent course. Ataxia-telangiectasia (AT) is a neurodegenerative primary immunodeficiency syndrome characterized by oculocutaneous telangiectasias, progressive cerebellar ataxia, and combined cellular and humoral immunodeficiency, which increases the susceptibility to opportunistic infections, including fungal pathogens. We present an unusual and complex case of chronic rhinosinusal mucormycosis with secondary cutaneous involvement in a pediatric patient with genetically confirmed AT. This case aims to underscore the diagnostic complexity and therapeutic challenges of managing invasive fungal infections in patients with underlying immunodeficiencies.

Materials & Methods:

The patient was a 15-year-old female with a history of genetically confirmed ataxia-telangiectasia. She presented with chronic nasal obstruction, recurrent sinusitis, and ulcerative lesions on the nasal mucosa and surrounding skin. Imaging studies (CT) showed destruction of sinus walls and palatal perforation. Multiple biopsies were performed for histopathology and culture. Direct microscopic examination and histopathologic staining (PAS and Grocott) revealed broad, non-septate hyphae. Fungal cultures grew *Rhizopus* species, and species-level identification as *Rhizopus arrizus* was confirmed via sequencing of the internal transcribed spacer (ITS) region. Susceptibility testing guided antifungal therapy.

Results:

The patient initially received broad-spectrum antibiotics and antifungals without clinical improvement. Upon confirmation of mucormycosis, intravenous amphotericin B deoxycholate was started at a dose of 1 mg/kg/day. Due to limited availability of liposomal amphotericin B in our hospital, oral itraconazole was added as adjunctive therapy. Multiple surgical debridements were performed to remove necrotic tissue. Topical agents, including Triticum vulgare and pirfenidone, were applied to promote re-epithelialization and manage secondary ulceration. Although partial control of the cutaneous lesions was achieved, the patient developed progressive respiratory complications and ultimately died due to systemic deterioration related to underlying immunodeficiency. No further fungal dissemination was observed at the time of death.

Conclusion:

This case highlights the importance of early and accurate diagnosis of chronic mucormycosis in immunodeficient patients, particularly those with rare conditions such as ataxia-telangiectasia. Chronic forms may mimic other granulomatous or neoplastic processes, delaying the appropriate management. A multidisciplinary approach combining surgical debridement, targeted antifungal therapy, and wound care is essential to control local infection. However, the overall prognosis remains poor in the context of profound immunodeficiency. Our report

emphasizes the need for heightened clinical suspicion and personalized therapeutic strategies when treating invasive fungal infections in pediatric patients with congenital immune disorders.

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**Abstract N°: 2669****Recombinant Zoster Vaccine Among Patients With Chronic Inflammatory Skin Diseases: A Cohort Study**Tai-Li Chen Chen¹, Sheng-Hsiang Ma¹, Chih-Chiang Chen¹¹Taipei Veterans General Hospital, Department of Dermatology, Taipei City, Taiwan**Introduction & Objectives:**

The recombinant zoster vaccine (RZV) has demonstrated effectiveness in both clinical trials and real-world settings. However, prior studies have predominantly compared vaccinated and unvaccinated cohorts, raising concerns about selection biases, including the healthy vaccinee bias. Additionally, although patients with chronic inflammatory skin diseases (CISDs) are at heightened risk of herpes zoster (HZ), data on the effectiveness of RZV in this vulnerable population remain scarce. Accordingly, this study sought to evaluate the effectiveness of RZV in patients with CISDs, relative to those who received the live attenuated vaccine (LAV).

Materials & Methods:

This retrospective cohort study analyzed data from the US Collaborative Network in TriNetX. Adults aged >18 years with CISDs between 2014 and 2021 were identified. CISD was defined as at least three confirmed diagnoses within one year of any of the following: psoriasis, atopic dermatitis, alopecia areata, hidradenitis suppurativa, vitiligo, or pemphigoid. To ensure mutual exclusivity of skin conditions, patients with multiple encounters in a year but different CISD diagnoses (e.g., atopic dermatitis at one visit and psoriasis at another) were excluded. Two cohorts were established to compare the effectiveness of RZV versus LAV among CISD patients. In the RZV cohort, all patients received at least one dose of the vaccine between November 1, 2017, and October 31, 2020. In the LAV cohort, all patients received at least one dose between October 1, 2014, and September 30, 2017. A target trial emulation design with propensity score matching was employed to compare patients initiating RZV with those receiving LAV. Hazard ratios (HRs) were estimated using Cox proportional hazards models. The primary outcome was incident herpes zoster (HZ). Secondary outcomes included ophthalmic zoster (OZ), postherpetic neuralgia (PHN), and complicated HZ. Stratified analyses were conducted by CISD category, age group (≤ 64 , 65–79, and ≥ 80 years), sex, systemic corticosteroid use, immunosuppressant use, and biologic use. Vaccine effectiveness (VE) was calculated as one minus the adjusted HR.

Results:

A total of 216,476 individuals with CISDs were included in the analysis. Compared to recipients of LAV, those who received RZV had a lower risk of HZ (HR: 0.62; 95% CI: 0.48–0.82), OZ (HR: 0.61; 95% CI: 0.37–0.98), PHN (HR: 0.64; 95% CI: 0.54–0.75), and complicated HZ (HR: 0.72; 95% CI: 0.59–0.88). Subgroup analyses revealed reduced risks in both the 1-dose and 2-dose groups. After adjustment, VE was 74% for 1 dose and 66% for 2 doses. These results were consistent across age groups, sexes, and all CISD categories. Additionally, RZV demonstrated significantly greater effectiveness among patients with any history of immunosuppressant or biologic use compared to those without such treatments. Multiple sensitivity analyses confirmed the robustness of the primary findings.

Conclusion:

The use of RZV appears to be associated with a lower long-term risk of HZ, PHN, and complicated HZ in patients with CISDs compared to LAV. Considering its widespread availability and favorable safety profile, strategies to improve RZV uptake in this population should be considered.



**Abstract N°: 2679****nodular lesions with fatal outcome: an atypical cause of panniculitis**

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Introduction & Objectives:

Skin lesions caused by non-tuberculous mycobacteria (NTM) have increased in recent years. We present the case of an immunosuppressed patient with disseminated infection due to *Mycobacterium Chelonae*.

Materials & Methods:

An 86-year-old male, with past medical history of interstitial nephritis who has been on prolonged prednisone and mycophenolate mofetil treatment. He was admitted with polyarthritides and indurated erythematous plaques on both thighs, some of which had a nodular morphology. Suspecting panniculitis, a skin biopsy was performed. On the fourth day, the patient developed fever of up to 38.7°C.

The biopsy revealed granulomatous structures composed of multinucleated giant epithelioid histiocytes and abundant neutrophils. Acid-fast bacilli were observed using the Ziehl technique. With a diagnosis of suppurative granulomatous panniculitis due to NTM, empirical treatment with moxifloxacin, imipenem, and azithromycin was started. Polymerase-chain reaction test on skin sample was positive for *M. Chelonae*. Culture performed on the skin sample also was positive for *M. Chelonae*. After eight days of treatment, the patient passed away due to multiple organ failure.

Results:

Clinical presentation of NTM skin infections varies according to the host's immunological status. In immunocompetent host, localized abscesses or cellulitis due to direct inoculation are more common. In immunosuppressed patients, disseminated skin infection with multiple subcutaneous nodules is frequent.

Regarding histological study, presence of granulomas with epithelioid histiocytes and multinucleated giant cells, as well as abscesses rich in neutrophils are the most common findings. In immunosuppressed patients, the inflammatory infiltrate is deeper, and abscess formation is constant, along with the presence of suppurative granulomas. Although suppurative granulomas may not be present in the early stages. Polymerase-chain reaction testing for *M. Chelonae* confirms the diagnosis.

As for treatment, due to the frequent resistance to monotherapy in *M. Chelonae*, multi-drug regimens are currently recommended.

Conclusion:

In conclusion, we present a case of disseminated granulomatous panniculitis due to *M. Chelonae*, highlighting the importance of considering this diagnosis in cases of panniculitis in immunosuppressed patients with routine sterile cultures. The knowledge of this entity will allow for early diagnosis and initiation of appropriate treatment.





Abstract N°: 2783

Acquired lymphedema due to recurrent herpes infection

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Introduction:

This is a 29-year-old woman with no drug allergies or toxic habits. Her medical history included childhood atopic dermatitis and dyshidrotic eczema. She worked as a high school teacher and was right-handed.

Referred from Primary Care for a one-year history of edema in the left upper limb, mainly affecting the forearm, wrist, and hand, associated with recurrent vesicles on the lateral side of the second left finger. Each flare was followed by 3–4 days of edema. No history of trauma, surgery, angioedema, or constitutional symptoms.

She was previously assessed by private Rheumatology and Dermatology services and treated empirically with valacyclovir, corticosteroids, pregabalin, NSAIDs, and antibiotics, without improvement.

On initial Dermatology assessment, no active lesions were noted. Physical exam revealed soft edema on the dorsum of the left hand, wrist, and forearm, with faint erythematous macules on the lateral aspect of the second finger. Radial and ulnar pulses were symmetric. Thoracic outlet maneuvers showed slight decrease in radial pulse with abduction and external rotation.

At that time, the differential diagnosis included thoracic outlet syndrome, vascular obstruction, and lymphatic drainage disorders.

Additional diagnostic tests

Blood work (electrolytes, renal function, hemogram, proteinogram, TSH, ANA, RF, CRP) was normal. X-rays were unremarkable. Hand ultrasound showed mild synovitis without Doppler uptake and marked subcutaneous edema. Doppler ultrasound ruled out venous thrombosis. MR angiography revealed diffuse subcutaneous edema without stenosis, occlusion, or malformation, ruling out thoracic outlet syndrome. Lymphoscintigraphy showed mildly impaired lymphatic drainage in the left upper limb, without tracer retention.

Six months later, the patient returned with mild worsening of the edema and a new vesicle on the same finger. Swab PCR was positive for HSV-2; biopsy showed a subcorneal pustule with viral cytopathic effect; IHC confirmed HSV-2 positivity in keratinocytes.

Diagnosis and Treatment

Given clinical findings, histology, PCR, and IHC, and after ruling out other causes, a diagnosis of acquired lymphedema secondary to recurrent HSV-2 infection was made. Due to frequent relapses (>6/year), valacyclovir 500 mg/day was initiated, along with referral to rehabilitation for manual lymphatic drainage, compression therapy, and mobility exercises.

After 6 months, only one vesicular outbreak occurred, versus bimonthly episodes prior to treatment. Edema persisted, though stable.

Conclusion

This case describes acquired lymphedema in the left upper limb secondary to recurrent HSV-2 infection. Unlike classic lymphedema etiologies, the lymphatic alteration here is related to confirmed recurrent herpetic episodes (histology, IHC, PCR). This pattern is consistent with the few cases described in the literature, where lymphedema persists despite effective antiviral therapy. Valacyclovir has reduced recurrence frequency, though lymphedema persists, suggesting irreversible lymphatic damage. Multidisciplinary management with antiviral suppression, physiotherapy, and compression is key to avoid progression. This case highlights the importance of considering HSV-2 in the differential diagnosis of atypical lymphedema and the need for further studies on its pathophysiology and optimal treatment.

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**Abstract N°: 2812****Disseminated Nocardiosis due to *Nocardia brasiliensis*: A Case Report**

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Introduction & Objectives:

Nocardiosis is an uncommon infection caused by aerobic, gram-positive bacteria of the *Nocardia* genus, commonly found in soil, water, and organic matter. *Nocardia brasiliensis* primarily affects the skin, while *N. asteroides* is more often associated with disseminated forms. Cutaneous involvement occurs in approximately 20% of cases and may present as primary superficial cutaneous nocardiosis, lymphocutaneous syndrome, mycetoma, or as part of disseminated disease. The latter is more frequent in immunocompromised individuals. Diagnosis requires microbiological isolation of the organism and must be differentiated from other bacterial, fungal, and mycobacterial infections. Treatment is based on prolonged antibiotic therapy, with sulfonamides as first-line agents. We report a case of disseminated nocardiosis.

Materials & Methods:

Case report

Results:

A 61-year-old male with a history of L2-L3 microdiscectomy and dural repair (September 2024) was admitted to the Emergency Department with six days of fever, dry cough, somnolence, quadriparesis, and cutaneous lesions. Initial investigations, including respiratory swabs and blood cultures, were negative. Chest CT revealed bilateral centrilobular opacities, ground-glass attenuation, and micronodules associated with mediastinal lymphadenopathy. Spinal MRI showed multisegmental spondylodiscitis, cerebrospinal fluid fistula, and a paravertebral fluid collection adjacent to the surgical site. Surgical debridement and drainage were performed, and empirical treatment with cefepime and vancomycin was initiated in the ICU. Collection cultures were negative. Dermatological examination revealed erythematous nodules—some with fluctuation, others necrotic—and scattered pustules on an erythematous base involving the trunk and all four limbs. Crusts were also noted on the labial mucosa. The patient reported prolonged intramuscular corticosteroid use. Skin biopsies and cultures were taken due to suspicion of disseminated fungal infection, septic emboli, or Mucha-Habermann disease. Histopathology showed dermal ulceration with abscess formation. *Nocardia brasiliensis* was isolated from both blood cultures and skin samples. The patient was diagnosed with disseminated nocardiosis. Empirical imipenem therapy was initiated, later switched to targeted treatment with trimethoprim-sulfamethoxazole and ciprofloxacin based on susceptibility testing. Hypogammaglobulinemia (0.46 g/dL) was detected, with no other significant immunological findings. The patient improved clinically and was transferred for rehabilitation. At discharge, he continued with outpatient antibiotic therapy.

Conclusion:

Disseminated nocardiosis is a rare but serious condition, particularly in immunocompromised patients. Its clinical presentation may mimic other infections, leading to delayed diagnosis. This case highlights the importance of including *Nocardia* in the differential diagnosis of cutaneous lesions with systemic involvement, and the need for prolonged, targeted antimicrobial therapy.





Abstract N°: 2863

Cutaneous Manifestations of Disseminated Fusariosis: A Diagnostic Clue in the Recognition of Systemic Disease.

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Cutaneous Manifestations of Disseminated Fusariosis: A Diagnostic Clue in the Recognition of Systemic Disease.

Introduction:

Fusarium spp. are a group of fungi that are soil and plant saprophytes and can cause mycotoxicosis in humans and animals. It is the second most common human pathogenic mold. Immunocompromised patients are more frequently affected, and the involvement of the skin is one of the first and most common presentation. It usually begins localized, as a cellulitis of the toes because of a breakdown of the skin barrier or as onychomycosis.

Fusarium spp. are one of the most drug-resistant fungi and despite the available treatment options, most of the time, it has a bad outcome.

Case Report:

We report the case of a 44-year-old female Costa Rican patient, with a recent diagnosis of acute myeloblastic leukemia, undergoing induction chemotherapy, who was admitted to the hospital because of fever, elevation of inflammatory biomarkers and absolute neutropenia.

The patient presented paronychia of the first toe of the right foot with exulceration. During the following week she developed multiple erythematous and purple indurated nodules, located in the face, trunk and limbs, without compromising palms and soles or mucous membranes.

Histopathological examination of the lesions revealed superficial perivascular inflammation, stains for fungi and mycobacteria were negative.

A fungal culture of the tissue of the lesions was performed, revealing growth of *Fusarium solani complex*. Treatment with intravenous voriconazole and amphotericin B was started, and she was admitted at the intensive care unit because of complications, such as pneumonia and disseminated fusariosis, leading the patient to refractory septic shock and death.

Discussion:

Fusarium spp. are a group of pathogenic opportunistic microorganisms that affects most commonly immunocompromised patients because of hematologic malignancies. The most implicated species in human infections are *F. solani*, *F. oxysporum* and *F. moniliforme*. *F. solani* is the most common found in human infections despite their immunological status. Skin involvement is one of the first signs of *Fusarium* infections and it's a clue for the diagnosis. The diagnosis can be confirmed by blood culture or by skin biopsy. Histopathologically hyphae of *Fusarium* are seen as hyaline and septate filaments that dichotomize in acute and right angles.

In immunocompetent patients the most common cutaneous manifestations are localized lesions due to a disruption of the skin barrier like trauma, burns or onychomycosis, and they initiate as a localized cellulitis. In immunocompromised patients the classic clinical presentation are painful subcutaneous purpuric or erythematous disseminated nodules, with or without necrosis, but also papular lesions, granulomas or ulcers and can affect extremities, trunk and head most frequently.

Fusarium spp. has a very poor prognosis because it has a high rate of drug-resistance to triazoles or other antifungal agents.

The only treatment that has shown good results in disseminated fusariosis are voriconazole + amphotericin B, but both alone has shown a poor in vitro activity against *fusarium*.

Prognosis for patients with fusariosis depends on several factors, but the most important is the patient's immunological status and the recovery of neutropenia. Disseminated infection in patients with hematological malignancies has a high morbidity and a mortality rate of up to 80% despite adequate treatment.

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**Abstract N°: 2879****From Eczema to Hansen's disease : A case of diagnostic oversight**Sonal Fernandes*¹, Ramesh Bhat M¹, Jacintha Martis¹¹Father Muller Medical College, Dermatology , Mangaluru, India**Introduction:**

Hansen's disease is a chronic disease with a variety of clinical presentations ranging from a solitary cutaneous rash to severe peripheral neuropathy caused by *Mycobacterium leprae*. Our case underscores the need to consider Hansen's disease as a provisional diagnosis in patients with unexplained rashes recalcitrant to topical therapy.

Case Report:

A woman in her early fifties presented with itchy, reddish to dark raised lesions over her body for 1–2 years. The lesions began on her arms and gradually spread to both upper limbs and upper back. Sun exposure worsened them. Despite multiple treatments over the year including oral steroids, antihistamines, topical steroids, and emollients there was no improvement. On examination, she had diffuse xerosis with multiple erythematous to dusky papules and annular plaques with raised borders on the extensor aspects of both upper limbs, ear pinna and back. Sensation to touch, pain, and temperature was intact. The ulnar and radial cutaneous nerves were palpable bilaterally. There were no mucosal lesions, pedal edema, or glove-and-stockings anesthesia. Routine blood tests were normal. Given the photo-aggravation, subacute cutaneous lupus erythematosus (SCLE) was considered. However, ear lobe infiltration, ichthyosis, and nerve thickening raised suspicion for Hansen's disease. Serum IgE, eosinophil count, and ANA were normal. Skin biopsy from the left forearm showed an unremarkable epidermis with dermal perivascular and peri-adnexal lymphocytic infiltrates, including epithelioid histiocytes and Langhans giant cells forming granulomas. A slit skin smear was negative for acid-fast bacilli, suggestive of borderline tuberculoid Hansen's disease. She was started on multibacillary multi-drug therapy and emollients. At her one-month follow-up, 90% of the lesions had resolved.

Discussion:

Several reports in the literature highlight the overlap between leprosy and eczematous dermatoses, often leading to misdiagnosis and inappropriate treatment. Rahman et al. documented two cases where leprosy was initially misdiagnosed as eczema, leading to delayed treatment. Both patients presented with chronic, non-pruritic eczematous lesions that were unresponsive to standard therapy. The chronicity of lesions and lack of significant pruritus were key differentiating features. Pavithran K's case series presented three patients with asteatotic eczema, contact dermatitis, and nummular eczema, respectively, all of whom were later found to have Hansen's disease. Chaudhari et al. described a 40-year-old female with generalized erythema, scaling, skin tightness, and swelling, later diagnosed as borderline lepromatous leprosy with a Type 1 reaction, further illustrating the polymorphic clinical spectrum of Hansen's disease. Beyond these classical cases, rare presentations of Hansen's disease including psoriasiform plaques, anetoderma-like lesions, ulcerative leprosy, pustular erythema nodosum leprosum (ENL), Lazarine leprosy, verrucous plaques, hypertrophic scarring, and histoid Hansen's disease have been documented.

Conclusion:

This review reinforces the need for heightened diagnostic vigilance in patients with chronic, recalcitrant dermatological conditions, particularly in regions with a high burden of leprosy. Recognizing atypical

presentations, integrating dermatological and neurological assessments, and leveraging advanced diagnostic tools are essential to prevent misdiagnosis, inappropriate treatment, and long-term complications.

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**Abstract N°: 2903****Aspergillus fumigatus Infection Following Dermal Lip Filler Injection**Joe Khodeir¹, Pia Obeid², Paul Ohanian¹¹University of Balamand , Dermatology , Beirut, Lebanon²Lebanese American University , Beirut, Lebanon**Introduction & Objectives:**

Fungal infections following dermal filler injections are exceptionally rare, especially in immunocompetent individuals. While bacterial and mycobacterial infections are more frequently reported, only one confirmed case of Aspergillus infection has been previously documented. We report a rare case of Aspergillus fumigatus infection after lip filler injection in an immunocompetent female, highlighting the role of systemic corticosteroids in promoting fungal growth and emphasizing the importance of early diagnosis and antifungal therapy.

Materials & Methods:

A 24-year-old immunocompetent female presented with persistent lip nodules and swelling four months after receiving filler injections from a non-medical provider. Despite multiple empirical antibiotic courses—including clindamycin, amoxicillin/clavulanic acid, and azithromycin—and a two-week course of high-dose oral corticosteroids (1 mg/kg/day), symptoms worsened. Examination revealed localized pustules and swelling of the lips, without systemic involvement. Skin biopsies were performed to rule out foreign body granuloma. Cultures for bacterial, fungal, and mycobacterial organisms were obtained. Simultaneously, hyaluronidase injections were administered to dissolve the filler, and pustules were drained. Bacterial and mycobacterial cultures returned negative. Histopathology revealed granulomatous inflammation with fungal filaments, and cultures confirmed Aspergillus fumigatus, resistant to itraconazole.

Results:

Due to disease progression, the patient was hospitalized and treated with intravenous voriconazole, resulting in rapid improvement and full resolution after two months

Conclusion:

This case illustrates a rare but serious complication of dermal filler injections. The use of systemic corticosteroids likely contributed to fungal proliferation by suppressing host immunity, delaying diagnosis and contributing to antifungal resistance. Clinicians should consider fungal infections in persistent or atypical filler-related complications




Abstract N°: 2906
Cutaneous Leishmaniasis mimicking verrucous squamous cell carcinoma in an immunocompromised host

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Introduction & Objectives:

Cutaneous leishmaniasis (CL) is a vector-borne disease caused by protozoa of the genus *Leishmania* endemic to parts of the Old and New Worlds. Atypical presentations may mimic neoplastic or infectious processes, posing significant diagnostic challenges, particularly in immunocompromised patients^{1,2}.

Materials & Methods:

We report a case of CL mimicking a verrucous squamous cell carcinoma involving the right hallux. Prior informed consent was obtained.

Results:

A 70-year-old Portuguese man with a history of stage IV marginal zone lymphoma and insulin-dependent diabetes with microvascular complications presented with a verrucous tumor involving the right hallux that had been present for over 15 years. The patient reported multiple episodes of spontaneous partial regression, but with a marked enlargement over the last 6 months. There was no history of trauma, and the patient denied fever, weight loss, or mucosal symptoms. Travel history included multiple visits to Tunisia, Morocco, and Israel in the last 20 years. On examination the lesion measured 8×4 cm, was malodorous, and featured both papillomatous and hyperkeratotic changes, on the dorsum and tip of the toe, respectively. There were no other skin or mucosal lesions and there were no palpable lymphadenopathies or organomegalies.

Initial diagnostic suspicion centered on verrucous squamous cell carcinoma (SCC). Skin biopsy demonstrated pseudoepitheliomatous hyperplasia with a dermal infiltrate of histiocytes harboring amastigote forms, compatible with cutaneous leishmaniasis. Serology was positive, and the parasite was identified in the skin biopsy with polymerase chain reaction as belonging to the *Leishmania donovani* complex. Comprehensive evaluations, including ENT assessment, bone marrow study, and abdominal ultrasound, found no evidence of mucosal or visceral involvement. The patient was initiated on liposomal amphotericin B (4 mg/kg/day), completing an induction phase over 5 days, followed by maintenance doses on days 10, 17, 24, 31, and 38. At the 6-week follow-up, a 50% reduction in lesion size was observed, with decreased malodor and hyperkeratosis.

This case underscores the existence of non-classical manifestations of CL, particularly in immunocompromised individuals. The long-standing lesion with verrucous morphology mimicked neoplasia, and the hallux location (a rare site for CL) further complicated diagnosis^{2,3}. *L. donovani*, typically associated with visceral disease, can cause chronic CL, especially in patients with impaired immune response⁴. In regions where leishmaniasis is not endemic, a high index of suspicion is required for timely diagnosis and treatment.

Conclusion:

Cutaneous leishmaniasis should be considered in the differential diagnosis of chronic verrucous lesions, even in atypical locations and in non-endemic areas. In immunocompromised hosts, classical clinical patterns may be absent, and histopathology remains a cornerstone for diagnosis. Early recognition is critical to avoid misdiagnosis and unnecessary surgical intervention.





Abstract N°: 2985

Cutaneous *Mycobacterium szulgai* Infection in the Setting of Biologic Therapy: A Diagnostic Reminder

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Introduction & Objectives:

Nontuberculous mycobacteria (NTM) are acid-fast aerobic bacilli found in the environment. In immunosuppressed individuals, they may cause a broad range of infections. *Mycobacterium szulgai* is a slow-growing NTM, first described in 1972, and a rare pathogen. With the increased use of invasive procedures and immunobiologics, cases have risen. We report a case of cutaneous infection by *M. szulgai* in a 45-year-old male on adalimumab for psoriasis and psoriatic arthritis.

Case Report:

A 45-year-old man with psoriasis and psoriatic arthritis, diagnosed in 2020, was followed by dermatology. He began treatment with methotrexate 25 mg/mL (1 mL weekly), but due to failure, adalimumab was started in January 2021.

After one year, he presented with an ulcer on the right flank, draining serous fluid for 45 days. An incisional biopsy was performed. Histopathology showed a cutaneous ulcer with scarring fibrosis, and cultures identified *M. szulgai*.

Treatment with rifampicin, ethambutol, clarithromycin, and levofloxacin for 6 months led to clinical improvement.

Discussion:

NTMs are widely distributed and may cause infections in immunocompromised patients. They can manifest as pulmonary disease, lymphadenitis, skin and soft tissue infections, bone involvement, or disseminated disease. Cutaneous signs include plaques, nodules, pustules, abscesses, and ulcers.

M. szulgai is rare, accounting for <0.5% of NTM infections, and has been isolated from water sources. Ye et al. reported 17 cases of cutaneous infection in the literature. Van Ingen et al. found 21 cases in the Netherlands (1999–2006).

Due to its rarity, no standard treatment exists. Most cases respond well to regimens including rifampicin, ethambutol, and clarithromycin, with or without fluoroquinolones.

Anti-TNF-alpha therapy increases the risk of TB and NTM infections. In a retrospective study of 239 patients, Winthrop et al. found 105 (44%) met criteria for NTM disease; 73 used infliximab and 7 adalimumab. Many were also on other immunosuppressants such as prednisone and methotrexate.

Conclusion:

Monitoring for NTM infections in patients using anti-TNF-alpha agents is essential, especially in endemic areas and among vulnerable populations.





Abstract N°: 2991

Multibacillary Hansen's Disease with Negative Slit-Skin Smear and Borderline Tuberculoid Histopathology: A Diagnostic Challenge in Resource-Limited SettingsI Komang Harry Supradnyan^{*1}, Ketut Suteja Wibawa¹, Kadek Dwi Cakradiningrat², Ida Ayu Diah Purnamasari³¹Buleleng General Hospital, Ganesha University of Education, Dermatology and Venereology, Singaraja, Indonesia²Ganesha University of Education, Singaraja, Indonesia³Ganesha University of Education, Dermatology and Venereology, Singaraja, Indonesia

Introduction & Objectives: Hansen's disease (HD), caused by *Mycobacterium leprae*, presents along a clinical-histopathological spectrum requiring accurate classification for appropriate treatment. In low-resource settings, limited diagnostic tools and specialist access can complicate classification, especially when clinical, histological, and bacteriological findings are discordant. We present a case from rural Indonesia where clinical signs strongly suggested multibacillary HD, while slit-skin smear was negative and histology indicated borderline tuberculoid (BT) leprosy. This report aims to emphasize the importance of clinical judgment in such conflicting presentations to avoid undertreatment and prevent disability.

Materials & Methods: A 57-year-old woman presented to a dermatology clinic in northern Bali with a six-month history of progressive red plaques on the arms, back, and legs, later involving the face. The lesions were hypoesthetic and occasionally pruritic. Neurological exam revealed thickened bilateral ulnar, auricular, and peroneal nerves, with thumb motor weakness and a claw hand deformity on the right fifth digit. Sensory testing confirmed hypoesthesia over the lesions. Cutaneous exam showed multiple well-demarcated erythematous plaques with central clearing ("punched-out" lesions), consistent with disseminated disease. Slit-skin smears from six sites (ears, limbs, back) were negative for acid-fast bacilli using Ziehl-Neelsen staining. Biopsy of the left upper arm showed hyperkeratotic squamous epithelium and granulomas of epithelioid histiocytes surrounding adnexal structures with occasional Langhans-type giant cells. No caseation or bacilli were found. Histopathology suggested borderline tuberculoid leprosy, contrasting with the clinical picture.

Results: Despite the histopathological diagnosis of borderline tuberculoid leprosy and the negative bacteriological findings, the patient presented with clinical features that clearly fulfilled WHO criteria for multibacillary leprosy, including more than five well-defined lesions, significant peripheral nerve involvement, and a visible deformity (claw hand). The case highlights a diagnostic paradox that often emerges in intermediate-spectrum leprosy cases, where the immune status of the host may dynamically influence tissue response and bacillary load. Given the patient's extensive disease burden and disabling nerve involvement, we determined the most appropriate course of action was to treat as multibacillary HD using the WHO MDT-MB regimen consisting of rifampicin, clofazimine, and dapsone. The decision prioritized the potential risk of undertreatment and long-term disability over the absence of demonstrable bacilli. The case emphasizes the need for comprehensive clinical evaluation in HD, particularly in areas with limited access to advanced histological or molecular diagnostics, where misclassification may result in suboptimal therapy and disease progression.

Conclusion: This case illustrates a rare yet important diagnostic dilemma in Hansen's disease, where limited histological and bacteriological evidence contrasts with advanced clinical presentation. In resource-constrained settings, such cases challenge reliance on definitive laboratory findings and emphasize the importance of clinical judgment. Treating based on the most severe clinical indicator is crucial to prevent disease progression, relapse, and irreversible complications.





Abstract N°: 3019

Unrecognized Lucio's Phenomenon with Fatal Outcome: A Case from Indonesia Highlighting Diagnostic Delays in Leprosy ReactionsI Komang Harry Supradnyan^{*1}, Ketut Suteja Wibawa¹, Ketut Alit Wira Adi Kusuma², Ida Ayu Diah Purnamasari³¹Buleleng General Hospital, Ganesha University of Education, Dermatology and Venereology, Singaraja, Indonesia²Ganesha University of Education, Singaraja, Indonesia³Ganesha University of Education, Dermatology and Venereology, Singaraja, Indonesia

Introduction & Objectives: Lucio phenomenon is a rare but often fatal leprosy reaction characterized by widespread vascular necrosis in patients with diffuse lepromatous leprosy. Originally described in Mexico, cases remain under-recognized in Southeast Asia, where diagnostic delays can lead to systemic deterioration. This report presents a fatal case of Lucio phenomenon with secondary infection, diagnosed late in a resource-constrained hospital. The objective is to emphasize the critical importance of early clinical recognition and immediate treatment initiation in rare reactional states of Hansen's disease.

Materials & Methods: A 65-year-old male presented with acute burning pain, numbness, and swelling in both extremities, followed by the rapid appearance of diffuse erythematous-to-violaceous plaques that ulcerated within hours. Additional findings included leonine facies, madarosis, infiltrated earlobes, and widespread hypoesthesia, suggesting multibacillary leprosy. Slit-skin smear examination revealed a positive result for acid-fast bacilli (Bacillary Index 4+), consistent with lepromatous spectrum disease. Swab culture from ulcer bases showed *Raoultella ornithinolytica*. Laboratory investigations revealed elevated creatinine, hyperkalemia, and leukocytosis. Histopathology and imaging were not performed due to rapid clinical deterioration. The constellation of ulceronecrotic skin lesions with a high bacillary load strongly indicated Lucio phenomenon.

Results: Despite initiation of systemic antibiotics, corticosteroids, and supportive care, the patient's condition worsened. Multidrug therapy (MDT) for leprosy had not yet been initiated due to the patient's unstable status. On the third day of hospitalization, the patient succumbed to presumed septicemia and multi-organ failure. The fatal outcome emphasizes the fulminant course of Lucio phenomenon, especially when diagnosis is delayed and MDT is not promptly administered. This case exemplifies the high mortality associated with Lucio's reaction and underlines the need for clinical decisiveness even before full diagnostic confirmation in endemic areas.

Conclusion: Lucio phenomenon can present as a dramatic and deadly reactional state in previously undiagnosed multibacillary leprosy. In patients presenting with necrotizing ulcerative lesions and high bacillary indices, immediate initiation of MDT is essential, regardless of resource limitations. This case underscores the urgent need for awareness and preparedness to act on clinical suspicion to reduce preventable deaths in endemic regions.



**Abstract N°: 3021****Primary Cutaneous Actinomycetoma Caused by *Nocardia* spp. Following a Chicken Peck in an Immunocompromised Patient**

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Introduction & Objectives:

Cutaneous nocardiosis is a rare opportunistic infection that can mimic fungal diseases such as sporotrichosis or mycetoma, particularly in immunocompromised patients. Early and accurate diagnosis is critical but often delayed due to overlapping clinical features, particularly in endemic areas. This case highlights the importance of considering nocardiosis as a differential diagnosis of chronic skin lesions unresponsive to antifungal therapy.

Materials & Methods:

A 70-year-old male, living with HIV and maintaining an undetectable viral load, presented with a one-year history of nodular lesions on the dorsal aspect of the right hand, extending to the wrist, following a chicken peck in a rural area. Initial empirical treatment with itraconazole 100 mg/daily was instituted and then raised for 300 mg/daily at an external facility, based on clinical suspicion of sporotrichosis. However, histopathological examination, including Grocott staining, and fungal cultures yielded negative results. Wrist ultrasound findings demonstrated poorly defined hypoechoic nodules and associated fistulous tracts with a confluent pattern, involving the subcutaneous tissue of the dorsal wrist. Multiple sinus tracts were observed extending toward the dermal layer. Despite prolonged antifungal therapy, no clinical improvement was noted. A second biopsy, including Fite-Faraco staining as well as hematoxylin and eosin, was performed in our department. In addition, a new microbiological analysis of the patient's skin tissue fragment was conducted.

Results:

The second biopsy demonstrated granulomatous inflammation with giant cells and neutrophilic microabscesses and a grain. Fite staining revealed filamentous, weakly acid-fast organisms. *Nocardia* spp. was diagnosed and then confirmed in skin tissue MALDI TOF based culture. The patient was treated with sulfamethoxazole-trimethoprim, leading to progressive clinical improvement and complete healing of the lesions. No systemic dissemination was observed during follow-up. Because of its partial acid-fast staining and filamentous structure, *Nocardia* may be misidentified as *Mycobacterium tuberculosis* in laboratory tests our investigation included a false positive gene xpert, however the positive grain in histopathological lead us to the correct diagnose.

Conclusion:

This case underscores the importance of maintaining a broad differential diagnosis in chronic cutaneous infections, particularly in immunocompromised individuals. Cutaneous Nocardiosis can mimic other infections clinically and in a laboratory setting. Histopathology combined with specific staining techniques, such as Fite, including MALDI TOF based culture, not widely available in developing countries, is essential for accurate diagnosis and effective management.

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**Abstract N°: 3057****Mycetoma: A neglected tropical disease.**Kamya Lalvani*¹, Bhushan Telhure¹¹Dr. Vasantrao Pawar Medical College, Hospital & Research Center, Dermatology, Nashik, India**Introduction & Objectives:**

Mycetoma is a chronic, suppurative granulomatous infection caused by either fungi (eumycetoma) or filamentous bacteria (actinomycetoma). The disease is endemic in many rural areas, particularly in regions with a warm, humid climate, and is often associated with agricultural activities, where individuals are at increased risk of traumatic inoculation by contaminated soil, plant material, or animal products. Despite being a recognized neglected tropical disease, mycetoma remains underreported in many parts of India. Limited access to healthcare and diagnostic resources delays diagnosis and treatment leading to severe disabilities and deformities. This case series highlights the clinical characteristics, diagnostic approaches, and therapeutic outcomes of 10 patients diagnosed with mycetoma.

Materials & Methods:

We retrospectively analyzed 10 microbiologically and/or histopathologically confirmed cases of mycetoma diagnosed at a tertiary care center between 2023-2025. Patient demographics, clinical presentations, diagnostic investigations, organism identification, treatment protocols, and outcomes were documented and reviewed.

Results:

The series included 7 males and 3 females, aged 25 to 60 years, primarily from rural or semi-urban areas. All patients presented with painless swelling with or multiple discharging sinuses and/or granular discharge, most commonly affecting the foot. Actinomycetoma was diagnosed in 6 cases, with *Nocardia spp.* identified in 4. Eumycetoma was confirmed in 4 patients, predominantly caused by *Madurella mycetomatis*. Diagnosis was based on clinical features, imaging, and laboratory findings including grain morphology, culture, and histopathology. Actinomycetoma cases responded well to prolonged antibiotic therapy (cotrimoxazole ± amikacin), while eumycetoma required antifungal treatment (itraconazole) along with surgical debridement in 2 cases. Follow-up at 6–12 months showed favorable outcomes in 8 patients, while 2 were lost to follow-up.

Conclusion:

This case series highlights the continued presence of mycetoma in rural areas often affecting individuals in low-resource settings. Early recognition and accurate differentiation between actinomycetoma and eumycetoma are essential for effective treatment and prevention of complications. Improved awareness among healthcare providers and integration of diagnostic tools at peripheral health centers are crucial for timely intervention.




Abstract N°: 3062
Chronic ulcer secondary to disseminated *Mycobacterium avium* infection with cutaneous and central nervous system involvement in a patient with advanced HIV; a case report

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Introduction & Objectives:

Mycobacterium avium (*M. avium*) is a nontuberculous mycobacterial species and a member of the *Mycobacterium avium* complex (MAC). Infection with these organisms can occur in both immunocompetent and immunocompromised individuals. We present the case of a patient with advanced HIV who developed disseminated *Mycobacterium avium* infection with cutaneous and central nervous system involvement.

Materials & Methods:

A 31-year-old male with a recent HIV diagnosis (viral load: 20,903,043 copies/mL; CD4 count: 49 cells/μL) was hospitalized for *Staphylococcus aureus* bacteremia and septic arthritis, as well as cytomegalovirus-related pancolitis. Dermatology was consulted due to the appearance of subcutaneous nodules that later ulcerated.

Physical examination revealed an oval-shaped ulcer measuring approximately 3.5 cm × 2 cm, with non-adherent edges localized to the posterior thorax on the right paravertebral region; the ulcer bed showed 80% granulation tissue and 20% fibrin and moderate serohematic exudate.

Initially, a pressure ulcer was suspected, and advanced dressings were applied without improvement. A biopsy and culture of the ulcer were performed. Histopathology was nonspecific. The patient continued to experience fever without an identifiable source, along with intermittent headaches. A lumbar puncture was performed, and *Mycobacterium avium* was cultured from the cerebrospinal fluid. Tissue culture from the ulcer also grew *Mycobacterium avium*, leading to the diagnosis of disseminated *Mycobacterium avium* infection with skin and central nervous system involvement.

Treatment was initiated with ethambutol (15 mg/kg/day), clarithromycin (500 mg every 12 hours), levofloxacin (500 mg every 24 hours), and antiretroviral therapy. The patient responded well, with resolution of fever and headaches, and progressive re-epithelialization of the ulcer aided by petrolatum gauze dressings.

Results:

Disseminated *Mycobacterium avium* (DMAC) infection is a serious opportunistic infection, primarily affecting individuals with advanced immunosuppression, particularly those with AIDS and CD4 counts below 50 cells/μL. While pulmonary and gastrointestinal involvement are most commonly reported, skin and central nervous system (CNS) manifestations are rare and often underdiagnosed. Cutaneous involvement may present with nonspecific findings, including nodules, ulcers, or cellulitis-like lesions, leading to diagnostic delays.

The growth of *M. avium* from both ulcer tissue and cerebrospinal fluid confirmed the diagnosis of DMAC with cutaneous and CNS involvement. Histopathology was nonspecific, highlighting the need for microbiological confirmation in suspected cases, for atypical infections in immunocompromised patients, especially when lesions are unresponsive to standard treatments.

Conclusion:

In immunocompromised patients with chronic, non-healing ulcers, the diagnosis can be challenging and requires further evaluation, including cultures and histopathological studies, to rule out opportunistic infections and provide appropriate treatment for proper healing.





Abstract N°: 3111

Planes, trains and cutaneous leishmaniasis: the cost of progress.

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Introduction & Objectives:

Leishmaniasis is a vector-borne infection caused by the protozoan parasite of the genus *Leishmania* and has been designated by the World Health Organization (WHO) as a neglected tropical disease, emphasizing its impact as a health and economic burden.

Transmission is considered zoonotic in most settings and involves the female phlebotomine (old world) and *Lutzomia* (new world) sandflies.

Leishmaniasis is considered endemic in almost 100 countries where an estimated 2 million new cases occur each year.

Clinical expressions vary, with the most frequent being Cutaneous leishmaniasis (CL), Mucocutaneous Leishmaniasis (ML) and Visceral Leishmaniasis (VL).

All clinical forms occur in Mexico, but the localized cutaneous form is the most frequent, with 99% of the new annually reported cases belonging to this form. The main causal agents in Mexico are *Leishmania Mexicana* and *Leishmania Braziliensis* with its primary vector being species of the sandfly *Bichromomyia olmeca olmeca*.

The sandfly inhabits tropical and selvatic areas of the country, and the regions of Campeche, Quintana Roo, Tabasco and Chiapas (south-southeast Mexico) continue to be the main endemic areas of transmission where the *L. parasites*, the vector sandflies and the small mammal reservoirs have been studied extensively.

Materials & Methods:

Epidemiologic information was gathered from Government Health Institutions as from a Dermatology Private Clinic representing the period of 2010-2024.

Results:

Although the incidence of cutaneous Leishmaniasis in Quintana Roo has been relatively stable throughout the last 15 years, a peak period was reported between 2022-2023, with the number of cases increasing by more than 4-fold.

Interestingly, this sustained peak plateaued during the end of 2023 and finally decreased by the end of 2024.

Conclusion:

This rise in cases is likely due to changes in the ecosystem secondary to the construction and subsequent deforestation associated with the "Tren Maya Project", one of the most ambitious and controversial projects in Mexico in the last decade. The railway covers 1,460 km throughout the Yucatan Peninsula and other southern bordering states. The common denominator between these southern states is the massive extension of their jungles alongside the remnants of the Great Mayan Culture.

The main objective of the Mayan Train is to promote tourism by connecting popular travel destinations throughout the Yucatan Peninsula, but has been surrounded with national and international criticism because of deforestation, displacement of local species, destruction of archeological sites as well as the contamination of the Cenotes, which are considered a big part of the regional identity and an important source of fresh water for the local population.

In 2022 the incidence of Leishmaniasis cases doubled compared to 2021. This peak corresponds with the beginning of the Mayan Train project and the massive deforestation which entails forcing the migration of the *Lutzomia* fly to urban areas. Both the construction and deforestation continued throughout 2023 which again can be seen in the exponential increase in cases that year.

Likewise, a surge in imported cases of Cutaneous Leishmaniasis acquired in Quintana Roo, Mexico, were reported by *Equihua Martínez et al* in 2023 in Berlin, Germany. Because the number of travelers to these regions has not changed, these findings support a general rise in cases in the Yucatan Peninsula.

The decrease in the number of cases reported by the end of 2024 coincides with the completion of the Mayan Train Project.

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Abstract N°: 3181

A rare presentation of cutaneous *Exophiala oligosperma* infection in an immunocompromised patient

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Introduction & Objectives:

A 65 year-old avid gardener with a background of atopic eczema and nodular prurigo presented with a rash on his right arm and right cheek. Past medical history included alopecia totalis, atrial fibrillation, left ventricular systolic dysfunction and a previous myocardial infarction. Treatment to-date had included six-years of mycophenolate mofetil (MMF) therapy for his atopic eczema which was discontinued due to a diagnosis of prostate cancer. He was subsequently switched to oral methotrexate which he remained on for a further six-years.

On examination he had a spreading pruritic cluster of erythematous lesions on his right cheek and an erythematous rash with multiple small pustules on his right forearm. An initial incisional biopsy from his right forearm showed caseating granulomatous dermatitis suspicious of a cutaneous fungal infection. Further punch biopsies were obtained for tissue culture. A review from Bristol national mycology centre revealed evidence of *Exophiala oligosperma* cutaneous infection and his methotrexate was discontinued. Exposure to plants and soil in his garden was suspected as the potential source of his infection.

Results:

Oral isavuconazole was commenced to treat his skin infection, however this was discontinued after five-weeks due to eosinophilia and impaired renal function. Repeat biopsy at this point showed multiple suppurative granulomas surrounding fungal elements suggestive of either ongoing chromoblastomycosis, blastomyces or both. Advice from the national mycology centre suggested 6-12 months of systemic azole therapy. Posaconazole was initiated but this was discontinued after two-weeks due to nausea and vomiting. He was subsequently switched to voriconazole but again this was discontinued after two-days due to visual side effects.

Given the multitude of side effects reported from systemic azole therapy, he was managed with topical terbinafine monotherapy alone. A dramatic clinical response has been noted despite only receiving approximately two-months of oral antifungal agents. A repeat biopsy for histology and tissue culture is currently pending to determine if any infection remains.

Conclusion:

Exophiala oligosperma is a species of black yeast which can cause opportunistic fungal infections in the immunocompromised patient. *Exophiala* infections are often chronic and recalcitrant. Detailed knowledge regarding its pathomechanism, virulence, associated predisposing factors to infection and host response remains scarce.

Cutaneous *Exophiala* infections remain the most common manifestation, however extracutaneous diseases

affecting eyes, heart, gastrointestinal tract, lungs, bones and bloodstream have been reported. Treatments for *Exophiala* species can include aggressive antifungal therapy and surgical intervention. Given the limited availability of antifungal susceptibility data, the optimal antifungal therapy and treatment duration remain unknown. Despite this, the duration of systemic antifungals is often long and treatment response is guided by clinical examination, histology and culture evidence.

In conclusion, we present an immunocompromised patient presenting with an atypical rash and highlight that such presentations should prompt the clinician to consider a potential diagnosis of an opportunistic cutaneous infection. We would recommend tissue culture for both fungal assessment and atypical mycobacterium is taken in such immunocompromised patients.

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**Abstract N°: 3187****Chromatic Variants of Pityriasis Versicolor and Molecular Species Identification Using Polymerase Chain Reaction-Restriction Fragment Length Polymorphism (PCR-RFLP)**

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Introduction & Objectives:

Pityriasis versicolor is a superficial mycosis caused by *Malassezia* spp., commonly affecting seborrheic areas with characteristic hypopigmented, hyperpigmented, or erythematous macules. Despite its high prevalence in tropical regions, species-level identification remains limited in many clinical settings.

Materials & Methods:

A cross-sectional study was conducted from 2016 to 2019 at Acapulco General Hospital and a private dermatology clinic. Patients with clinically suspected pityriasis versicolor and no recent antifungal or immunosuppressive therapy were enrolled. Skin scales were examined microscopically and cultured on modified Dixon agar. Isolates were identified by macroscopic and microscopic features, catalase testing, and PCR-RFLP analysis using *Hha*I and *Bst*CI enzymes.

Results:

Of 75 patients enrolled, 49 (65%) yielded culture-positive results. Most patients were aged 11–20 years (40.8%) and male (65%). The hypochromic variant was most common (63.8%), especially in males (66.7%). PCR-RFLP identified *M. globosa* (33.3%) and *M. furfur* (31.9%) as predominant species, followed by *M. restricta* (11.6%) *M. sympodialis* (8.7%), and *M. slooffiae* (2.9%). Mixed infections occurred in 10 cases. Species identification was inconclusive in 11.6% of isolates. Among infants, *M. furfur* and *M. restricta* were the most frequently identified species.

Conclusion:

M. globosa and *M. furfur* were the leading causative agents of pityriasis versicolor in this tropical Mexican cohort, particularly in hypochromic lesions and male patients. PCR-RFLP proved to be a reliable tool for species-level identification, highlighting the diversity of *Malassezia* spp. in clinical infections.



**Abstract N°: 3244****Electrochemical Biosensing in Human Skin Infections**Liu Yang^{*1, 2}, Onur Parlak^{1, 2}¹Dermatology and Venereology Division, Department of Medicine Solna, Karolinska Institutet, Stockholm, Sweden, Stockholm, Sweden²Center for Molecular Medicine, Karolinska University Hospital, Stockholm, Sweden, Stockholm, Sweden

Introduction & Objectives: Bacterial infections are common in various skin conditions and play a crucial role in disease progression and exacerbations. *Staphylococcus aureus* (SA) and *Pseudomonas aeruginosa* (PA) are among the most frequently isolated bacterial strains from infected skin sites, particularly in chronic wounds. However, clinical challenges such as the difficulty of obtaining samples from deep wounds or biofilm-covered areas, time-consuming and labor-intensive diagnostic procedures, and the limited sensitivity of conventional detection methods pose significant obstacles. These challenges often lead to delayed treatment, increasing the risk of disease worsening and complications. In response, our study aims to develop novel electrochemical biosensing strategies for the rapid, sensitive, and accurate detection of pathogenic microorganisms by targeting the dynamic release of infection-induced biomarkers, including antimicrobial peptides and inflammatory cytokines.

Materials & Methods: We constructed two complementary skin infection models: a three-dimensional (3D) epidermal model using primary human keratinocytes that closely mimic the structural and functional properties of the native human epidermis, and an ex vivo human skin model derived from excised tissue samples; infections were induced by applying *Pseudomonas aeruginosa* strain PAO1 and *Staphylococcus aureus* strain USA300 under controlled conditions to simulate natural infection and promote biofilm formation. Following bacterial inoculation, the models were monitored over time for the sequential release of key biomarkers, including antimicrobial peptides and pro-inflammatory cytokines, with biomarker expression quantified via qPCR on skin tissue samples and ELISA on culture media; this work represents the initial phase aimed at characterizing infection-induced biomarker profiles before proceeding with sensor development.

Results: Our preliminary findings demonstrate that SA and PA display distinct invasion patterns in the established infection models, and that bacterial infection triggers a dynamic, sequential release of biomarkers, with significant upregulation of specific antimicrobial peptides (e.g. hBD2) and inflammatory cytokines (e.g., IL-1b, IL-6, IL-8, CCL20) occurring prior to any observable structural damage to the skin; these results validate that both the 3D in vitro epidermal and ex vivo human skin models can reliably simulate clinical infection conditions and provide quantifiable biomarker signatures.

Conclusion: By leveraging the distinct and early release patterns of infection-specific biomarkers, our approach sets the foundation for developing a real-time, point-of-care wearable electrochemical biosensor platform; future work will involve integrating an array of electrochemical sensors functionalized with target-specific aptamer elements and validating their performance against conventional biochemical assays, which is expected to facilitate timely clinical interventions and ultimately improve patient outcomes in skin infections caused by pathogens such as SA and PA.





Abstract N°: 3292

Single lesion dermatosis - a nonspecific presentation and an unexpected diagnosis

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Introduction:

The clinical spectrum of Hansen's disease is variable. The tuberculoid pole, characterized by effective cell-mediated immunity against *M. leprae*, manifests as hypopigmented or erythematous lesions, either singular or in small numbers, associated with local hypoesthesia or anesthesia, predominantly distributed on the trunk or extremities.

Case report:

Case 1: A 36-year-old man from Brazil, who was infected with HIV-1 and was under antiretroviral therapy, presented with a single erythematous patch measuring 3x3 cm on the inner left thigh, with a 3-year duration, asymptomatic, without local hypoesthesia or anesthesia. Case 2: A 27-year-old woman from Nepal, with no significant medical history, presented with an annular plaque with an erythematous border, measuring 8x6 cm, on the right external malleolar region, associated with local hypoesthesia. Case 3: An 18-year-old man from Cape Verde, with no significant medical history, reported a hypopigmented patch with regular and well-defined borders on the right hemiface, which had been slowly evolving since childhood and was asymptomatic. Over the last 4 months, it became erythematous, edematous, and accompanied by ipsilateral lagophthalmos. A skin biopsy was performed in every case, and the three of them revealed findings consistent with Hansen's disease in its tuberculoid form (granulomatous infiltrate in the papillary dermis following the dermal vascular-nervous axes, composed of tuberculoid granulomas without necrosis, containing epithelioid histiocytes, Langerhans cells, and lymphocytes at the periphery, with no infectious agents); bacilloscopy results were negative. All patients began anti-bacillary treatment; the third patient also received prednisolone due to a type 1 leprosy reaction.

Conclusion:

A high level of suspicion is required to diagnose tuberculoid forms of Hansen's disease, which can present with single, nonspecific, and usually asymptomatic lesions. Tactile, pain, and thermal hypoesthesia or anesthesia in the affected areas is an important clue, when present. This differential diagnosis should be considered, especially in patients from endemic areas with recalcitrant and long-lasting lesions.



**Abstract N°: 3303****Vaccines in Dermatology: Current state-of-the-art and future directions**

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Introduction & Objectives:

Dermatological vaccines play an essential role in preventing a wide range of diseases, ranging from common skin infections to skin neglected tropical diseases and malignancies, and have become a cornerstone of medicine and public health. The World Health Organization (WHO) currently recognizes over 40 human diseases for which vaccines are either available or are currently in development. By synthesizing evidence from existing literature, we aim to comprehensively evaluate the efficacy, safety, and immunogenicity of vaccines used in dermatology, including both approved vaccines and those currently being researched.

Materials & Methods:

A literature search was conducted on PubMed, clinicaltrials.gov and Embase to identify studies on vaccine candidates related to dermatological conditions and their recent advances.

Results:

We identified vaccines targeting dermatoses and malignancies (acne vulgaris, atopic dermatitis, and melanoma); infectious diseases (human papillomavirus (HPV); varicella zoster virus (VZV); herpes zoster (HZ); warts; smallpox; mpox; hand, foot, and mouth disease (HFMD); candidiasis and Group B Streptococcus (GBS); and neglected tropical diseases (Buruli ulcer, leprosy, and leishmaniasis) and discuss the various vaccine platforms, immune targets, efficacy and safety profile. These include 4 vaccine platforms in melanoma, 4 for atopic dermatitis (targeting *S. aureus* or BCG), off-label intralesional MMR or Candida antigens for viral warts, for leprosy: BCG, MIP and LepVax vaccines, at least 9 vaccine candidates for leishmaniasis and 5 for mpox. Varying efficacy was found for these vaccines.

Conclusion:

Significant progress has been achieved in understanding the immunopathogenic mechanisms of dermatological diseases, which facilitates the development of targeted vaccines for both prevention and treatment. Aligned with its Immunization Agenda 2030 (IA2030), the WHO has designated 17 high-priority global endemic pathogens for vaccine research and development. Notably, at least eight of these are skin pathogens, highlighting the critical need for ongoing research in this field. However, challenges persist, including the standardization of outcome measures for clinical trials, ensuring vaccine safety across diverse populations, and effectively translating findings from animal models to human subjects. Further research is essential to refine these vaccines, bridge existing

knowledge gaps, and successfully implement these innovations in clinical practice.

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**Abstract N°: 3444****The role of nitric oxide metabolites in the clinical course of zoophilic trichophytosis**Marufjon Maxsudov¹, Jakhongir Maxsudov¹¹Tashkent, Tashkent, Uzbekistan**The role of nitric oxide metabolites in the clinical course of zoophilic trichophytosis****Introduction & Objectives:**

Recent research in dermatophytosis pathogenesis has highlighted the role of nitric oxide (NO) as a key mediator of cellular signaling and intercellular communication in biological systems. Given its influence on immune modulation and inflammation, NO is increasingly investigated for its involvement in fungal skin infections. To evaluate the role of nitric oxide metabolites in the clinical course and severity of different forms of trichophytosis.

Materials & Methods:

A total of 25 patients (14 male, 11 female; aged 10–67 years) with various clinical forms of zoophilic trichophytosis were examined. Clinical forms included superficial scaly trichophytosis (12 cases, 48%), infiltrative form (9 cases, 36%), and infiltrative-suppurative form (4 cases, 16%). A control group included 10 healthy individuals. All participants underwent mycological confirmation and biochemical evaluation. Serum nitric oxide levels were assessed via the sum of nitrate and nitrite (NO_2^- and NO_3^-) concentrations, according to the method described by P.P. Golikova et al. (2000).

Results:

Serum analysis revealed a statistically significant elevation of nitric oxide metabolites in trichophytosis patients ($15.3 \pm 3.3 \mu\text{mol/L}$) compared to the control group ($9.5 \pm 0.31 \mu\text{mol/L}$) ($p < 0.001$). Notably, patients with infiltrative-suppurative trichophytosis exhibited the highest NO metabolite levels, suggesting a correlation between disease severity and NO-system activation.

Conclusion:

The findings support that enhanced nitric oxide activity is a key pathogenic factor in the progression of complicated forms of trichophytosis. NO-system activation may suppress antioxidant defense mechanisms and promote the formation of cytotoxic compounds, contributing to tissue damage and chronic inflammation. These data offer potential for future therapeutic strategies targeting the NO pathway in patients with severe dermatophytosis.



**Abstract N°: 3462****Cutaneous leishmaniasis: The association between clarithromycin and metronidazole: First-line treatment or an interesting therapeutic alternative?**

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Introduction & Objectives:

Leishmaniasis is a tropical disease caused by an intracellular parasite of the leishmania type transmitted to humans through the bite of a phlebotome. It is characterized by clinical polymorphism, benign in its localized cutaneous (LC) form and resistant to treatment in its diffuse cutaneous form.

We report a series of 12 cases of localized cutaneous leishmaniasis treated by combination of metronidazole and clarithromycin (MC) . And whose aim is to evaluate the efficacy, tolerance and evolution of this therapeutic alternative.

Materials & Methods:

We report the case of 12 patients. Admitted to the Dermatology Department for skin smear-confirmed cutaneous leishmaniasis for the period of one year : January 2024 -January 2025 . Patients were treated with metronidazole and clarithromycin with different therapeutic responses.

Results:

The average age was 41.7 years, with extremes of 9 and 75 years. Seven patients presented with ulcero-necrotic forms, particularly of the face, and 5 with erysipeloid forms. The dermoscopic features were : generalized erythema 41.66% , white starburst-like pattern 41.66% , hyperkeratosis 58.33% , hairpin vascular structures 33.33% .

Eight patients received the therapeutic protocol in 1st intention 66.66%. Four patients received Glucantime after partial improvement. Eight patients showed good improvement of the lesions with subsidence 66.66% . On the other hand, four showed minimal therapeutic improvement 33.33% , requiring the combination of other measures such as cryotherapy, dynamic phototherapy. Or even the use of injectable glucantime, particularly for the erysipeloid form. Four patients had experienced digestive signs as adverse effects of treatment, notably vomiting.

Our study shows that the metronidazole-clarithromycin MC is an effective therapeutic option in the treatment of cutaneous leishmaniasis with a 67% efficacy percentage despite tolerable side effects.

Conclusion:

Leishmaniasis is a widespread endemic disease with mandatory reporting. It is characterized by clinical polymorphism. The MC association, by its effectiveness, its easy oral administration in ambulatory, its accessible cost and its safety represents thus a very good therapeutic alternative of the LC of the old world.





Abstract N°: 3485

Under the skin: the other side of tattoos.

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Introduction & Objectives:

Nontuberculous mycobacteria (NTMs) include a group of saprophytic agents found in the environment, traditionally divided into rapidly growing (RGM) or slowly growing mycobacteria (SGM). Skin exposure to NTMs resulting from skin abrasions or penetration through trauma can lead to skin infections that often require long antibiotic treatment.¹ Tattooing is associated with these infections due to improper sterilization and/or ink contamination. ² Clinical manifestation include papules, pustules, ulcers, or plaques at the tattoo site. A biopsy is necessary and culture, as well as the performance of molecular techniques to arrive at the diagnosis. ²

Materials & Methods:

A 44-year-old woman began with papules and pustules on the left thigh at the tattoo site after 1 week of tattooing. A biopsy was performed, it reported multifocal granulomatous dermatitis and suppurative granulomas. A mycobacterium was culture and identified as *Mycobacterium peregrinum*. Infectious Diseases Department also evaluated the patient and decided to start antibiotic therapy according to minimum inhibitory concentration.

Results:

Lately, outbreaks of NTMs skin infection related to tattoos have been reported. *Mycobacterium Chelonae* was the most common cause, although *M. abscessus* and others species have also been reported.¹ Dilution of black ink with contaminated water has been described as a risk factor.²

Mycobacterium peregrinum is an opportunistic NTM, which belongs to the RGM group, and compared with other RGM, it rarely causes skin infections (1%-3.3% of all RGM infections). ^{3, 4}

Conclusion:

It is important to make diagnosis after clinical suspicion with histopathology and microbiological techniques to establish targeted treatment as well as to carry out epidemiological control measures to promote better tattooing practices.

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2 Mudedla, S., Avendano, E. E., & Raman, G. (2015). Non-tuberculous mycobacterium skin infections after tattooing in healthy individuals: A systematic review of case reports. Dermatology online journal, 21(6) 13030/qt8mr3r4f0

3 Wachholz, P. A., Sette, C. S., Caitano do Nascimento, D., Soares, C. T., Diório, S. M., & Masuda, P. Y. (2016). Mycobacterium peregrinum Skin Infection: Case Report. Journal of cutaneous medicine and surgery, 20(3), 249-

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Abstract N°: 3490

Challenging skin manifestations of cutaneous tuberculosis

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Introduction & Objectives: Tuberculosis presents with marked polymorphism in terms of its clinical manifestations and behavior. However, this type of clinical presentation is uncommon as a form of tuberculids.

We report two clinical cases with some differences and similarities.

Materials & Methods: Clinical Cases: first patient, a 27-year-old woman with a history of lupus, undergoing corticosteroid treatment, presented with one-month-evolving skin lesions. Initially nodular, the lesions later ulcerated and painful, located on the forearms, buttocks, and posterior thighs. They were associated with fever and complicated by spondylitis, leading to hospitalization. A bone biopsy and additional tests were performed. Second case, a 41-year-old woman with no significant past medical history presented with a four-year history of postprandial vomiting, early satiety, and unexplained weight loss. Dermatological examination revealed indurated, erythematoviolaceous nodules symmetrically distributed on the lower extremities.

Results: in case 1 laboratory tests revealed normochromic-normocytic anemia. A skin nodule biopsy from the lower limb showed lobular panniculitis with vasculitis and granulomas in both the septal and lobular areas. Bone biopsy: GeneXpert test was positive for *Mycobacterium tuberculosis*.

Case 2, laboratory: normochromic-normocytic anemia. Upper and lower endoscopy: nonspecific findings. Skin biopsy revealed a dermatosis with a multifocal granulomatous pattern affecting the dermis and hypodermis, with foci of necrosis. PAS and Ziehl-Neelsen (ZN) stains were negative. A laparoscopically-guided omentum biopsy showed lymphocytic and granulomatous dermatosis, with numerous bacilli detected by ZN staining.

Both cases showed favorable outcomes after initiating anti-tuberculosis treatment.

Conclusion: Erythema induratum of Bazin is a rare cutaneous manifestation of tuberculosis, classified as a tuberculid. It represents one of the cutaneous manifestations of tuberculosis. Its presenting as panniculitis secondary to hypersensitivity to the Koch bacillus. The main differential diagnoses include erythema nodosum and cutaneous lupus erythematosus. It presents as a form of panniculitis resulting from a hypersensitivity reaction to *Mycobacterium tuberculosis*.

Diagnosing this condition in the absence of active tuberculosis remains a significant clinical challenge. Interferon-gamma release assays and polymerase chain reaction (PCR) testing can aid a diagnosis when interpreted alongside histopathological findings. However, early clinical suspicion is crucial to ensure prompt investigation and treatment, thereby reducing the risk of relapse and permanent scarring.





Abstract N°: 3579

Tinea Nigra: An Important Differential Diagnosis of Melanocytic Lesions

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Introduction & Objectives:

Tinea nigra* (TN) is a rare superficial phaeohyphomycosis caused by *Hortaea werneckii*. It is characterized by a well-defined brownish-black macular lesion, predominantly in the acral region. Diagnosis is challenging due to a lack of medical awareness. It can be assessed through dermoscopic criteria and confirmed by direct mycological examination and culture. Treatment includes topical imidazoles.

This case report and literature review aim to highlight the importance of the differential diagnosis of pigmented macules in the palmoplantar region, as well as emphasize the need for a thorough medical history to ensure diagnostic accuracy for this rare condition.

Materials & Methods:

A comprehensive review of the literature was carried out for this case, noting that tinea nigra has only 183 articles published in indexed medical databases.

Results:

A 4-year-old girl, presented with a well-defined, hyperpigmented macule with a smooth, non-keratotic surface on the left palm. The mother reported that the lesion had evolved over approximately one month. The patient denied any symptoms. After performing a direct mycological examination and culture of a scraping from the lesion, tinea nigra was diagnosed. An antifungal solution was prescribed, leading to complete resolution of the condition.

Conclusion:

Tinea nigra (TN) is a rare superficial phaeohyphomycosis, first described in 1891 by Alexandre Cerqueira in Brazil. It accounts for only 0.085% of all mycoses and is primarily found in tropical and subtropical regions.

Caused by *Hortaea werneckii*, TN manifests as a well-defined, asymptomatic brownish-black macule, most commonly on the palms. It affects young females predominantly and remains confined to the stratum corneum without keratinolysis. Adhesion occurs due to the fungus's hydrophobic nature, facilitated by the lipid matrix of the acral skin. Pigmentation results from dihydroxynaphthalene-melanin deposition in the fungal cell wall.

TN is frequently misdiagnosed, with only 2.6% of general practitioners identifying it correctly. Diagnosis is based on direct mycological examination (KOH) and culture. In our case, skin scrapings mounted in 10% KOH demonstrated short, tortuous dematiaceous hyphae with anelloconidia. Culture macroscopy showed filamentous dark brown or olivaceous colonies. The microscopic examination revealed septate hyphal elements and 2-celled yeast cells producing anelloconidia typical of *Hortaea werneckii*. Dermatoscopy shows pigmented spicules, brownish bands, and fine dots that do not follow the grooves or ridges of the dermatoglyphs. Some authors describe a pattern parallel to the ridges, mimicking acral melanoma, reinforcing the need for complementary testing.

Differential diagnoses include chemical pigmentation, lentigines, melanocytic nevi, melanoma, and Addison's disease. Treatment consists of keratolytics and topical antifungals, with resolution typically within two weeks.

TN is a rare, often overlooked condition requiring early recognition to prevent unnecessary procedures. Diagnosis through dermoscopy and mycological examination ensures effective management with simple topical treatments. Increasing medical awareness is essential for accurate diagnosis and patient care.

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Abstract N°: 3593
Changes in epidemiological trend of pediatric sporotrichosis in a Mexican referral center

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Introduction & Objectives:

Sporotrichosis is a chronic subcutaneous mycosis caused by the thermally dimorphic fungi of the *Sporothrix schenckii* complex. Considered endemic of tropical and subtropical regions in Latin America, Africa and Asia;1 Mexico being reported, in some studies, as the country with the highest prevalence in the continent.2

As important as this disease is for our region, in the past years we have observed a decrease in the frequency, with hypothesis about changes in laboral conditions been proposed in studies involving adult patients.3

The objective of this study is to evaluate the epidemiological trend in pediatric patients with sporotrichosis in recent years.

Materials & Methods:

Eleven-year retrospective study (2014-2024) involving pediatric patients with a confirmed sporotrichosis diagnosis. Age, sex and clinical variant, were the variables investigated, also the average number of cases per year was calculated. Mycological identification was made by culture.

Results:

We collected ten cases of pediatric sporotrichosis, with a mean frequency observed of 0.9 cases/year and the years of 2014 and 2016 as the ones with more frequency with 3 cases each. The demographic data obtained was a mean age of 6.69 (0.9-16 years), with higher prevalence on male patients with 7 (70%). The two clinical presentations encountered were cutaneous-lymphangitic and cutaneous-fixed being equally reported with 4 cases each and in the remaining cases was not mentioned. The main topography affected was the face with 7 (70%), followed by trunk, upper and lower limbs presenting one case each.

Previous studies like García-Vargas et al, were they evaluated the data between 1983-2006 in our same institute, in contrast with our results they reported a mean of 5.7 cases/year,3 which denotes the decrease in frequency of presentation that we found in our study. Besides the previous hypothesis of changes in lifestyle, socioeconomic and laboral conditions,4 we can also inquire about the climate change, as an increase in temperature can act as a contributing factor in a less favorable environment for fungal soil growth. The ideal temperature for soil growth of this fungus is 22 to 27°C,2 and in reports from the Mexican National Service of Meteorology we can observe an increase of roughly 1°C in the mean, minimum and maximum temperatures registered between 1971-2000 and the years evaluated in this research.5

The demographic variants of sex and age were similar to the previous reported with more prevalence on male and in infant to early childhood patients (0-6 years).6

In contrast with studies like Yao et al were they reported cutaneous fixed as being the most frequent in pediatrics,

our clinical data didn't show any predilection in a clinical variant. The topography was similar in both, showing predilection in the face.⁶

Conclusion:

This retrospective study examined ten cases of pediatric sporotrichosis at a referral center in Mexico. Compared to a previous research at the same center, this study indicates a significant reduction in incidence. This decline may be attributed to changes in lifestyle, socioeconomic conditions, and occupational exposures. Additionally, climate change, specifically the observed increase in regional temperatures, may be contributing to a less favorable environment for the soil growth of *Sporothrix* species, being this a promising factor to explore in future studies relating sporotrichosis incidence.

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Abstract N°: 3598

Molecular Identification of *Fonsecaea pedrosoi* in Chromoblastomycosis: Insights from Paraffin-Embedded Human Skin Biopsies and Clinicopathology

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Introduction & Objectives:

Chromoblastomycosis (CBM) is a chronic fungal infection caused by dematiaceous fungi. In some cases, culture methods fail to identify the fungal species, and fresh tissue for molecular identification is unavailable. The use of molecular techniques on formalin-fixed, paraffin-embedded (FFPE) samples can aid in identifying the causative agent. This study aimed to identify fungal species in histopathologically confirmed cases of CBM using PCR and rDNA sequencing of FFPE skin biopsies and to describe their clinicopathological features.

Materials & Methods:

This retrospective study used FFPE samples from nine CBM patients from remote regions of Mexico. The Samples were submitted to the Mycology Section at the Hospital General “Dr. Manuel Gea González” (2000–2016) for molecular identification of the causative agent and characterization of clinicopathological features.

Results:

Lesions were most commonly located on the forearm (four cases), with one case each on the buttock, back, foot, and leg. One patient presented with cutaneous dissemination. Verrucous plaques were observed in 88.9% of cases. Histology and direct examination confirmed CBM, showing muriform cells and varying degrees of dermal fibrosis in all cases. DNA extracted from FFPE samples was amplified and sequenced for the 18S-ITS1-5.8S-ITS2-28S rRNA region, identifying *Fonsecaea pedrosoi* with 100% homology in all cases.

Conclusion:

This study identifies *F. pedrosoi* as the predominant pathogen of CBM in the evaluated samples of Mexican origin and demonstrates the reliability of molecular identification using FFPE samples.



**Abstract N°: 3712****Atypical waves: Non-sporotrichoid *Mycobacterium Marinum* skin infection in an immunocompromised scuba-diver**Claudine Howard-James^{*1}, Kevin Molloy¹¹Tallaght University Hospital, Dublin, Ireland**Introduction & Objectives:**

A 58-year-old male presented with a 3-4 month history of an enlarging painful ulcer on his left medial knee. He had a history of psoriatic arthritis, treated with methotrexate and adalimumab for the last five years. He had travelled to over twenty countries in the past two years, and his hobbies included scuba diving and seawater/freshwater swimming. One year prior, he recalled freshwater swimming in a cave lake in Brazil. Subsequently, he developed small erythematous papules on each knee with rapid resolution on the right knee. The left knee lesion slowly enlarged, and he sought medical attention in Ireland nine months later. He received antibiotics and topical steroids, and was switched from adalimumab to infliximab for a presumed diagnosis of pyoderma gangrenosum. The lesion's growth accelerated over 8 weeks, leading to an acute presentation to the Emergency Department with severe pain and limited mobility.

Materials & Methods:

On examination, he had a 20x10 cm erosive plaque on his left knee with an exudative base and a ragged erythematous edge. He also had a 2.5x2 cm ulcerative lesion on his right flank and a hyperpigmented patch on his right knee. He denied fevers or systemic symptoms. Interferon-gamma release assay (IGRA) was positive (previously negative in 2019 while on immunosuppression). A skin biopsy from the left leg demonstrated ulceration, mixed inflammation and underlying dermal necrosis. Necrotising granulomas were seen, and both auramine and Ziehl-Nelsen stains were positive for abundant acid-fast bacilli. Skin biopsy from the right flank showed similar findings.

Results:

A mycobacterial culture was incubated at 30°C and after four weeks, *Mycobacterium marinum* was identified. *M. marinum* is a free-living, slow-growing, non-tuberculous mycobacteria (NTM) found in both cold and warm fresh and saltwater environments. It can cause a tuberculosis-like disease in fish and opportunistically infect humans when injured skin is exposed to a contaminated aqueous environment. The typical presentation is a "fish tank granuloma"; solitary or multiple nodules, plaques or ulcerated lesions which spread in a sporotrichoid pattern along lines of lymphatics, commonly on the upper limb.

Conclusion:

This case represents a highly unusual cutaneous *M. marinum* presentation, with non-contiguous ulcerative lesions in an immunocompromised host. The diagnostic delay highlights the challenges of recognising atypical non-tuberculous mycobacterial infections, particularly in immunosuppressed patients.





Abstract N°: 3897

Photodynamic Therapy for Cutaneous Leishmaniasis

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Introduction & Objectives:

Cutaneous leishmaniasis (CL) is a parasitic dermatosis for which treatment options often involve systemic or intralesional therapies that may carry a significant burden, especially in pediatric patients. Photodynamic therapy (PDT), including both conventional (C-PDT) and daylight modalities (DL-PDT), has emerged as a non-invasive and well-tolerated alternative. We report a series of six PCR-confirmed CL cases—three pediatric and three adult patients—successfully treated with 10% 5-aminolevulinic acid (ALA)-based PDT at the Dermatology Unit of the University of Messina, Italy.

Materials & Methods:

Six patients (3 children and 3 adults) with confirmed CL by PCR were treated with either

C-PDT or DL-PDT, using 10% ALA in polyethylene glycol ointment (Biosynth AG, Staad, Switzerland).

For C-PDT, 10% ALA was applied under occlusion for 3 hours. Illumination was performed using a diode red light source emitting at 630 nm (S630, Alpha Strumenti, Milan, Italy), positioned 50 mm from the skin surface, delivering a skin irradiance of approximately 160 mW/cm². The light exposure lasted 8 minutes, corresponding to a total light dose of 75 J/cm².

For DL-PDT, an organic sunscreen with SPF 30 was applied to all sun-exposed areas 15 minutes before ALA application. A 1-mm thick layer of 10% ALA was applied to the entire lesion and left uncovered for 30 minutes indoors. The patient was then exposed to continuous daylight for 2 hours in a hospital garden. After exposure, residual ALA was removed and a soothing cream applied. Lesions were covered for 24 hours to avoid further light activation.

Both protocols were administered in three sessions at one-month interval. All patients received home care instructions, including applying a bland emollient cream and local non-alcoholic disinfection solution.

Results:

All six patients achieved complete clinical resolution of lesions at six-month follow-up, with only minimal post-treatment scarring. No systemic or severe local adverse events were reported. Treatment was well tolerated across the cohort, with only a mild burning sensation reported during illumination in a few cases.

Conclusion:

This case series highlights the efficacy and excellent safety profile of both conventional and daylight PDT using 10% ALA in the management of cutaneous leishmaniasis. The non-invasive nature, favorable tolerability, and excellent clinical outcomes make ALA-PDT a compelling alternative to more aggressive treatment options, particularly in pediatric patients.



**Abstract N°: 3941****Chronic Infectious Complication in a Diabetic Patient Following Long-Term Self-Administration of Anabolic-Androgenic Steroids: A Case Report**Kial Intissar¹, Mariem Aboudourib¹, Bendaoud Layla¹, Ouafa Hocar¹, Amal Said¹¹CHU Mohamed VI de Marrakech, dermatology venereology, Marrakech, Morocco**Introduction & Objectives:**

The use of anabolic androgenic steroids (AAS) for non-medical purposes has become increasingly common, particularly among young adults for aesthetic or athletic reasons. While the systemic effects of AAS are well documented, the local complications, particularly infectious ones, remain underexplored. This report presents the case of a patient with recurrent dermatohypodermatitis due to intramuscular AAS injections.

Clinical observation

A 31-year-old male with a 6-year history of type 1 diabetes, managed with insulin therapy, presented with recurrent episodes of red, warm, and painful swelling in both arms and thighs. He reported self-administering AAS for muscle development from 2016 to 2018. The first episode occurred two weeks after the initial injection. Six such episodes have been documented, with the most recent one prompting an emergency consultation.

On presentation, the patient had a fever of 40°C, without palpable lymphadenopathy. Dermatological examination revealed diffuse, ill-defined swelling, without signs of necrosis, localized on the arms and anterior-medial thighs. Deep skin biopsy revealed an inflammatory infiltrate with diffuse fibrosis. The patient was treated with amoxicillin-clavulanic acid (4g/day for 7 days), resulting in significant clinical improvement.

Conclusion:

This case highlights the infectious and inflammatory risks associated with AAS injections, especially in diabetic patients. There is a need for increased awareness of the potential consequences of these practices and for a broad diagnostic approach when atypical skin lesions occur in at-risk individuals.



**Abstract N°: 3943****Tinea Capitis in adult**

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Introduction & Objectives:

Tinea Capitis (TC) is a common fungal infection in children but rare in adults. The aim of our study is to report the epidemiological characteristics of scalp TC in our region and to identify the causative agents.

Materials & Methods:

A 16 year retrospective descriptive study (2008 -2024) including all the adult cases (over the age of 18) of Tinea Capitis confirmed by a parasitological examination, in the parasitology laboratory of Sfax.

Results:

Over the study period, 2877 cases of scalp TC were recorded, including 138 cases in adults (4.79%), with a sex ratio (F/M) of 1,3. The average age was 40 years (18 to 82 years). Regarding medical history, one patient tested positive for HIV, and another was receiving systemic corticosteroid therapy.

Contact with animals was noted in 11 cases (7.97%), including 8 with cats and 3 with cattles. Family members were affected in 4 cases. Clinically, the presentation consisted of one or more scaly, alopecic plaques in 131 cases (95%), with 10 cases being suppurative, and a kerion in 7 cases (5%). Lesions were associated with dermatophytosis of the glabrous skin in 10 cases (7.2%), onychomycosis in 8 cases (5.7%), and interdigital intertrigo in one case. The direct examination was negative in 12 cases (8.6%). The culture identified *Microsporum canis* in 60 cases (43.4%), *Trichophyton violaceum* in 44 cases (31.8%), *Trichophyton verrucosum* in 10 cases (7.2%), *Trichophyton mentagrophytes* in 4 cases (2.9%), *Trichophyton soudanense* and *Microsporum langeronii* in one case each. No fungal growth was observed in 18 cases (13%).

Conclusion:

Tinea Capitis is considered rare in adults, as shown in this and other studies (3–5%). It is nevertheless far from being exceptional. The predominance of female cases is consistent with data reported in the literature, especially in perimenopausal women, which is likely a result of the involution of sebaceous glands following decreased blood estrogen levels during menopause.

Unlike the literature, where adult scalp TC is primarily caused by anthropophilic dermatophytes, we observed a shift in the spectrum of causative species, with an increase in zoophilic dermatophytes in 74 cases (61.6%), mainly *Microsporum canis*, compared to anthropophilic dermatophytes in 46 cases (38.4%). Despite the low proportion of animal contact.

Systemic conditions such as diabetes, malignancy, and immunosuppressant therapy can influence the incidence of adult TC. However, in our cohort, only 2 out of 138 patients were immunocompromised, suggesting that systemic immunosuppression is not the primary etiological factor. TC should be considered in the differential diagnosis of scalp diseases, even in immunocompetent adults.





Abstract N°: 3996

Cutaneous Tuberculosis as a complication of a cosmetic procedure.

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Introduction & Objectives:

Cutaneous tuberculosis is not a well-defined entity but comprises a wide spectrum of clinical manifestations, rare clinical manifestation of Mycobacterium tuberculosis complex infection, comprising approximately only 1 to 2% of all TB cases. How the disease clinically presents is variable due to external factors such as the host's immunity, the site of the infection, or even the surrounding environment of the host.

Primary inoculation TB results from the entry of mycobacteria into the skin or, less frequently, the mucosa of a person who has not previously been infected or who has no natural or artificial immunity to Mycobacterium tuberculosis. The risk factors for cutaneous disease include HIV/AIDS, dermal piercing, tattoos, mesotherapy, acupuncture, intravascular devices, postsurgical infections, freshwater or saltwater injuries, chronic pulmonary diseases, and renal transplant.

Materials & Methods:

A 41 year old female presents to the dermatology consultation with a localized dermatosis to the head and neck where it affected the forehead, it was bilateral and symmetrical constituted with nodules of about a centimeter in diameter, they were the color of the skin, of firm consistency, well defined borders and of cupuliform appearance, the evolution was acute and no symptoms were referred by the patient. She had no significant history of disease but that 15 days prior to the consultation she received a cosmetic procedure perform as told by the patient with African bee poison administered in mesotherapy as a treatment to ritides, the applications of said substance corresponded with the dermatosis that presented in this consultation. A escisional biopsy was performed in one of the nodules.

Results:

The histopathology reported: chronic granulomatous inflammation associated with giant multi nucleus Langerhans cells, which were indicative of Mycobacteria infection. A PCR was run to differentiate species, and the results consisted of Mycobacterium tuberculosis. The diagnosis of cutaneous tuberculosis was integrated and treatment of 6 months with multi drug therapy was prescribed by the infectious disease department with complete resolution of the dermatosis and no significant adverse effects.

Conclusion:

Regarding the following case, an earlier stage of cutaneous tuberculosis from an exogenous source, a mesotherapy procedure with an infected substance containing mycobacterium tuberculosis highlights the highly adaptative mechanisms that this microorganism displays when proliferating and how the host immunity can precipitate the evolution of the clinical manifestation or rather stop it. Therefore, an individual with an immune response not compromised is capable of a rapid granulomatous response that limits the progression of the disease, in this case the classic ulceration of the lesions was not observed, because of the rapid diagnostic protocol performed the skin lesion were still nodules when the biopsy was performed. The PCR, a highly sensitive

and specific diagnostic tool that confirms the histologic finding and determined the exact serotype of the bacilli, the classic multi-drug treatment (rifampicin, pyrazinamide, ethambutol e isoniazid) was prescribed with a favorable response.

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Abstract N°: 4097

Erythema Induratum of Bazin: a case report associated with tuberculous lymphadenitis

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Introduction & Objectives:

Erythema Induratum of Bazin (EIB) is a rare, chronic, nodular eruption caused by tuberculin hypersensitivity. It is associated with *Mycobacterium tuberculosis* (MTB) infection. The incidence of extrapulmonary tuberculosis is of 7.4- 13.7 %. Currently there are a few cases reported of EIB, probably because of a decrease in the incidence of MTB infection. We present a case of a female patient with a previous history of tuberculous lymphadenitis, who presented with nodular lesions of the legs.

Materials & Methods:

Female patient of 59 years old, with a previous history of tuberculous lymphadenitis treated with rifampicin, isoniazid, pyrazinamide and ethambutol for 9 months. She consults for 1-month, painful, nodular lesions on her legs. A skin biopsy was taken, which reported a lobular panniculitis. She had a previous PPD with an induration of 15 mm. A chest x-ray was taken with no significant findings. She received a new course of antituberculous treatment, with prednisone and pentoxifylline. Complete resolution of the lesions was observed after 3 months of treatment, with only post-inflammatory hyperpigmented macules.

Results:

Tuberculids are a type of hypersensitivity reaction, associated with an extracutaneous focus of MTB infection. EIB is considered a type of tuberculid, along with papulonecrotic tuberculid, lichen scrofulosorum and nodular tuberculid. Tuberculids are extremely rare (<1 % of all cutaneous tuberculosis). The diagnosis of tuberculids is usually made with a positive PPD, tuberculous involvement of lymph nodes or internal viscera, absence of MTB from skin biopsy or culture and resolution of the lesions with antituberculous treatment.

EIB affects predominantly middle-aged women. It is presented as flares of violaceous nodules or plaques in the legs (anterolateral areas and posterior aspects). The center of the lesions can become ulcerated, and the periphery can present with a collarette of desquamation. Typically, the lesions can present with recurrent episodes every 3-4 months, without evidence of systemic symptoms. It can resolve spontaneously, with post inflammatory lesions and atrophic scars. Diagnosis of EIB is made with the previous history of MTB infection, the clinical manifestations, a positive PPD (>15 mm), biopsy and complementary studies whenever there is suspected internal viscera involvement. The histopathology usually shows lobular panniculitis, associated with various degrees of granulomatous inflammation with focal necrosis and vasculitis. Treatment is based in antituberculous treatment with isoniazid, rifampin and pyrazinamide; usually a course of 6 to 9 months is recommended. In cases where there is not a response, treatment is based on anti-inflammatory drugs, tetracyclines, antimalarials and prednisone. However, this treatment do not avoid recurrences.

Conclusion:

EIB is a rare type of tuberculid, usually associated with tuberculous lymphadenitis or pulmonary tuberculosis. Despite the decrease in the incidence of MTB infection in high-income countries, it is very important to suspect of EIB in middle-age women who present with lesions clinically similar to erythema nodosum. There is no well-

established regimen of treatment for EIB, however lesions tend to respond to antituberculous treatment. This supports the established association between EIB and MTB infection.

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**Abstract N°: 4163****A diagnostically challenging case of cutaneous tuberculosis presenting with facial atrophic plaque in a 8-year-old boy**yang Gu^{*1}¹Children's hospital of Soochow University, Suzhou, China**Introduction & Objectives:**

Cutaneous tuberculosis is an uncommon form of tuberculosis, difficult to diagnosis due to its rare nature and the fact that it may present in different clinical forms. The pediatric population is particularly vulnerable to TB. Therefore, it is significant for the pediatric dermatologist to make the accurate and timely diagnosis.

Materials & Methods:

We present a diagnostically challenging case of cutaneous tuberculosis presenting with facial atrophic plaque without visceral involvement in an 8-year-old boy.

Results:

In our case, a skin biopsy was consistent with tuberculoid granulomas. The tuberculin skin test showed a 12mm induration and The Interferon-Gamma Release Assay was positive. However the skin sample sent for metagenomic next-generation sequencing was negative. The perceptible regression of lesions was remarkable in response to anti-tuberculosis therapy.

Conclusion:

We report our experience and emphasize on traditional diagnostical work up of pediatric cutaneous tuberculosis.



**Abstract N°: 4217****Citrobacter koseri infection of the nose masquerading as keratoacanthoma: A case report and review of the literature**

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Introduction

Citrobacter koseri (*C. koseri*) is a rare Gram-negative bacillus of the gastrointestinal tract that infrequently causes infections. When pathogenic, it typically causes CNS infections of neonates or immunocompromised hosts.¹ Skin and soft tissue infections (SSTIs) due to *C. koseri*, however, are exceedingly rare—only 4 out of 1,562 SSTI isolates demonstrated growth of *C. koseri* in an Antimicrobial Surveillance Program.² Literature on *C. koseri* SSTIs is limited to a handful of case reports describing folliculitis, cellulitis, and abscesses.³ We present a unique case of a *C. koseri* tunneling infection inducing cutaneous neoplasia-like changes mimicking eruptive keratoacanthoma (KA) in an immunocompetent man leading to delayed diagnosis and management followed by a systematic review.

A 40 year-old male presented to clinic for a second opinion on multiple enlarging, non-tender lesions on the nose. Initially a single acneiform papule, the lesion evolved into a 3 cm plaque with 4 satellite nodules over 4 months. Prior biopsies suggested squamous cell carcinoma (SCC) and recommended surgery and radiation, but the rapid clinical course in an immunocompetent male made SCC less likely prompting 3 scouting punch biopsies which revealed an endophytic keratinocytic proliferation with interconnecting cyst-like spaces, syringosquamous metaplasia, and numerous neutrophilic microabscesses (Figure 1A-1B). While fungal and mycobacterial cultures were negative, tissue culture grew *C. koseri* confirming the diagnosis of a multifocal KA-like hyperplastic response to infection. Surgical excision and radiation was held off, and instead started on ciprofloxacin for 14 days with rapid resolution. Two-month follow-up showed residual atrophic scars and no recurrence was noted over five years.

Methods

A comprehensive review was performed using PubMed/MEDLINE to identify *C. koseri*-related SSTIs comprising terms such as “*Citrobacter koseri*,” “*Citrobacter diversus*,” “skin infection” and related variations.

Results

Only 9 cases of *C. koseri* SSTIs were reported, 2 of which were polymicrobial (Figure 2). Of all the cases except for one abscess, presentations resolved completely with solely antibiotics without procedural intervention (Table 1).

Conclusion

Pseudoepitheliomatous hyperplasia (PEH) is a recognized benign entity associated with mycobacteria and fungi that imitates KA and SCC clinically and histopathologically.⁴ While *C. koseri* has been associated with colonic hyperplasia mimicking gastrointestinal adenomas and carcinomas, infections have not previously been known to masquerade as cutaneous carcinomas.⁵ Upon further history, the development of these lesions were hypothesized to be a result of iatrogenic inoculation of the nasal skin with *C. koseri*, a gastrointestinal microbe, during the exit of EGD tubing given onset immediately following EGD. This case cautions dermatologists to expand the spectrum of rare pathogens resulting in extraordinary hyperplastic change mimicking carcinoma and highlights the

importance of clinical vigilance with thorough history and infectious work-up including tissue cultures when clinical course do not align with presumptive histopathologic diagnosis. With timely diagnosis, patients can avoid potentially harmful procedural risks and resolve with appropriate antibiotic management alone.

Table 1. Reported Cases of *Citrobacter koseri* Skin and Soft Tissue Infections

<i>Infection Type</i>	<i>Age/Sex</i>	<i>Pathogen</i>	<i>Comorbidity</i>	<i>Source</i>	<i>Surgery</i>	<i>Therapy</i>	<i>Reference</i>
<i>Cellulitis</i>	30 M	<i>Citrobacter diversus</i> (koseri)	MM	Community	none		Bishara et al. 1998
<i>Folliculitis</i>	28 M	<i>Citrobacter diversus</i> (koseri)	Acne	Community	none	Trimethoprim-sulfamethoxazole	Chastain et al. 2000
<i>Folliculitis</i>	49 M	<i>Citrobacter koseri</i>	Folliculitis decalvans + rosacea	Community	none	Ciprofloxacin	Garcia-Bustinduy et al. 2002
<i>Cellulitis</i>	60 F	<i>Citrobacter koseri</i>	BC-CLL	Community	none	Amoxicillin-clavulanic acid and ofloxacin	Kluger et al. 2010
<i>Facial nodules</i>	86 M	<i>Citrobacter koseri</i>	None	Community	none	Amoxicillin / Clavulanic acid	Sherif et al. 2018
<i>Folliculitis</i>	15 M	<i>Citrobacter koseri</i>	Acne	Community	none	Ceftriaxone	Raia et al. 2015
<i>Cellulitis + abscess</i>	16 F	<i>Citrobacter koseri</i>	Acne	Community	I&D	Ciprofloxacin and clindamycin	Khreis et al. 2025
<i>KA-like metaplasia</i>	40 M	<i>Citrobacter koseri</i>	None	Nosocomial	none	Ciprofloxacin	Current case

Figure 1A. Keratoacanthoma-like endophytic metaplastic proliferation of the right nasal sidewall

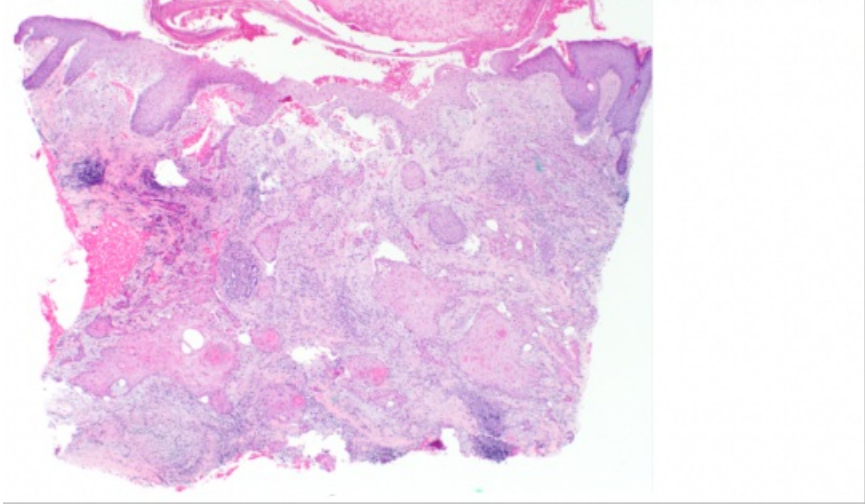
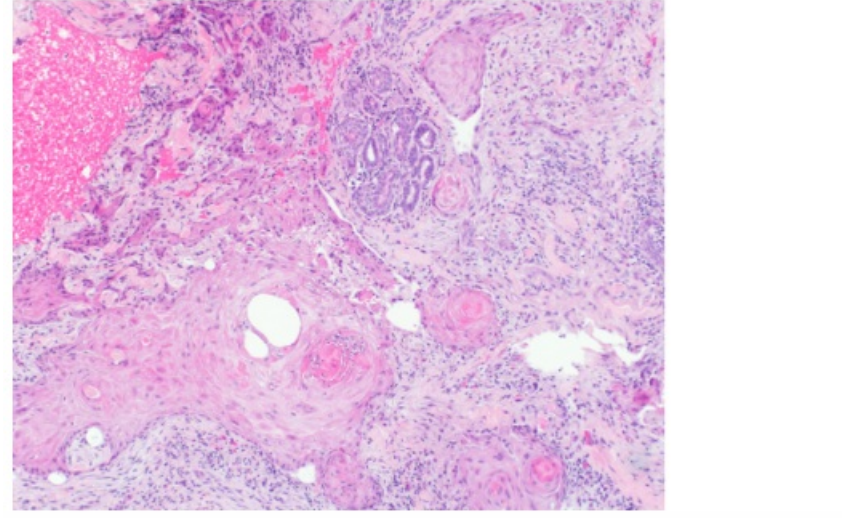


Figure 1B. Interconnecting cyst-like spaces in background of syringosquamous metaplasia and numerous neutrophilic microabscesses along adnexal structures.



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**Abstract N°: 4227****Bullous Scabies: A Rare Mimicker of Autoimmune Blistering Diseases**

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Introduction & Objectives:

Scabies is a highly contagious skin infestation caused by *Sarcoptes scabiei* var. *hominis*. It affects individuals regardless of age or socioeconomic status and remains a public health challenge, particularly in resource-limited settings. Transmission occurs mainly via prolonged skin-to-skin contact.

The hallmark symptom is intense nocturnal pruritus. Typical clinical findings include burrows, pruritic papules, inflammatory nodules, and hyperkeratotic crusts. Vesicles are often observed on palms and soles in children. Rarely, scabies mimics other dermatoses such as impetigo, psoriasis, urticaria, or bullous pemphigoid. Bullous lesions are uncommon, most often seen in elderly patients.

Bullous scabies may be clinically and histopathologically indistinguishable from bullous pemphigoid. The term refers to cases with blisters >5 mm and confirmed presence of mites or their products. Misdiagnosis may result in inappropriate immunosuppressive therapy. We report a case of an elderly male with bullous lesions initially suspected to be bullous pemphigoid but ultimately diagnosed with bullous scabies.

Materials & Methods:

A single case was evaluated. Written informed consent was obtained from the patient before diagnostic procedures and presentation.

Results:

A 73-year-old male presented with a two-week history of pruritic bullous eruptions on both thighs. Initial symptoms included generalized nocturnal pruritus followed by tense blister formation. There was no history of fever, trauma, drug intake, or mucosal/systemic involvement.

Physical examination revealed multiple erythematous plaques with tense, serohemorrhagic bullae (0.3–1.2 cm) on the thighs. Nikolsky sign was negative. Additional papules were present on the lumbar region and abdomen. No mucosal or facial involvement was noted. Dermoscopy showed burrows on finger webs and wrists.

A 4-mm punch biopsy was performed from the left medial thigh with a differential diagnosis of:

1. Bullous scabies
2. Bullous pemphigoid
3. Leukocytoclastic vasculitis

Histopathology showed subepidermal separation and perivascular lymphohistiocytic infiltrate suggestive of an insect bite reaction. Direct immunofluorescence (DIF) was negative. Based on the clinical, dermoscopic, and histological findings, the final diagnosis was bullous scabies.

Treatment with topical 5% permethrin and oral ivermectin resulted in complete resolution within three weeks.

Conclusion:

Bullous scabies is a rare clinical variant seen predominantly in elderly or immunocompromised individuals. It may mimic bullous pemphigoid both clinically and histologically. Key distinguishing features include severe nocturnal itching, burrows, and identification of mites or their products. DIF findings are usually negative or non-specific.

Accurate diagnosis is essential to avoid unnecessary immunosuppression. Prompt antiparasitic therapy ensures rapid recovery. Clinicians should maintain a high index of suspicion in elderly patients presenting with tense bullae and pruritus.

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Abstract N°: 4237

Recurrent Herpes Zoster Ophthalmicus revealing a rare immune deficiency in a child

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Introduction & Objectives:

Herpes zoster ophthalmicus (HZO) occurs due to the reactivation of the latent varicella-zoster virus. It is rare in children and can point to underlying immunodeficiencies. We present a case of a 9-year-old girl who experienced recurrent episodes of HZO, ultimately leading to the diagnosis of a Natural killer (NK) cell deficiency.

Materials & Methods:

A 9-year-old girl with a medical history of three episodes of recurrent ocular herpes zoster, treated with oral acyclovir and healed, who presented with another episode of HZO. She developed a vesicular skin rash on the forehead and left upper eyelid with conjunctival hyperemia in the context of a fever. The patient was hospitalized and was treated with intravenous acyclovir. An isolated immunodeficiency in Natural Killer (NK) lymphocytes (CD56+/CD16+) was confirmed by lymphocyte immunophenotyping, which justified prophylactic treatment with valacyclovir 1g/day and cotrimoxazole 20mg/kg/day

Results:

Herpes zoster ophthalmicus (HZO) refers to reactivation involving the ophthalmic division of the trigeminal nerve (V1). HZO in children is uncommon and should raise suspicion for underlying immunodeficiency, particularly in the context of recurrent infections. Natural killer (NK) cells are part of the innate immune defense, and are especially useful in combating certain viral pathogens. NK cell deficiency is a subset of primary immunodeficiency disorders in which an abnormality of NK cells represents a major immunological defect resulting in the patient's clinical immunodeficiency. In our case, the 9-year-old girl's recurrent episodes led to the identification of an isolated NK cell deficiency, which played a crucial role in her susceptibility to repeated viral reactivation. This case highlights the importance of considering immunodeficiency in pediatric patients with recurrent viral infections and emphasizes the role of early detection and appropriate prophylactic treatment to prevent complications.

Conclusion:

This case underscores the importance of investigating underlying immunodeficiencies, particularly NK cell deficiency, in pediatric patients presenting with recurrent episodes of herpes zoster ophthalmicus. Although rare in children, HZO can serve as a clinical indicator of primary immunodeficiency. Early recognition and appropriate prophylactic treatment are essential to prevent serious complications.

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**Abstract N°: 4364****Cutaneous co-infection with molluscum contagiosum and disseminated histoplasmosis illustrating immune reconstitution inflammatory syndrome in an HIV patient**

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Introduction & Objectives: Histoplasmosis is a granulomatous disease caused by the dimorphic fungus *Histoplasma* spp., most commonly presenting with pulmonary involvement. Cutaneous manifestations, usually secondary to dissemination, include molluscum-like papules, plaques, ulcers, and acneiform lesions. Molluscum contagiosum (MC), in contrast, is a viral dermatosis caused by a poxvirus, characterized by asymptomatic umbilicated papules. We report a case of coexistence of these two conditions in an adult female patient, discussing clinical-epidemiological aspects and illustrating an uncommon presentation.

Materials & Methods: A 23-year-old woman living with HIV for three years, with a history of antiretroviral therapy (ART) interruption and reinitiation two months prior, presented with a viral load of 788,000 copies/mL and a CD4 count of 22 cells/mm³. She reported the appearance, one month earlier, of a crusted nasal plaque and umbilicated papules on the face, limbs, and pubic area. Some umbilicated lesions had central hemorrhagic crusts, while others exhibited a shiny surface. Biopsies were performed on a crusted facial papule and a shiny suprapubic papule for histopathological examination and fungal culture.

Results: PAS staining revealed two distinct patterns: the suprapubic lesion showed granular eosinophilic inclusions displacing the keratinocyte nuclei, compatible with MC, while the facial lesion showed intracellular yeasts within histiocytes. Fungal culture of the facial lesion revealed filamentous colonies with hyaline septate hyphae and tuberculate macroconidia, confirming disseminated histoplasmosis. The patient was treated with amphotericin B for 14 days, followed by itraconazole, with progressive improvement of crusted umbilicated lesions. However, shiny lesions persisted for several months.

Conclusion: Over 90% of MC cases occur in the pediatric population. Affected adults are usually young and sexually active, with some degree of immunosuppression, as in this case. The clinical presentation of histoplasmosis depends on several factors such as pathogen virulence, age, and underlying diseases. It is closely related to impaired cellular immunity. Co-infection with HIV and CD4 count <50 cells/mm³ often leads to disseminated disease, as observed in this patient. Cutaneous lesions are reported in most Brazilian cases of histoplasmosis and are often more extensive than those reported in the United States, possibly due to the cutaneous tropism of South American strains. Immune reconstitution inflammatory syndrome (IRIS) is associated with partial immune recovery and pre-existing infections, and it is more frequent in patients who recently started ART with CD4 <50 cells/mm³. This may explain the extensive and diverse presentation in this case.

The gold standard for diagnosing histoplasmosis is fungal culture and histopathological examination of affected tissues, which in this case also confirmed MC, highlighting the coinfection and the importance of maintaining a high index of suspicion for cutaneous histoplasmosis in immunosuppressed patients, even in molluscum-like lesions.



**Abstract N°: 4376****Papular Variant of Cutaneous Larva Migrans: A Diagnostic Challenge in a Child**

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¹Instituto de Dermatologia Professor Rubem David Azulay, Rio de Janeiro, Brazil

Introduction & Objectives:

Cutaneous larva migrans is a parasitic dermatosis prevalent in tropical and subtropical regions. It is caused by hookworm larvae, primarily *Ancylostoma braziliense* and *Ancylostoma caninum*, commonly found in the feces of infected dogs and cats. These larvae penetrate human skin upon contact with contaminated soil. As they cannot complete their life cycle in humans, they migrate within the epidermis, producing characteristic pruritic, linear, erythematous, serpiginous lesions typically on the lower limbs. Recently, atypical clinical presentations have been increasingly reported, posing diagnostic challenges, especially when there is no clear epidemiological link. In this context, this case report aims to present a rarely documented atypical clinical variant of cutaneous larva migrans in a pediatric patient.

Materials & Methods:

Accompanied by his parents, a six-year-old male patient, with a complete vaccination record, presented to the outpatient dermatology clinic due to a ten-day history of a progressively evolving cutaneous eruption. The condition, which initially manifested as a solitary erythematous papule on the dorsal region, rapidly expanded to form multiple confluent erythematous papules and plaques with erosive and crusted surfaces in certain areas. The lesions were associated with intense pruritus and signs of excoriation. The parents denied the presence of fever, respiratory symptoms or gastrointestinal complaints. Upon detailed anamnesis, the patient's mother reported that he had been playing in sandy soil at a nearby construction site frequently visited by stray cats.

Results:

The combination of environmental exposure, age, intense pruritus and papular lesions raised the suspicion of an atypical form of cutaneous larva migrans. A clinical diagnosis was proposed and treatment was initiated with one dose of oral ivermectin at 200 µg/kg, repeated after seven days. On account of impetigo on the face, azithromycin 500 mg was prescribed once daily for five days. Topical betamethasone dipropionate 0.5 mg with gentamicin 1 mg cream was prescribed three times daily. After five days of treatment, rapid clinical improvement was observed, with complete relief of pruritus by day fifteen, leaving only mild post-inflammatory hypo- and hyperpigmentation.

Conclusion:

Atypical presentations of cutaneous larva migrans extend beyond the serpiginous linear lesions, including rarely described clinical variants such as the papular form. This case presents exuberant papular lesions which may be explained by a delayed-type hypersensitivity reaction to a high larval burden. Considering its atypical morphology and the nonspecificity of complementary diagnostics tests, the diagnosis is dependent on elements such as epidemiological suspicion and presence of intense pruritus. Empirical treatment with antiparasitic agents remains a valuable diagnostic and therapeutic strategy, particularly in pediatric patients, where biopsies may be impractical or insufficient. In the context of increasing global mobility, the potential for imported cases in non-endemic areas highlights the importance of having highly trained healthcare professionals around the globe.



**Abstract N°: 4383****Combined Therapy with 5-Flucytosine and Itraconazole for Refractory Chromoblastomycosis**

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Introduction & Objectives: Chromoblastomycosis is a deep subcutaneous mycosis caused by traumatic implantation of dematiaceous fungi, typically found in soil, wood, and decomposing organic matter. It is more prevalent in tropical and subtropical regions, primarily affecting individuals engaged in rural activities. Most causative agents belong to the order *Chaetothyriales*, with *Fonsecaea pedrosoi* being the most common species in Brazil. Clinically, it presents as chronic, progressive verrucous lesions in which muriform cells can be identified on direct examination and histopathology. Treatment relies on prolonged antifungal therapy, with or without destructive methods. We report a case of refractory chromoblastomycosis successfully managed with a combination of 5-flucytosine and itraconazole.

Materials & Methods: A 48-year-old male, originally from a tropical region, presented to a tertiary infectious disease center with a chronic dermatologic lesion on the right lower limb, diagnosed as chromoblastomycosis via biopsy 11 years prior. He reported lesion onset during agricultural activity, initially appearing as a slowly progressing verrucous plaque on the right ankle.

At admission, he had previously received itraconazole 200 mg/day for approximately 7 years, the last two in combination with terbinafine 250 mg/day, in addition to surgical procedures, all without clinical success. Physical examination revealed an extensive verrucous ulcerated plaque on the dorsum of the right foot and lower leg, with multiple additional plaques ranging from 1 to 5 cm along the limb.

A new biopsy showed pseudoepitheliomatous hyperplasia, granulomatous inflammatory infiltrate, and muriform bodies. Fungal culture revealed a dark colony with dematiaceous septate hyphae and Cladosporium-type sporulation, consistent with *Fonsecaea pedrosoi*.

Due to therapeutic refractoriness, itraconazole was increased to 800 mg/day. After six months with no improvement, treatment with liposomal amphotericin B (5.5 g total) was attempted, also without success. A regimen combining 5-flucytosine (6 g/day) and itraconazole (400 mg/day) was then initiated.

Results: Resolution of the skin lesions was achieved after six months of combined therapy with itraconazole and 5-flucytosine.

Conclusion: The treatment of chromoblastomycosis is challenging and often requires antifungal combinations or destructive modalities. Resistance may occur even at high itraconazole doses. Some fungal species can form biofilms and adhere to skin and subcutaneous tissue, contributing to treatment resistance. The combination of itraconazole with 5-flucytosine has been reported as effective in managing resistant and refractory cases. Early diagnosis and appropriate treatment are essential to prevent disability and reduce the risk of malignant transformation of chronic lesions.



Abstract N°: 4389

Lobomycosis: report of an exuberant presentation with striking microscopic findings and combined clinical-surgical therapy.

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Introduction & Objectives:

Lobomycosis, currently termed lacaziosis, is a deep, chronic, fungal infection caused by the traumatic implantation of *Lacazia loboi* into skin tissue. It presents as keloid-like nodular lesions, mainly affecting the auricular pavilion and extremities. This rare condition is more common in Central and South America, especially in the Amazon basin. This study aims to present a clinical case of lacaziosis with extensive and exuberant cutaneous lesions, which showed significant improvement following long-term oral itraconazole therapy in combination with multiple serial surgical excisions of the nodules. The case includes detailed microscopic and histopathological findings using hematoxylin-eosin (H&E), Grocott's methenamine silver (GMS), periodic acid-Schiff (PAS) staining and lactophenol cotton blue.

Case report:

A 57-year-old male patient presented with nodular lesions exhibiting a keloid-like appearance that began with a single nodule after local trauma involving contact with the ground and wood. The lesion demonstrated progressive growth and dissemination across the distal region of the right lower extremity. Pink, hard, and diffuse groups of nodules were observed with a hyperchromic surface and areas of desquamation. Histological examination using H&E, GMS and PAS staining revealed numerous macrophage aggregates in both the superficial and deep dermis, containing large quantities of spherical fungal structures. Direct fungal microscopy of tissue specimens using potassium hydroxide (KOH) and lactophenol cotton blue stain was performed and revealed globular bodies with a double-contoured refringente membrane and homogeneous cytoplasm, often forming linear groupings that reproduced by catenulate budding. These findings led to the diagnosis of lacaziosis, previously known as lobomycosis or Jorge Lobo's disease, named in honor of the Brazilian dermatology professor Jorge de Oliveira Lobo (1931). For our patient, we associated the use of oral itraconazole 200mg per day for 1 year with surgical excision of three or four nodules every three months. Clinical improvement was observed, and the patient remains under follow-up at the dermatology service.

Discussion:

The treatment of lacaziosis depends on the clinical presentation. Surgical excision remains, to date, the most effective therapeutic approach, especially for isolated and circumscribed lesions in the early stages. Cryosurgery has also been reported to yield favorable outcomes. Regarding oral pharmacological options, clofazimine is commonly used and has been associated with lesion improvement. A one-year combination of clofazimine and itraconazole resulted in clinical and histopathological remission, as reported by Fisher et al. The microorganisms involved are resistant to phagocytosis and digestion by macrophages, which contributes to the chronic nature of the infection, and they cannot be cultured in any available medium.

Conclusion:

Given that this is a rare tropical disease, more commonly found in the Amazon basin region, there are few studies addressing effective and definitive therapeutic approaches for lobomycosis. We conclude that the combination of serial surgical excisions of the lesions and prolonged use of itraconazole proved beneficial, leading to improvement of pre-existing lesions and control over the emergence of new ones.

Images:

Figure 1:

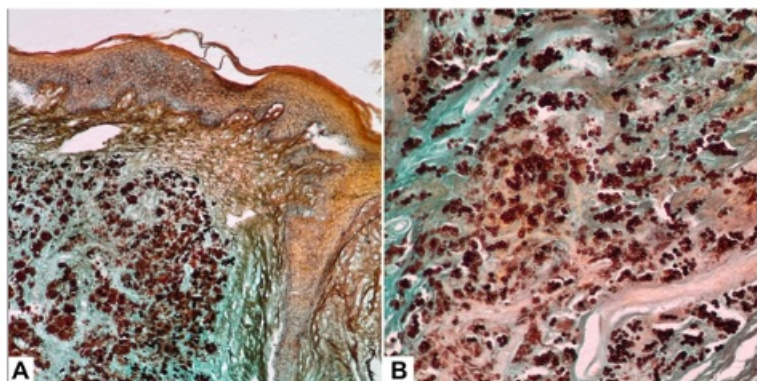


Figure 2:

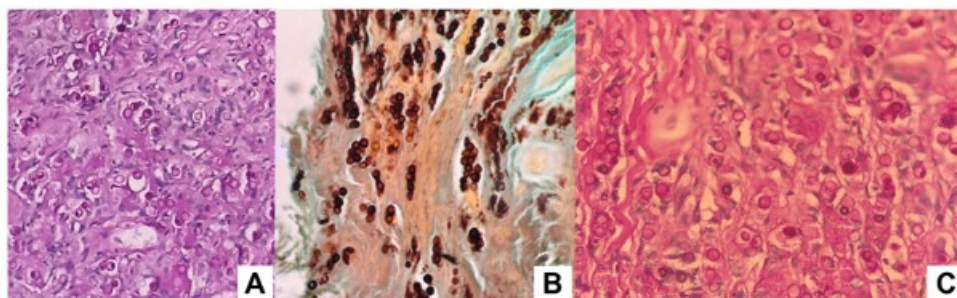


Figure 3:

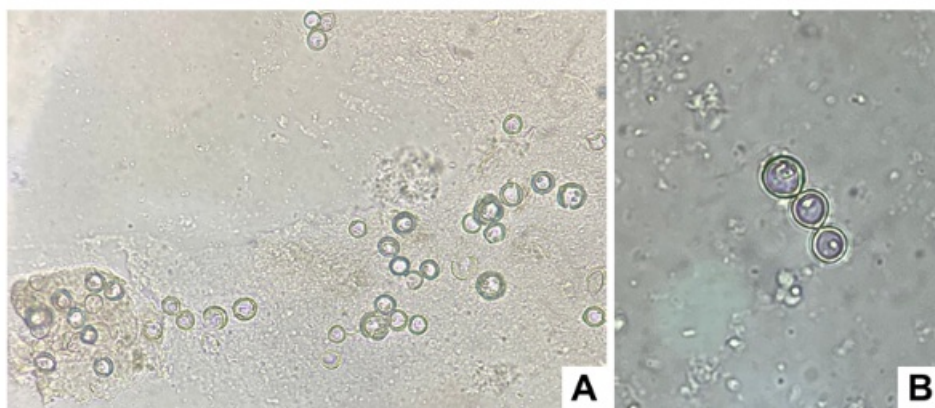
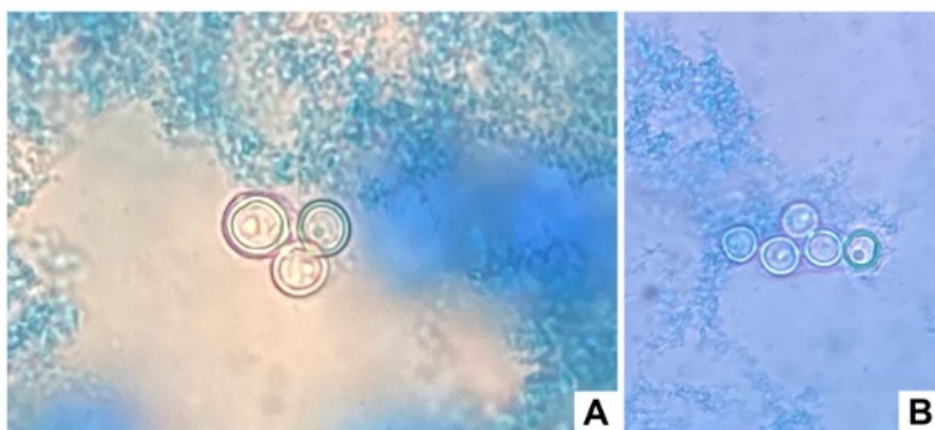


Figure 4:




Abstract N°: 4390
Lucio's Phenomenon as a Late Manifestation of Undiagnosed Leprosy: A Two-Case Report

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Introduction & Objectives:

Lucio's Phenomenon (LP) is a rare and severe condition, with ongoing debate regarding its classification. Some authors consider it a variant of type 2 leprosy reaction, while others describe it as a distinct third type, associated with coagulation abnormalities. This study aims to report two clinical cases of LP in patients with diffuse lepromatous leprosy, diagnosed within an average interval of three months. Due to the temporal proximity of these diagnoses—both involving a rare entity—we reference Velpeau's Law: "Rare cases come in pairs." Moreover, we highlight the importance of early diagnosis of leprosy, a neglected tropical disease.

Case Reports:

Case 1: A 66-year-old male patient presented with multiple linear erythematoviolaceous lesions on the hands, abdomen, lower limbs, and bilateral plantar regions. Fissures and an ulcerated lesion on the right heel with exposure of muscle tissue were also identified. The patient reported a progressive decrease in lower limb strength. Following skin biopsies and laboratory investigations, a diagnosis of lepromatous leprosy and Lucio's phenomenon LP was established, with high bacillary index (BI). Alternative multidrug therapy with ofloxacin was initiated due to dapsone-induced pancytopenia.

Case 2: A 56-year-old female patient presented with erythematoviolaceous lesions in both lower limbs and fever. Skin biopsy findings were consistent with lepromatous leprosy and LP Lucio's phenomenon. Diagnosis was confirmed by high bacillary index BI, positive acid-fast bacilli in skin fragment and Fite-Faraco staining. Microscopy findings showed presence of fibrinoid necrosis in the walls of small and medium-caliber vessels, some with microthrombi. Both patients were diagnosed at an advanced stage of the disease and already exhibited leprosy reactional states at the time of admission.

Discussion:

Brazil still maintains high rates of leprosy incidence, ranking second in the world number of cases. Lucio's phenomenon was first described by Lúcio and Alvarado in 1852 in Mexico, and it was named as such by Latapi and Zamora in 1948. It generally occurs between three to four years after the onset of the disease, usually in untreated patients. It can occur in Lucio's leprosy and in other forms of Virchowian leprosy. The three criteria that confirm Lucio's phenomenon (LP) are: ulcerated and ulceronecrotic skin lesions, vascular thrombosis, and proliferation of intact Hansen's bacilli in the endothelial cells of arterioles. It may result from two mechanisms: either as an immune-mediated event or through the direct effect of *M. leprae* presence in the vessel. Moreover, the excessive proliferation of Hansen's bacilli invades the vessel walls, damaging endothelial cells, leading to endothelial proliferation and reduction of the vascular lumen. This, associated with inflammatory reactions and alterations in the coagulation system, results in vascular thrombosis, ischemia, infarction, and tissue necrosis, generating the histopathological changes characteristic of the LP phenomenon. There are recommendations for parenteral corticosteroid administration. There is no consensus in the literature regarding the use of thalidomide

in patients without previous ENL. There are reports of oral medications being used, such as dapsone, clofazimine, corticosteroids, and thalidomide, among others.

Conclusion:

We highlight the importance of early diagnosis of leprosy, a neglected tropical disease.

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**Abstract N°: 4398****When dermatologist faces an urological emergency**

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Introduction & Objectives:

Necrotizing fasciitis (NF) is a rapidly progressive, life-threatening soft tissue infection characterized by widespread fascial necrosis. While NF most commonly affects the extremities, abdominal wall, and perineum (Fournier's gangrene), isolated involvement of the penis is extremely rare. Thus, the aim of this report is to make dermatologist aware of this rare clinical presentation as early diagnosis and prompt surgical intervention are crucial to reduce morbidity and mortality.

Materials & Methods:**Results:**

A 66-year-old man with a medical history of rheumatoid arthritis on non-steroidal anti-inflammatory drugs, presented to our Dermatology Department, with acute penile pain, swelling, and erythema diagnosed initially as contact dermatitis, rapidly progressing to necrosis of the penile shaft. On examination, crepitus and foul-smelling discharge were noted. Laboratory results showed a biological inflammatory syndrome. Imaging revealed gas in the subcutaneous tissues of the penis without scrotal involvement. Broad-spectrum intravenous antibiotics were initiated immediately, and urgent surgical debridement was performed. Microbiological cultures grew polymicrobial flora, including *Escherichia Coli* and *Streptococcus Pyogenes*. The patient underwent multiple debridement followed by reconstructive surgery. He recovered well with preserved urinary and sexual function.

Conclusion:

NF of the penis is an exceptionally rare presentation of a typically more widespread and aggressive soft tissue infection. In most cases, penile NF is polymicrobial, involving a combination of aerobic and anaerobic organisms, as seen in Fournier's gangrene. However, isolated penile involvement—without scrotal or perineal extension—suggests a more localized initial insult, often associated with minor trauma, recent instrumentation, or underlying comorbidities such as diabetes mellitus, HIV infection, malignancy, or chronic corticosteroid use, or non-steroidal anti-inflammatory drugs as our patient. These factors compromise local immune defence mechanisms, facilitating bacterial invasion and unchecked tissue destruction. Early clinical signs may mimic less severe infections such as cellulitis or balanitis, or contact dermatitis as was the case of our patient, which can delay diagnosis. Key clinical features suggestive of NF include disproportionate pain, systemic signs of toxicity, skin discoloration, crepitus, and rapid progression. Prompt, aggressive surgical debridement remains the cornerstone of management and is the most important determinant of survival. Delay in surgery is associated with increased mortality. Penile necrotizing fasciitis is a urological emergency that requires a high index of suspicion, especially in at-risk populations. Early diagnosis and prompt surgical intervention are key to improving survival and preserving penile function.

**Abstract N°: 4416****Tinea pseudoimbricata caused by *Nannizzia gypsea* in an immunocompetent patient**

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Introduction & Objectives: Tinea pseudoimbricata is a fungal infection that clinically mimics Tinea imbricata, characterized by concentric annular plaques. While Tinea imbricata is caused by *Trichophyton concentricum* and occurs commonly in indigenous or rural populations in endemic regions (Oceania, Southeast Asia, and Latin America), pseudoimbricata, usually associated with immunosuppression or excessive use of topical corticosteroids, can present similarly. This report describes an atypical case of Tinea pseudoimbricata caused by *Nannizzia gypsea* in an immunocompetent patient residing in an urban area.

Materials & Methods: A 21-year-old woman presented to a secondary care dermatology clinic with a one-month history of a lesion on the left upper limb, which began as a papule at the site of a mosquito bite. She was initially treated at a primary care facility with topical dexamethasone and a five-day course of oral prednisone. However, she continued using the topical steroid for about three weeks, during which the lesion progressively enlarged. Dermatological examination revealed an erythematous-squamous plaque with well-defined concentric rings surrounding the initial lesion, measuring approximately 5 cm, located on the ventral surface of the left forearm. Direct mycological examination revealed multiple septate hyaline hyphae. Fungal culture showed a pale beige-colored surface and an orange reverse. Microscopic examination revealed septate hyphae with ellipsoidal macroconidia, thin walls, and up to 6 septations, consistent with *Nannizzia gypsea*.

Results: Given this clinical evolution, the hypothesis of Tinea pseudoimbricata was raised, and treatment with 2% ketoconazole cream was initiated, along with discontinuation of topical dexamethasone. After two weeks of treatment with topical ketoconazole, clinical resolution of the lesion was observed, confirming the efficacy of antifungal treatment.

Conclusion: The presence of concentric annular lesions in patients without epidemiological history for Tinea imbricata should raise suspicion for Tinea pseudoimbricata, necessitating confirmation through mycological examination and culture to identify the etiological agent. The pathogenesis of Tinea pseudoimbricata may be related to a decreased T-cell response to fungal antigens, with a predominance of humoral immunity. The indiscriminate use of topical and oral corticosteroids creates a state of immunosuppression that favors the clinical presentation described. Management involves the use of topical or oral antifungals and, most importantly, discontinuation of corticosteroid therapy. The recognition of concentric plaques in fungal lesions, marking an atypical presentation of dermatophytosis in dermatological examination, should alert the physician to investigate corticosteroid abuse, which may be accompanied by side effects such as telangiectasias and cutaneous atrophy, or the patient's immunosuppressive state. Complementary investigation for acquired immunodeficiency, malnutrition, and immunosuppressive drug use is mandatory.





Abstract N°: 4421

Folliculocentric Pityriasis Versicolor: Importance of Suspecting Atypical Variants in Clinical Dermatology

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Introduction & Objectives: Pityriasis versicolor is a superficial skin infection caused by yeast of the *Malassezia* genus, predominantly *M. globosa* and *M. furfur*. These yeasts thrive in sebaceous areas, as they depend on lipids for energy due to their inability to synthesize fatty acids. Risk factors include heat, humidity, prolonged use of immunosuppressive corticosteroids, pregnancy, diabetes mellitus, and malnutrition. Folliculocentric pityriasis versicolor is a rare presentation that manifests as small perifollicular hypochromic or hyperchromic papules or macules, which may coalesce, generally asymptomatic, and predominantly located in the upper trunk and axillary regions. Here, we describe a series of cases of this variant, which tends to be underdiagnosed due to its resemblance to other dermatoses such as progressive macular hypomelanosis, vitiligo, keratosis pilaris, and follicular mycosis fungoides.

Materials & Methods: We describe a case series of four patients with folliculocentric pityriasis versicolor, all presenting with hypopigmented perifollicular lesions predominantly on the trunk and proximal limbs.

Results: In Patient 1 (female, 47 years), the lesions were present for 3 years with previous improvement after fluconazole, followed by recurrence. Dermoscopy revealed perifollicular hypopigmented macules with scale and pigment network reduction. Histopathology from three sites showed *Malassezia* yeasts and thin, non-septated hyphae with PAS staining. In Patient 2 (female, 20 years), white papules on the back were confirmed by direct microscopy showing pseudohyphae and yeasts. Patient 3 (male, 52 years) had a similar clinical presentation. Patient 4 (female, 54 years) presented with perifollicular hypopigmented macules with Zireli's sign; direct mycological exam revealed numerous pseudohyphae.

Conclusion: The diagnosis is clinical, aided by Wood's lamp examination, which reveals yellow-green fluorescence in 50% of cases, and by direct microscopy with potassium hydroxide (KOH), showing yeast and short hyphae in the characteristic "spaghetti and meatballs" pattern. Dermoscopy can help visualize affected follicles, with decreased perifollicular pigment network and scaling, as well as a hyperchromic halo around the primary lesion in about 60% of cases. This condition should be differentiated from various differential diagnoses like progressive macular hypomelanosis, in which folliculocentric red fluorescence under Wood's lamp due to accumulation of *Propionibacterium acnes* may help distinguish it from pityriasis versicolor. All described patients exhibited the hypochromic pattern, more commonly seen in individuals with darker phototypes. When hyperchromic, it mimics keratosis pilaris. Treatment is similar to the classic form and includes topical antifungals. In more resistant cases, oral antifungals may be indicated. Treatment response is generally good, although pigmentary changes may persist for some time after treatment. We believe raising awareness of this presentation can prevent misdiagnoses, delays in identifying the condition, and inadequate treatments.





Abstract N°: 4459

Verrucous tungiasis: an unusual manifestation of a common parasitic disease

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Introduction & Objectives: Tungiasis is a neglected tropical disease caused by the penetration of the female flea *Tunga penetrans* into the skin. It is endemic in several Latin American countries and affects up to 40% of individuals living in areas of extreme poverty. The infestation is usually located in the periungual regions of the feet and presents a self-limited course. However, in endemic areas, reinfection is the rule, leading to chronic and exuberant forms such as verrucous tungiasis, which may resemble other dermatoses like subcutaneous mycoses, tuberculosis verrucosa cutis, and viral warts. Misdiagnosis is common due to its polymorphic clinical presentation and its ability to mimic a wide range of infectious, inflammatory, and even neoplastic conditions. Recognition of this uncommon presentation is essential for appropriate management and prevention of complications.

Materials & Methods: We report the case of a 55-year-old male residing in a rural area and working as a coachman, who presented with painful, verrucous, and hyperkeratotic plaques predominantly affecting the dorsal aspects of the feet, pododactyls, and calcaneal regions, where fissures were also observed. Some lesions displayed central black dots. An ongoing outbreak of tungiasis in the patient's municipality, along with the presence of black dots, raised clinical suspicion for the diagnosis. Mechanical extraction of the embedded fleas was performed, and the patient was treated with oral ivermectin, 18 mg once weekly for three weeks. Tetanus immunization was updated accordingly.

Results: The verrucous lesions showed complete involution after mechanical extraction, with full resolution of the associated plantar hyperkeratosis. The observed morphologies correlated with stages III and IV of the Fortaleza Classification, which describes the dynamic progression of tungiasis lesions.

Stage	Description	Timeframe after Penetration	Clinical Characteristics
I	in statu penetrandi	30 minutes to several hours	Reddish spot (~1 mm) appears; penetration in progress
II	Hypertrophy begins	1–2 days	Whitish nodule with central black dot (anal-genital opening), surrounded by erythema
III	Maximum hypertrophy	2 days – 3 weeks	Painful, watch-glass-like lesion with hyperkeratosis and desquamation; egg and feces expulsion
IV	Involution	3–5 weeks	Black crust covering a dead parasite
V	Residual scarring	6 weeks to several months	Scar in the stratum corneum

Table 1. Fortaleza classification of Tungiasis lesions

Conclusion: Verrucous tungiasis is an underrecognized yet exuberant clinical variant of a common parasitic disease. In endemic regions, chronicity resulting from repeated reinfection can lead to atypical and deforming manifestations, complicating diagnosis and increasing morbidity. Recognizing the full clinical spectrum—including verrucous presentations—is essential to avoid unnecessary diagnostic procedures and inappropriate treatments. Although tungiasis is both preventable and treatable, untreated cases may progress to secondary bacterial

infections, lymphedema, and even autoamputation. Enhancing early recognition, particularly in endemic and resource-limited settings, is critical for preventing complications and improving patient outcomes.

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**Abstract N°: 4527****Clinical Characteristics of Candida Onychomycosis Cases at a Tertiary Dermatology Center in Hungary**Eszter Szlavicz^{*1, 2}, Dorottya Keresztes², Gabriella Mohos³, Rolland Gyulai^{2, 4}, Zsuzsanna Lengyel²¹Archiepiscopal College of Veszprém, Veszprém, Hungary²Medical Faculty, University of Pécs, Department of Dermatology, Venereology and Oncodermatology, Pécs, Hungary³Semmelweis University, Centre for Translational Medicine, Budapest, Hungary⁴Albert Szent-Györgyi Health Center, Department of Dermatology and Allergology, Szeged, Hungary

Introduction & Objectives: Onychomycosis is a common disease, affecting 5-20% of the population. Species belonging to the genus *Candida* are considered the most important pathogen in the pathogenesis of onychomycosis. Nail infections caused by them show characteristic clinical symptoms, the most common being the proximal subungual type, which can lead to severe nail deformity and may be accompanied by paronychia.

The objective of our research was to conduct a survey of cases of *Candida* onychomycosis in the patient material of the Department of Dermatology, Venereology and Oncodermatology, University of Pécs, from July 2018 to October 2023.

Materials & Methods:

During the native microscopic examination of nail scrapings, 20% ammonium hydroxide was used. The culture was performed on 4% Sabouraud glucose agar (containing 20U/ml penicillin, 40U/ml streptomycin and 0.4mg/ml cycloheximide). Further analysis of the *Candida* cultures was performed using *Candida* chromagar (CHROMagar, Springfield, USA) and MALDI-TOF mass spectrometry.

Results: Based on our results, we confirmed onychomycosis caused by *Candida* species in a total of 141 cases (13.14%, total cohort n=1073), with a female predominance. Fingernail infections were presented in 58.15% of the patients, while we found toenail infections in 41.85%. Non-albicans *Candida* species also dominate in fingernail and toenail infections, with their presence detected in 80.14% of the cases. Among the non-albicans *Candida* species, *Candida parapsilosis* proved to be the most common pathogen (44.64%). Regarding comorbidities, onychomycosis was most often associated with diabetes mellitus, thyroid diseases and peripheral circulatory disorders.

Conclusion: In terms of disease prevention, treatment and avoidance of recurrent infections, epidemiological studies of onychomycosis is of particular importance. The increasing prevalence of non albicans *Candida* infections may also indicate the selection of species that are resistant to the widely used antifungal agents.



**Abstract N°: 4608****Foot Fungal Infections in Type 1 Diabetes**LEILA BENAHMED¹, Nassiba Zerrouki^{1, 2}, Nada Zizi^{1, 2}¹Mohammed VI University Hospital Center, Dermatology, Venereology, and Allergology Department, Mohammed VI University Hospital Center, Oujda, OUJDA²Mohamed I University, Epidemiology, Clinical Research, and Public Health Laboratory, Faculty of Medicine and Pharmacy, Mohammed First University, Oujda, Morocco, OUJDA

Introduction & Objectives: Foot mycosis refers to superficial fungal infections that commonly affect the soles, interdigital spaces, and toenails. These infections are frequently encountered in clinical practice and are more prevalent in diabetic patients compared to the general population. Although generally benign, they can become a source of concern in individuals with diabetes due to underlying metabolic and immune dysfunctions. Chronic hyperglycemia leads to significant metabolic and immunological alterations, impairing skin barrier function and predisposing patients to fungal colonization and infection. When indicated, antifungal treatment should be administered, and good glycemic control combined with structured therapeutic education plays a crucial role in the prevention and management of these infections in diabetic individuals. The objective of this study was to evaluate the prevalence of foot mycoses in patients with type 1 diabetes and to assess the impact of glycemic control and therapeutic education on their progression.

Materials & Methods: We conducted a retrospective, descriptive, and analytical study over a nine-year period, from 2014 to 2023, involving patients with type 1 diabetes. A systematic clinical and dermatological examination was performed for all patients hospitalized in the diabetology department of the university hospital. Glycemic control was assessed through HbA1c measurements. In cases of strong clinical suspicion, a mycological examination was conducted to confirm the diagnosis.

Results: Among the 435 patients included, the mean age was 20.2 ± 10 years, with a sex ratio of 0.98. The mean baseline HbA1c was 10.6%, with more than half of the patients showing poor glycemic control. Dermatological examination revealed onychomycosis in 11.6% of cases, interdigital intertrigo in 8.1%, and plantar involvement in 6.9%. All patients received therapeutic education, and those with confirmed fungal infections who expressed willingness to be treated received appropriate antifungal therapy—topical in mild cases and systemic in moderate to severe cases.

After six months of follow-up, the mean HbA1c decreased to 7.8%, and a marked reduction in fungal infections was observed: onychomycosis decreased to 8.2%, interdigital intertrigo to 1.3%, and plantar involvement to 4.8%. A weak correlation was observed between glycemic control (HbA1c) and the occurrence of foot fungal infections. The correlation coefficients were 0.015 for onychomycosis, -0.045 for interdigital intertrigo, and 0.075 for plantar involvement.

Chi-square tests showed no significant association between HbA1c levels and the presence of foot fungal infections (onychomycosis $p = 0.529$; interdigital intertrigo $p = 0.422$; plantar involvement $p = 0.597$). Logistic regression analysis also demonstrated no strong effect of HbA1c on the likelihood of developing fungal infections. For onychomycosis, the p -value was 0.335; for plantar involvement, the p -value was 0.103.

Conclusion: In conclusion, foot fungal infections were prevalent among patients with type 1 diabetes, but no significant association was found between glycemic control and the occurrence of these infections. This suggests that other contributing factors, such as foot hygiene, environmental conditions, and individual susceptibility, may

play a more significant role in the development of these infections.

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Abstract N°: 4609

Treatment resistant Chromoblastomycosis

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Introduction & Objectives:

Chromoblastomycosis is a verrucous dermatosis caused by several genera of pigmented fungi. Typically, it's a chronic expanding verrucous plaque commonly over lower or upper extremities. Commonest aetiology of Chromoblastomycosis in Sri Lanka is *Fonsecaea pedrosoi*.

We have encountered patients with extensive chromoblastomycosis with significant treatment difficulties.

Materials & Methods:

This is a manual labourer carrying sand baskets in his back, who has developed itchy nodules over the back which has progressed to erythematous verrucous plaques with areas of atrophy. Adequate medical treatment was not administered until it spread to the bilateral hands and scalp. After six years of disabling disease, he was diagnosed with Chromoblastomycosis by *Fonsecaea pedrosoi* by histology and culture.

Itraconazole along with cryotherapy was started, with poor response even after 6months. Terbinafine with, itraconazole and potassium iodide was added. Still the response was poor

Results:

Finally, voriconazole 200mg bd was started. A marked improvement was noted within one month of the treatment. He was free of new lesions by 3 months of treatment. However, voriconazole was continued for 2more months.

Conclusion:

Voriconazole is a new second generation triazole. It demonstrates activity invitro antifungal action against *Fonsecaea pedrosoi*, *F. monophora*, *F. nubica* and *Cladophilophora carrionii*. Posiconazole and itraconazole also used in chromoblastomycosis. The clinical benefit of voriconazole in treatment of resistant disabling disease needs to be highlighted. However early detection and early treatment is paramount in management.



**Abstract N°: 4611****Varicella-Zoster Virus Infection Mimicking Bullous Dermatoses**Martina Part^{*1}¹Faculty of Medicine, Comenius University in Bratislava, Dept. of Dermatovenereology, Bratislava, Slovakia**Introduction & Objectives:**

Infections with *varicella-zoster virus* (VZV) are usually considered benign infections. Primary infection results in varicella. It is characterized by generalized vesicular rash with fever. Reactivation of latent VZV from dorsal root ganglia results in herpes zoster, a localized cutaneous eruption accompanied by neuralgic pain. In immunocompetent individuals, the clinical manifestation and overall course of disease is very typical. However, in immunocompromised patients, VZV infections can present atypically, which can pose diagnostic and therapeutic challenges.

Materials & Methods:

We present a case of 30-year-old male suffering from numerous annular arranged vesicles without mucosal involvement. Based on the morphology of the skin lesions, the differential diagnosis included IgA bullous dermatosis, bullous pemphigoid, and erythema multiforme. Viral etiology was not considered due to the atypical appearance and absence of systemic symptoms. Considering the patient's overall clinical conditions, we proceed to initiate an intravenous corticosteroid therapy.

Results:

Methylprednisolon in the starting dose of 80 mg daily was administered intravenously without efficacy. The dose of methylprednisolon was increased to 160 mg daily, but the skin vesiculobullous lesions progressed rapidly. Surprisingly, an autoimmune disease was not confirmed with performed test (including skin biopsies), but the viral etiology was suggested. In our patient was identified the defect in cellular immunity. The systemic corticosteroids were detracted and antiviral therapy was initiated. Aciklovir in the standard dose of 750 mg daily (given in 3 divided doses) was administered intravenously. Within a few days, the lesions rapidly and completely resolved.

Conclusion:

A diverse range of inflammatory dermatoses are characterized by vesicles or bullae. The viral etiology should be considered in the differential diagnosis of all vesiculobullous eruptions, particularly when the standard therapy is ineffective or disease progression is observed during immunosuppressive treatment. In immunocompromised patients, atypical VZV infections may clinically mimic autoimmune bullous dermatoses, potentially leading to misdiagnosis and inappropriate immunosuppressive treatment, as documented in our case report.





Abstract N°: 4648

Autoinoculation Treatment for Periungual Verrucae: Complete Clearance in Two Recalcitrant CasesKadir Atacan Yıldız^{*1}, İris Güler Gül¹, Muazzez Cigdem Oba Kaymaz¹, Server Serdaroglu¹¹Istanbul University-Cerrahpasa, Cerrahpasa Medical Faculty, Dermatology, Istanbul, Türkiye

Introduction & Objectives: Periungual verrucae are common causes of functional and aesthetic impairment in the adolescent and young adult population. Many treatment options with variable efficacy exist. Because of the proximity to the nail matrix, destructive modalities may result in nail dystrophy. Autoinoculation is an immunotherapeutic method, in which a part of the verruca is relocated to the deep dermis or subcutaneous tissue in order to intensify the immune response. In this report, we present two cases with recalcitrant periungual verrucae, treated with autoinoculation.

Materials & Methods: The first patient is a 15-year-old male who presented to our department with periungual verrucae around all of his fingers. Additionally, there were subungual verrucae under the nail plate of the thumb and index finger of his left hand. His condition started 1,5 years ago. He had been treated with cryotherapy for four sessions, topical keratolytics and inosine pranobex for a month, and lastly topical immunotherapy with squaric acid dibutyl ester for three months. None of these modalities resulted in any improvement.

The second patient is a 29-year-old female who had a verruca with both periungual and subungual components on the middle finger of her right hand. Due to the extension from the lateral nail fold to the nail bed, onycholysis was noticeable. Her lesion first appeared 7 years ago. She applied a topical solution containing salicylic acid with 5-fluorouracil to her lesion from time to time with no response.

We decided to perform autoinoculation treatment in both patients. The technique described by Haider Abdul-Lateef Mousa in 2024 was employed. Povidone iodine was applied, and lidocaine was infiltrated to the area to be treated. A 20-gauge needle was inserted in the center of the lesion towards the subcutaneous tissue, and then it was moved back and forth in different directions for 10 times. For the first patient, one of the lesions was chosen and the procedure was performed only on that lesion.

Results: The first patient showed partial response after the first session. The number of his lesions gradually decreased and after a total of four sessions, all the lesions disappeared. Similarly, the second patient showed complete response after two sessions. The interval between two sessions was one month for both patients. No adverse events including nail dystrophy or postinflammatory changes occurred.

Conclusion: The nail unit verruca represents the most frequently encountered tumor affecting the nail. Although the majority of the cases are self-limited, treatment-refractory lesions may have detrimental effects on the quality of life. A wide range of treatment options have been described in the literature, including both destructive and immunotherapeutic modalities. Since the verrucae are located in the epidermis distant from the circulation, the immunogenic stimulation might not result in effective immune response. To overcome this barrier, autoinoculation can be accomplished with various techniques. This recent technique that we used is safe and cheap, and it resulted in complete clearance in our patients.



**Abstract N°: 4676****The Potential of Luliconazole as an Adjuvant Therapy for Terbinafine-Resistant *Trichophyton* Species**Holly Hodge*¹¹Texas A&M, College of Medicine, Dallas, United States**Introduction & Objectives:**

Rising resistance to terbinafine, a first-line treatment for dermatophytosis, has been reported in several *Trichophyton* species. This resistance, primarily driven by mutations in the squalene epoxidase gene, has led to chronic, recalcitrant infections. *T. rubrum*, *T. interdigitale*, and the newly identified *T. indotineae* have shown particularly high resistance rates. *T. indotineae*, first identified in India, has now spread globally, posing a significant public health concern. Alternative treatments are often limited by emerging resistance and systemic side effects. Luliconazole, a topical agent that inhibits lanosterol 14 α -demethylase, demonstrates potent in vitro activity and a favorable safety profile. This review evaluates the clinical efficacy of luliconazole against terbinafine-resistant *Trichophyton* species and its potential role as a primary or adjunctive therapy.

Materials & Methods:

A systematic literature review was performed using PubMed and Embase with the keywords “luliconazole” combined with “*T. indotineae*,” “*T. interdigitale*,” or “*T. rubrum*.” Study designs were limited to randomized controlled trials, observational studies, case studies, systematic reviews, and meta-analyses. The publication years were restricted to 2019 through 2025, and only studies published in English were included. Only studies with confirmed involvement of *T. indotineae*, *T. interdigitale*, or *T. rubrum* that addressed clinical outcomes were included. Extracted data included study design, sample size, *Trichophyton* species, resistance profile, type of treatment intervention, efficacy outcomes, and reported adverse effects. A comparative analysis was performed to discern trends and discrepancies regarding the clinical effectiveness and safety of luliconazole.

Results:

Ten studies met the inclusion criteria: eight case reports and two comparative trials. Clinical outcomes varied; several cases reported complete resolution with luliconazole monotherapy, while others required adjunctive treatment with systemic antifungals such as itraconazole or fosravuconazole. One comparative study demonstrated luliconazole’s superior efficacy and lower relapse rates compared to clotrimazole, and in another comparative study, luliconazole achieved a 100% clinical and mycological cure rate. Reported adverse effects across all studies were minimal, involving only mild reactions at application sites.

Conclusion:

Luliconazole shows promise as a therapeutic option for terbinafine-resistant dermatophytosis, particularly when used adjunctively. Its high potency, favorable safety profile, and efficacy across various *Trichophyton* species support its potential role in clinical management. However, current evidence is limited to small-scale studies and case reports. Large-scale randomized controlled trials are warranted to validate its effectiveness given the public health threat posed by rising terbinafine resistance and the global spread of *T. indotineae*.



**Abstract N°: 4794****Cutaneous loxoscelism: a new case report**

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Introduction & Objectives: Loxoscelism refers to all cutaneous or visceral manifestations induced by a bite from a spider of the genus *Loxosceles*. It is responsible for numerous cases of envenomation worldwide. We report a case of cutaneous loxoscelism

Materials & Methods: A 32-year-old woman with no previous pathological history presented with a sudden-onset painful erythematous patch on the left arm. Questioning revealed a mildly painful stinging sensation that had occurred while sitting in the chair, and the concomitant capture of a spider twenty-four hours previously. On clinical examination, the patient was febrile, in average general condition, and presented with a painful inflammatory placard on the left arm, with centrifugal extension centred on a zone of necrosis surrounded by a clear halo with a highly inflammatory perimeter. She also presented with slightly pruritic erythematous placards in the inguinal folds. Biological tests were unremarkable. The diagnosis of cutaneous loxoscelism was accepted, and treatment with systemic corticosteroids (0.5mg/kg/d) and an antihistamine was instituted, together with necrectomy, with good improvement after one week.

Results: The manifestations of loxoscelism are diverse. They can range from a simple urticarial, erythematous reaction at the site of the bite to ulceration and necrosis. The positive diagnosis of loxoscelism ideally relies on the capture and identification of the spider responsible, which is rarely done in practice. In our observation, the diagnosis of cutaneous loxoscelism was considered certain, in the presence of formal proof by capture of the spider.

Conclusion: Envenomation by *Loxosceles* spider bites is a little-known and probably under-diagnosed pathology. Various clinical aspects have been described, sometimes intertwined, and our observation illustrates the importance of identifying the genus responsible in order to make the diagnosis with certainty.



**Abstract N°: 4796****Cutaneous Phaeohyphomycosis Due to *Exophiala* spp: A Case Report**Pamela Cambroner¹, Marcela Campos¹, Jaime Pozuelo¹, Yósselin Morales¹¹Hospital México, San José, Costa Rica**Introduction & Objectives:**

Phaeohyphomycosis is a fungal infection caused by a heterogeneous group of organisms known as “dematiaceous” or “melanized” fungi.** These fungi are characterized by the presence of melanin in their cell walls, which is believed to act as a virulence factor. Melanin provides resistance against oxidative damage induced by free radicals within the host’s phagocytic cells. It also binds to hydrolytic enzymes and antifungal agents, thereby inhibiting their activity. Dematiaceous fungi are commonly found in soil, plants, and decaying wood. Immunocompromised patients, particularly those who have undergone organ transplantation, represent the population most affected by these fungi. The infection may present as mucocutaneous or disseminated disease. Fungal inoculation typically occurs through traumatic implantation, although inhalation of spores is another possible route of infection.

Materials & Methods:

Informed consent was given for presentation of the case.

Results:

A 66-year-old male with a known medical history of renal transplantation, chronic obstructive pulmonary disease, and bladder cancer. The patient was chronically immunosuppressed, receiving tacrolimus 1.5 mg BID PO, azathioprine 100 mg QD PO, and prednisolone 5 mg QD PO. He presented to the dermatology clinic with a nodular lesion exhibiting ulcerated areas on the distal phalanx of the second digit of the left hand. The patient reported a history of trauma at the affected site involving a splinter from a tree. Histopathological examination revealed pseudoepitheliomatous hyperplasia and pale brown, yeast-like structures. PAS and Grocott stains demonstrated the presence of fungal hyphae. Culture identified *Exophiala spinifera*. The patient underwent surgical excision of the lesion followed by antifungal therapy with oral itraconazole 200 mg QD for four months, resulting in complete resolution of the lesion.

Conclusion:

Phaeohyphomycosis is an uncommon condition caused by darkly pigmented fungi. Transplant recipients, such as the patient described in this case, are at increased risk due to prolonged immunosuppression. Systemic involvement should always be ruled out. Cutaneous lesions may present as papules, plaques, pustules, nodules, or ulcers, and may appear as solitary or multiple lesions. They are often asymptomatic and tend to localize to exposed areas of the extremities and head. These findings are comparable with those present in our patient. Histopathological examination with hematoxylin and eosin staining may reveal fungal hyphae. Detection is more sensitive with periodic acid–Schiff staining. When pigmentation is not readily apparent, special stains such as Fontana-Masson and Gomori-Grocott are recommended. For the treatment of cutaneous phaeohyphomycosis, surgical excision of the lesion combined with systemic antifungal therapy is recommended.



Abstract N°: 4797

**Coexistence of Chromoblastomycosis and Well-Differentiated Squamous Cell Carcinoma in a Rural Farmer:
A Severe Case Requiring Limb Amputation**

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Introduction & Objectives:

Chromoblastomycosis is a chronic fungal infection endemic to tropical regions. Long-standing lesions may mimic or coexist with malignant neoplasms, particularly squamous cell carcinoma (SCC), complicating diagnosis and treatment.

Materials & Methods:

A 59-year-old male agricultural worker from a rural area in Costa Rica presented with a 7-year history of a progressively enlarging verrucous lesion on the left leg, initially self-treated with alcohol. The lesion evolved into a 20×15 cm vegetating tumor with keloid scarring and limited joint mobility. Multiple biopsies confirmed chromoblastomycosis due to *Fonsecaea pedrosoi*. Despite antifungal therapy with itraconazole and cryotherapy, the lesion continued to enlarge. Repeated biopsies raised suspicion for neoplasia.

Results:

Final histopathological evaluation after a supracondylar amputation confirmed a well-differentiated squamous cell carcinoma. Surgical margins were clear of fungal and neoplastic involvement. No inguinal metastases were found.

Conclusion:

This case exemplifies the severe complications of delayed diagnosis and inadequate early treatment in chromoblastomycosis. Chronic inflammation, persistent trauma, and pseudoepitheliomatous hyperplasia may contribute to malignant transformation or mask coexisting SCC. In endemic settings, chromoblastomycosis should be considered in chronic verrucous lesions. Early identification and aggressive management are critical to prevent mutilating outcomes such as amputation.



**Abstract N°: 4950****Cutaneous leishmaniasis in patients under biologic therapies. A Spanish CLINI-AEDV Multicenter Study**

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Background: The use of anti-TNF α (tumor necrosis factor-alpha) agents has been associated with the reactivation of chronic granulomatous infections, including leishmaniasis, whether newly acquired or latent. Cases of atypical or recurrent cutaneous (CL) or mucocutaneous leishmaniasis (MCL) have been reported in patients on biologic treatments, particularly in endemic regions, such as Mediterranean countries.

Objective: To describe the clinical features of CL and MCL in patients receiving biological therapy in an endemic area, and evaluate their management in real-life clinical practice, including diagnostic strategies, therapeutic approaches, and decisions on immunosuppressive treatment continuation.

Methods: An ambispective descriptive study was conducted. Participating dermatology centers reported retrospective and prospective cases of CL or MCL occurring during biological therapy. Data on clinical presentations, diagnostics, treatments, and outcomes were collected and analyzed.

Results: Seventy-one patients were included (62 with CL and 8 with MCL). The most common underlying condition was inflammatory bowel disease (33.8%). Most patients had been receiving biologic therapy for more than one year before diagnosis. Lesions were multifocal in 40% and larger than 1 cm in diameter in 94.4%. Disease persistence despite first-line treatment occurred in 3 patients (4.2%) and recurrence, in 6 patients (8.5%).

Treatment failures were more frequent in MCL (50%) than CL (8.1%). Biologic therapy was discontinued in 53.5%, leading to worsening of the underlying disease in 46.5%. No significant difference in cure rates was observed between patients who continued vs. discontinued biologics ($p=0.868$).

Conclusion. Our study highlights the clinical burden of CL and MCL in patients undergoing anti-TNF α therapy in endemic areas, emphasizing the diagnostic and therapeutic challenges involved. Discontinuation of biologic therapy did not significantly affect cure rates. These findings underscore the need for further research to establish standardized strategies that optimize the balance between infection control and the management of underlying inflammatory diseases.

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Abstract N°: 4952

Voriconazole is effective in totally drug resistant cases of dermatophytosis

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Introduction & Objectives: Dermatophytosis affects 25% of the world population. In countries like India, the treatment of this condition has become difficult since last 10-15 years as majority of the cases don't respond to standard oral antifungal treatment. Those cases have been labelled as recalcitrant dermatophytosis. Dermatologists in India routinely advise higher dose & longer duration of currently available oral antifungals like terbinafine, fluconazole, griseofulvin & itraconazole. Although, itraconazole has become a drug of choice, some cases do not respond to itraconazole even in higher dose. Various combinations of oral antifungals too fail. Such cases may be labelled as totally drug-resistant (TDR) dermatophytosis. This case study presents 4 such cases who failed all standard oral antifungals given over appropriate dose & duration. Voriconazole, a triazole antifungal although not routinely used in the treatment of dermatophytosis was used as a desperate attempt to see if it works in such cases. High cost of this drug limits its use.

Materials & Methods: All these cases were treated by us with higher dose (based on previous intake of antifungals) of all the 4 drugs & found to be TDR cases. The consideration of standard dose of terbinafine, fluconazole, itraconazole & griseofulvin was 250mg, 150mg, 200mg & 500mg per day. While higher dose was 500mg for terbinafine & 1000mg for Griseofulvin per day. For Fluconazole, it was 6mg/kg/day (maximum dose of 400mg) and for itraconazole 5mg/kg/day (Maximum dose of 400mg). This study presents 4 such cases. Three of them were males & 1 female. Case 1 was a female aged 66 years with dermatophytosis of 4 years. Case 2 was a male aged 31 years with dermatophytosis of 4 years duration. Case 3 was a 44-year-old male with dermatophytosis of 17 years while case 4 was a 35-year-old male with duration of the disease 5 years. All the cases were treated with tablet voriconazole 200mg twice a day for 4 to 6 weeks till complete clearance of the skin lesions. They were called for follow up at 2 weeks intervals till completion of 12 weeks. Other treatment given was oral antihistamines, topical moisturizer & general hygiene measures.

Results: All the cases showed improvement at the end of 2 weeks with complete clearance of skin lesions at 4 weeks in case 3 & 4. While case 1 & 2 the skin lesions healed at week 6. A further follow up at 2 weekly intervals did not show any recurrence at the end of 12 weeks. No significant side effects were recorded. Thus, this case study showed that all 4 cases of TDR dermatophytosis healed fully with voriconazole. If the treatment duration is shortened by giving voriconazole, it is worth as high cost of the drug will be compensated as the duration is reduced.

Conclusion: Voriconazole is effective even in the totally drug-resistant cases of dermatophytosis. If used consistently in a greater number of cases, the price of the drug may come down & morbidity is reduced.





Abstract N°: 4969

Case of Photodistributed Varicella with concomitant doxycycline use

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Introduction & Objectives:

Primary varicella infection typically presents with papulovesicular eruption, sometimes with pustules, beginning from the trunk and spreading to face and limbs. Photodistributed varicella is a rare presentation of varicella with cutaneous lesions predominantly over sun exposed areas. We present a case of varicella that was aggravated by ultraviolet light exposure, with concomitant doxycycline use.

Case report:

An 18-year-old male, who was previously well with no past medical history, presented with skin rashes for 4 days. He was treated for acne vulgaris with oral doxycycline for 2 months prior to his presentation.

Five days prior to rashes onset, he went on a fishing trip with prolonged sun exposure, and he experienced sunburn over his face, arms and lower legs. There was no immediate itch or rashes after sun exposure. The rashes were not associated with fever, prodromal symptoms or constitutional symptoms. There was no known sick contact or exposure to varicella zoster recently.

On examination, there were multiple papules, pustules and vesicles over erythematous base predominantly over photodistributed areas - face, neck, arms, distal thighs, lower legs and dorsal feet, with relative sparing over his left wrist where he had worn a watch, bilateral dorsal feet where he had worn his sandal and his abdomen, trunk and proximal thighs. There were few necrotic papules over the face. There was no mucosal involvement.

Varicella zoster virus (VZV) PCR swab from skin lesions returned positive. A skin punch biopsy was conducted and demonstrated an intracorneal blister with vacuolar interface dermatitis, superficial to deep perivascular inflammation with mild nuclear dust. EBV encoded RNA (EBER) is negative. Direct Immunofluorescence is negative. Other investigations noted a normal total white cell count with presence of atypical monocytes. His hemoglobin count, platelet, creatinine, C-reactive protein, Procalcitonin were normal. Syphilis and HIV screening tests were negative.

He was treated as for primary varicella infection and received oral acyclovir for 1 week. Review at 2 weeks showed complete resolution of the rashes.

Discussion and Conclusion:

Photodistributed Varicella is a rare presentation of cutaneous varicella, with reports of occurring between 2 to 10 days after an acute sun exposure or sunburn. Lesions can also appear monomorphic which differs from the typical polymorphic eruption in primary varicella.

The pathogenesis of photodistributed presentation of varicella is unclear. Postulated mechanisms include the direct inflammatory properties of acute ultraviolet exposure, which may in turn lead to increased capillary permeability and invasion by viruses. Another proposed pathogenesis includes the immunosuppression in affected skin after ultraviolet ray exposure, leading to a preferential cutaneous presentation of varicella infection in photodistributed areas.

We present a case of photodistributed varicella precipitated by recent ultraviolet exposure, along with concomitant doxycycline use with its known phototoxic side effect. In cases with polymorphic eruption over photodistributed areas, other important differential diagnoses to consider include hydroa vacciniforme, hydroa vacciniforme-like lymphoproliferative diseases, pseudoporphyria and polymorphic light eruption.

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**Abstract N°: 5002****Eumycetoma Caused by *Pseudallescheria boydii*: Case Report with Good Response to Voriconazole**Lara Johnsson Justo Silva^{*1}, Caroline Heleno Chagas de Carvalho¹, Walter Belda Jr¹¹University of Sao Paulo, Dermatology, São Paulo, Brazil**Introduction & Objectives:**

Eumycetoma is a chronic fungal infection mainly affecting skin and subcutaneous tissues and, rarely, internal organs. Its clinical triad includes painless swelling, fistula formation, and purulent or seropurulent discharge with "grains." The lower limb is the most commonly involved site (82% of cases). Diagnosis relies on clinical detection of grains, direct microscopy, cultures, and occasionally biopsy. Differential diagnoses include sporotrichosis, chromoblastomycosis, and neoplasms. Identifying the etiological agent is essential due to differences in antifungal susceptibility. Without timely treatment, lesions can extend to deep structures, causing destruction, deformity, loss of function, and possible amputation. While *Madurella mycetomatis* is most common, we report a case of extensive eumycetoma caused by *Pseudallescheria boydii*, initially considered for amputation, successfully managed with voriconazole, preserving limb function and anatomy.

Materials & Methods:

We reviewed the medical records and lab results of a patient with eumycetoma under care in a tertiary hospital since 2014.

Results:

A 54-year-old immunocompetent white male, professional driver, presented in 2014 with a two-year history of a mass and fistulas on the right foot. Histopathology supported eumycetoma. Initial fungal cultures were negative. Due to lesion extent, amputation was advised, but treatment with terbinafine (250 mg/day) and itraconazole (400 mg/day) was started to attempt limb preservation. From December 2014 to May 2017, despite therapy, the condition persisted. A new culture identified *Pseudallescheria boydii*, prompting a switch to voriconazole (400 mg/day). Due to its unavailability in the public health system, terbinafine was reintroduced from September to December 2017. By January 2018, the lesion remained active, impairing function. MRI showed grouped oval subcutaneous lesions in midfoot and forefoot, involving metatarsals and proximal phalanges I-IV, extending toward extensor tendons and the dorsal pedal artery without clear invasion, measuring 9.0 × 6.0 × 2.0 cm, consistent with mycetoma. Voriconazole was reinitiated in January 2018 and maintained since. The patient gradually improved, with lesion reduction, fistula closure, and full functional recovery of the foot. He remains under regular follow-up every four months.

Conclusion:

Eumycetoma is uncommon in immunocompetent individuals and usually follows traumatic inoculation. Standard care combines surgery with antifungals before and after the procedure. Delayed diagnosis often results in extensive lesions involving vital structures, making surgery more disabling. Additionally, socioeconomic challenges may hinder adherence to prolonged treatment, increasing resistance and complications. In this case, accurate diagnosis and pathogen identification enabled targeted antifungal therapy, preserving foot function and avoiding amputation and prosthesis.



**Abstract N°: 5027****Crusted Scabies in a 35-year-old Female with Systemic Lupus Erythematosus**Arielle Joy Rosales¹, Victoria Patiño-Guillano¹¹Southern Philippines Medical Center, Dermatology, Davao City, Philippines**Introduction and Objectives:**

Crusted scabies is a highly contagious and severe variant of scabies characterized by hyperkeratosis, fissures, and heavy mite infestation. It is frequently associated with immunosuppression. Systemic lupus erythematosus (SLE), an autoimmune condition, predisposes patients to atypical infections including crusted scabies due to impaired immune responses. This report highlights a case of crusted scabies in an immunocompromised adult female with SLE, emphasizing the challenges in diagnosis and management in a resource-limited setting.

Materials and Methods:

We report the case of a 35-year-old woman with systemic lupus erythematosus who developed extensive hyperkeratotic lesions consistent with crusted scabies. Diagnosis was confirmed via dermoscopy, microscopy, and skin biopsy. Due to ivermectin unavailability, she was treated with oral albendazole, topical permethrin, and keratolytics. Isolation and contact prophylaxis were implemented. Clinical improvement was noted after two weeks.

Results:

The patient presented with thick, pruritic, grayish-white crusts and hyperkeratotic plaques with deep fissures on the trunk, face, and extremities. She had a 7-month history of lesions and irregular use of topical permethrin, with self-treatment using herbal remedies proving ineffective. Ink burrow test, dermoscopy, and microscopy revealed multiple *Sarcoptes scabiei* mites. Histopathology showed numerous intracorneal mites, parakeratosis, and dermal lymphohistiocytic infiltrates with eosinophils. Laboratory evaluation revealed anemia, electrolyte disturbances, and proteinuria. A diagnosis of crusted scabies was made. Due to unavailability of ivermectin, treatment consisted of oral albendazole with topical permethrin and keratolytics. Isolation and contact prophylaxis were implemented, leading to clinical resolution after two weeks.

Conclusions:

Crusted scabies in immunocompromised individuals presents a diagnostic and therapeutic challenge. Early recognition through clinical and laboratory assessment is essential to prevent misdiagnosis and transmission. While ivermectin remains the drug of choice, oral albendazole may serve as an effective alternative in settings where ivermectin is unavailable. Comprehensive care including keratolytics, isolation, and treatment of contacts is critical to successful management. This case underscores the need for flexible therapeutic approaches and vigilance in endemic or resource-constrained environments.



**Abstract N°: 5094****Postherpetic abdominal pseudohernia: An uncommon complication of herpes zoster**ayser duyan¹, Arzu Kilic*¹, ilkay can¹, caner göllü¹¹Balikesir University School of Medicine, Dermatology, Balikesir, Türkiye**Introduction & Objectives:**

Postherpetic abdominal pseudohernia is a rarely seen complication of herpes zoster. Accurate recognition of this condition is critical to avoid unnecessary diagnostic imaging and surgical intervention. This case report aims to emphasize the clinical features and diagnostic considerations of postherpetic abdominal pseudohernia.

Materials & Methods:

A 58-year-old male presented with an abdominal mass on his left side. The size of the mass was enlarging while the patient was coughing. It was learnt that the patient had multiple painful erythematous eruptions on his left abdomen three months ago and was diagnosed as herpes zoster infection involving the left T11 dermatome and was treated with oral valacyclovir. Due to persistent pain, pregabalin was also prescribed. Following the onset of symptoms, a left abdominal wall protrusion appeared, which became noticeable during coughing.

Results:

Abdominopelvic computed tomography revealed no intraperitoneal abnormalities. Based on the clinical findings, a diagnosis of postherpetic abdominal pseudohernia was made.

Conclusion:

Herpes zoster is a viral infection affecting the dorsal root ganglia and sensory nerve fibers,

clinically presenting with a unilateral vesicular skin eruption and painful sensory

disturbances along a dermatomal distribution. While sensory abnormalities are the primary manifestation, motor neuropathy can also occur. The proposed mechanism of muscle weakness involves direct viral transmission from the dorsal root ganglia and sensory fibers to the ventral horn cells and motor roots. Although the overall prognosis is favorable, complete recovery rates vary between 55% and 78%. Symptoms may persist for a median duration of 6.8 months, with a reported range of 1.5 to 12 months.

In middle-aged or elderly individuals presenting with an abdominal wall bulge particularly in areas corresponding to the T10–T12 dermatomes, a history of herpes zoster infection should be carefully investigated. Early recognition of postherpetic abdominal pseudohernia is essential to avoid misdiagnosis and prevent unnecessary diagnostic procedures or surgical interventions. Given the disease's self-limiting course and favorable prognosis, a strategy of close monitoring and expectant management is recommended.





Abstract N°: 5109

Vasculitis, purpura, and sepsis after raw oyster consumption: Unveiling a hidden Infection

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Vasculitis, purpura, and sepsis after raw oyster consumption: Unveiling a hidden Infection

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Introduction:

Although vasculitis is typically associated with autoimmune disorders, it can also be secondary to infections or certain medications. *Listeria monocytogenes* is a gram-positive foodborne pathogen known to cause invasive infections such as sepsis and neurolisteriosis, particularly in immunocompromised individuals. Cutaneous vasculitic manifestations due to *Listeria* are extremely rare and not well characterized in the literature.

We present a case of sepsis-associated cutaneous vasculitis in a patient with *Listeria monocytogenes* bacteremia.

Observation:

A 57-year-old man with type 1 diabetes, chronic kidney disease on hemodialysis, and a history of hormone-treated breast cancer, presented with a rapidly progressive purpuric eruption involving the limbs and lower back, associated with fever, hypotension, and confusion.

Physical examination revealed widespread purpura on the limbs and lower back. Initial workup showed inflammatory syndrome (CRP 92 mg/L, PCT 165 µg/L), moderate thrombocytopenia, and metabolic alkalosis.

A purpura fulminans was suspected in the context of sepsis. Empirical antibiotic therapy with cefotaxime was initiated, and the patient was admitted to intensive care. The lumbar puncture was sterile. The skin biopsy showed a perivascular lymphocytic infiltrate, consistent with small-vessel vasculitis, without leukocytoclasia or fibrinoid necrosis. Direct immunofluorescence was negative. Blood cultures later grew *Listeria monocytogenes*, prompting a switch to amoxicillin and gentamicin.

Despite appropriate treatment, the patient progressed to multiorgan failure and disseminated intravascular coagulation, leading to death. A detailed history obtained after the patient's death revealed consumption of raw oysters a few days before the symptoms, considered the likely source of infection.

Conclusion:

This case highlights an unusual presentation of *Listeria monocytogenes* sepsis with associated cutaneous vasculitis in an immunocompromised host.

Infectious vasculitis should be considered in patients with purpuric eruptions and systemic symptoms, especially in the context of immunosuppression. *Listeria monocytogenes*, though rarely implicated, may present with skin

involvement. Thorough clinical investigation, including dietary history, may reveal unexpected exposures and help guide diagnosis and treatment.

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**Abstract N°: 5124****Exploring non-necrotizing dermo-hypodermatitis in the penile region: A rare and curious location**

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Introduction & Objectives:

Non-necrotizing bacterial dermo-hypodermatitis of the external genitalia is extremely rare. It occurs mainly in uncircumcised, sexually active men. Streptococcus is the main causative pathogen. Appropriate antibiotic treatment resolves symptoms and prevents complications. Through this case report, we aim to raise clinical awareness about the possibility of this condition occurring in an uncommon anatomical site, and outline the treatment approach and outcome.

Materials & Methods:

This is a descriptive case report detailing the clinical presentation, diagnosis, management, and follow-up of a patient with non-necrotizing dermo-hypodermatitis localized to the penile region.

Results:

45-year-old heterosexual man, operated 10 years earlier for a benign testicular tumor, presented with acute painful swelling of the penis with dysuria. He reports having shaved his pubic hair 5 days before the onset of symptoms. He reports no previous similar episodes or traumatic sexual practices. Examination revealed an asthenic patient, febrile at 38.5°, with a painful warm edematous erythematous plaque over the entire penis and pelvic region, without scrotal involvement. Dermatological assessment revealed folliculitis of the pubis and bilateral inguinal adenopathy. There was no necrosis or urethral purulent discharge. Biological tests revealed a hyperleukocytosis of 15,000/mm³ with a predominance of neutrophils and a CRP of 140. Urine cytobacteriology and sexually transmitted infection tests were negative. Ultrasound revealed extensive soft tissue infiltration with no visible collection. Doppler examination revealed no thrombosis. We started the patient on a dual-antibiotic regimen of Amoxicillin- Clavulanic Acid and ciprofloxacin, with a favorable outcome within the first 48 hours.

Conclusion:

Dermo-hypodermatitis of the penis is a medical emergency characterized by acute, inflammatory and sometimes painful edema. Known to colonize the throat and genital tract of women, group A and B streptococci are the bacteria most often isolated in cases of penoscrotal erysipelas, which can be transmitted during vaginal or oral intercourse. Other germs should be considered in cases of immunodepression. A history of perineal surgery, pelvic radiotherapy, penoscrotal lymphedema and intra-cavernosal injections are the main contributing factors. The differential diagnosis is essentially with the early pre-necrotic phase of Fournier's gangrene and contact eczema, particularly in cases of allergy to condom latex.





Abstract N°: 5166

Candidal Sycosis: A Case Report

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Candidal Sycosis: A Case Report

Introduction & Objectives:

Sycosis refers to a deep inflammation of the hair follicles, typically affecting the beard area. While most cases are bacterial or dermatophytic in origin, Candida-related sycosis is an uncommon condition that is rarely described in the literature. Herein, we report an unusual case of sycosis, highlighting its clinical presentation and diagnostic considerations.

Materials & Methods:

One case report study and a bibliographic search.

Results:

We report the case of a 47-year-old man with a medical history of hypertension, heart failure, and advanced kidney disease due to nephrolithiasis. He consulted for skin lesions that had been evolving over the past two weeks, primarily affecting his face.

Clinical examination revealed erythematous nodules with an indurated base and overlying crusts, located on the cheeks, chest, and scalp. The chin showed well-demarcated erythematous plaques topped with a few pustules. No superficial lymphadenopathy was found, and the patient was afebrile.

At that point, differential diagnoses included staphylococcal sycosis and cutaneous tuberculosis. Bacterial cultures were negative, while direct microscopy and culture revealed *Candida albicans*. Histopathological examination showed features consistent with granulomatous infectious dermatosis.

Given the patient's comorbidities and multiple medications, we opted for topical ciclopirox combined with strict hygiene measures. After one month, complete healing was achieved without any residual scarring or sequelae.

Conclusion:

Candidal sycosis is an uncommon fungal infection of the beard area that poses diagnostic and therapeutic challenges. It is often initially mistaken for bacterial or dermatophytic folliculitis, potentially delaying appropriate treatment. Unlike staphylococcal sycosis, which begins with superficial folliculitis and progresses into pustular plaques on a raised erythematous base, *Candida* sycosis typically presents as painful, inflammatory, multinodular plaques in the beard region, often with pustules and patchy hair loss. Dermatophytic sycosis, more frequent in rural settings, is characterized by unilateral or asymmetrical distribution, preservation of the upper lip, sharply demarcated annular plaques, and milder, less painful inflammation.

Microbiological tests are generally sufficient to confirm the diagnosis. However, in atypical cases, a skin biopsy may be helpful to exclude other differential diagnoses such as eosinophilic folliculitis, folliculotropic mycosis fungoides, or pseudofolliculitis barbae.

Management should always include appropriate hygiene, along with antifungal or antibiotic treatment based on the underlying cause. For Candida or dermatophyte infections, topical or systemic antifungals, such as terbinafine or azole derivatives, are the mainstay. Treatment should be adjusted according to disease severity, comorbidities, and potential drug interactions.

This case highlights the need to consider Candida as a possible cause of atypical sycosis. It is a condition that is easy to confirm and treat when recognized, with an excellent prognosis under appropriate management.

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Abstract N°: 5264

Using Subcutaneous 1470nm laser in the treatment of cutaneous leishmaniasis a case report

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I prefer: ORAL presentation

Using Subcutaneous 1470nm laser in the treatment of cutaneous leishmaniasis a case report

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Introduction & Objectives: Cutaneous Leishmaniasis is a complex skin infection which affects esp. pediatric age group in endemic areas such as Iran. Many efforts have been done to treat this parasitic infection effectively but we encounter many cases who are resistant or cannot tolerate gold standard treatment of pentavalent antimoniate agents. Thus, there is a need to find effective single agent or multi agent alternative regimens.

Materials & Methods: Hereby I present a young adult man with a rapidly progressive large plaque of ulcerated leishmaniasis plaque on the elbow with combination of fluconazole 6mg/kg daily and three sessions of subcutaneous 1470nm diode laser. IN each session about 400 joules energy is delivered using a 300micrometer fiber with linear ends (Eufoton endolift method, Italy). Energy was delivered in Mult-directions using 3.5-watt, Ton=50 msec, Toff=100 msec.

Results: At the first presentation treatment was started with fluconazole 400 mg daily and cryotherapy weekly but after 3 sessions there is no improvement. So, with the consent of the patient according the previous jobs of successful use of fractional 1540nm non-ablative resurfacing laser in the treatment of resistant leishmaniasis subcutaneous 1470nm laser was delivered subcutaneously in a multidirectional mode in conjunction with continuous use of fluconazole daily. After the first session of laser, improvement was started with a decrease in the size of central ulcer and the degree of erythema and induration. Totally three sessions of subcutaneous laser on a weekly basis were performed and at the end complete re-epithelialization of the wound and complete loss of induration and erythema is achieved.

Conclusion: According to this study one can conclude that near infrared lasers can be added to the oral or intralesional antileishmanial drugs to improve the efficacy of treatment and appearance of the final scar. Delivering the laser energy using microfibers subcutaneously can increase the efficacy of treatment and decrease the required sessions due to more efficient energy delivery to the affected tissue at the depth of skin where applying laser energy superficially may not reach to at the early sessions due to presence of more induration.



**Abstract N°: 5278****The vinyl adhesive tape technique with methylene blue for diagnosis of superficial fungal skin infections**

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Introduction & Objectives:

Direct microscopy with potassium hydroxide (KOH) from lesional skin scrapings is a common method to identify superficial fungal skin infections. However, this technique has certain drawbacks, including potential skin injury caused by the blade and the challenge of visualizing transparent hyphae and yeasts. The vinyl adhesive tape (VAT) technique presents a safer alternative for collecting fungal specimens. Additionally, methylene blue (MTB) staining enhances the contrast of fungal hyphae. This study aimed to assess the positivity rate of the VAT technique using MTB staining in patients with superficial fungal skin infections confirmed by skin scraping and direct microscopy with KOH.

Materials & Methods:

A cross-sectional study was conducted between 2022 and 2025 in a tertiary hospital on adult patients with superficial fungal skin infections, specifically dermatophytosis, pityriasis versicolor, and cutaneous candidiasis. These infections were confirmed through positive skin scraping and direct microscopy with KOH. Patients with tinea capitis, tinea unguium, and mucosal candidiasis were excluded from the study. For all participants, the VAT technique with MTB staining was performed at the same site as the skin scraping. Dermatophytosis was diagnosed by the presence of septate hyphae, pityriasis versicolor by the observation of yeasts and short hyphae, and candidiasis by the presence of pseudohyphae and yeasts. Two blinded dermatologists conducted direct microscopic examinations at various magnifications. In cases of discordance, a third dermatologist provided the final determination. Data on demographics, clinical characteristics, and hyphal index were recorded. The primary outcome was the positivity rate of the VAT technique with MTB. Secondary outcomes included identifying factors associated with positive results.

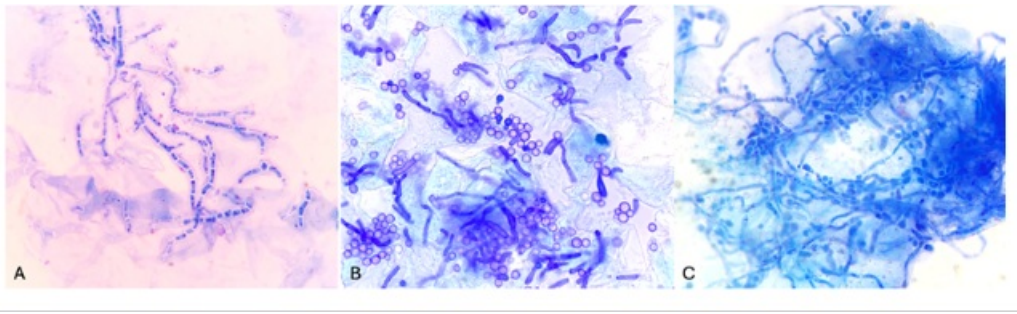
Results:

The study included 197 participants, with a mean (SD) age of 50.87 (19.21) years, of whom 44% were female. The proportion of superficial fungal skin infections was 59.9% (118/197) dermatophytosis, 20.3% (40/197) pityriasis versicolor, and 19.8% (39/197) cutaneous candidiasis. The overall positivity rate of the VAT technique with MTB was 88.8% (175/197), with positivity rates of 82.8% for dermatophytosis, 100% for pityriasis versicolor, and 97.4% for cutaneous candidiasis. MTB effectively stained fungal hyphae, providing a distinctive contrast between the blue color of the hyphae or yeasts and the pale background (Figure A-C). Complications from skin scraping with a blade, primarily skin injuries, occurred in 8.1% (16/197) of cases. Factors significantly associated with a positive result using the VAT technique with MTB included the type of infection (pityriasis versicolor and candidiasis, $p < 0.001$), onset of clinical presentation (≤ 1 month, $p = 0.014$), thickness of the lesion (less indurated lesions, $p = 0.002$), location of the lesion (flexural areas, $p = 0.041$), and a high hyphal index (hyphal index 2-4, $p = 0.005$).

Conclusion:

The VAT technique with MTB staining is as effective as skin scraping for direct microscopy with KOH and presents a safer method for diagnosing superficial fungal skin infections. For diagnosing pityriasis versicolor, this technique

is particularly effective, showing a 100% positivity rate. Factors associated with positive results include a clinical presentation onset of one month or less, less indurated lesions, location in flexural areas, and a high hyphal index.



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Abstract N°: 5297

Bullous dermatosis mimicking severe bullous impetigo with mucosal involvement in an adult immunocompetent patientJan Stanič¹, Bor Hrvatin Stančič¹, Martin Zupan¹, Alenka Tominšek¹¹University Medical Centre Ljubljana, Department of Dermatovenereology, Ljubljana, Slovenia

Introduction & Objectives: Bullous impetigo (BI) is a superficial *Staphylococcus aureus* (SA) infection, typically affecting infants and young children (1,2). Its occurrence in immunocompetent adults is rare, especially in severe, widespread forms with mucosal involvement, and may mimic autoimmune bullous dermatoses (ABD).

Results: A 43-year-old Caucasian male with no significant medical history, presented to dermatologic urgent care after 10 days of rapidly worsening, painful bullae and erythematous annular plaques with peripheral scaling, initially confined to the trunk but progressing over several days to involve the extremities, oral mucosa, and right conjunctiva. The patient worked in a children's theater. The acute onset and rapid dissemination raised suspicion of an infectious etiology, despite clinical features mimicking ABD. Laboratory findings showed elevated inflammatory markers (CRP 41 mg/L; leukocytes $15.3 \times 10^9/L$). Autoimmune serologies (ANA, ENA, anti-dsDNA), infectious panels (HIV, hepatitis B/C, RPR, TPHA), and immunoserology for pemphigus/pemphigoid antibodies (ELISA, IIF) were negative and DIF was non-specific. Histopathology demonstrated subcorneal pustules filled with neutrophils, psoriasiform hyperplasia, parakeratosis with bacterial colonies, and a superficial dermal neutrophilic infiltrate. SA (4+) was isolated from lesion cultures, confirming BI.

Given the rapid clinical progression, extensive skin and mucosal involvement, and culture results, antibiotic therapy was promptly initiated. The patient received oral amoxicillin-clavulanate (875/125 mg every 12 hours for 14 days), topical fusidic acid, and antiseptic washes, resulting in rapid regression of lesions and normalization of inflammatory markers in 14 days.

Conclusion: Impetigo is a common, highly contagious bacterial skin infection most frequently observed in children, with 30% of cases bullous (1–3). BI is almost exclusively caused by SA and 90% of cases occur in children less than 2 years old (1,2). While BI typically presents with localized bullae and thin yellow-brown crusts, widespread involvement with mucosal lesions in adults is rare, particularly in immunocompetent individuals (1,2,4).

BI can clinically and histologically mimic ABD, such as pemphigus foliaceus, due to shared disruption of desmoglein-1 by bacterial toxins or autoantibodies. However, BI lacks the positive immunologic findings (DIF, ELISA) seen in ABD. Awareness of this diagnostic overlap is essential to avoid inappropriate treatment (1,3–6).

We present a rare case of BI in an adult, where clinical features mimic ABD. Unlike ABD, which often has a prodromal phase and slower progression, BI evolves rapidly, warranting early consideration of antibiotic therapy when acute, widespread bullous lesions develop. Additionally, widespread lesions including involvement of oral and conjunctival mucosa in an immunocompetent adult makes our case even more atypical. Clinicians should remain aware of its potential occurrence in adults to prevent misdiagnosis and unnecessary treatment. Negative serology, histopathology, acute development of painful/itchy bullous lesions, history (contact with children), positive bacterial cultures, and rapid response to antibiotic therapy are key to confirming the diagnosis. Early recognition and treatment are crucial, therefore it is imperative to consider BI even in atypical presentations in immunocompetent adults.





Abstract N°: 5351

A rare case of chronic Lupus Vulgaris secondary to Mycobacterium bovis infection in an immunocompetent individual – an 80 year history.

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²Oxford University Hospitals NHS Foundation Trust, Oxford, United Kingdom

Introduction & Objectives:

Cutaneous tuberculosis (TB) is an uncommon presentation of extrapulmonary TB, most commonly due to *Mycobacterium tuberculosis* and, rarely, *Mycobacterium bovis*. *M. bovis* is a notifiable disease in the UK and can be acquired following interaction with infected animals, and consumption of unpasteurised milk or dairy. 505 cases of *M. bovis* were reported from 1999-2021 in the UK.¹ We present the case of a 96-year-old British female with asymptomatic lesions affecting her right eyelid, right cheek and posterior right arm which had been enlarging over 5 years. She had a background of heart failure, hypertension, osteoarthritis, atrial fibrillation, pulmonary embolism and a previous stroke.

Materials & Methods:

Initial examination revealed a large, indurated erythematous firm plaque extending from the right lateral canthus around the eyebrow to the medial canthus involving the eyelid and extending onto the nasal bridge; approximately 6 cm in size. Another ill-defined lesion was noted on the right cheek. On dermoscopy, both lesions had arborising blood vessels and were unpigmented. The posterior right upper arm had a 20 cm scaly plaque.

Results:

Biopsies of the right eyebrow, right cheek and right upper arm demonstrated tuberculoid granulomatous inflammation with negative special stains. IGRA ELISpot assay was negative, and tissue cultures were also negative for Mycobacteria.

The patient later revealed she previously had a right thigh lesion diagnosed as 'lupus' in 1942, initially treated with Finsen's lamp phototherapy at Addenbrooke's hospital, which was interrupted by World War II. This same lesion recurred as a fungating plaque in 2007 which was excised as possible squamous cell carcinoma clinically, but histology revealed granulomatous inflammation.

Repeat biopsies were performed and tissue was sent for TB PCR, which returned positive for *M. tuberculosis* complex. Histology revealed caseating necrosis in tuberculoid granulomas and focal suppuration. Rare acid fast bacilli were identified on Ziehl-Neelsen and Wade Fite stains. Treatment initially commenced with quadruple therapy (rifampicin, isoniazid, ethambutol and pyrazinamide) alongside pyridoxine for an estimated 6 months, whilst awaiting cultures. *M. bovis* was subsequently identified following whole genome sequencing and was expectedly resistant to pyrazinamide, hence this was discontinued. Unfortunately, the patient passed away from pneumonia following a fall prior to completing her treatment.

Conclusion:

This is a rare case of cutaneous TB presenting as lupus vulgaris caused by *M. bovis*. This case is of particular interest as it is likely that the patient had chronic Mycobacterial infection for 80 years, that reactivated with ageing and immune senescence. The initial negative cultures made the diagnosis challenging in this case, and the TB

ELISpot is insufficiently sensitive as a rule out test for active TB disease. Tissue culture with whole genome sequencing confirmed the diagnosis of *M. bovis* infection and should be considered when suspicious for Mycobacterial infection.

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**Abstract N°: 5407****Diffuse lepromatous leprosy with Lucio's phenomenon in a case with delayed diagnosis and iatrogenic immunosuppression**Tshewang Choden¹¹Khesar Gyalpo University of Medical Sciences of Bhutan, Department of Dermatology, Thimphu, Bhutan**Introduction & Objectives:** A case report on Diffuse lepromatous leprosy with Lucio's phenomenon with delayed diagnosis and iatrogenic immunosuppression

Materials & Methods: Case presentation 32-year-old mother of three children presented with fever and multiple painful ulcers on both legs to the medical department. In retrospect history she had multiple erythematous nodules all over the body associated with recurrent episodes of fever, joint pain and swelling of hands and feet for the last three years. Gradually the skin lesion lead to ulceration over time. During that time, she was seen by a medical doctor and started on oral glucocorticoids, on and off for the past three years as she was given a diagnosis of Sarcoidosis and started on mycophenolate mofetil. Her disease condition continued to worsen and was referred to the National hospital. During this presentation, she had persistent fever with erythematous lesions with burning sensation on both upper and lower limbs and lesions evolving to ulceration on bilateral legs. She also complained of nasal stuffiness but no epistaxis, no visual symptoms or peripheral neuropathy. On examination, she had a diffusely infiltrated face with a yellowish tinge, complete madarosis of both eyebrows, a saddle nose deformity. Erythematous to violaceous purpuric retiform plaques were seen on both the legs and thighs with multiple shallow ulcers with slough. Both ulnar nerves were thickened and regular with no sensory loss. Disability grade 0. Eyes and mucous membrane were normal Gram negative bacilli was demonstrated from swabs from the ulcer. Slit skin smear showed MI of 29% and of BI 4+. Skin biopsy revealed infiltrating bacilli on the blood vessel suggestive of Lucio's phenomenon. She was diagnosed as lepromatous leprosy with erythema nodosum leprosum and Lucio's phenomenon and was started on MDT-MB and the prednisolone that she was on was continued at 30mg per day. On the fourteenth day her liver enzymes started rising and hemoglobin dropped, this trend continued on subsequent blood tests. Dapsone was stopped and she was started on Ofloxacin together with monthly Rifampicin and daily clofazimine. She was also started on oral thalidomide. With daily wound care, all her ulcers re-epithelized and she was discharged. A month later she presented again with new onset nodules and ulcer on legs despite being on MDT, prednisolone and Thalidomide. She was restarted on Dapsone, Ofloxacin was stopped and her liver function monitored.

Results: Lucio's phenomenon is a rare, life-threatening reaction seen in untreated diffuse non nodular lepromatous leprosy. It is difficult to diagnose, especially in non-endemic areas, leading to delayed treatment. No standardized therapy exists, but multidrug therapy, steroids, anticoagulants, antibiotics, and surgical interventions have shown varying success. Early recognition and aggressive treatment are essential for better outcomes.

Conclusion: Lucio's phenomenon is a rare presentation of leprosy, our patient had diffuse leprosy and typical features of Lucio's, a case probably complicated due to delayed diagnosis and inadvertent use of systemic immunosuppressive agents. This case also shows the importance of Dapsone in the treatment of leprosy and Lucio's phenomenon



**Abstract N°: 5455****Papulonecrotic Tuberculid as the Initial Manifestation of Lymph Node Tuberculosis**José Ramos¹, Hugo Leme¹, Ângela Roda¹, João Alves¹¹Hospital Garcia de Orta, Almada, Portugal**Introduction & Objectives:**

Tuberculids are rare cutaneous hypersensitivity reactions ("id" reactions) to mycobacterial antigens, typically associated with an underlying active tuberculosis focus elsewhere in the body. These lesions usually do not yield positive cultures for *Mycobacterium tuberculosis*, making diagnosis challenging. However, modern molecular techniques such as Polymerase Chain Reaction (PCR) can detect mycobacterial DNA in cutaneous tissue, providing a critical diagnostic clue. We present a rare case of papulonecrotic tuberculid, serving as the initial presentation of ganglionic tuberculosis, aiming to emphasize the dermatologist's role in recognizing cutaneous manifestations of systemic diseases.

Clinical case:

A 37-year-old woman from Guinea-Bissau was referred to our Dermatology department with a one-year history of papules and pustules on her limbs. She denied systemic symptoms. On physical examination, multiple papules, pustules, and hyperpigmented scars were observed on the upper limbs, buttocks, thighs, and lower legs. An initial diagnosis of infectious folliculitis was considered, and treatment with oral doxycycline and topical clindamycin and benzoyl peroxide was initiated, resulting in only transient improvement. Due to recurrence, blood tests and skin biopsies for histopathological and microbiological evaluation were performed. Notable findings included an erythrocyte sedimentation rate >100 mm/h. Histopathology revealed ulceration with a non-necrotizing granulomatous infiltrate. Microbiological cultures were negative. However, PCR analysis of the skin biopsy identified *Mycobacterium tuberculosis*, and the Interferon-Gamma Release Assay (IGRA) was positive.

Based on clinical, histological, and molecular findings, the diagnosis of papulonecrotic tuberculid was established. The patient was referred to Infectious Diseases, where further workup, including imaging and lymph node aspiration, confirmed the presence of ganglionic tuberculosis. Standard antituberculous therapy was initiated: rifampicin, isoniazid, pyrazinamide, and ethambutol for two months, followed by four additional months of isoniazid and rifampicin. Four weeks after starting treatment, complete resolution of the cutaneous lesions was observed, with no emergence of new lesions.

Conclusion:

This case highlights a rare presentation of papulonecrotic tuberculid as the cutaneous manifestation of ganglionic tuberculosis. Diagnosis was made possible by combining clinical suspicion with histopathology and molecular techniques, particularly the identification of *Mycobacterium tuberculosis* DNA by PCR, despite negative cultures. Dermatologists play a crucial role in identifying systemic diseases based on cutaneous findings.

Disclosure: This case was previously published in Acta Médica Portuguesa. Citation:

Ramos J, Leme H, Roda Â, Alves J. Papulonecrotic Tuberculid as Manifestation of Lymph Node Tuberculosis. Acta Med Port. 2025 Mar 3;38(3):199-200. doi: 10.20344/amp.22669



**Abstract N°: 5638****When Fungi Masquerade a Tumor: Disseminated Histoplasmosis in a Non-HIV Immunosuppressed Patient**

Luisa Fernanda Betancourt Galvis^{*1}, Karen Lizeth Hernández Jaime¹, Felipe de Jesús Bustos Rodríguez², Bertha Sotelo García¹, Aída Ramírez González¹

¹Old Civil Hospital of Guadalajara (Fray Antonio Alcalde), Dermatology, Guadalajara, Mexico

²Hospital Civil Nuevo, Patology, Guadalajara, Mexico

Introduction & Objectives:

Histoplasmosis is a systemic fungal infection caused by *Histoplasma capsulatum*. Inhalation of microconidia leads to pulmonary infection, where the fungus converts to intracellular yeast forms that may disseminate hematogenously. Disseminated histoplasmosis is classically associated with HIV/AIDS, but non-HIV-related immunosuppression, such as chronic alcohol and drug abuse, can also predispose patients to this opportunistic infection.

Materials & Methods:

A 54-year-old male with history of intravenous heroin, fentanyl use, smoked crystal meth, and severe alcoholism (5–6 liters of alcohol daily) presented to the dermatology service with a 3-month history of a painful, progressive anterior thoracic mass.

Physical examination revealed a localized dermatosis on the anterior chest, predominantly on the left hemithorax, consisting of a well-defined, skin-colored tumor extending from the sternal midline to the left clavicle, with an erythematous papule on the surface and associated tenderness.

Ultrasound revealed an infiltrative tumor-like lesion involving the sternocleidomastoid muscle, displacing the airway to the right and obscuring the left thyroid lobe. The lesion measured was 77×47×30 mm, along with atypical lymph node conglomerates in the left jugular chain.

Initial Tru-cut core needle biopsy was negative for malignancy but showed severe abscessed inflammation and reactive intracellular yeasts on PAS stain, raising suspicion for a fungal etiology. Due to limited diagnostic information, a second biopsy was performed, showing xanthogranulomatous chronic inflammation.

Immunohistochemistry: CD68 positive in macrophages; MELAN-A, HMB45, S100, and CKAE1/AE3 were negative. PAS and Grocott stains were positive for intracellular yeast forms compatible with *Histoplasma spp.* Ziehl-Neelsen and Fite-Faraco stains were negative.

HIV, HCV, and HBV serologies were negative, hemoglobin: 11.09 g/dL; creatinine: 0.53 mg/dL; CRP: 3.2 mg/L; normal liver function tests. The patient was treated with itraconazole 400 mg twice daily for 3 months under infectious disease supervision.

Results:

Disseminated histoplasmosis is typically associated with severe immunosuppression, especially in the context of HIV. However, chronic alcoholism and drug addiction also significantly impair cellular immunity, predisposing individuals to opportunistic infections such as histoplasmosis. In this case, the initial clinical suspicion was sarcoma due to the tumor-like appearance. However, intracellular yeasts prompted further investigation and ultimately led to the correct diagnosis.

Recognizing non-traditional forms of immunosuppression is essential for early diagnosis and timely treatment. This case underscores the importance of maintaining a broad differential diagnosis when evaluating atypical cutaneous and subcutaneous lesions, particularly in vulnerable populations.

Conclusion:

Disseminated histoplasmosis should be considered in the differential diagnosis of cutaneous and subcutaneous masses, even in patients without classic risk factors like HIV. Early recognition of “non-traditional” immunosuppression can lead to timely antifungal therapy, improving patient outcomes and reducing complications.

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**Abstract N°: 5739****Anogenital Condylomata in Children: Do Not Overlook Sexual Abuse.**Boumediene Dahmani¹¹aboubakr belkaid university , medecine faculty , Tlemcen University Hospital Center, TLEMEN , Algeria**Introduction & Objectives:**

Condylomata acuminata (CA) are secondary to an infection of keratinocytes by HPV, a DNA virus. In adults, transmission is primarily sexual. In children, several modes of transmission exist: perinatal (in utero and during delivery), and horizontal (auto-inoculation and so-called "innocent" or non-sexual hetero-inoculation). Therefore, the discovery of CA in a child requires a thorough investigation to determine the mode of transmission and to rule out the possibility of sexual abuse. Children of all ages can develop CA, with a peak between zero and four years old; girls are affected twice as often as boys. Sexually transmitted diseases in children secondary to sexual abuse are poorly documented.

Observation:

A case is reported from our department where investigating the possibility of sexual abuse remains paramount. We report the case of L.M., an 11-year-old girl (gender inferred from "Reçue"), the third of five siblings. Born from a normal, full-term pregnancy. She presented for consultation with perianal vegetating lesions that had been present for over 10 months. For this child, the family history revealed no history of STIs in the parents. Examination of the parents revealed no Condylomata Acuminata (CA) or common warts. Serological tests, namely HIV, TPHA (Treponema Pallidum Hemagglutination Assay), and VDRL (Venereal Disease Research Laboratory), were negative.

Discussion:

Anogenital condylomata (CA/CAG) in children result from an infection of the child by Human Papillomavirus (HPV) genotypes 1, 11, and 2. The most important issue in children concerns the suspicion of sexual abuse. In our patient, who hid this lesion for several months (9 months), a forensic interview revealed that the child was a victim of sexual abuse by a group of 3 individuals.

Conclusion:

Our observation confirms the existence of sexual abuse in children. Sexually transmitted infections serve as a good indicator of this phenomenon, which is probably underestimated by dermatologists.





Abstract N°: 5761

Development and Pilot Testing of ScabiesHeal: The World's First Multilingual Mobile Application for Scabies Awareness, Assessment, and Treatment Guidance

Hajira Butt^{*1}, Muneeza Rizwan¹

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Introduction & Objectives:

Scabies is a highly prevalent yet neglected parasitic skin infestation in low-socioeconomic countries like Pakistan. It is often underreported due to limited awareness, poor treatment adherence, and language barriers. While mobile health (mHealth) apps are rising globally, no targeted digital solution exists for improving scabies management. This study presents ScabiesHeal — the world's first multilingual, free mobile healthcare application designed to enhance patient education, boost treatment adherence, and improve scabies outcomes. We aimed to develop, implement, and evaluate ScabiesHeal's effectiveness compared to standard physician counselling.

Materials & Methods:

ScabiesHeal was developed as a collaborative pilot project between dermatologists (Fazaia Postgraduate Medical Institute) and software engineers (National University of Science and Technology) using React Native and Firebase. Key app features include:

- Educational videos, infographics, and step-by-step treatment instructions (all original, copyrighted content)
- Illustrated audio-visual guides on Permethrin 5% application
- Medication trackers, reminders, and push notifications to reinforce adherence and preventive measures
- Multilingual support (Urdu, English, Pashto, Sindhi, Balochi, Arabic) to overcome literacy and language barriers
- User-friendly design for all literacy levels
- Free public access

The study comprised three phases:

- \1. Development — user-centered design and multilingual localization
- \2. Usability Testing — internal testing for functionality, navigation, and language accuracy
- \3. Pilot Evaluation — A quasi-experimental pre-post study with 100 clinically diagnosed scabies patients at PAF Hospital Islamabad. Participants were randomized: Group A (n=50) received standard dermatologist counselling; Group B (n=50) used ScabiesHeal for 10–14 days. Disease knowledge and treatment adherence were measured at baseline and 2-week follow-up using validated questionnaires. Group B additionally assessed app usability and satisfaction.

Results:

Both groups improved, but Group B (ScabiesHeal) showed significantly superior outcomes:

Knowledge Gain: 100% correctly understood scabies transmission, treatment, and prevention vs. 70% in Group A (p < 0.001)

Treatment Adherence: Higher adherence to Permethrin application, hygiene measures, and follow-up in Group B ($p = 0.0016$)

Satisfaction & Usability: 94% of Group B rated the app “excellent,” highlighting the effectiveness of visual aids and multilingual content.

Conclusion:

ScabiesHeal is a pioneering digital health app that improves scabies education and treatment adherence, outperforming physicians counselling in this pilot study. By delivering multilingual, healthcare directly to patients, it effectively bridges communication gaps that hinder management in endemic regions. With strong usability and satisfaction scores, ScabiesHeal holds promise for scalable deployment across scabies-endemic communities. A Phase 4 study is planned to assess long-term clinical outcomes. These findings advocate for the broader application of digital health tools to control infectious dermatological diseases and enhance public health awareness.

Note: ScabiesHeal will be publicly launched at the conference via QR code and download link. The app is entirely free, with official copyright registration (IPO-Pakistan Application No. 1145/2025, 1146/2025) with the authors.

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Abstract N°: 5798

Cutaneous leishmaniasis. Case report.

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²Hospital Ángeles. , Puebla, Mexico

Introduction & Objectives:

Cutaneous leishmaniasis is currently an endemic pathology, with a worldwide distribution, most cases have been reported in South America, the Mediterranean Sea basin and areas of Asia and Africa. It is common in people living in rural areas or working in the forest, military and construction workers.

Case Report

A 21-year-old male, exchange student in Mexico, originally from Piura, Peru, with no relevant medical history. He went for consultation for the presence of polymorphous dermatosis of subacute evolution, associated with pruritus, which began in November after having gone to the Sierra de Piura (Peru). He went to the general practitioner indicating medical management with ciprofloxacin and itraconazole for 14 days.

Physical examination revealed lesions of papular appearance, ulcerations, hematic crusts, erythema and scales that converged forming plaques with poorly defined and irregular borders, on the upper extremities, on the right side affecting the inner side of the arm in the proximal third and the fifth finger on its inner lateral side; on the left hand it affected the inner side of the wrist, bilateral and asymmetrical, the rest of the skin and adnexa were unaltered.

With clinical suspicion of dermatophytic granuloma of Mjocchi, treatment was continued with itraconazole 200 mg every 24 h for four weeks and aluminum fomentations with calcium.

One month later she attended a follow-up visit, reporting worsening of the lesions after two weeks of treatment. Wart-like lesions were observed, with well-defined borders, elevated, erythematous-violaceous infiltrates, with multiple hematic crusts and anfractuous surface, with a diagnostic impression of cutaneous leishmaniasis vs. warty tuberculosis.

Results:

The patient was then submitted to biopsy of one of the lesion and sent to pathological anatomy, with the report of pseudoepitheliomatous hyperplasia and dense inflammatory infiltrate in the dermis, which consists of lymphocytes and histiocytes, at higher magnification with numerous Leishman bodies in their cytoplasm.

Therefore, the diagnosis of cutaneous Leishmania was made and treatment with meglumine antimoniate was started as follows: first day 1.5, second day 3 g, then 4.5 g, until completing 20 days, intramuscularly, achieving resolution of the lesions.

Conclusion:

Clinical manifestations may vary depending on the patient's immune response. The most common presentation is a papule evolving into a painless ulcerating nodule in solitary or multiple form appearing on exposed sites such as the face and extremities. The lesions may heal spontaneously in a few months without scarring within 3 to 6

months, with a recurrence rate of 33% if not treated promptly. However, some tend to chronicity and dissemination leaving severe sequelae depending on the virulence of the species and the immune status of the host.

The importance of this zoonosis is to identify the dermatosis and give a correct approach to avoid mutilations and dissemination that can compromise the patient's life. Given the limited availability of drugs to treat this infection, timely diagnosis and treatment is of utmost importance.

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**Abstract N°: 5832****Cutaneous schistosomiasis localized to the left groin fold in a 13-year-old child**

Lamissa Cisse^{*1}, maimouna bassoum¹, karim kone¹, Mamoudou Diakité¹, Mamadou Gassama¹, adama dicko¹, Ousmane Faye¹

¹dermatology hospital bamako, Bamako, Mali

Cutaneous schistosomiasis localized to the left groin fold in a 13-year-old child**Introduction:**

Schistosomiasis is a disease caused by trematodes, which is rife in certain regions. Contagion occurs through the skin by direct inoculation. Genitourinary involvement is characteristic. Cutaneous involvement is rare and more difficult to recognize. These lesions may be confused with malignant tumors or other infectious conditions. They are most often found on the back or abdomen.

We report an inguinal localization in a teenager.

Observation:

A 13-year-old boy presented to the dermatology department with a skin tumor on left groin. The lesions had been evolving for over a month, with progressive extension. The patient had a history of intermittent terminal hematuria over the past two years.

On clinical examination, he was in good general condition with no fever. There was a main lesion and satellite lesions. The main lesion consisted of confluent nodules grouped in clusters measuring 2cm/0.5cm. Lesion surfaces were erosive in places. Satellite lesions consisted of linear papules on the left thigh and a few papules and nodules on the scrotum. These lesions varied in size. The nodules were not painful to palpation, although the patient complained of a tingling sensation at times. There was no inguinal adenopathy. The rest of the clinical examination was normal. Direct examination of the urine sample revealed eggs with terminal spurs. Blood count showed hypereosinophilia. Histological examination revealed granulomas centred on schistosome eggs. Abdominal ultrasonography described bilharzian cystitis.

The patient was treated with Praziquantel at a dose of 40mg/kg per day in a single dose, combined with local care. The evolution was marked by a clear regression of the lesions, with subsidence of the nodules and complete healing of the ulcers in three weeks.

Discussion/conclusion :

We report a peculiar case of bilharzian granuloma, remarkable for its topography and multi-nodular, ulcerative clinical presentation.

ulcerative-bourgeonnante inguino-crural. The lesions may have been irritated during walking. Lesions of the inguino-crural and genital region are more commonly found in female patients. The course of the disease paralleled that of the urinary tract, with spectacular regression of the lesions after a few weeks of treatment.

Cutaneous bilharzian granuloma is a parasitosis with a rare cutaneous manifestation, and should be considered in the presence of an atypical papulo-nodular eruption in an endemic area. **





Abstract N°: 5937

From Eyelid Ulceration to Globe Enucleation: A Rare Case of Spontaneous Necrosis in an Elderly Patient With Diagnostic and Management Challenges.

Nada Naciri¹, Badr Ama¹, Bendaoud Layla¹, Mariem Aboudourib¹, Hocar Ouafa¹, Amal Said¹

¹Arrazi Hospital, Mohammed VI University Hospital, Faculty of Medicine and Pharmacy of Marrakech, Biosciences and Research Laboratory FMPM, Cadi Ayyad University, Department of Dermatology – Venereology, Marrakesh, Morocco

Introduction:

Progressive palpebral necrosis is a rare manifestation in dermatology and ophthalmology, posing significant diagnostic and therapeutic challenges. We report the case of an elderly woman who developed palpebral necrosis that progressed to globe necrosis, requiring enucleation. Several diagnoses, including *Bacillus anthracis* infection, were initially considered but ultimately ruled out. This case highlights the complexity of chronic necrotic ulcerations and the importance of a multidisciplinary approach.

Case report:

An 88-year-old woman presented with a one-month history of burning micturition and urinary retention, followed by sudden bilateral palpebral edema and inflammation. Her history included systemic hypertension, bilateral blindness secondary to ocular hypertension for 12 years, and prior cataract surgery on the right eye.

On examination, she was afebrile and stable. The right eye showed severe swelling, purulent discharge, corneal perforation, neovascularization, and retinal detachment. The left eye exhibited globe rupture and upper eyelid necrosis. Skin exam showed xerosis; gingival hypertrophy was observed.

Labs results showed pancytopenia, low vitamin B9, elevated inflammatory markers, and negative autoimmune serologies. Cultures identified *Pseudomonas aeruginosa* in orbital pus and *Candida lusitanae* in urine. Imaging showed preseptal and orbital cellulitis with globe rupture, suggesting necrotizing fasciitis. Bone marrow aspirate showed no malignancy.

The patient underwent urgent orbital exenteration of the left eye and was treated with intravenous ceftriaxone and metronidazole, later switched to ciprofloxacin and clindamycin. She also received fluconazole, folate, anticoagulation, wound care, and nutritional support.

Discussion:

Palpebral necrosis is a rare and severe condition that requires careful differential diagnosis. In our case, we initially considered multiple etiologies, including cutaneous anthrax, due to the necrotic nature of the lesion. While anthrax is an uncommon cause of palpebral necrosis, documented cases exist in the literature. However, investigations ruled it out.

Bacteriological analysis of an eyelid fragment identified *Pseudomonas aeruginosa*, prompting a reconsideration of the infectious etiology. Previous studies, such as Chaudry et al., have linked palpebral necrosis to *P. aeruginosa* infections, suggesting direct bacterial invasion and necrosis, possibly exacerbated by local vascular compromise or immune dysregulation.

Farris et al. described eyelid necrosis of infectious origin, while Nagasaka et al. discussed rapidly progressing

dermal necrosis. Bamberger et al. also identified *Pseudomonas* infections as a cause of tissue necrosis. These findings reinforce our hypothesis.

Other causes, such as iatrogenic complications, were considered. However, the patient had undergone cataract surgery over ten years ago. Additionally, envenomation-related necrosis from spider or tick bites, reported in similar cases, was ruled out as the patient had no history of arthropod bites.

Conclusion:

This case highlights the role of *Pseudomonas aeruginosa* in palpebral necrosis. While initially suspected to be anthrax, investigations identified *P. aeruginosa*. Early diagnosis and proper treatment are crucial to prevent tissue damage. Further research is needed to understand the pathophysiology of *P. aeruginosa*-induced necrosis and improve management.

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Abstract N°: 5959

Trichoscopic Evaluation in the Diagnosis of Tinea, A One-Year Prospective Study

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Introduction & Objectives:

"Within the context of tinea capitis (TCC), particular aspects of the hair shaft have been described since 2008: comma hair (CV), corkscrew hair (CTB), barcode-like hair (CCB), and zigzag hair (CZZ), identified as specific signs. The main objective of our study was to evaluate the diagnostic performance of trichoscopy in terms of sensitivity and specificity, and to highlight its value in the clinical approach to tinea capitis, considering the type of parasitism."

Materials & Methods:

"This was a diagnostic, prospective study conducted over one year, carried out between March 2024 and March 2025. All patients for whom the diagnosis of tinea was suspected and confirmed by a positive mycological examination were included. Each patient underwent a clinical examination, a Wood's lamp examination, a hair pluck test, a mycological sample with direct examination under optical microscopy, and a dermoscopic examination of the scalp (trichoscopy) with photographs. For each patient, two blind rereadings of the trichoscopic photographs were performed by at least two dermatologists, blinded to the mycological results and the Wood's lamp results. Trichoscopy was considered positive if it showed at least one specific sign (on at least two hairs) among those described in the literature: comma hair (CV), corkscrew hair (CTB), zigzag hair (CZZ), barcode-like hair (CCB), or a whitish sheath." "The results were compared with the results of the positive mycological examination, allowing us to distinguish the following types of tinea: microsporic tinea capitis (TTM), trichophytic tinea capitis (TTT), inflammatory tinea (TI), and favic tinea (TV)."

Results:

"Forty-five patients were included in the study. The mycological examination was obligatorily positive, and the results showed: 66.7% microsporic tinea capitis (TTM), 20% trichophytic tinea capitis (TTT), and 13.3% inflammatory tinea. No favic tinea was identified. The Wood's lamp examination showed a sensitivity of 76.67% and a specificity of 84.61% for the identification of essentially microsporic tinea. The sensitivity of trichoscopy was 83.06%, with a specificity of 79.72%, a positive predictive value of 89.3%, and a negative predictive value of 92.9%. The signs of comma hair (CV) and corkscrew hair (CTB) were significantly associated with trichophytic tinea capitis (TTT), with a sensitivity of 77.7% and 77.7% respectively, and a specificity of 83.3% and 93.3% respectively. The zigzag and barcode-like appearances were significantly more frequent in microsporic tinea, with a sensitivity of 76.6% and 93.33%, and a specificity of 66.6% and 88.8% respectively. Inflammatory tinea presented a combination of signs with a predominance of inflammatory signs: erythema (100%), pustules (83%), crusts (100%), comma hair (CV) (98%), and corkscrew hair (CTB) (67%)."

Our study confirms that the presence, even isolated, of signs such as CV, CTB, CZZ, CCB, or a whitish sheath is specific to tinea. CCB seems to be particularly specific to microsporic tinea. And that the sensitivity and specificity of this examination, which is rapid, painless, reproducible, and non-invasive, are high."

Conclusion:

"Through the dermatoscope lens, trichoscopy remains an indispensable ally in the quest for diagnosis and

therapeutic monitoring of tinea. Thanks to its non-invasive, rapid, and accessible approach, it presents itself not only as a method of observation but also as a true daily clinical partner.”

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Abstract N°: 5963

When the Clinic Uncovers Leprosy in 2025: A Case ReportBillal Alibakir¹, haoui hanane¹, Zohra El Osmani¹, Serradj Amina¹¹University Hospital institution , Department of Dermatology, oran

Introduction & Objectives: Leprosy, or Hansen's disease, is a chronic granulomatous infection caused by *Mycobacterium leprae*, primarily affecting the skin and peripheral nerves [1]. The Ridley-Jopling classification places the lepromatous form at the multibacillary pole, characterized by deficient cell-mediated immunity and a high bacillary load [2]. Despite multidrug therapy, leprosy remains endemic in sub-Saharan Africa [3].** We report here a case of lepromatous leprosy in a Cameroonian patient. **Materials & Methods:** Patient B. M., a 32-year-old Cameroonian man residing in Oran, presented with dyschromic macules (hypochromic on the thighs and lower back) and well-demarcated, dry, keratotic hyperchromic plaques on the anterior aspects of both legs. Infiltrated nodules on the knees, shoulders, and face generated a characteristic leonine facies; these lesions had persisted for two years. Neurological examination revealed tingling and prickling paresthesias with localized hypoesthesia over the dyschromic and infiltrated areas. Skin biopsy demonstrated granulomas composed of epithelioid cells surrounded by lymphocytes, plasma cells, and giant cells without caseous necrosis. Bacilloscopic examination (direct smear and culture) confirmed *M. leprae*. Based on the clinical, histological, bacilloscopic, and epidemiological data, the diagnosis of lepromatous leprosy (LLP) was established. Treatment with dapsone (100 mg/day) and rifampicin (600 mg/month) was initiated (clofazimine being unavailable), yielding significant lesion regression and improved cutaneous sensitivity.**

Results: This case underscores the value of early clinical signs, particularly leonine facies, a hallmark of multibacillary LLP [6][2]. Sensory disturbances hypoesthesia and paresthesias within lesions constitute one of the three major WHO diagnostic criteria and should promptly direct clinicians to peripheral nerve involvement by *M. leprae* [1][4][8], characteristic of leprous neuropathy [7][8]. Bacilloscopy remains the diagnostic gold standard: nearly 100 % specific, with sensitivity proportional to bacillary load; its positivity confirmed multibacillary disease and justified immediate standard multidrug therapy (MDT) [9]. Skin biopsy sensitivity and specificity vary, sometimes necessitating PCR when diagnosis is equivocal [8]. The combination of dapsone and rifampicin led to rapid lesion clearance and sensory recovery, demonstrating the efficacy of standard multibacillary MDT [9]. Finally, the long incubation period up to thirty years in some reports poses challenges for early detection and highlights the need for prolonged surveillance of at-risk populations [10]**

Conclusion: Optimal LLP management hinges on rapid recognition of typical cutaneous and neurological signs, followed by appropriate MDT to reduce bacillary load and preserve nerve function [9], while emphasizing sustained screening efforts and health education in endemic regions [3].





Abstract N°: 6020

Clinical Spectrum of Demodicosis Among Filipinos with Brown Skin: A Case Series

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Introduction & Objectives:

Demodex spp. are common ectoparasites inhabiting the pilosebaceous units. Abnormal density of *Demodex* mites can trigger skin disorders known as demodicosis. Its clinical manifestations may mimic other skin diseases resulting in a diagnostic challenge. This case series reports four cases of demodicosis among Filipino patients with brown skin, their varying clinical spectrum and approaches to treatment.

Case Series

Case 1 is a 32-year-old male who developed erythematous macules, papules, pustules and plaques with scales infested with *Demodex* mites on the zygomatic and centrafacial areas. Skin punch biopsy revealed *Demodex* mites within the follicular infundibula surrounded by dense neutrophilic infiltrates. Patient was treated with permethrin 5% cream twice daily for 2 months, and isotretinoin (10mg/day) for 2 months with significant improvement.

Second case is a 43-year-old male with recalcitrant rosacea-like eruption. Patient had a 3-year history of erythematous papules and plaques on the forehead, nose and zygomatic areas, initially treated with topical corticosteroids with no significant improvement. Dermoscopy of the glabellar plaque revealed perifollicular yellowish-brown scales on a background of telangiectasia. On histopathology, lymphocytes surround hypertrophied sebaceous lobules and *Demodex* mites within the follicular ostia. Patient was managed with Permethrin lotion with a remarkable decrease in erythema at 50% and 80% in 2 and 4 weeks, respectively. The residual erythematous papules resolved dramatically with low dose isotretinoin for 6 months.

In the third case, a 38-year-old female complained of a nodular plaque on the left temporal area with associated discharge. Patient used unregulated lightening products containing tretinoin, hydroquinone 2% and clobetasol 0.05% cream for 6 years with minimal improvement. Clinical and histopathological diagnosis revealed rosacea, dyschromia with demodicosis and patient was prescribed low dose isotretinoin and ivermectin 1% cream for the demodex infestation. Significant improvement was observed after 2 months.

Last case is a 19-year old male with 2 years history of mildly pruritic, erythematous macules on the cheeks, nose, and chin with eventual black crusting. Initial dermatologic consult was done diagnosed as verruca plana planned for ECT and curettage. Another consult done, diagnosed as eczema and was prescribed mometasone furoate 0.1% cream and anti-acne medications with no improvement. Skin punch biopsy revealed spongiotic dermatitis, tinea versicolor and demodicosis and was treated with topical ivermectin 1% cream and low dose isotretinoin for 3 months with significant improvement.

Conclusion:

Demodicosis is a common skin condition with varying clinical features often underdiagnosed or mistaken for other dermatoses. This case series has documented four cases of demodicosis in patients with diverse clinical manifestations, predisposing factors and therapeutic responses. These findings underscore the importance of early clinical recognition, adequate laboratory investigation and individualized treatment approaches to achieve favorable outcomes.

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**Abstract N°: 6128****A case of Comet Sign revealing a *Pyemotes Ventricosus* Dermatitis**

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Introduction & Objectives:

Pyemotes Ventricosus Dermatitis (PVD) is a rare pruritic dermatitis caused by mites' bite called *Pyemote Ventricosus* which parasitizes xylophagous insects such as wood-boring beetle. It can be present in furniture, clothes or can be airborne. Herein we report a case of PVD revealed by a Comet sign.

Results:

A 50-year-old man with no significant medical history presented with the acute onset of a pruritic, erythematous lesion on the chest that had been evolving over the past five days. His history was negative for recent travel to tropical regions, new medications, or contact with animals. Physical examination revealed, in the parasternal area, an erythematous, pseudo-urticarial plaque featuring a central, darkly pigmented papule measuring approximately one centimeter, with subtle, linear, and slightly serpiginous extensions. No other cutaneous or mucosal abnormalities were observed. Dermoscopic evaluation demonstrated diffuse erythema without evidence of microvesicles. Upon further questioning, the patient disclosed that most of his bedroom furniture was made of wood. He had recently noticed small exit holes and the presence of wood-boring beetles in his old wardrobe. In light of the lesion's clinical characteristics and the confirmed exposure to wood-infesting insects, a diagnosis of *Pyemotes*-associated dermatitis (PVD) was established.

Discussion & Conclusion:

The first case of PVD was reported in France in 2005. The appearance of the lesion described above is consistent with the well known "Comet Sign", described in literature, pathognomonic of PVD. The lesion typically begins as a papule surrounded by an erythematous plaque within 6 to 8 hours following the insect bite, sometimes with vesicles. This is followed by the appearance of filiform, serpiginous tracks in the next 12 to 24 hours, likely due to localized lymphangitis resulting from a delayed reaction to the mite's saliva. The Comet Sign, though characteristic, is not consistently present, which can make diagnosis challenging, especially as similar lesions may be seen in conditions like bedbug bites. One distinguishing feature is lesion location: *Pyemotes*' bites typically affect covered areas, while bedbug bites are more common on exposed skin. In unclear cases, a tape test on infested wood can confirm mite presence, but this is generally unnecessary when the Comet Sign is observed, as in our case. PVD is a benign and self-limiting dermatitis. The lesions typically regress spontaneously within 1 to 3 weeks without specific treatment, and in this case, complete resolution occurred within just a few days. Topical corticosteroids and antihistamines are generally sufficient to manage symptoms. In our patient, the lesion resolved completely within 4 days of treatment. To prevent future infestations, it is essential to remove any infested items, refinish or seal wooden furniture, and control room humidity. These measures help reduce the likelihood of further exposure to wood-boring insects and recurrence of the condition.

Pyemotes ventricosus dermatitis might be an underdiagnosed entity. It should be considered in the differential diagnosis of acute onset pruritic eruption, particularly in individuals exposed to infested wooden objects.



**Abstract N°: 6331****Transient lymphopenia without immunodeficiency in an adult with varicella**fatima zayoun¹, rachadi hanane¹, hali fouzia¹, soumia chiheb¹¹university hospital center ibn rochd, dermatology and venerology, Casablanca**Transient lymphopenia without immunodeficiency in an adult with varicella****Introduction & Objectives:**

Varicella, a primary infection caused by the varicella-zoster virus (VZV), is typically benign in children but can lead to serious complications in adults, such as pneumonia, hepatitis, or encephalitis. Although transient lymphopenia may occur during viral illnesses, it is rarely reported in immunocompetent adults. We present the case of a young, immunocompetent adult who developed a severe form of varicella associated with marked transient lymphopenia.

Materials & Methods:**Results:**

An 18-year-old male with no significant past medical history presented with a three-day history of a generalized vesicular rash, accompanied by fever and headaches. Physical examination revealed numerous vesicular lesions, some umbilicated, crusted, or pustular distributed across the face, scalp, trunk, and limbs, sparing the mucous membranes. Right periorbital edema with conjunctival hyperemia was also noted. Laboratory investigations showed elevated C-reactive protein (50 mg/L), marked lymphopenia (780 cells/mm³), and hepatic cytolysis, with liver enzymes elevated to three times the upper limit of normal. HIV serology was negative. Antiviral therapy, combined with local supportive care, led to rapid clinical improvement and normalization of lymphocyte counts within 48 hours.

Conclusion:

The occurrence of transient lymphopenia in an immunocompetent adult with varicella warrants recognition. It should not systematically raise concern for immunodeficiency, especially in the absence of clinical or biological indicators suggestive of immunosuppression.



**Abstract N°: 6396****Diagnostic and Therapeutic Challenges of Cutaneous Leishmaniasis in a Non-Endemic Region: A Case Report**Adam Yu¹, Airiss Chan², Luis Sanchez-Espino^{2, 3}¹University of Alberta, Faculty of Medicine and Dentistry, Edmonton, Canada²University of Alberta, Department of Dermatology, Edmonton, Canada³University of Alberta, Department of Pediatrics, Edmonton, Canada**Introduction & Objectives:**

Cutaneous leishmaniasis (CL) is a growing global health concern, increasingly affecting pediatric populations. Although traditionally endemic to tropical and subtropical regions, CL is being reported in non-endemic countries like Canada due to increased international travel. This introduces diagnostic delays and limited treatment options. We present a pediatric case of imported CL to highlight diagnostic and therapeutic challenges in non-endemic settings.

Materials & Methods:

A retrospective review of a single pediatric case was conducted, including clinical history, diagnostic workup, treatment course, and outcomes. Diagnostic methods included histopathology, special staining, and polymerase chain reaction (PCR) for species identification. Therapeutic interventions and responses were documented over an 18-month period.

Results:

A 17-year-old male from Western Canada presented with persistent skin ulcers three months after traveling to the Yucatán Peninsula, Mexico. The patient initially developed erythematous papules on his anterior neck that progressively ulcerated and enlarged. Despite treatment with topical steroids and multiple courses of oral antibiotics, the lesions worsened. Punch biopsy revealed granulomatous inflammation, and staining confirmed the presence of *Leishmania* parasites with the characteristic “marquee sign.” Polymerase chain reaction identified *Leishmania mexicana* as the causative agent eight months after the onset of symptoms.

The patient was initially treated with oral fluconazole, but the lesions did not resolve. Subsequent treatment with intravenous liposomal amphotericin B, administered in two courses (total dose 2,380 mg), resulted in partial improvement. However, the patient developed a *Staphylococcus aureus* superinfection, requiring additional antibiotics. Due to limited access to first-line therapies in Canada, miltefosine was only made available through Health Canada’s Special Access Program (SAP) 18 months after symptom onset. A four-week course of miltefosine led to complete re-epithelialization with minimal side effects.

Conclusion:

This case highlights the growing need for heightened awareness of CL in pediatric patients, particularly those with travel histories to endemic regions. Early recognition and timely access to effective treatments, such as miltefosine, are critical for improving outcomes in pediatric cutaneous leishmaniasis. This is especially important in non-endemic regions where access to appropriate therapies is often delayed.





Abstract N°: 6562

Favorable Outcome of Sporotrichoid Leishmaniasis Treated with Fluconazole

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Introduction

Cutaneous leishmaniasis (CL) can pose therapeutic challenges in patients with comorbidities that contraindicate first-line treatments. We report a case of sporotrichoid leishmaniasis that responded favorably to fluconazole.

Case report:

A 63-year-old woman with a history of cardiac disease (on long-term therapy) presented with multiple nodular lesions that appeared 4 months after a stay in the endemic region of Essaouira, Morocco. Clinical examination revealed 10 dermo-epidermal, erythematous-purplish nodules with central crusting, localized on the forehead (1 lesion), left upper limb (1 lesion), and in a linear distribution along the right forearm (7 lesions). Dermoscopy showed diffuse erythema, star-like white patterns, and central ulceration. PCR confirmed infection with *Leishmania tropica*. Due to contraindications to intramuscular glucantime (because of her cardiac condition), treatment with **fluconazole 150 mg/week for 6 weeks** was initiated, resulting in complete regression of lesions.

Conclusion:

This case highlights the efficacy of **fluconazole** (150 mg/week for 6 weeks) in treating **sporotrichoid cutaneous leishmaniasis caused by *Leishmania tropica*** in a patient with a **formal contraindication to antimonials** (cardiac disease). The favorable outcome supports fluconazole as a **valid therapeutic alternative** when classical systemic treatments (e.g., glucantime) cannot be used.




Abstract N°: 6612
Trichophyton indotineae dermatophytosis in a patient with Familial Mediterranean Fever: what a (therapeutic) journey

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Introduction & Objectives: An alarming increase of terbinafine-resistant dermatophytosis cases caused by *T. indotineae* is reported outside the Asian subcontinent where this new species is now endemic. The cause is not known and migration, international travel, the concomitant use of topical corticosteroids in combination with antifungals as well as the irrational exposure to drugs targeting SQLE enzyme have been suggested. Although evidence is limited, itraconazole is currently recommended in cases of terbinafine resistance. Due to enzyme inhibition, it has the potential for serious drug interactions - including colchicine, used in in familial Mediterranean fever (FMF) - and their combined use may result in colchicine intoxication. Herein we report the complicate therapeutic journey of *T. indotineae* in a patient with FMF.

Materials & Methods: A 20-year-old man on colchicine treatment for FMF presented to our dermatology department for the assessment of widespread pruritic annular erythematous discrete scaly plaques on his face, trunk and extremities. The eruption started approximately 7 months before presentation on his groins and thighs and was initially treated with an over-the-counter cream containing miconazole and hydrocortisone. The lesions continued to spread, and therefore the patient contacted his general practitioner who, following a positive PCR for *T. interdigitale*, initiated treatment with oral terbinafine at a dose of 250 mg daily and topical mometasone furoate cream. Despite 3 months of treatment, only a partial improvement was noticed, and the patient was referred to us for evaluation.

Results: Presuming a tinea incognito or terbinafine-resistant widespread dermatophytosis, a culture was sent for fungal culture that revealed the presence of *T. indotineae*, resistant to terbinafine (MIC 8mg/L) but sensitive to itraconazole. The patient, of Lebanese origin, denied any travel outside Europe in the 2 years prior to the onset of the lesions. His brother had similar lesions that have completely resolved with systemic terbinafine. After consulting with the rheumatologist, colchicine treatment was interrupted and oral itraconazole 200 mg daily was initiated, resulting in partial improvement after 4 weeks of treatment. The treatment was extended to 2 months and despite initial improvement, the patient experienced a reoccurrence of the lesions during the treatment. Detailed anamnesis revealed that since he stopped colchicine treatment the patient had had repeated FMF attacks that required systemic corticosteroids. The patient was put on anakinra treatment by the rheumatologist and itraconazole treatment was extended to 3 months as a new culture revealed preserved sensitivity to itraconazole. This led to complete resolution of the lesions with no reoccurrence after 3 months.

Conclusion: In terbinafine-resistant dermatophytosis, the challenges seem to go beyond difficulties in species identification, susceptibility testing and identifying clinical breakpoints. Our presented case underscores the need for increased awareness of drug interactions and safety concerns of prolonged or combined antifungal treatments. Our case also supports the hypothesized link between corticosteroid use and antifungal resistance, raises the importance of a multidisciplinary approach in complex cases with risk for drug interactions and the need for

evidence-based treatment guidelines in antifungal-resistant dermatophytosis.

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**Abstract N°: 6677****Co-infection of *Trichophyton mentagrophytes* and *Aureobasidium pullulans* in a Patient with Resistant Dermatophytosis**

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Introduction & Objectives:

Tinea corporis is a common superficial fungal infection primarily caused by dermatophytes, most frequently *Trichophyton* species including *T. mentagrophytes*. Although dermatophytoses are routinely encountered in clinical practice, the co-occurrence of dermatophytes with non-pathogenic fungi remains rarely reported. *A. pullulans*, an environmental fungus, is seldom implicated in human infections, especially among immunocompetent individuals. This case report aims to describe an uncommon co-infection case involving *T. mentagrophytes* and *A. pullulans*, emphasizing the importance of recognizing possible mixed fungal etiologies in resistant dermatophytic infections.

Materials & Methods:

A 26-year-old woman with a history of hypertension presented with itchy, erythematous, annular plaques located on her face, trunk, right medial thigh, right forearm, vulva, inguinal area, lower abdomen, and left axilla. The lesions had persisted for 2.5 years, during which the patient had previously been treated with terbinafine (250 mg/day) for 3 months and itraconazole (100 mg/day) for 1 month without complete resolution. Skin scrapings were obtained for microscopic examination and fungal cultures. Samples were cultured on Sabouraud dextrose agar (SDA), potato dextrose agar (PDA), and dermatophyte agar.

Results:

Direct microscopic examination of skin scrapings from the patient's trunk using 10% potassium hydroxide (KOH) revealed fungal hyphae and yeast cells. Yeast colonies appeared after four days of incubation at 25°C on Actidione Sabouraud Dextrose Agar (SDA; Oxoid, UK), Potato Dextrose Agar (PDA; Becton Dickinson GmbH, Germany), and Dermatophytes agar base (Condalab, Spain). Dermatophyte colonies developed after 14–21 days. The yeast isolates were identified as *A. pullulans* through MALDI-TOF mass spectrometry MALDI Biotyper® (Bruker). Dermatophyte colonies cultured from the specimens were microscopically identified as *T. mentagrophytes* species complex using the cellophane tape method with Lactophenol Cotton Blue staining. PCR testing for the potential pathogen *Trichophyton indotineae* was not performed, as this assay is unavailable in the country. Antifungal susceptibility tests of the yeast and mold colonies isolated from the skin scraping were performed using the E-test (bioMérieux, Marcy l'Etoile, France; agar diffusion gradient test) method on RPMI 1640 agar medium (Multicell) supplemented with 2% glucose (Oxoid), 1.5% agar (Oxoid), and MOPS buffer (Sigma). Resistance to terbinafine was detected (MIC values: 0.016 and 0.125 µg/mL; agar plate method). Treatment with oral itraconazole (400 mg/day) resulted in significant clinical improvement, with nearly complete resolution of lesions within two weeks. She remains under follow-up.

Conclusion:

This case emphasizes the unusual coexistence of *T. mentagrophytes* and the environmental yeast *A. pullulans* in a patient with tinea corporis. Clinicians should be aware of the potential for mixed fungal infections, particularly in cases exhibiting atypical clinical findings or suboptimal treatment responses. Further research is required to determine the clinical significance and pathogenic potential of *A. pullulans* in superficial fungal infections, especially in immunocompetent patients.

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**Abstract N°: 6718****A Rare Cutaneous Presentation of *Mycobacterium kansasii* Tenosynovitis in an Elderly Immunosuppressed Woman: A Case Report**

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Introduction & Objectives:

Mycobacterium kansasii is a slow-growing nontuberculous mycobacterium (NTM), typically associated with pulmonary infections. Extrapulmonary manifestations such as tenosynovitis are rare and frequently misdiagnosed due to their indolent course and similarity to inflammatory arthritis. We present a unique case of *M. kansasii* tenosynovitis with a cutaneous presentation in an elderly immunosuppressed patient, emphasizing the importance of early suspicion and tailored management.

Materials & Methods:

A retrospective review of clinical data, imaging, histology, and microbiological findings was performed for a 98-year-old woman with a history of giant cell arteritis on low-dose corticosteroids. The patient presented with progressive subcutaneous nodules and wrist swelling following minor trauma. Initial management was based on presumed inflammatory arthritis.

Results:

Initial treatment with methotrexate and corticosteroids yielded no improvement. MRI revealed extensive tenosynovitis, and biopsy showed granulomatous inflammation. Acid-fast bacilli staining was negative, but cultures confirmed *Mycobacterium kansasii*. Due to the patient's frailty, treatment was initially deferred. Upon clinical progression, she was started on azithromycin, ethambutol, and rifampicin, which was discontinued after five weeks due to adverse effects but resulted in symptom resolution. Recurrence occurred one year later and was managed with the same regimen for nine weeks, again leading to resolution. Two years from initial presentation, the patient remains asymptomatic, having never required surgery or prolonged antimycobacterial therapy.

Conclusion:

This case highlights an uncommon presentation of *M. kansasii* tenosynovitis with subcutaneous nodules mimicking inflammatory arthritis. Complete clinical resolution was achieved without surgery or extended antimicrobial treatment. Clinicians should maintain a high index of suspicion for atypical infections in patients with treatment-resistant tenosynovitis, especially in those who are immunosuppressed. Early biopsy and microbiological confirmation are key to prompt diagnosis and favorable outcomes.



**Abstract N°: 6721****Scytalidium dimidiatum as an Emerging Cause of Onychomycosis: A Case Report**

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Introduction & Objectives:

Onychomycosis caused by *Scytalidium dimidiatum* is an uncommon fungal infection of the nails, often resistant to conventional antifungal treatments. This pathogen predominantly affects individuals residing in tropical and subtropical regions and is frequently misdiagnosed as dermatophyte infections due to similar clinical presentations. This case aims to highlight diagnostic challenges and the importance of accurate fungal identification to ensure effective management.

Materials & Methods:

A 25-year-old female presented with a six-month history of progressively worsening thickening, discoloration, and brittleness of the toenails. Clinical examination revealed yellow-brown discoloration, hyperkeratosis, and onycholysis predominantly affecting multiple toenails. Direct microscopy (KOH preparation) and fungal culture were performed. Cultures yielded *Scytalidium dimidiatum*, confirming the diagnosis.

Results:

Clinical findings, combined with direct microscopy and fungal culture results, established the diagnosis of *Scytalidium dimidiatum* onychomycosis. The patient was initiated on systemic terbinafine therapy along with topical antifungals, although previous literature suggests limited efficacy with standard antifungals. Close monitoring and prolonged treatment were planned due to anticipated resistance.

Conclusion:

Scytalidium dimidiatum should be considered in cases of onychomycosis unresponsive to standard treatments, particularly in younger patients without typical dermatophyte exposure risks. Accurate diagnosis using fungal culture is essential, as management typically requires a tailored and prolonged therapeutic approach due to inherent resistance.





Abstract N°: 6765

Bacillary Angiomatosis revealing AIDS stage : a case report

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Introduction & Objectives:

Bacillary angiomatosis is also known as epithelioid angiomatosis is an uncommon disease and is a disorder characterized by neovascular proliferation in the skin or the internal organs and presenting as tumor-like masses due to infection with *Bartonella henselae* or *Bartonella quintana*. Originally, bacillary angiomatosis was described in HIV patients but is known to occur in other non-HIV immunocompromised states as well as in immunocompetent persons.

The most common clinical presentation is a papule that develops into a reddish to a purple nodule, which appears vascular.

Materials & Methods:

We report a rare case of bacillary angiomatosis revealing the AIDS stage in a patient, highlighting its clinical and histopathological features.

Results:

A 68-year-old patient with a medical history of HIV infection since 20 years and psychosis since 15 years, both marked by poor adherence, and antiretroviral therapy was discontinued one year ago.

He presents with diffuse lesions over the entire body, non-pruritic and non-painful, evolving over the past three months in a febrile context with deterioration of general health.

Clinical examination revealed multiple, firm, well-demarcated erythematous-violaceous papules and nodules with a telangiectatic base, painless on palpation, along with subcutaneous nodules, distributed over the entire skin surface, including the scalp, as well as the oral and nasal mucosae.

The dermoscopy showed reddish-violaceous lacunae, structureless whitish areas, arborizing and linear vessels.

Biologically, the patient had underlying human immunodeficiency virus (HIV) infection, with a recent cluster of differentiation 4 (CD4) T-cell count of 43 cells/ μ L and a high viral load of 250,000 copies/mL of ribonucleic acid (RNA). The patient was at the AIDS stage.

Histopathological examination identified a regular skin architecture with a lobular capillary proliferation in the mid-dermis, composed of capillaries lined by prominent cuboidal endothelial cells, admixed with degenerated polymorphonuclear cells. Warthin-Starry staining was not available to highlight bacilli.** The histopathological findings were compatible with bacillary angiomatosis.

Considering the clinical and dermoscopic aspects of the lesions, as well as the histopathological findings, a final diagnosis of bacillary angiomatosis was made.

The patient was prescribed erythromycin 500 mg twice daily for three months, along with antiretroviral therapy.

Conclusion:

Skin lesions of bacillary angiomatosis can be mistaken for Kaposi's sarcoma or pyogenic granuloma. Thus, a skin biopsy is paramount to establishing a diagnosis. Diagnosis can also be rapidly established using polymerase chain reaction assays, serologic testing, or electron microscopy. The drugs of choice for the treatment are usually doxycycline or macrolides, but several treatments such as cephalosporins, penicillins, macrolides, aminoglycosides, rifampin, dapsone, ciprofloxacin, have been tried with favorable results. Combination therapy may be necessary for patients with severe diseases. Since this is a potentially fatal disease in immunocompromised patients, associated with high morbidity and mortality, early diagnosis and prompt treatment are essential to achieve a favorable prognosis.

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**Abstract N°: 6771****Trichophyton mentagrophytes-associated necrotizing fasciitis mimicking calciphylaxis: a rare presentation of invasive dermatophytosis**

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Introduction:

Dermatophytes are usually restricted to the stratum corneum, hair, and nails. Invasive dermatophyte infections extending beyond the dermis are rare and often occur in immunocompromised individuals. Necrotizing fasciitis due to dermatophytes is exceptionally uncommon and poorly recognized clinically.

Clinical Case:

A 79-year-old man with diabetes, chronic kidney disease and recent kidney transplantation presented with two painful necrotic ulcers on the left lower limb. He was under immunosuppressive therapy including mycophenolate, tacrolimus and prednisone. A biopsy was taken with suspicion of calciphylaxis. A tinea culture was taken from desquamative lesions on the foot. One week later, due to worsening pain, CT imaging revealed cellulitis with fluid tracking along fascial planes. Emergency surgical debridement was performed. Histopathology showed fungal hyphae in the dermis and subcutis. Tissue cultures grew *Trichophyton mentagrophytes*, bacterial cultures were negative. Beta-D-glucan was elevated. Despite treatment with liposomal amphotericin B and antibiotics, the patient died one week later. Retrospective review revealed a prior “eczema” diagnosis on the same limb 16 years earlier.

Discussion:

Deep dermatophytosis includes Majocchi’s granuloma, deep dermal infection, pseudomycetoma, and disseminated disease. Wang et al. reviewed 160 cases of deep dermatophytosis from 2000 to 2020, identifying only 8 disseminated cases. Major risk factors included superficial dermatophytosis, organ transplantation, immunosuppressive therapy, diabetes, trauma, and *CARD9* or *STAT3* mutations. These mutations were linked to early-onset, treatment-resistant tinea, elevated eosinophils and IgE, mixed dermatophyte infections, and increased mortality. Only one other case of dermatophyte-induced necrotizing fasciitis has been reported. In the present case, transplant-related immunosuppression and diabetes likely contributed to disease progression. Although genetic testing was not performed, an underlying mutation is possible. Management requires prompt antifungal therapy and sometimes also surgical debridement.

Conclusion:

This case illustrates an unusual and fatal presentation of invasive dermatophytosis mimicking calciphylaxis. In immunosuppressed patients with necrotic or violaceous skin lesions and disproportionate pain, invasive fungal infection should be considered. Early biopsy and mycological confirmation are crucial for timely diagnosis. Preventive treatment of superficial tinea in high-risk patients is essential to avoid progression to severe or fatal invasive disease.





Abstract N°: 6788

Managing neglected tropical diseases in resource poor settings: Experience in three casesNibedita Patro¹, Binayak Dwari¹, Namrata Nidhi¹, Ayesha Sitam¹, Prajnajit Tripathy¹, Priyadarshini Mishra¹¹Hi-Tech Medical College, Bhubaneswar, India

Introduction & Objectives: Mycetoma and deep mycosis form a rare but potentially disabling group of neglected tropical diseases (NTDs), challenging in every aspect from diagnosis to management. Mycetoma can be caused by bacteria (actinomycetoma) or fungus (eumycetoma). These conditions mostly affecting the low socio-economic strata and unavailability of culture methods and diagnostic facilities in resource poor settings create further difficulties. We present three cases, two of actinomycetoma and one of subcutaneous phycomycoses posing diagnostic difficulties and successfully treated on the basis of clinical diagnosis and therapeutic trial.

Materials & Methods: Two patients presented with multiple discharging papules and nodules on a base of ill defined hyperpigmented firm to hard swelling of skin distributed over left lower leg in case 1 (3 1/2 years duration) and lateral upper right thigh in case 2 (2 years duration). An overnight saline-soaked gauze dressing in both the cases didn't yield any granules. A skin biopsy revealed dense inflammatory infiltrate comprising of lymphocytes, plasma cells and histiocytes, and negative GMS and PAS staining for fungus. The third patient (case 3) presented with diffuse hyperpigmented subcutaneous plaque involving the vulval area, upper thighs and both buttocks, gradually progressing over 6 months. Fingers could be insinuated under the plaque at the margins. A skin biopsy revealed dense chronic inflammatory cell infiltrate comprising of lymphocytes, plasma cells, and eosinophils. A GMS stain showed short, broad, aseptate fungal hyphae.

Results: Case 1 was started with modified Welsch regimen (one cycle included, injection amikacin 15mg/kg daily + cotrimoxazole 320/1600mg twice daily + rifampicin 10mg/kg daily, all three for 21 days, then continue with only cotrimoxazole for 15 days) and continued for 4 cycles.

Case 2 was started with cotrimoxazole 320/1600mg twice daily + rifampicin 10mg/kg daily for 3 months.

Case 3 was given itraconazole 200mg twice daily for 3 months.

All three patients showed significant improvement at the end of 3 months.

Conclusion: The lack of advanced diagnostic infrastructure and/or poor affordability by the patient hinders the exact diagnosis in many diseases. A thorough knowledge of the clinical presentation and a high index of suspicion helps managing the NTDs like actinomycetoma and subcutaneous phycomycoses. The treatability of these conditions with easily available, low-cost drugs when diagnosed at an early stage, further emphasizes the role of clinical diagnosis in a resource poor setting.



**Abstract N°: 6792****Lymphocytoma cutis in child**

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Introduction & Objectives:

A patient ,11 years old, on summer vacation in Macedonia, came for a medical examination in August due to swelling of auricle. The patient lives in Germany . The swelling of the earlobe was red – blue in color , nodular in nature , and about 2 cm in diameter. No insect bite was observed, no flaking or pain, no itching. The lesion had been present about 2 months. On palpation , there was mild tenderness and slightly snlarged lymph nodes on the same side of the neck. No enlarged lymph nodes werw found on the opposite side of the neck or in other papable regions. There was no history of insect bites , and neither the patient nor other family members experienced itching. The famyli reported frequent nature walks, but neither the patient nor the parents noticed a tick bite. When asked specifically about ticks, the parents immediately stated that they live in an endemic area in Germany for *Ixodes ricinus*. They also mentioned that a vaccine exists in their region for protection against tick- borne diseases, but their child had not received it. A complete laboratory analysis was performed , showing normal blood count, erythrocyte sedimentation rate, C- reactive protein, and liver function tests. However, lactate dehydrogenase levels were increased, and most importantly, both IgM and IgG for *Borrelia burgdorferi* were increased. This confirmed the suspicion of Lyme disease and Lymphocytoma cutis. Antibiotic treatment with Amoxicillin capsules a 500 mg every 8 hours (1 capsule per dose) was immediately initiated for total of 4 weeks. After 2 weeks , the lesion began to reduce in size , and by the end of the treatment , it had completely resolved.

Materials & Methods:

Laboratory , blood

ELISA

Results:

Hight levels of Lactat dehidrogenasis

IgM I IgG for *Borrelia burgdorferi* increased

Leucocytes, erythrocytes and platlets normal

Erythrocyte sedimentation rate normal

Hepatogram normal

Conclusion:

The conclusion is that we should always consider Lyme disease in all its forms , including lymphocytoma cutis, as Lyme disease does not always start with the typical erythema migrans. Timely recognition, confirmation , and appropriate treatment of Lyme disease leads to full recovery.



**Abstract N°: 6883****Descriptive study on body regions of predilection in patients attending the central leprosy clinic, Colombo**

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Descriptive study on body regions of predilection in patients attending the central leprosy clinic, Colombo

Introduction & Objectives:

Leprosy is a chronic infection of skin and nerves, with predilection for different body regions. Even though certain body regions are considered sites of predilection, the frequency of occurrence of lesions in these sites and their relation to other disease characteristics has not been studied in detail. Objective was to study the frequency of occurrence of skin lesions in different sites and to study their relationship to demographic and disease characteristics.

Materials & Methods:

Retrospective analysis of clinical records was conducted. Demographic and clinical data, including the occurrence of lesions in different body regions, obtained from the clinic records of 217 consecutive patients attending the central leprosy clinic from 2020 to 2023 were entered into an Excel worksheet.

Results:

Records of 217 patients, average age 39.4 years (range 8 – 81), 68% males, were analyzed. Left elbow (63, 29%) right elbow (60, 27.6%), face (53, 24.4%) back and front of the trunk (47, 21.6% & 42, 19.4%) were the most commonly affected sites. One elbow was affected in 75 (34.6%) instances confirming that the elbow is a significant site of predilection. There were 114 patients with single lesion leprosy, where 40 (35.1%) had elbow involvement. 75% of elbow lesions had negative skin smear. There was remarkable symmetry between right and left and front and back of chest.

Conclusion:

The elbow is a significant site of predilection for leprosy. These findings help to develop a graphic description of areas of predilection for leprosy lesions that would be useful in training health care workers and health volunteers in active case detection.



**Abstract N°: 6927****sesame oil and cutaneous leishmaniasis: uncovering a natural therapeutic ally**Balsam Saadaoui¹, Nesrine Ben salah¹, Houda Raiss¹, Soua Yosra¹, bel hadj ali Hichem¹, Zili Jameleddine¹¹مستشفى فطومة بورقيبة بالمنستير, dermatology, Monastir, Tunisia**sesame oil and cutaneous leishmaniasis: uncovering a natural therapeutic ally****Introduction & Objectives:**

Cutaneous leishmaniasis is an endemic disease in our country. The skin lesions caused by this condition often result in scars that are difficult to treat. However, treatment options are challenging, and the restrictions on glucantime necessitate the consideration of other therapeutic alternatives. We report a case of a patient effectively treated with sesame oil.

Materials & Methods:

NA

Results:

A 56-year-old man, with a medical history of diabetes treated with oral antidiabetics, presented with a 7-day history of ulcerative, crusted lesions on both upper limbs. The patient reported experiencing an insect bite in the affected areas one week prior to the appearance of the skin lesions. On physical examination, five non-itchy, erythematous, crusted ulcerative lesions were noted on both upper limbs, with the largest lesion measuring 4 to 5 cm in size. No mucosal lesions were observed. Laboratory findings confirmed the diagnosis of leishmaniasis. The patient categorically refused any conventional leishmaniasis treatment. Consequently, we opted to treat him with local application of sesame oil. The patient returned after five days, showing remarkable improvement.

Conclusion:

Leishmaniasis induces both humoral and cellular immune responses to the bite of the phlebotomine sandfly, resulting in an inflammatory reaction at the bite site and leading to the development of cutaneous ulcers. A recent study demonstrated that sesamin, a lignan found in sesame oil, has anti-inflammatory effects by significantly reducing the expression of interleukin 1 and 6 (IL-1 and IL-6) mRNA in human fibroblast cell lines. This may explain the spectacular improvement seen in our patient following the daily application of sesame oil to the skin lesions within five days. Additionally, we noted that the patient forgot to apply the oil to one lesion on his upper arm, which allowed us to confirm the treatment's effectiveness. While the treated lesions showed a reduction in erythema and crusting, the untreated lesion remained unchanged. This suggests that sesame oil could be a promising therapeutic alternative for patients with contraindications to both local and systemic glucantime treatment. In conclusion, sesame oil may offer a viable alternative treatment for cutaneous leishmaniasis, particularly for patients who cannot use conventional therapies like glucantime. Sesame oil, due to its anti-inflammatory properties, could be an effective, accessible, and safe option for managing this condition. Further studies are needed to confirm its efficacy and establish its role in the treatment of leishmaniasis.



**Abstract N°: 6975****An outbreak of Monkeypox virus disease in Saudi Arabia- A series of 15 cases**Kamal Ahmed¹¹Mohammad Dossary Hospital, Dermatology, Al Khobar , Saudi Arabia**An outbreak of Monkeypox virus disease in Saudi Arabia- A series of 15 cases****Introduction:**

Mpox, previously known as monkeypox, is a viral illness caused by the monkeypox virus. It is an enveloped double-stranded DNA virus of the *Orthopoxvirus* genus in the *Poxviridae* family, which includes variola, cowpox, vaccinia and other viruses. Mpox spreads from person to person mainly through close contact with someone who has mpox, including members of a household. Close contact includes skin-to-skin (such as touching or sex) and mouth-to-mouth or mouth-to-skin contact (such as kissing), and it can also include being face-to-face with someone who has mpox.

Mpox causes signs and symptoms which usually begin within a week but can start 1–21 days after exposure. Symptoms typically last 2–4 weeks but may last longer in someone with a weakened immune system. Symptoms include rash, fever, sore throat, lymphadenopathy.

Case presentation:

A series of 15 cases of patients with clinical features suggestive of MPOX virus disease presented in the Dermatology Outpatient department from Jan 2024 to April 2024. Patients presented with varied clinical manifestations ranging from varicella-like rash to severe edema over the penis. All the patients were isolated and tested for MPOX virus by PCR testing. Almost all the cases showed positive results.

Conclusion:

Mpox virus causes clinical manifestations ranging from mild to very severe disease. High index of suspicion is very important for testing the cases presenting with a typical rash suggestive of MPOX. In the last one or two years, multiple cases of MPOX have been reported in the Eastern region of Saudi Arabia. Most of the cases gave history of sexual contact with sex worker.



**Abstract N°: 7010****Beyond the Rash : Facial Palsy in a Child with Ramsay Hunt Syndrome**

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Introduction & Objectives:

Acne fulminans (AF) is a rare and severe variant of nodular acne, marked by acute onset of ulceronecrotic lesions and systemic inflammation. Though its exact pathogenesis remains unclear, it is believed to involve an exaggerated immune response to *Cutibacterium acnes*, potentially precipitated by isotretinoin in predisposed individuals. While musculoskeletal involvement is well documented, the occurrence of concurrent skin infections such as paronychia and cellulitis raises questions about whether these manifestations represent secondary bacterial infections or are part of the inflammatory spectrum of AF. We present a case highlighting this diagnostic and therapeutic challenge

Materials & Methods:

We report the case of a 17-year-old male with a history of conglobate acne treated with isotretinoin for six months. Following a dosage increase from 20 mg to 40 mg/day, he developed ulceronecrotic facial and truncal lesions, bilateral paronychia, and preseptal cellulitis. The patient reported febrile sensations but had no musculoskeletal complaints. A comprehensive clinical evaluation, laboratory tests, and imaging were conducted to guide diagnosis and treatment.

Results:

The patient presented with marked inflammatory lesions, paronychia affecting two fingers, and unilateral preseptal cellulitis confirmed on orbital CT (stage 1). Laboratory findings included significant leukocytosis (23,000/ μ L), thrombocytosis (574,000/ μ L), and elevated C-reactive protein (CRP, 57 mg/L), while hepatic and renal function remained normal. He was started on oral amoxicillin-clavulanate for 10 days and systemic corticosteroids (prednisone 0.5 mg/kg/day), resulting in rapid clinical and biological improvement. Isotretinoin was temporarily discontinued and later reintroduced at a lower dose without recurrence of severe symptoms.

Conclusion:

This case underscores the complex interplay between inflammatory and infectious processes in AF. The close temporal association between isotretinoin dose escalation and symptom onset suggests a causative role of the drug in triggering severe inflammation. The co-occurrence of paronychia and cellulitis complicates the clinical picture, emphasizing the need to distinguish between infectious superimposition and inflammatory extension of AF. Laboratory evidence of neutrophilic leukocytosis and elevated CRP supports a mixed etiology. Effective management required a combined therapeutic approach using both corticosteroids and antibiotics. This case highlights the importance of individualized treatment strategies and multidisciplinary care to ensure optimal outcomes and prevent complications in severe acne fulminans.

**Abstract N°: 7025****A Case of Maltreated Scabies**Syed Hasnain*¹, Amber Yasmin²¹Shaikh Zayed Hospital, Department of Dermatology, لاہور, Pakistan²Shaikh Zayed Hospital, Department of Dermatology, Lahore, Pakistan

Introduction & Objectives: Scabies is a common parasitic skin infestation caused by *Sarcoptes scabiei* var. *hominis*, typically presenting with nocturnal pruritus and a characteristic rash. Though easily treatable with topical agents and antiparasitic medications, misdiagnosis and inappropriate treatment can lead to serious complications. We aim to present a case of maltreated scabies in a young adult male, emphasizing the consequences of systemic steroid misuse and the importance of proper diagnosis and treatment.

Materials & Methods: A 27-year-old male presented with a 4-month history of generalized pruritus and 3-month history of multiple discharging sinuses. He had been misdiagnosed and repeatedly treated by local practitioners with systemic corticosteroids, leading to overt cushingoid features, hypertension, diabetes, and extensive bacterial and fungal infections. Dermatologic examination revealed widespread striae atrophicans, abscesses, tinea corporis, excoriated lesions, and crusted erosions in typical scabies distribution. Inpatient workup included CBC, glucose monitoring, blood pressure management, and ultrasound Doppler of abscesses. Multidisciplinary care was initiated including dermatology, cardiology, and surgical consultation

Results: Investigations confirmed steroid-induced Cushing's syndrome, new-onset hypertension, and hyperglycemia. Management included tapering systemic steroids, oral ivermectin, topical permethrin, oral and topical antifungals, IV antibiotics (linezolid), and antihypertensives. The patient showed clinical improvement within a week. Blood glucose and pressure normalized, abscesses subsided, and pruritus resolved. He was discharged with education on proper treatment and a follow-up plan.

Conclusion: This case highlights the risks of unregulated steroid use and improper management of scabies, a disease that is simple to treat but often neglected. Education on early diagnosis, avoidance of self-medication or quack remedies, and timely access to dermatological care are critical to prevent iatrogenic complications. Public health awareness, especially in under-served communities, is essential to manage scabies effectively and prevent its morbidity.

(Supporting pictures available in full case report, if and when required)



**Abstract N°: 7034****An unusual case of tinea incognito of the scalp in a child.**

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Introduction & Objectives:

Kerion celsi is a severe inflammatory variant of tinea capitis, a superficial fungal infection of the scalp that predominantly affects young children [1]. Kerion celsi is characterized by painful, purulent nodules and carries a risk of permanent scarring alopecia if not promptly diagnosed and treated [2].

Materials & Methods:

We present a case of a 5-year-old boy with chronic, erythematous, scaly lesions on the neck, initially treated with topical corticosteroids, which likely masked the underlying dermatophyte infection and contributed to diagnostic delay. A dermatological consultation was performed, and mycological examination of skin scrapings was ordered. Direct microscopy confirmed the presence of fungal elements, and culture revealed *Trichophyton mentagrophytes*. Further history revealed that the patient's family is involved in cattle farming, representing a likely zoonotic source of infection [3]. Systemic antifungal treatment with terbinafine was initiated at a dose of 62.5 mg/day (patient weight: 15 kg) for a total duration of 42 days. Concurrent topical therapy included 5% clotrimazole in a compounded formulation and isoconazole (Travogen). The patient responded well to the therapy. Follow-up examinations at 2 and 4 months confirmed mycological cure, and clinical improvement was observed. Despite persistent cervical lymphadenopathy during treatment, it gradually resolved and was no longer detectable 12 months after therapy completion.

Conclusion:

This case underscores the importance of considering fungal infections in the differential diagnosis of chronic scalp and neck lesions, especially in children with a history of animal contact. Early recognition and appropriate antifungal treatment are crucial to prevent irreversible complications.

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**Abstract N°: 7050****Candida incognita: an underrecognized entity mimicking chronic inflammatory dermatosis**Oumaima Zouine¹, Sara Elloudi¹, Zakia Douhi¹, Meryem Soughi¹, Hanane Baybay¹, Fatima Zohra Mernissi¹¹CHU HASSAN II, Fes, Morocco**Introduction & Objectives:**

Candida incognita is a rare and underrecognized form of cutaneous candidiasis modified by prolonged topical corticosteroid use. Unlike tinea incognita, this condition is not described in the literature. Corticosteroid-induced immunosuppression alters clinical features, leading to misdiagnosis as eczema or psoriasis. In diabetic patients, impaired immunity and disrupted skin barrier increase fungal susceptibility. This case aims to highlight the need for mycological testing in corticosteroid-dependent dermatoses to avoid diagnostic errors and inappropriate treatment.

Materials & Methods:

We report the case of a 60-year-old diabetic patient with chronic pruritic lesions on the lower limbs lasting over a year. Temporary improvement was reported with topical corticosteroids, followed by relapse. A full clinical examination, dermoscopy, and mycological testing were performed.

Results:

The patient had two bright red, erythematous plaques with annular borders and excoriated papules, fissured plantar keratoderma, and interdigital intertrigo. Diffuse pachyonychia was also present. Dermoscopy revealed diffuse dotted vascularization, which is uncommon in chronic inflammatory dermatoses. Differential diagnoses included stasis eczema, psoriasis, and widespread dermatophytosis. Mycological testing confirmed a *Candida* spp. infection. The patient was treated with oral fluconazole and topical terbinafine for six weeks, leading to complete resolution of the lesions within three months.

Conclusion:

This case illustrates the importance of recognizing *Candida incognita* in chronic corticosteroid-modified dermatoses. Prolonged corticosteroid use leads to local immunosuppression and microbiome disruption, creating favorable conditions for fungal persistence. Diabetes further increases susceptibility. Misdiagnosis may result in inappropriate and prolonged corticosteroid use, worsening the infection. This case underscores the role of mycological testing in any chronic erythematous dermatosis resistant to corticosteroids, especially in immunocompromised patients. Early identification can avoid unnecessary treatments, guide appropriate therapy, and improve patient outcomes. Raising awareness about *Candida incognita* can help clinicians avoid common diagnostic pitfalls in chronic dermatoses.





Abstract N°: 7065

measles in northern morocco: clinical insights, severe outcomes and the crucial role of vaccination

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Introduction & Objectives:

Measles in Northern Morocco: Clinical insights, Severe Outcomes and the crucial role of vaccination.

Introduction :

Measles, a highly contagious viral infection transmitted by air, remains a public health problem despite vaccination, with a worldwide upsurge reported by the WHO. In view of the measles epidemic observed. In our study, we describe the clinical features of measles cases in the northern region of Morocco, analyse the most frequent complications and the severity criteria observed. We assess the impact of vaccination status on the clinical presentation of the disease and identify the public health challenges associated with measles management.

Materials & Methods:

We conducted a prospective multicentre descriptive and analytical observational study of adult patients with measles at the CHU Mohamed 6 in Tangiers between May 2024 and January 2025. All patients aged 16 and over with clinical features compatible with measles and/or confirmed measles serology requiring hospitalisation were included in the study.

The diagnosis of measles was made according to the criteria defined by the French Ministry of Health (table S1). On admission, the clinical characteristics of the patients were documented and, on discharge, all complications arising during hospitalisation were recorded in the patients' medical records.

The data collected was coded, entered and validated for static analysis using SPSS software.

Results:

- A total of 313 patients were enrolled, including 201 women (64.2%) and 112 men (35.8%). Of these, 260 (83.1%) had no previous medical history. 29 women (14.4%) were pregnant.
- The majority of patients were young, with a mean age of 33 years (15--64 years). 101 patients (32.3%) had unknown vaccination status, 85 (27.2%) were unvaccinated and 127 (40.6%) were vaccinated.
- All patients had a fever (100%). Other common symptoms were: Asthenia: 294 (93.9%), Headache: 213 (68.1%), Cough: 212 (67.7%), Vomiting: 178 (56.9%), Conjunctivitis: 281 (89.8%), Koplik's spots: 148 (47.3%), Pharyngitis: 78 (24.9%), Arthralgias: 94 (30%).
- The most frequent complications were: Liver damage: 238 (76%), Pneumonia: 113 (36.1%), Pancreatitis: 1 (0.3%), Encephalitis: 8 (2.6%), Urinary tract infection: 12 (3.8%), Keratitis: 8 (2.6%), Tachycardia: 1 (0.3%), Otitis: 3 (1%), PTA (Threatened premature delivery): 11 (3.5%), UFM (Fetal death in utero): 5 (1.6%), Death: 2 (0.6%).

- Severity criteria observed: Apnoea: 2 (0.6%), SaO₂ < 92%: 106 (33.9%), RF > 60 cycles/min: 108 (34.5%), Purpura: 15 (4.8%), Convulsions: 8 (2.6%), Cyanosis: 11 (3.5%), Extensive radiological damage: 45 (14.4%), Difficulty feeding: 78 (24.9%), Consciousness disorder: 8 (2.6%).
- Biological data: summarised in table S2.
- The clinical course was generally favourable, with progressive resolution of symptoms with appropriate treatment.

Conclusion:

The results show that measles in northern Morocco continues to be a major public health problem, with serious complications, particularly among unvaccinated and vulnerable populations.

Strengthening vaccination and health education strategies, as well as improving diagnosis and clinical follow-up, are essential to controlling this disease.



Abstract N°: 7089

Widespread Tinea Corporis Mimicking a Psoriasis Flare: A Case Report

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Introduction & Objectives:

Tinea corporis (TC), also known as dermatophytosis of glabrous skin, is a superficial fungal infection primarily caused by *Trichophyton* species. It typically presents as annular, erythematous plaques with central clearing and peripheral scaling. Despite its classic appearance, diagnosis may be challenging, especially when the clinical presentation is atypical or overlaps with other dermatoses such as psoriasis.

Materials & Methods:

A 27-year-old male with a longstanding history of plaque psoriasis (PP) since adolescence, managed intermittently with undocumented topical and oral treatments, presented with pruritic, annular, erythematous, and scaly lesions on the upper limbs. Based on his medical history, the lesions were presumed by his dermatologist to be a psoriatic flare, and treatment was initiated with methotrexate and topical corticosteroids.

The erythema initially subsided before newer lesions recurred and rapidly disseminated to involve the trunk, buttocks, and lower limbs, leading the patient to consult at our unit. Examination revealed widespread scaly, erythematous plaques with occasional pustules. Notably, onychodystrophy was observed on the left index and right first toenail. Given the atypical features and rapid progression, TC was suspected. A mycological examination of skin and nail scrapings was performed and revealed filamentous mycelia.

Results:

TC was retained and the patient was treated with oral terbinafine at 250 mg daily. Complete resolution of cutaneous lesions was achieved within two months.

This case underscores the diagnostic challenge posed by TC in patients with chronic dermatoses. Misdiagnosis is particularly likely when fungal infections mimic or coexist with inflammatory conditions like psoriasis. In our case, this was probably further compounded by the prescription of methotrexate and topical corticosteroids. While these treatments may transiently suppress inflammation and reduce erythema, they impair the host's ability to clear fungal infections, leading to its rapid progression and dissemination. This phenomenon is well-documented and is referred to as "Tinea Incognito", a term first coined by Ive and Marks in 1968.

The interplay between PP and dermatophytosis remains poorly understood. Although the incidence of TC in psoriasis patients is debated, onychomycosis is reportedly more common and may serve as a reservoir for autoinoculation. Moreover, immunosuppressive therapies used in PP may reduce cutaneous immunity, potentially predisposing to fungal infections. A recent retrospective study; however, indicated a statistically significant increase in fungal infections among patients receiving IL-17 inhibitors, but not with other systemic therapies.

Conclusion:

This case illustrates the importance of distinguishing between psoriasis and fungal infections, especially before initiating immunosuppressive therapy. In uncertain cases, mycological testing should be promptly conducted.

Further studies are required to elucidate the complex relationship between psoriasis, its treatments, and susceptibility to dermatophytosis.

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**Abstract N°: 7100****Isolated Lip Leishmaniasis: A Diagnostic Pitfall**

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Introduction & Objectives:

Cutaneous leishmaniasis is very common in the Mediterranean basin, where *Leishmania infantum*, transmitted by *Phlebotomus* species such as *P. papatasi*, *P. perfiliewi*, and *P. perniciosus*, is responsible for the vast majority of cases. The lip is considered an unusual site of infection. Herein, we report the case of a 66-year-old patient with isolated leishmaniasis of the upper lip.

Case report :

A 66-year-old female patient presented with a lip lesion that had started 10 months earlier as a slowly enlarging nodule with overlying yellow crusts and scales. Medical history revealed that she had undergone surgical treatment for cleft lip and palate. On examination, the lip appeared erythematous and edematous, with swelling and redness extending from the midline to the left oral commissure. Palpation revealed a firm consistency. The lesion was asymptomatic. Suspecting cheilitis granulomatosa, a lip biopsy and PCR analysis were performed. Histopathological examination revealed an inflammatory infiltrate composed of lymphocytes, histiocytes and plasma cells, with no granuloma formation. PCR confirmed the presence of a parasite of the species *Leishmania infantum*. The patient was successfully treated with systemic meglumine antimoniate (Glucantime®) at a dose of 100 mg/kg/day for 2 weeks, with remission achieved within approximately 2 weeks. No relapses were observed during follow-up.

Discussion:

Leishmaniasis presents a wide spectrum of clinical manifestations, including cutaneous (CL), diffuse cutaneous (DCL), mucocutaneous (MCL), and visceral leishmaniasis (VL). Cutaneous leishmaniasis of the lips appears to be very rare, based on the few published cases to date. It may mimic orofacial granulomatosis, such as Crohn's disease, sarcoidosis, foreign body giant cell granuloma, or Melkersson-Rosenthal syndrome. Clinically, it is characterized by gradual, progressive enlargement of one or both lips, with macrocheilitis being the final presentation. A papule, nodule, or plaque often develops within the swelling and may ulcerate, becoming covered by crusts and scales. It has been hypothesized that *Leishmania infantum* strains involved in isolated MCL may have acquired differential resistance to high and low temperatures, enabling them to survive preferentially in mucous membranes. Failure to visualize amastigotes on histopathological examination does not exclude the diagnosis of MCL. In such cases, culture, immunofluorescence assay (IFA), and PCR are valuable diagnostic tools. Lip involvement can be managed with intralesional injections, systemic treatment, or a combination of both, depending on the clinical presentation and the infecting species.

Conclusion:

Due to its heterogeneous and often underestimated clinical presentation, mucocutaneous leishmaniasis (MCL) remains a diagnostic challenge for both clinicians and parasitology researchers. In this report, we highlight the importance of clinician awareness in diagnosing perioral leishmaniasis lesions, which are rare and can be mistaken for other conditions—particularly in individuals living in or traveling to regions where the parasite is endemic.



**Abstract N°: 7103****Recurrent Tinea Versicolor: Effective Management with Itraconazole and Maintenance Therapy**Milica Bojić¹, Milos Bojić², Ana Popović¹, Milena Djurović¹, Kana Ljaljević³¹Clinical center of Montenegro, Clinic of dermatovenereology, Podgorica, Montenegro²Clinical center of Montenegro, Department of plastic and reconstructive surgery, Podgorica, Montenegro³Medical faculty, University of Montenegro, Podgorica, Montenegro

Introduction&Objectives: Tinea versicolor is a common superficial fungal infection caused by *Malassezia* species, typically presenting as hypopigmented or hyperpigmented macules on the trunk and upper extremities. *Malassezia* is lipophilic and requires oil for growth, which explains its predilection for sebum-rich areas of the skin. While topical antifungals are generally effective, some cases become recurrent due to host factors such as increased sebum production or skin microbiome imbalance. Itraconazole and fluconazole, both systemic azole antifungals, act by inhibiting ergosterol synthesis, although they differ in pharmacokinetics and tissue distribution. Itraconazole is both lipophilic and keratinophilic, allowing it to accumulate effectively in the skin and sebaceous glands. It is commonly administered as 200 mg daily for 5–7 days or 100 mg daily for 15 days. Its ability to prevent relapse is likely related to its prolonged retention in cutaneous tissues. Fluconazole, while less lipophilic, has a longer systemic half-life and simpler dosing regimens. It is typically prescribed as 300 mg once weekly for 2–4 weeks or as a single 400 mg dose in some protocols. Its ease of use enhances patient adherence.

Results: We present a case of a 29-year-old otherwise healthy male (Fitzpatrick phototype III), with a two-year history of persistent tinea versicolor. The patient, who is physically active, exhibited extensive scaly macules on the anterior and posterior trunk and shoulders, unresponsive to multiple courses of topical antifungals including miconazole, ketoconazole, selenium sulfide 2.5%, and ciclopirox olamine 0.77% in cream and lotion formulations. Laboratory investigations were unremarkable, with no evidence of immunodeficiency. Under Wood's lamp examination, classical yellow-white to copper-orange fluorescence was repeatedly observed, and skin scrapings confirmed the presence of *Malassezia* species.

The patient underwent several courses of oral fluconazole (200 mg weekly for 2–3 weeks), which resulted in improvement but was followed by recurrence within weeks. Subsequent treatment with oral itraconazole 200 mg daily for ten days, along with long-term maintenance therapy (a combination of topical antifungals) and lifestyle modifications (minimizing heat and humidity exposure), led to sustained disease control.

Conclusion: This case highlights the challenges in managing chronic tinea versicolor and underscores the importance of individualized treatment strategies for recurrent infections. In our case, itraconazole—combined with adjunctive maintenance therapy—ultimately achieved disease resolution. Its clinical effectiveness may be attributed to its lipophilic and keratinophilic properties, which promote greater accumulation and prolonged retention in the skin and sebaceous glands, thereby enhancing its antifungal activity in lipid-rich environments. Regardless of the systemic agent selected, long-term control of tinea versicolor requires consistent maintenance therapy and lifestyle modifications aimed at reducing factors that favor fungal overgrowth, such as heat, humidity, and excessive sweating.

**Abstract N°: 7140****Mycology online course: a Brazilian Dermatology Society pre-pandemic experience.**

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Keywords: mycology; continuing medical education; curriculum

Introduction & Objectives:

Medical mycology is a big part of dermatology curriculum at residency stage. This stage of education will form the basis of knowledge on regular infectious diseases attendance at outpatient clinics or hospital experience. Brazilian Dermatology Society (SBD) currently

brings together more than ten thousand members. These members are either dermatologists or residence students who collaborate with the specialty through original studies, especially in infectious and tropical diseases. The aim of this abstract is to describe our experience with an online course offered for SBD members.

Materials & Methods:

This free course was developed in collaboration with SBD board, one mycology specialist and three residence students in 2018. We used our society's virtual platform and financial resources allocated for the educational development of our members. It consisted in three modules according to the construction of the learner's knowledge: basic, intermediate and advanced with clinical challenges, starting with a basic quiz to assess the user's expertise. In each module the participant had to complete video classes, podcasts, quizzes with gamification to gradually fix and build knowledge in mycology applied to dermatology.

Results:

From November 2018 until October 2019, the total number of enrollments was 4,075 students. The basic module was the most popular, accounting for approximately 70% of the total enrollments (2850 students out of 4075). The completion rate for the basic module was approximately 39% (603 students completed out of 1538 who started). The advanced module and the intermediate one had higher completion rates (around 86% and 81% of students respectively).

Conclusion:

Although this study describes a one-year experience, we observed great participation (about 40% of our society's members) and engagement with this course, specially from students taking the advanced module, which included challenging clinical cases and therapeutic controversies. Considering the development and launching of this pilot course was made before the pandemic's online learning boom, it was considered as a remarkable unprecedented project that served as a reference for other virtual courses subsequently developed by our scientific society. One limitation of this study was the inability to get secondary data from the participants, such as age, sex or academic background, ever since this information wasn't able in our platform. For future courses we suggested the collection of this data to better understand the profile and distribution of potential students.



**Abstract N°: 7191****Assessing Knowledge and Perceptions Towards Mpox Among Healthcare Workers: Gaps and Implications for Public Health Education**

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Introduction & Objectives:

The unexpected global surge in human monkeypox (Mpox) cases in 2022, affecting over 100 nonendemic countries, highlighted a critical gap in healthcare preparedness. With over 97,000 cases reported by June 2024, Mpox has become a global health threat. This study aims to assess healthcare workers' (HCWs) knowledge, attitudes, and practices regarding Mpox to identify gaps and improve response strategies.

Materials & Methods:

Between October and December 2024, we conducted a cross-sectional online survey of 240 healthcare professionals, including students, residents, nurses, and specialists. The survey assessed knowledge of Mpox's clinical signs, transmission, diagnostic methods, and prevention strategies.

Results:

While 89.83% of HCWs had heard of Mpox, only 10.34% had received formal education on it. Social media and internet searches were the primary sources of information for 70.34% and 60.17%, respectively. Significant knowledge gaps were identified, especially regarding transmission methods and diagnosis. For instance, only 46.61% correctly identified transmission via shared dishes, and 34.48% relied solely on clinical signs for diagnosis. Though most participants supported hand hygiene and isolation, only 53.39% knew about the availability of vaccines.

Conclusion:

Despite widespread awareness of Mpox, our findings reveal substantial gaps in HCWs' knowledge that could hinder effective diagnosis and treatment. This underscores the need for targeted, evidence-based training and accessible information from reliable sources. Effective communication strategies are essential for ensuring healthcare workers are equipped to manage the disease and prevent its spread. In conclusion, this study emphasizes the urgent need for continuous education and up-to-date training for healthcare professionals on Mpox. Strengthening knowledge dissemination and prevention efforts, such as mass vaccination and clear communication, will be crucial to controlling this global health challenge.





Abstract N°: 7196

Generalized Exanthematous and Pustular Dermatophytid: Another Facet of Inflammatory Tinea

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Introduction & Objectives:

Dermatophytids are cutaneous manifestations of immunological origin linked to sensitization to a dermatophyte. They are frequently described in association with interdigital intertrigo (IDI) and more rarely with tinea capitis. We report an original case of generalized exanthematous and pustular dermatophytid (GEPD) secondary to a kerion.

Materials & Methods:

A 7-year-old girl, followed for vitiligo under topical treatment, consulted for a tinea of inflammatory appearance in the context of inappropriate applications of topical antifungal and corticosteroid-based treatments evolving for one month. There was a pustular exanthem consisting of non-follicular, non-confluent micro-pustules on an erythematous background in the retroauricular region, which rapidly extended to the face, trunk, and upper and lower limbs, accompanied by fever at 39°C, an altered general condition, and cervical lymphadenopathy. This presentation occurred 08 days after the initiation of terbinafine. There was no involvement of the skin folds. The rest of the clinical examination was normal.

Laboratory findings showed leukocytosis at 21,000/mm³ with 16,000/mm³ polymorphonuclear neutrophils, and a CRP of 37 mg/L.

Bacteriological and mycological samples from the pustules were sterile. And the mycological sample from the tinea concluded a kerion of Celsus due to *Trichophyton mentagrophytes*.

Given the hypothesis of GEPD, oral corticosteroid therapy with prednisolone was introduced at a dose of 0.5 mg/kg/day, under cover of cefotaxime and aminoglycoside antibiotic therapy, in combination with terbinafine. The eruption and general signs disappeared in four days.

Results:

Described for the first time by Jadassohn in 1918, dermatophytids are estimated to affect 4.2% of children and up to 17% of adults with dermatophytosis.

Dermatophytids occur in the acute phase of the infection 10 to 15 days after contamination, or on average 13 days after the introduction of antifungal treatment (1). These are the phases where the release of dermatophyte antigens is maximal. This corresponds to our case where the interval was 08 days.

The main differential diagnosis to consider is acute generalized exanthematous pustulosis (AGEP), especially when it occurs after the introduction of antifungal treatment. In our patient, the absence of confluence of the pustules, and the absence of involvement of the skin folds, makes it possible to rule out AGEP and maintain the antifungal treatment essential for recovery.

More generally, dermatophytid lesions can appear regardless of the antifungal prescribed, often even before its introduction; it is not a drug eruption.

It is probable that the application of very potent corticosteroids, in our case, led to the development of an

inflammatory tinea and, as a result, the occurrence of a dermatophytid.

Conclusion:

GEPD remains a rare entity but one that should not be overlooked and should not be confused with AGEPS secondary to antifungal treatment. The latter must imperatively be continued in combination with corticosteroid therapy to achieve recovery.

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**Abstract N°: 7202****Antibiotic-Resistant Cellulitis Treated with Colchicine: A Case Report**

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Introduction & Objectives:

Infectious cellulitis is a common bacterial skin infection typically treated with antibiotics. However, some cases are resistant to standard therapies, posing a therapeutic challenge. This case report describes a 75-year-old patient with bilateral lower limb cellulitis, unresponsive to multiple antibiotics, but significantly improved with colchicine. The objective is to highlight the potential of colchicine as an alternative treatment for antibiotic-resistant cellulitis and contribute to the limited literature on this topic.

Cas report:

Patient Profile: 75-year-old male with a history of heart disease, hypertension, type 2 diabetes, benign prostatic hyperplasia, and pulmonary emphysema;

Clinical Presentation: Bilateral lower limb cellulitis with warm, erythematous, edematous, and painful legs (Figure 01). Laboratory Tests: Unremarkable, with negative C-reactive protein test, normal erythrocyte sedimentation rate, and white blood cell count of 6100. Soft Tissue Ultrasound: Confirmed bilateral leg cellulitis.

Treatment History: Over 2 months, the patient received multiple antibiotics during several hospitalizations, including cefazolin, vancomycin, metronidazole, pristinamycin, amoxicillin-clavulanic acid, gentamicin, ciprofloxacin, cefixime, and imipenem/cilastatin. No clinical or ultrasonographic improvement was observed; instead, the cellulitis extended to the thighs.

Intervention: After ruling out drug interactions, considering the patient's comorbidities and polypharmacy, colchicine was initiated at a dose of 1 mg daily for its anti-inflammatory properties.

Results (discussion):

At 45 days post-colchicine initiation, reassessment showed a highly favorable clinical and ultrasonographic response, with significant improvement in the cellulitis.

Conclusion:

This case report highlights the successful use of colchicine in treating antibiotic-resistant cellulitis, suggesting its potential as an alternative therapy. Although colchicine is not typically indicated for bacterial infections, its anti-inflammatory properties may be beneficial in such cases. Further studies are needed to confirm its efficacy and elucidate its mechanism of action in cellulitis.





Abstract N°: 7250

Tropical-origin skin ulcers: An inside-out diagnosis.

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Introduction & Objectives: Ulcerated lesions in tropical settings pose a diagnostic challenge, with differentials including neoplasms and rare infections. We present a case initially treated under a presumed diagnosis; lack of response and internal involvement led to a revised, accurate diagnosis and cure.

Materials & Methods: Case report

Results: A 62-year-old male farmer from a 1100 m.a.s.l. town presented with two mildly painful papules on the left malar region, which enlarged, became verrucous and ulcerated. A similar lesion appeared on the right wrist. Initial biopsy showed pseudoepitheliomatous hyperplasia, lymphohistiocytic infiltrate with plasma cells, and scarce amastigotes, suggesting cutaneous leishmaniasis. He received miltefosine (due to right bundle branch block) and later meglumine antimoniate, without improvement. Appearance of a pharyngeal lesion and persistent skin involvement led to referral. Amphotericin B was started as third-line therapy. Lack of response prompted consideration of tuberculosis and paracoccidioidomycosis. Chest CT revealed nodules and ground-glass opacities. Clinical suspicion of paracoccidioidomycosis justified continuing amphotericin B, leading to complete resolution. Review of the initial biopsy showed the amastigotes were actually budding yeast, confirming the diagnosis.

“Tropical verrucous syndrome” encompasses chronic verrucous/ulcerated skin lesions in tropical regions due to causes like leishmaniasis, SCC, verrucous TB, sporotrichosis, chromoblastomycosis, and paracoccidioidomycosis. Leishmaniasis is most frequent (61.5/100,000) compared with sporotrichosis (8/100,000) and cutaneous TB (1.5% of extrapulmonary TB). Diagnosis often relies on finding amastigotes, though conventional methods have limited sensitivity (54–96%) and specificity (46%). Amastigotes are confused with yeast, mycobacteria, or artifacts. PCR enhances accuracy but is often unavailable. In this case, pulmonary findings and antifungal response supported paracoccidioidomycosis, later confirmed histologically.

Paracoccidioidomycosis is endemic in Latin America (1.5–2.2/100,000 in Colombia), primarily affecting males aged 30–60. Infection occurs via inhalation, with lungs as the main site (96%), and potential dissemination. Two forms exist: subacute (common in children/immunocompromised) and chronic (seen here). Isolated pulmonary disease is rare (25%). Lymphatic and mucosal involvement occur in 34–72% and 50% of cases, respectively. Skin lesions, seen in 25%, are polymorphic and often on the head and neck. Oral lesions are typically “mulberry-like” on palate or gums. Dissemination to adrenal glands or the reticuloendothelial system may cause up to 22.7% mortality.

Diagnosis is via direct identification of multipolar budding yeast in KOH preps or biopsies, showing pseudoepitheliomatous hyperplasia and plasma cell infiltrates. Silver stains help; serology is useful but often unavailable. Cultures take 20–30 days. Itraconazole is first-line; ketoconazole or voriconazole are alternatives. Amphotericin B is used for severe or disseminated cases—our patient received it due to misdiagnosis but showed complete response.

Conclusion: We report a chronic multifocal paracoccidioidomycosis case misdiagnosed as leishmaniasis, emphasizing the importance of thorough evaluation in tropical ulcers and considering internal involvement for accurate “inside-out” diagnosis.

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**Abstract N°: 7251****When Mycetoma Isn't What It Seems: Reclassifying a Misdiagnosed Case of Botryomycosis**

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Introduction & Objectives:

Botryomycosis is a rare, chronic suppurative bacterial infection that often mimics fungal or actinomycotic infections, both clinically and histologically. The classical triad of mycetoma — swelling, sinus tracts, and discharge of grains — is shared by eumycetoma, actinomycetoma, and botryomycosis, making clinical differentiation difficult. We report a case of botryomycosis in an immunocompetent man, initially misdiagnosed as actinomycetoma, to emphasize the importance of precise clinical, histopathological, and imaging evaluations in distinguishing these overlapping entities.

Materials & Methods:

Clinical data, photographic documentation, and imaging findings were retrieved from the patient's medical records. No statistical analysis was performed, as this is a descriptive case report.

Results:

A 30-year-old male presented with a six-year history of progressive, suppurative nodules and sinus tracts on the right foot, associated with swelling and multiple atrophic scars (Figure 1). According to the patient, the onset of symptoms followed an episode of playing football barefoot while traveling through a countryside region. He had no history of chronic illness or immunosuppressive conditions. The clinical triad raised suspicion for mycetoma. An initial histopathological report from another facility diagnosed actinomycetoma based on filamentous bacterial aggregates. However, upon reevaluation at our institution, histology revealed coccoid bacterial clusters with the Splendore-Hoeppli phenomenon, supporting the diagnosis of botryomycosis (Figure 2). Fungal cultures were negative. Dermatologic ultrasonography demonstrated deep soft tissue involvement and osseous extension from the first to the fourth toes (Figure 3). Previous antibiotic therapy with trimethoprim-sulfamethoxazole yielded partial improvement. Due to the extent of bone involvement, surgical referral was indicated. Unfortunately, no bacterial pathogen was isolated via tissue culture, which hindered targeted antimicrobial selection.

Conclusion:

This case illustrates how botryomycosis can be mistaken for actinomycetoma both clinically and histologically, especially when relying on classical triad features and insufficiently specific pathological interpretation. Careful histopathological review and imaging are essential to distinguish among mycetoma subtypes, which require distinct therapeutic approaches. Although culture confirmation remains ideal for antimicrobial tailoring, advanced imaging and surgical planning are crucial when bone involvement is detected. Clinicians and pathologists must be aware of these diagnostic subtleties to ensure timely and effective treatment.



**Abstract N°: 7259****Mycetoma beyond borders: actinomycetoma in a non endemic setting**Sofia El haitamy¹, Zakia Douhi¹, Meryem Soughi¹, Sara Elloudi¹, Hanane Baybay¹, Fatima Zohra Mernissi¹¹university hospital center hassan II, dermatology, Fez, Morocco**Introduction & Objectives:**

Madura foot (mycetoma) is a chronic granulomatous infection caused by fungi (eumycetoma) or filamentous bacteria (actinomycetoma), typically presenting as a painless pseudotumor with progressive swelling, draining sinuses, and grain discharge. While endemic to tropical regions within the “mycetoma belt,” sporadic cases in temperate climates often remain underrecognized, leading to delayed diagnosis due to clinical mimicry. We report a case of actinomycetoma in a 28-year-old farmer from a non-endemic area, highlighting histopathological features and diagnostic challenges.

Case report:

The patient presented with a two-year history of progressive swelling of the left plantar region and intermittent discharge of whitish grains following a soil-contaminated foot injury. Initial misdiagnoses in primary care contributed to referral delay. Clinical examination revealed a subcutaneous mass over the calcaneus with multiple fistulae, fibrin-coated ulceration, and visible white granules. CT and MRI revealed soft-tissue hypertrophy, osteolytic changes, and calcaneal sequestra. A characteristic “dot-in-circle” sign central hypointense dots within hyperintense rings on T2-weighted MRI was observed. Histopathology showed dense neutrophilic infiltrates surrounding basophilic filamentous aggregates and grains, consistent with actinomycetoma. Culture identified *Actinomyces* spp., confirming the diagnosis. The patient was treated with a combination of amoxicillin-clavulanate (30 mg/kg/day), amikacin (15 mg/kg/day), and streptomycin (1 g/day), along with local wound care. At six-month follow-up, ulcer healing and marked clinical improvement were noted.

Discussion:

The indolent progression and non specific symptoms of mycetoma often delay diagnosis in non-endemic areas. Grain color is suggestive: black for eumycetoma, white/red for actinomycetoma. Histopathology is essential actinomycetoma shows fine, Gram-positive filaments, whereas eumycetoma presents with thicker, PAS positive hyphae. The basophilic filaments and neutrophilic response in this case supported a bacterial origin. Absence of caseous necrosis and true granulomas helped rule out cutaneous tuberculosis. Although WHO guidelines advocate molecular sequencing in culture negative cases, such tools remain inaccessible in low-resource areas. Radiologically, the “dot-in-circle” sign is pathognomonic on MRI, while CT is critical for bone assessment. Actinomycetoma, comprising 40% of mycetoma cases, requires prolonged antibiotic therapy (6–12 months) with aminoglycosides and β -lactams. Eumycetoma often requires surgical debridement with antifungals.

Conclusion:

This case underscores the need for increased awareness of mycetoma in temperate zones. WHO’s recognition of mycetoma as a neglected tropical disease reinforces the importance of early biopsy and protective footwear in high risk environments to prevent disability.

**Abstract N°: 7335****Cutaneous Leishmaniasis Treated With Itraconazole: A Case Report**

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Cutaneous Leishmaniasis Treated With Itraconazole: A Case Report**Introduction:**

Leishmaniasis is a vector-borne infection caused by Leishmania genus protozoa. It is predominantly reported in Middle Eastern countries, including Saudi Arabia, Algeria, Iran, Iraq, and Afghanistan, as well as in regions of Brazil and Peru. The disease is associated with various risk factors, such as poverty, malnutrition, migration, and inadequate housing conditions.

which contribute to its endemicity in these regions.

The most common type of leishmaniasis is cutaneous leishmaniasis (CL), which is estimated to affect between 600,000 and 1 million new cases annually worldwide. Although CL is not life-threatening, it is a significant public health concern due to its potential for permanent scar formation, decreased quality of life, stigmatization, and long-term psychological consequences.

Clinically, CL presents as solitary or multiple verrucous or ulcerated plaques on exposed body areas prone to sandfly bites. In some cases, these lesions may be accompanied by satellite lesions and nodular lymphangitis.

Objective:

To report a case of cutaneous leishmaniasis successfully treated with oral itraconazole, and to highlight the clinical presentation, diagnostic process, and potential role of itraconazole as an effective therapeutic option in the management of cutaneous leishmaniasis.

Materials & Methods:

This is a case of Cutaneous Leishmaniasis treated with Itraconazole

Results:

A 61 year old male presented with a 2 months history of itchy, erythematous, heavy, crusted plaques on both cheeks and the nasal bridge, which had progressively increased in size. He had recently traveled to Makkah but had no history of travel prior to the onset of symptoms, and his family history was not significant. There were no systemic symptoms of nasal obstruction, epistaxis or discharge from nose, weight loss, facial flushing, or photosensitivity.

Upon physical examination, there's a well-defined erythematous plaque measuring approximately 5 × 4 cm on the nasal bridge extending to the bilateral cheeks, with overlying heavy crusting and surrounding erythema (Figure 1). The lesion was non-tender on palpation, and sensation over the area was intact, which helped rule out leprosy. There was no associated lymphadenopathy or mucosal involvement.

Routine laboratory tests, polymerase chain reaction (PCR) and acid-fast bacilli culture were unremarkable. After

excluding other granulomatous disorders, a skin punch biopsy was taken from the lesion and Histopathological examination showed a chronic noncaseating granulomatous inflammation with numerous dot-shaped microorganisms, consistent with amastigotes of *Leishmania* species (Figure 2).

Treatment with oral itraconazole was started at a dose of 200 mg twice daily for 30 days. After 30 days there was significant improvement (Figure 3).

Conclusion:

This case highlights the effectiveness of oral itraconazole in treating cutaneous leishmaniasis. Clinical suspicion and early detection are critical, and should involve a comprehensive approach, including clinical evaluation, histopathology, and laboratory testing. Oral itraconazole proves effective in managing CL; however, further research and clinical data are necessary to refine treatment protocols and assess the comparative effectiveness across different *Leishmania* species.



Abstract N°: 7339

Tinea Capitis Caused by *Microsporum canis* in an Elderly Female with Cervical Cancer: Case Report

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Introduction: Tinea capitis, a dermatophyte infection of the scalp and hair follicles, is predominantly observed in prepubertal children, with adult cases accounting for less than 5% of reported infections. *Microsporum canis*, a zoophilic dermatophyte transmitted via contact with infected animals, is a leading cause of tinea capitis in endemic regions. Adult-onset tinea capitis is often associated with immunosuppression, including diabetes mellitus, hormonal changes, or occult malignancies, necessitating comprehensive systemic evaluation. Terbinafine, an allylamine antifungal, is first-line therapy for *Trichophyton* species; however, its efficacy against *Microsporum* infections remains debated due to variable susceptibility profiles. This case underscores the diagnostic challenges, therapeutic considerations, and the critical role of investigating comorbidities in adult patients presenting with atypical fungal infections.

Case Report A 72-year-old woman with well-controlled type 2 diabetes mellitus and hypertension presented with a 3-month history of pruritus, scaling, and a solitary alopecic plaque on the left occipitoparietal scalp. Dermatological examination revealed a 10 cm circular plaque with broken hair shafts, perifollicular scaling, and erythema. Dermoscopy identified “Morse code-like” hairs and white sheaths, while Wood’s lamp examination demonstrated bright-green fluorescence, pathognomonic for *Microsporum* infection. Oral terbinafine (250 mg/day) was initiated, leading to clinical resolution within 90 days, confirmed by negative mycological cultures and Wood’s lamp examination. Given the atypical presentation in an immunocompetent-appearing adult, systemic evaluation was pursued. Pelvic imaging (ultrasound and MRI) incidentally identified a cervical mass, later confirmed as squamous cell carcinoma via biopsy. The patient was referred to gynecologic oncology for staging and management, highlighting the incidental discovery of malignancy during dermatological workup.

Conclusion: This case illustrates that adult-onset tinea capitis, particularly caused by *M. canis*, should prompt thorough investigation for underlying immunosuppression or neoplasia, even in patients with well-controlled comorbidities. The successful use of terbinafine challenges historical assumptions about its limited efficacy against *Microsporum* species, suggesting strain-specific susceptibility. Dermatologists play a pivotal role in bridging cutaneous findings to systemic pathologies, emphasizing multidisciplinary collaboration. Early malignancy detection in this case underscores the importance of integrating dermatological diagnoses into broader clinical contexts, potentially improving oncological outcomes through timely intervention.



**Abstract N°: 7372****Olecranon Bursitis Due to *Sporothrix schenckii* in a Patient with Chronic Lymphocytic Leukemia: A Rare Presentation of Sporotrichosis**Tarek Zieneldien¹, Janice Kim², sophia ma¹, John Greene³¹Johns Hopkins University School of Medicine, Baltimore, United States²Michigan State University College of Osteopathic Medicine, East Lansing, United States³Moffitt Cancer Center, Tampa, United States

Introduction & Objectives: Sporotrichosis is a condition that typically presents as cutaneous or lymphocutaneous disease after inoculation through trauma. It is caused by the dimorphic fungus *Sporothrix schenckii*, and it usually presents as pustules or papules characterized by ulcerative nodules with local lymphatic involvement. Deep localized infections, such as olecranon bursitis, are rare and primarily occur in immunocompromised individuals. Here, we describe a unique case of isolated *S. schenckii* olecranon bursitis in an immunocompromised patient without clear trauma or recent environmental exposure.

Materials & Methods: A 59-year-old woman with chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), treated with acalabrutinib, presented with persistent right elbow swelling following a hematoma from failed IV access on January 2022. Within a month, she developed diffuse arm cellulitis that was treated with three antibiotic regimens from February to May of 2022, resulting in improvement except for persistent swelling over the right olecranon. On August of 2022, imaging showed soft tissue contour that was consistent with olecranon bursitis. On September of 2022, an ultrasound-guided aspirate removed 10 mL of serous fluid in which bacterial and acid-fast bacilli cultures were negative, but fungal culture grew 1+ *Sporothrix schenckii* complex. Despite initial treatment with terbinafine 500 mg BID, response was poor. In December 2022, she underwent surgical debridement with vacuum-assisted closure placement and pathology confirmed granulomatous inflammation and necrotic tissue with growth of *S. schenckii*. Even though terbinafine susceptibility was confirmed, clinical failure and potential drug interactions with her chemotherapy led to transition to antifungal therapy with posaconazole 300 mg daily and her condition improved significantly.

Results: The patient denied gardening within the past six years, although prior to that, she worked in her garden growing tomatoes in Colorado. However, she does not recall ever previously getting a puncture or trauma, and imaging showed no evidence of disseminated infection. Her right elbow is now healed with no edema or redness after completing approximately 11 months of treatment with posaconazole.

Conclusion: This case illustrates an unusual presentation of deep localized sporotrichosis in an immunocompromised host without clear environmental exposure or trauma. Clinicians should consider fungal etiologies such as *S. schenckii* in patients with atypical, persistent bursitis, especially when standard bacterial treatments fail. In immunosuppressed patients, treatment may require prolonged courses and adaptation due to drug interactions, as well as surgical intervention.



**Abstract N°: 7407****Stigma analysis in patients with leprosy**

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Introduction & Objectives: Leprosy (HD) is a chronic disease, affecting people of any sex or age group, with a long clinical course and which, when left untreated, can cause deformities/physical disabilities, making its impairment visible, which can lead to social stigma. We sought to analyze the report of situations of social stigma in leprosy patients at the HD referral outpatient clinic in a university.

Materials & Methods: We applied the Brazilian version of the Explanatory Model Interview Catalog (EMIC) – Stigma Scale for people with HD in 37 leprosy patients; we also made an open question to describe some experience in this sense. Quantitative results were evaluated with Mann-Whitey and Kruskal-Wallis tests.

Results: We had 22 patients (59.46%) who said they had never suffered a situation of social prejudice due to leprosy. The statistical correlation between different clinical variables (gender, age, education, color, clinical stage of the disease), as well as the correlation between each of the clinical signs/symptoms of HD and the final EMIC score did not show any statistically significant association.

Conclusion: Despite these findings, the existence of social stigma is clearly a problem that interferes with a better result in the eradication of the disease, and must be corrected by the health authorities.



**Abstract N°: 7411****Conquering Challenges in Papulonecrotic Tuberculid: A Case Report**Sajana Bhandari*¹¹Gandaki Medical College , Dermatology , Pokhara, Nepal**Introduction & Objectives:**

Papulonecrotic tuberculid is one of the the tuberculids characterized by chronic, recurrent and symmetrical eruption of necrotizing skin papules in crops mostly over the extensor of limbs. It is a rare condition and on top of that, there are very few case reports of papulonecrotic tuberculid reported from our part of the world. We report a case of 33 years old male who presented with multiple erythematous papules with subsequent central ulceration and crusting mostly on bilateral upper limbs and trunk for 20 days. The patient had no history suggestive of pulmonary tuberculosis

Materials & Methods:

His baseline investigations including serological test for syphilis, chest x-ray, and sputum test for tuberculosis were unremarkable. The significant laboratory findings were increased ESR along with a strongly positive Mantoux test. However, the biopsy showed features like multinucleated giant cells, vague granuloma, dermal neutrophilic collection and extravasated red blood cells, which could not pin point towards the diagnosis of vasculitis.

Results:

Despite the limited evidence, we started him on anti-tubercular treatment (ATT) based on the clinical picture and positive Mantoux test. There was gradual improvement after the initiation of ATT with complete resolution at 8 weeks. The patient completed the total course of ATT with no recurrence in two and half years period.

Conclusion:

This changelling scenario highlights the significance of clinical judgement along with the importance of empirical therapy in such diagnostic difficulties.



**Abstract N°: 7412****A visible yet overlooked disease: Delayed diagnosis of leprosy in Brazil**

Anna Carolina Barcellos¹, Sarah Fadel¹, Ana Elisa Barreto Calixto¹, Ana Luiza Cavalcanti¹, Clara Marques¹, Yasmin Rocha¹, Fernando Belles¹, Thatiane Romero¹

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Introduction & Objectives:

Leprosy is a chronic infectious disease caused by the bacilli *Mycobacterium leprae* and *Mycobacterium lepromatosis*. Although considered a rare condition in Europe, it remains prevalent in developing countries such as Brazil and clinical presentation depends on the host's immune response.

This case illustrates a delayed diagnosis of borderline tuberculoid form in a patient with skin lesions persisting for over two years. The analysis of such cases contributes to improved understanding of the clinical spectrum of leprosy and facilitates earlier detection and intervention, ultimately helping to reduce the stigma and discrimination associated with the disease.

Materials & Methods:

A 60-year-old hypertensive female patient presented to a dermatology outpatient clinic with a three-month complaint of an erythematous-infiltrated plaque on the right malar region, associated with pruritus and burning. She also reported hypopigmented macules with an erythematous halo on the lower limbs for over two years, associated with pruritus, dysesthesia, and intermittent edema. The patient had previously sought medical care and had been treated empirically with ivermectin and several antibiotics, without clinical improvement.

Results:

Skin biopsy was performed and histopathological analysis revealed epithelioid granulomas within deep vascular pathways, surrounded by a lymphocytic halo, numerous Langhans-type multinucleated giant cells, and a peripheral nerve bundle encased by non-epithelioid histiocytes. Wade-Fite staining was negative for acid-fast bacilli, with a bacteriological index = 0. Despite the absence of bacilli, the clinical and histopathological findings confirmed the diagnosis of borderline tuberculoid leprosy. Multidrug therapy with clofazimine, dapsone, and rifampicine was initiated and the patient is still in follow-up.

Conclusion:

This case highlights the ongoing diagnostic challenges and exemplifies the persistent underdiagnosis of leprosy, even in endemic countries such as Brazil. The patient's prolonged course over two years with cutaneous and neurological signs highly suggestive of leprosy of the disease.

The borderline tuberculoid form should be considered among differential diagnoses in cases involving hypochromic-centered macules associated with neurological alterations. In endemic regions, the diagnosis of leprosy remains primarily clinical, based on the identification of hypopigmented or erythematous skin lesions with sensory loss and/or thickened peripheral nerves upon physical examination. A negative acid-fast bacilli should not be regarded as an exclusion criterion.

This case underscores the urgent need for enhanced awareness and training of primary care professionals and dermatologists regarding the heterogeneous clinical manifestations of leprosy. Timely clinical suspicion and early

diagnosis are crucial for reducing disease burden, preventing permanent disabilities and interrupting transmission chains.

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**Abstract N°: 7414****Cutaneous Paecilomyces in an Immunocompetent Host**Rochelle Monteiro*¹¹Father Muller Medical College, dermatology, Mangaluru, India**Introduction & Objectives:**

Paecilomyces are saprophytic fungi found usually in decaying organic matter and soil.

Infection in humans is uncommon, usually follows inoculation secondary to trauma, and is seen in immunocompromised hosts. Cutaneous hyalohyphomycosis in immune-competent individuals is rare, and most often difficult to treat. We report a case of a young healthy woman, developing cutaneous hyalohyphomycosis with a favourable response to oral itraconazole.

Materials & Methods:

A 28-year-old female, presented with complaints of painful reddish raised lesions over the nose for 6 months. There was a history of trauma over the area, due to a road traffic accident one year ago. Examination revealed a few erythematous and edematous crusted papules and pustules over the dorsum of the nose, with infra-orbital edema. A differential diagnosis of conidiobolomycosis was considered. A skin biopsy and fungal culture was performed. Histopathological features were suggestive of a chronic inflammatory process, favouring infective etiology. PAS and GMS stains were positive for fungi. The culture revealed velvety, olive-brown colonies indicating growth of Paecilomyces lilacinus species.

Results:

The patient was initiated on capsule itraconazole 200 mg twice daily, for 4 months, with periodic monitoring of liver function tests. Follow-up visits showed a gradual improvement with almost clearance of lesions at the end of 4 months.

Paecilomyces lilacinus now known as Purpureocillium lilacinum, is a ubiquitous saprophytic mould, it is an opportunistic pathogen associated with mostly ocular infections, catheter related fungemia, deep and disseminated infections seen in immunocompromised patients. Paecilomyces species most frequently associated with human infections include P. lilacinus and P. variotii. The cutaneous clinical manifestations observed are variable like solitary or disseminated skin eruptions with erythematous macules, papules, vesicles or, nodules with a necrotic centre. observed. Diagnosis is based on fungal culture or histological study of lesions. Paecilomyces lilacinus grows well on routine fungal culture like Sabouraud dextrose agar (SDA) producing brownish colonies and malt extract 2% w/v agar producing flocculant, vinaceous to violet colonies. Paecilomyces on microscopy

shows long, tapering, flask-shaped sterigmata that end in a sharp point and long, unbranched chains of conidia, which are generally shorter and fewer in number.

Conclusion:

Cutaneous Paecilomyces although an uncommon pathogen, is potentially treatable. Hence it needs to be considered in our differential diagnoses of atypical appearing mycoses occurring secondary to trauma.



**Abstract N°: 7422****Genital Nodular Scabies and the relevance of the topography of lesions**

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Introduction: Genital Nodular Scabies is an infestation caused by the *Sarcoptes Scabiei* mite. Scabiotic nodules are less common in classic scabies. Therefore, the most common symptoms are erythematous, firm and itchy structures involved in the genital region.

Case Report: A 23-year-old male patient was referred to the dermatology outpatient clinic, by urology, due to allergies in the genital region. The patient reports that about 3 months ago, after casual sexual intercourse, some papular, itchy lesions appeared distributed over the genital region and thighs. Subsequently, the lesions spread throughout the body, being more pronounced in the wrist region, between the fingers, chest, armpits and thighs and genitals. The itching was more intense at night and upon waking up. On dermatological examination, these lesions were small, erythematous papules and some shades under the skin of the affected areas. Through the history and morphotopographic characteristics of the lesions, the diagnosis of scabies was made. Using ivermectin 6mg for every 30kg/weight, with a repeat dose after 7 days, in addition to care for personal clothing and bedding, there was a regression of the lesions, with a reduction in symptoms, except for the lesions in the genital region which were nodular. and highly pruginous. Prednisolone 40mg/day was used for 14 days, associated with ivermectin once a week for 1 month, with a total reduction in lesions.

Conclusion: The case shows the importance of an adequate diagnosis and dermatological treatment of Genital Nodular Scabies, which is an endemic disease and sometimes linked to STIs. Furthermore, this report shows the characteristics and evolution of the pathology.



**Abstract N°: 7450****Non-Feline Animal-Transmitted Sporotrichosis: A Case Series from a Mexican Reference Center**Pamela Rodríguez Salgado*¹, Alexandro Bonifaz Trujillo¹, VALERIA LYZZETE DIAZ MOLINA¹¹General Hospital of Mexico Dr. Eduardo Liceaga, Ciudad de México, Mexico**Non-Feline Animal-Transmitted Sporotrichosis: A Case Series from a Mexican Reference Center****Introduction & Objectives:**

Sporotrichosis is a subcutaneous fungal infection caused by *Sporothrix* spp. While zoonotic transmission by domestic cats—particularly involving *Sporothrix brasiliensis*—has been well documented in Brazil, infections related to non-feline animals remain underrecognized. This study aims to describe a case series of sporotrichosis transmitted by non-feline animals, highlighting alternative zoonotic pathways and expanding current knowledge on the epidemiology of the disease in Latin America.

Materials & Methods:

We performed a retrospective review of sporotrichosis cases diagnosed at a dermatology reference center in Mexico from 2007 to 2024. Inclusion criteria were confirmed or highly suspected non-feline zoonotic transmission. We analyzed clinical presentation, exposure history, fungal identification, treatment, and outcomes.

Results:

Eight cases were identified with exposure linked to armadillos, squirrels, rats, a domestic dog, and one controversial case involving a spider bite. Patients were aged 8 to 28 years and presented with the lymphocutaneous form of sporotrichosis, primarily on the limbs. Direct traumatic inoculation via scratches or bites was reported in all cases. All isolates were identified as *Sporothrix schenckii*. Treatment with potassium iodide or itraconazole led to clinical resolution or significant improvement in all patients. The case involving a spider bite, though rare, was included due to positive culture and clear temporal association. These findings reinforce the role of non-feline animals as potential reservoirs, especially in rural and semi-rural environments.

Conclusion:

This case series underscores the importance of considering non-feline animals as relevant but underrecognized sources of zoonotic sporotrichosis. Unlike the feline-driven epidemic in Brazil, all cases in this study were linked to *S. schenckii* and non-feline vectors, especially armadillos and rodents. Early recognition of animal contact beyond felines is crucial in endemic regions to prevent diagnostic delays and initiate timely antifungal therapy. These findings contribute to a more comprehensive understanding of sporotrichosis transmission dynamics and support the inclusion of non-feline exposure history in clinical evaluations.





Abstract N°: 7455

“Unusual mixed-form paracoccidioidomycosis with nasal destruction and multiorgan involvement in an HIV patient: A diagnostic challenge”

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Title

“Unusual mixed-form paracoccidioidomycosis with nasal destruction and multiorgan involvement in an HIV patient: A diagnostic challenge”

Introduction & Objectives

Paracoccidioidomycosis (PCM) is a systemic mycosis endemic in Latin America, typically presenting as chronic pulmonary or mucocutaneous disease. In HIV patients, PCM can manifest atypically, with rapid progression and multiorgan involvement. We report a rare case of mixed-form PCM (acute/subacute and chronic) in a young HIV patient, highlighting diagnostic pitfalls and the importance of early suspicion in immunosuppressed individuals.

Materials & Methods

A 21-year-old male, HIV-positive (diagnosed 1 year prior, on antiretroviral therapy – ART since December 2024), presented with a 6-month history of a destructive nasal lesion, followed by multiple facial/chest ulcers, night sweats, and 20 kg weight loss. Physical examination revealed a vegetating nasal nodule with yellow crusts, molluscum-like papules, ecthymoid ulcers, and tender cervical lymphadenopathy. Differential diagnoses included sporotrichosis, leishmaniasis, and cutaneous tuberculosis. Direct mycological examination (nasal secretion) showed double-walled budding yeasts; skin biopsy demonstrated granulomas with microabscesses and giant cells containing spores. PAS/Grocott stains confirmed *Paracoccidioides* spp. (“steering wheel” pattern). CT revealed cerebellar, pulmonary, and seminal vesicle lesions.

Results

The patient was diagnosed with disseminated mixed-form PCM (acute/subacute and chronic) and treatment was initiated with liposomal amphotericin B and sulfamethoxazole-trimethoprim (SMX-TMP) due to neurological involvement. Remarkable clinical/radiological improvement occurred within 2 months, with full resolution of skin lesions. The rapid progression after ART initiation suggested immune reconstitution inflammatory syndrome (IRIS).

Conclusion

This case illustrates an aggressive, mixed-form PCM in an HIV patient, with overlapping features and multiorgan involvement. Early diagnosis (requiring histopathology and imaging) and combined antifungal therapy were crucial to prevent fatal outcomes. PCM should be considered in HIV patients with atypical cutaneous/neurological manifestations, even in non-endemic regions.

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**Abstract N°: 7457****Borderline Lepromatous Leprosy, Details that Matter: A Case Report**Raquel Ramirez^{*1}, cuiting feng¹, Alberth Elizondo¹¹Hospital Max Peralta, San José , Costa Rica**Introduction & Objectives:**

Leprosy, also known as Hansen's disease, is a chronic infection of the skin and peripheral nerves caused by *Mycobacterium leprae*, an acid-fast, slow-growing, obligately intracellular bacillus. The most common routes of transmission are respiratory secretions and skin contamination. Risk factors include close contact with infected individuals and immunodeficiency. The infection has an incubation period of 2 to 4 years and presents with a wide spectrum of clinical manifestations, reflecting the host's immune response. According to the Ridley-Jopling classification system, there are five forms of leprosy: tuberculoid, borderline tuberculoid, borderline, borderline lepromatous, and lepromatous. The borderline lepromatous form is characterized by numerous lesions, often symmetrical, hypopigmented, erythematous, hypoesthetic, and with extensive peripheral nerve involvement. The clinical diagnosis is based on the typical signs of skin lesions and nerve enlargement. Some patients may develop an immune response. This case represents a diagnostic challenge in an immunocompetent patient. The objective is to highlight its clinical presentation and diagnostic approach.

Materials & Methods:

Descriptive case study with patient consent for publication. Bacilloscopy and skin biopsy were performed for confirmation.

Results:

A 64-year-old male farmer, with a history of hypertension and a recent *Neisseria gonorrhoeae* infection, presented to the emergency department with obstructive voiding symptoms, penile lesions, more than 10 kg of unintentional weight loss over 3 months, and severe fatigue. Clinical examination revealed disseminated erythematous and violaceous plaques with defined borders and an infiltrative appearance across the trunk and limbs. Ulcerated lesions with central necrosis were observed on the scalp, nasal dorsum, and penis. Multiple small warty lesions were noted between fingers and toes. Whitish plaques were visible on the tongue, which detached with scraping. The symptoms had evolved over approximately one year. Hansen's disease was suspected and confirmed via skin biopsy, which showed an inflammatory infiltrate composed of lymphocytes and epithelioid histiocytes forming tuberculoid granulomas without necrosis, involving peripheral nerves. The patient was treated with Rifampicin 600 mg and Clofazimine 300 mg single dose, followed by daily Dapsone 100 mg and Clofazimine 50 mg. By day 20 of treatment, star-shaped vasculitic lesions appeared on lower extremities, consistent with Lucio's phenomenon.

Conclusion:

The clinical diversity in this case made the diagnosis challenging. The wide range of elementary lesions initially suggested other conditions, such as cutaneous manifestations of neoplasms. Imaging also revealed gastric body thickening, raising suspicion for cutaneous lymphoma, which was ruled out through a negative skin flow cytometry. The key to the correct diagnosis was recognizing the characteristic skin lesions with hypoesthesia and notable systemic involvement.





Abstract N°: 7467

Stealthy nerves, Elusive disease: The diagnostic dilemma of Pure Neuritic Leprosy

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Introduction

Pure Neuritic Leprosy (PNL) is a distinct form of leprosy characterized by exclusive nerve involvement without skin lesions, making diagnosis difficult due to lack of specific clinical markers and thus complicating management. Nerve biopsy remains the gold standard for diagnosis, but has low sensitivity. Auxiliary diagnostic techniques include skin/nasal mucosa biopsy, FNAC, PCR, immunohistochemistry, HRUS, MRI and nerve conduction study (NCS). A combination of these tests is vital for early diagnosis, timely management, and prevention of disability.

Aims & Objectives

To describe concordance between the findings of Nerve biopsy Histopathology, Nerve biopsy PCR and Nerve conduction study (NCS) of peripheral nerves in clinically diagnosed cases of PNL.

Materials & Methods:

It is a cross-sectional study done at a tertiary care hospital for a period of 2 years. Inclusion criteria were patients of all ages and both sexes with sensory loss with or without motor deficit, mononeuropathy, mononeuropathy multiplex, or polyneuropathy, having thickened nerves with preserved reflexes, with no detectable cutaneous lesions. Exclusion criteria were leprosy neuropathy with skin lesions and patients who received MDT in the past. NCS of peripheral nerves of bilateral upper limbs and lower limbs were done for 40 clinically diagnosed PNL patients. Nerve biopsy of a pure sensory nerve was performed under LA and sent for HPE and PCR for *M. leprae* 16S ribosomal RNA and RLEP gene detection. Sural nerve (16), ulnar cutaneous nerve (23) and radial cutaneous nerve (01) were biopsied.

Results:

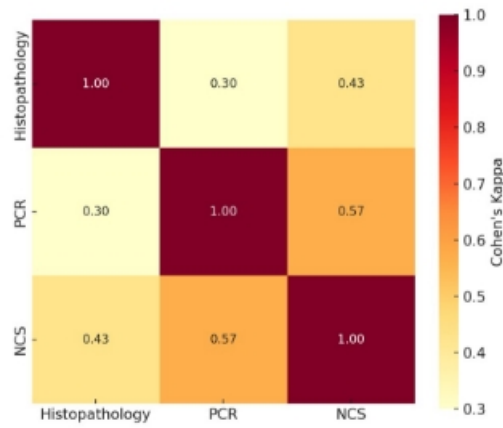
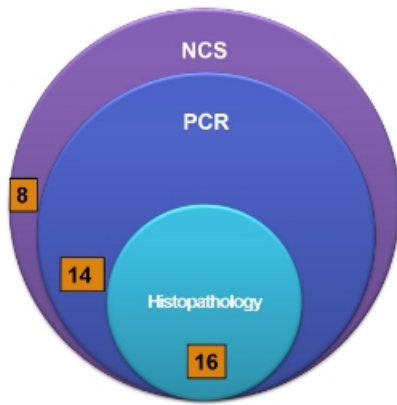
NCS revealed sensory-motor axonal neuropathy in 13 patients and pure sensory axonal neuropathy in 27 patients. Nerve biopsies of all 40 patients were negative for *M. leprae* on Fite-Faraco stain. Histopathology revealed no definitive features (Foam cells with AFB or caseous necrosis) in any patients, suggestive features (Perineural or endoneural inflammation & infiltrate, perineural fibrosis, granuloma) in 40% (16) and was normal/equivocal in 60% (24) of the cases. Among 40 clinically diagnosed PNL cases, 80% (32) were found to be PCR positive for *M. leprae* thus confirming the diagnosis. Cohen's Kappa values representing agreement between these modalities ranged from fair ($\kappa = 0.3$) between histopathology & PCR, moderate ($\kappa = 0.43$) between histopathology and NCS and moderate ($\kappa = 0.57$) between PCR & NCS. [Figure 1, 2] Overall, substantial agreement (Fleiss' Kappa = 0.63) was demonstrated between 3 modalities in the diagnosis of PNL.

Figure 1: Heatmap showing pairwise Cohen's Kappa values representing agreement between 03 modalities.

Figure 2: Venn diagram displaying the potential diagnostic overlap among the 03 modalities.

Figure 1: Heatmap showing pairwise Cohen's Kappa values representing agreement between 03 modalities.

Figure 2: Venn diagram displaying the potential diagnostic overlap among the 03 modalities.



Conclusion:

Combination of Nerve biopsy histopathology, PCR and NCS facilitates diagnosis of PNL in doubtful cases. Substantial overall agreement was observed between these 3 modalities, underscoring the need for a multimodal diagnostic strategy, for objective confirmation of the diagnosis, in clinically diagnosed and empirically treated PNL patients. Out of all 3 modalities studied, PCR is the most reliable technique providing conclusive results with 80% positivity. NCS findings usually precede the clinically apparent nerve function impairment (NFI) and can detect subclinical neural involvement, although findings do not provide conclusive evidence of leprosy. Being a preliminary study, limitations are small sample size and single centre study.





Abstract N°: 7476

A dissimulate presentation of de novo histoid type of lepromatous leprosy as rheumatoid arthritis.

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Introduction:

Histoid leprosy is an uncommon variant of lepromatous leprosy that usually follows treatment failure but occurred as de novo in our case.

Objectives:

To highlight varied clinical profile & prevent error of misdiagnosis sometimes, as it can lead to severe reactions and deformities.

Materials & Methods:

Case history

- A 28-year-old female, presented with sudden onset of multiple raised skin to dark coloured lesions over body, associated with itching since 1 month.
- No h/s/o fever, epistaxis, difficulty in buttoning/unbuttoning blouse, slipping of chappals, or h/s/o sensory loss.
- O/E: Multiple skin coloured to hyperpigmented non tender nodules of various size present over dorsum of bilateral hands & feet, posterior aspect of legs.
- K/C/O Rheumatoid Arthritis since 5 months, took treatment for 2 months.
- On investigating, AFB stain was strongly positive, SSS was negative & skin biopsy was s/o Lepromatous leprosy-histoid type.
- Nerve examination-left ulnar nerve thickened.
- Sensory tests-Pain, fine touch, & temperature lost over left foot(dorsum-plantar) & left index & middle finger(palmar).
- Special test-Normal.
- Patient started on MDT.

Results:

We noted remarkable improvement within one month of starting treatment. Now patient still taking MDT MB.

Histoid leprosy, a rare form of lepromatous leprosy, has distinctive clinical and

histopathological features, typically presents as a sudden onset of dome-shaped lesions, often linked to dapsone resistance/anti-leprosy treatment, or rarely arising de novo as in this case where there was no history of MDT intake.

Conclusion:

Leprosy is a great mimicking disease so it becomes vital to take detailed patient history, awareness of inflammatory symptoms, laboratory abnormalities, avoid misinterpreting serologic findings to prevent diagnostic errors.

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Abstract N°: 7508

Assessment of problems faced by Leprosy Patients in Release from Treatment (RFT) Phase

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Introduction & Objectives:

Release from treatment (RFT) signifies the completion of the standard WHO-multidrug therapy (MDT), and considered to be the end of the active treatment phase. However It may not suggest the complete cure and patient may have issues like recurrent reactions, relapses, neuritis, neuropathy, deformities even after completion of MDT.

There is paucity of data on issues faced by leprosy patient in the RFT phase.

This study aims to describe the clinical and neurological spectrum of leprosy patients who are released from treatment to understand the common problems faced by these patients.

Materials & Methods:

Patients who are release from treatment (RFT) following up at a leprosy clinic of our hospital and a leprosy care centre in the same city were included in the study. Any case that is released from fixed duration multidrug therapy and coming with any clinical symptoms and signs related to activity or consequences of leprosy was included. Detailed history, cutaneous examination, skin biopsies, laboratory and radiological investigations were done as the indication. Data were compiled in MS Excel.

Results:

Total A total of 70 patients were studied. Age of the patient ranged from 21 to 70 years with maximum number of patients were in 6th decade (28.57%) and 5th decade (25.71%). 47 cases (67.14%) were males, and 23 cases (32.8%) were females with Male: Female ratio of 2:1. Majority of cases 83.0% received multibacillary regimen while 17% patients received paucibacillary regimen. In the present study, out of 70 cases of RFT, 45 cases complained of persistent of skin lesions, 55 patients had sensory impairment over extremities, 23 cases had Motor deficit, 20 patients had deformity (16 with trophic ulcer, 2 with lagophthalmos, 2 with facial palsy, 5 with claw hand and 3 with foot drop), 14 patients had persistent paranesthesia, 4 patients presented with relapse of leprosy. Five patients presented with lepra reaction. Reactions were more common in males. 5 patients developed recurrent type 2 reactions, 2 patients developed type 1 reaction, especially those with initial high bacillary index.

Conclusion:

Problems faced by patients in RFT phase include deformity, relapse, reactions, persistent skin lesions and neuropathy(motor & sensory).

All the RFT cases need regular follow-up and physiotherapy to prevent deformity and to diagnose relapse and reactions at the earliest. Our study also emphasizes need of post-RFT surveillance and care for treatment and rehabilitation of leprosy patients.



**Abstract N°: 7562****A Randomized Controlled Assessor-Blinded Trial of Methotrexate compared to Prednisone in the Management of Hansen's Disease Patients with Type 1 Reaction in a Tertiary Government Hospital**Patricia Anne Nicole Ecarma¹¹East Avenue Medical Center, Dermatology, Quezon City, Metro Manila, Philippines**Introduction & Objectives:**

To determine the effectiveness of methotrexate versus prednisone in the treatment of Hansen's Disease (HD) patients with type 1 reaction (T1R). Specific objectives were as follows: to describe the demographic profile of participants, to compare clinical severity scores, clinical outcomes, recurrence rates, frequency of adverse events, and difference of quality of life treatment scores between the two treatment arms.

Materials & Methods:

A randomized controlled assessor-blinded trial among leprosy patients with T1R was conducted. A total of 33 patients were randomly allocated into two treatment groups: Prednisone or Methotrexate. Evaluation of lesions, nerve function impairment, sensory testing, and voluntary muscle power were assessed at enrollment and re-assessed periodically for 32 weeks. Quality of life was evaluated with an SF-36 health-related quality of life assessment tool. Outcomes were measured* using the clinical severity score, recurrence rate, adverse events and quality of life.

Results:

Results of the study show that T1R were most commonly observed in adult males with borderline to lepromatous leprosy subtype, occurring within 12 months of diagnosis and MDT treatment. Prednisone was observed to yield higher Clinical Severity Scores after 32 weeks of treatment. Faster T1R recovery and improvement in skin and sensory function was observed in those who took methotrexate. There is no significant difference in EHF (eyes, hand, feet) scores for both treatment arms. Although MTX had no relapse rates, there is no significant difference in recurrence of T1R between the two treatment arms. Minor adverse events such as moon face, acne, fungal infection and gastric pain were observed in those who took prednisone. Quality of life scores in both treatment arms improved.

Conclusion:

This study is the first assessor-blinded randomized control trial assessing methotrexate, an immunosuppressant, in the management of leprosy type 1 reactions in our country. After 32 weeks of treatment, methotrexate yielded lower Clinical Severity Scores and could be considered a safe alternative second-line drug for patients with T1R who are not improving with prednisone or are experiencing adverse effects related to prednisone. This study illustrates the intricacy in the management of leprosy inflammation. With that, further studies on better treatment agents for HD patients with reactions and nerve damage are warranted.





Abstract N°: 7644

Challenging Cutaneous infections: A case series of 4 patients

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Introduction & Objectives:

Cutaneous infections caused by rare pathogens always pose a diagnostic and therapeutic challenge.

Here we present 4 rare cases of infectious diseases consisting of cutaneous leishmaniasis, subcutaneous zygomycosis and 2 cases of cutaneous tuberculosis following intramuscular injections and BCG vaccination.

Materials & Methods:

Case 1: A 38-year-old-male resident of Bihar presented with hypopigmented lesions over body for 3 years. He was diagnosed as leprosy and received Multibacillary Multidrug therapy without improvement. Since last 6 months he was experiencing fever associated with multiple erythematous papules nodules, plaques and subcutaneous swellings face, neck, penis, trunk, extremities with generalized lymphadenopathy. Based on histopathology and laboratory investigations patient was diagnosed as Post Kala Azar Dermal Leishmaniasis. He was treated with liposomal amphotericin B and oral miltefosine with complete resolution of lesions.

Case 2: A 40-year-old-female, presented with complaint of painful facial swelling of left side and discharging sinus over the left zygomatic region for past 6 months associated with ipsilateral headache. Patient was a known diabetic on treatment. Cutaneous examination revealed diffuse induration, erythema and swelling of left side of face with overlying ulcerative nodule. Radiological investigations revealed lytic destructive lesion in left zygomatic and premaxillary area. Histopathology confirmed diagnosis of subcutaneous phaeohiphomycosis. Patient was treated with oral itraconazole and surgical debridement of affected area with complete resolution.

Case 3: A 30-year-old-female, presented with painful red raised lesion with pus discharge over left arm gradually increasing in size and number for 6 months. Patient gave history of receiving intramuscular analgesic injections at the same site 8 months back. Cutaneous examination revealed multiple tender erythematous nodules present over left arm arranged in a linear pattern. Histopathology revealed multiple granulomas in the dermis and subcutis. First line Line probe assay detected mycobacterium tuberculosis. Patient was started on anti-tuberculous therapy with improvement.

Case 4: A 70-year-old-male, presented with itchy red raised lesion over right arm since 2 months. There was a history of receiving BCG injection at the same site 2 months prior to appearance of lesion associated with moderate grade fever and generalized weakness. Histopathology revealed presence of well-defined granulomas in the dermis with positive Mantoux test. Patient was diagnosed as cutaneous tuberculosis at the site of BCG vaccination site and started on anti-tuberculous therapy.

Conclusion: Considering the similarities in the clinical presentation of various infectious granulomatous diseases, clinicopathological correlation and microbiological diagnostic aids are always required for confirmation of diagnosis.



**Abstract N°: 7665****The Mite Behind the Mask: When Scabies Played Atopic Dermatitis**elif nur canbazoğlu¹, İsmail Ünal¹, Aslan Yürekli¹¹University of Health Sciences Gülhane Training and Research Hospital, Dermatovenereology , ANKARA, Türkiye**Introduction & Objectives:**

Scabies is an ectoparasitic infestation caused by *Sarcoptes scabiei* var. *hominis*, currently affecting more than 200 million individuals worldwide. In recent years, its prevalence has shown a marked increase, posing a significant public health challenge. Clinically, scabies typically presents with intense pruritus and multiple erythematous papules, often accompanied by excoriations, and most commonly distributed on the interdigital spaces, flexural surfaces of the wrists, and genital regions. Due to its ability to mimic a wide range of dermatoses- including atopic dermatitis, allergic contact dermatitis, and arthropod bite reaction- scabies is frequently misdiagnosed. This diagnostic challenge not only delays appropriate treatment but also results in prolonged patient suffering and unnecessary healthcare costs. Therefore, confirmation through dermoscopic and microscopic examination is essential for accurate diagnosis. Here, we report a case initially misdiagnosed as atopic dermatitis and treated with multiple systemic and topical agents for 12 months.

Materials & Methods:

An 18-year-old female presented with persistent multiple itchy, erythematous papules predominantly involving intertriginous areas and acral sites. She had previously been treated with topical corticosteroid ointment, antihistamines, systemic corticosteroids, cyclosporine, and dupilumab but her lesions persisted (12 months), and she was referred to our outpatient clinic.

Results:

Based on clinical suspicion, scabies was considered, and skin scrapings from affected areas were examined under light microscopy, revealing adult mites, eggs, and scybala. Dermoscopy guided lesion sampling and revealed diagnostic signs such as the delta wing and mini triangle signs. Under UV dermoscopy, the ball sign was also observed. Depending on clinical, dermoscopic, and microscopic findings the patient was diagnosed with scabies. A therapeutic regimen of oral ivermectin (200 mcg/kg, days 1 and 8) combined with topical 12.5% sulfur ointment applied overnight for three consecutive days resulted in full clinical remission.

Conclusion:

Scabies may resemble various pruritic and eczematous conditions. Ruling out scabies before diagnosis is crucial to avoid unnecessary and prolonged treatments. Scabies can be effectively treated when diagnosed promptly and managed with appropriate therapy.



**Abstract N°: 7698****Vegetative lesions in a leishmaniasis-endemic area: think beyond infection**

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Introduction & Objectives:

Cutaneous leishmaniasis, a parasitic disease endemic in Morocco, manifests mainly as erythematous or ulcerated lesions, often resistant to standard treatments. This pathology represents a major diagnostic challenge, particularly in rural areas and endemic regions, where it can mimic other dermatological conditions. Among these, hypertrophic lichen planus, although less common, is a variant of lichen planus that can present hypertrophic lesions similar to those seen in leishmaniasis. This clinical resemblance can complicate the differential diagnosis, underlining the importance of a rigorous diagnostic approach to avoid errors and ensure appropriate management.

Materials & Methods:

We report the case of a 75-year-old female patient, followed for hypertension, asthma, and undocumented Alzheimer's disease, and with an allergy to Aspirin. She was hospitalized for suspected cutaneous leishmaniasis, diagnosed following the appearance, a year and a half ago, of painless, non-pruritic, vegetating erythematous plaques on the left lower limb, following an insect bite. In view of this presentation, a biopsy and dermal smear suggested cutaneous leishmaniasis, and treatment with local injections of Meglumine Antimoniate was initiated, due to cardiac contraindications to the systemic injection (left bundle branch block and secondary repolarization disorder). The patient was also put on a Metronidazole-Clarithromycin combination for three weeks, with no clinical improvement. Subsequently, treatment with fluconazole (200 mg/day) was attempted, but without favorable results. As part of her management, a new skin biopsy was performed, and the diagnosis was redirected to hypertrophic lichen planus. Treatment with occlusive dermocorticoids led to significant clinical improvement.

Results:

Cutaneous leishmaniasis is a common parasitic infection in endemic regions, characterized by erythematous or ulcerated skin lesions. Diagnosis is based on clinical, parasitological, and sometimes serological criteria. However, inflammatory conditions such as hypertrophic lichen planus can present similar lesions, notably vegetative and erythematous, complicating the diagnosis. Hypertrophic lichen planus is a rare form of lichen planus, with chronic lesions often localized on the lower limbs. Its etiopathogenesis remains partially understood, and it can be difficult to distinguish from chronic skin infections such as leishmaniasis. Skin biopsy is essential for diagnosis, showing a specific lichenoid infiltrate. Treatment relies mainly on topical dermocorticoids, often used in occlusion, and can be effective when an accurate diagnosis is made.

Conclusion:

This case highlights the need to reconsider the diagnosis in the event of therapeutic failure, even in areas endemic for cutaneous leishmaniasis, as is the case in Morocco, and to consider lichen vegetans among the differential diagnoses of vegetative lesions. It also emphasizes the importance of a rigorous diagnostic approach, combining clinical examination, parasitological tests, and skin biopsy to avoid misdiagnosis.





Abstract N°: 7704

Crusted Scabies in a 3 month old baby with atopic dermatitis

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Introduction & Objectives:

Scabies, also known as mange, is an infectious dermatosis, whose the etiological agent is a mite that parasites humans: *Sarcoptes scabiei var hominis*. Highly contagious, it is transmitted directly through interpersonal contact. There is no predilection for sex or social economic class, but it is more frequent in environments with poor hygiene conditions.

The lesions are characterized by erythematous papules, isolated, disseminated or grouped and are very pruritic, with a predilection for warm areas such as the armpits, groin, genital region, interdigital region and wrists. When almost the entire body is affected, the condition is known as Crusted Scabies (Norwegian Scabies).

This study aims to discuss a rare case of Crusted Scabies in an infant with atopic dermatitis.

Materials & Methods:

After obtaining consent, the patient's medical records, skin exam and direct search for ectoparasites were analyzed. Research included comprehensive of literature search on Pubmed focusing on crusted scabies and immunosuppression factors.

Results:

We present a 3-month-old male child, with history of atopic dermatitis, with pruritic crusted lesions on the palms and soles. He was treated with antibiotic and systemic corticosteroids, without improvement. The lesions worsened and spread to the entire body, as well as pruritus, associated with irritation and crying. On the dermatologic exam, he presented disseminated dermatosis characterized by erythematous papules that converged to form plaques, scaling and yellow-green thick crusts on the palms and soles.

The hypothesis of "Norwegian Scabies" was raised and a direct search for ectoparasites was performed with positive result with numerous mites. The patient received topical treatment with 5% permethrin lotion for 7 days and with 10% precipitated sulfur lotion for another 10 days. Family members received concomitant treatment with oral ivermectin and guidelines on. Personal hygiene and clothing care. Some papules remained, and low potency topical corticosteroid was used for 7 days.

Conclusion:

Norwegian scabies is a rare dermatosis, especially in immunocompetent patients between 0 to 20 years old. Systemic corticosteroids, immunosuppressants, alcohol and drugs, type 2 diabetes and HIV are the main factors related to immunosuppression.

Although not considered a risk factor for scabies, atopic dermatitis may be associated with scabies.

We highlight the rarity and exuberance of the Crusted Scabies in a baby without immunosuppression, and atopic dermatitis as a previous skin condition, and also the excellent response to topical treatments: 5% permethrin and 10% precipitated sulfur lotions.





Abstract N°: 7715

Disability assessment in Leprosy

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Introduction :

In the world, "Leprosy" is a leading cause of peripheral neuropathy and disability. As per WHO, 'disability' is defined as "Inability of person to carry out functions, considered normal for an individual"

Case Report:

Aim:- Deformity assessment in cases of leprosy

A retrospective cohort study was performed. 450 cases of leprosy were taken into study for the period of 6 years. Cases released from the treatment were studied along with the new cases enrolled under multidrug therapy. A comprehensive examination was done for each case

Results:

Total cases-450 (330males and 285females)

26.5%(n=119) deformity in patients released from treatment.

35.6%(n=160) deformity were noticed at moment of diagnosis.

The most commonly affected areas of impairment: hands 37.7%(n=170), feet 33.3%(n=150) eyes 28.8%(n=130).

Mainly two types of disability were seen:

1. Tissue infiltration
2. Due to nerve damage

Conclusion:

Active intervention, wide spread awareness and implementation of MDT(multidrug therapy) usage has been successful in curing and reducing the prevalence of leprosy. WHO has graded disability into 3 grades. Grade 2 remains the severe most. Disability assessment remains a very relevant measure of leprosy control. Our study had 33% in grade 0, 51.1% grade 1 and 15%as grade 2.

Nerve involvement test was done in each case and record was maintained. Ulnar nerve was the most involved nerve followed by anterior tibial nerve and lateral popliteal nerve. These findings help us to understand the importance of simple test like nerve function impairment test. In our study, deformities occurred even in cases who were released from the treatment. This can be attributed to the fact that the on-going nerve damage even after treatment.

37.7% had hand disability, 33.3% feet disability and 28.8% eyes disability. Deformities of hands and feet were more due to repeated work trauma. Even in advanced stage hands, feet and eyes were most commonly affected.

Trophic ulcers (41%) were seen commonly followed by claw hand, foot drop and wrist drop. Patients were advised to regularly check for any red spots, blisters or any new active ulcers. Self-care was highly stressed upon.

Leonine facies, ear deformity, resorption of fingers, madarosis was also noted.

Early diagnosis and prompt treatment of the reactions is highly stressed upon to prevent the physical disabilities.

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**Abstract N°: 7733****Cutaneous lesion caused by *Filobasidium uniguttulatum* in the suprapubic region: an unusual case in an immunocompetent patient**

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Introduction:

F. uniguttulatus is an uncommon yeast-like fungus belonging to the *Cryptococcus* genus whose clinical relevance has been observed in immunosuppressed patients in the form of ventriculitis and invasive meningitis resistant to first-line antifungals. However, its pathogenic role in the skin remains uncertain. We present a case of a cutaneous lesion in an immunocompetent male where *C. uniguttulatus* was isolated and successfully treated with topical ciclopiroxolamine.

Case report:

A 26-year-old male with no relevant medical history consulted in Dermatology due to a slightly pruritic scaly plaque with well-defined borders at the base of the penis of more than two years of evolution. Following microbiological isolation of *C. uniguttulatus*, he was treated by his primary care physician with clotrimazole and subsequently with topical flutrimazole with little improvement. After repeated isolations of this species, our department prescribed miconazole combined with hydrocortisone for two weeks without achieving resolution. Given the absence of documented topical treatments in the literature, ciclopiroxolamine was initiated for one month with the prospect of performing an antimycogram if there was a new therapeutic failure before considering systemic treatments. The complete resolution of the cutaneous lesion was achieved without recurrence at 6 months. Serological tests, including HIV, HCV, HBV and syphilis, returned negative.

Discussion:

Filobasidium uniguttulatum, formerly known as *Cryptococcus uniguttulatus*, is a basidiomycete fungus formerly classified under *Cryptococcus*. It has been isolated from various environmental sources, including bird feces and contaminated soils, suggesting that it may be a common saprophyte in these environments. In immunocompromised hosts, it is an infrequent cause of ventriculitis and meningitis, usually resistant to first-line antifungals, with liposomal amphotericin B being the most effective treatment for systemic infections.

Its pathogenic role in the skin is sparsely documented and remains uncertain. It has been isolated in vaginal and cervical exudates in asymptomatic women as an unusual saprophytic microorganism. Conversely, it was identified as an etiological agent of onychomycosis in diabetic patients. Recently, a mixed facial skin infection by *C. uniguttulatum* and *M. tuberculosis* was described in an immunocompetent patient; however, without definitive evidence of the fungus's etiopathogenic involvement in the lesion

Conclusion:

Based on the available evidence, this report describes the first documented case of a cutaneous infection clearly attributed to *F. uniguttulatum* as the sole pathogen responsible for the lesion. Our case highlights resistance to topical azoles (clotrimazole, flutrimazole, miconazole), underscoring potential azole cross-resistance and* being this case the first to describe the resolution of a skin lesion with topical ciclopiroxolamine, circumventing the risk

of systemic treatments.

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**Abstract N°: 7753****A Global Public Health Challenge: Scabies in Indigenous Communities and Re-emergence in Europe**

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Introduction & Objectives:

Scabies remains a significant dermatological public health issue globally. In Northern Australia, it is endemic in remote Indigenous communities, contributing to considerable morbidity. Despite improvements in health and welfare, Indigenous Australians continue to experience a disproportionate burden of scabies-related complications compared to non-Indigenous Australians and Indigenous populations in other high-income countries. In parallel, Europe is witnessing a resurgence of scabies outbreaks, underscoring its re-emergence even in well-resourced health systems. The aim is to systematically review the prevalence of scabies among Indigenous populations in Australia, New Zealand, and Canada, while contextualising findings within the recent re-emergence of scabies in Europe.

Materials & Methods:

A comprehensive search was conducted in PubMed, Embase, Cochrane Library, ScienceDirect, and Google Scholar for records available up to September 2024 on scabies prevalence in Indigenous populations in Australia, New Zealand and Canada. Additionally, recent studies were reviewed to summarise emerging European outbreaks.

Results:

From 466 records screened, 22 studies met inclusion criteria. In Australia, scabies prevalence among Indigenous children under 5 reached up to 75%, with a median of 68% in those under 1 year. Prevalence was 29% in the Northern Territory and 19% in Far North Queensland. New Zealand reported a prevalence of 23% among Māori children and 72% among Pacific Islander children. No peer-reviewed prevalence studies were found for Indigenous populations in Canada, though scabies was described as a significant concern. Data limitations included lack of age stratification and underrepresentation of urban Indigenous populations.

In Europe, recent outbreaks have highlighted scabies' persistent relevance. The UK reported a sharp rise in cases in 2023, compounded by shortages of key treatments like permethrin. Netherlands noted a threefold increase in incidence of scabies in the last decade (2011 – 2020), and Italy experienced a 170% and 146% rise in cases post-COVID in the Lazio and Messina regions from 2022 to 2023, respectively. These trends signal the need for strengthened surveillance and access to effective treatments across both endemic and non-endemic regions.

Conclusion:

This review reveals a significant scabies burden among Indigenous Australians, especially in young children, and highlights critical data gaps in Canada and urban settings. The concurrent resurgence of scabies in Europe reinforces the global importance of scabies as a public health concern. Targeted epidemiological studies and sustained investment in treatment accessibility and education are essential to achieve scabies control and ultimately eradication, both in Indigenous communities and broader populations.

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Abstract N°: 7758

Dermatophyte Contamination of Hair Clippers and Cleaning Brushes in Copenhagen Hair Salons

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Introduction & Objectives:

Tinea capitis (TC) is a fungal infection of the hair and scalp, typically affecting children aged 3–7 years. However, in the fall of 2024, a sudden increase in TC cases caused by *Trichophyton (T.) tonsurans* was observed among teenage boys and young men in the capital region of Denmark. A majority of the affected individuals had recently received a haircut with an electric hair clipper at a hair salon prior to symptom onset. Hairdressing tools have previously been reported as a potential transmission pathway in the literature. We therefore hypothesized that electric hair clippers in hair salons could be a source of infection spread.

The study objective is to investigate if anthropophilic dermatophytes could be found in electric clippers from hair salons.

Materials & Methods:

Sample size calculation was performed using a prevalence of 5% and a probability of finding one event of 90% using the formula for sample size to detect disease. A minimum of 45 hair salons were needed to detect at least one case.

Hair salons were randomly selected from municipalities in Greater Copenhagen, which covered all parts of the city including both low- and high-income areas. The inclusion criteria were hairdressers in Copenhagen who used electric clippers and provided oral consent. We guaranteed full anonymity for all study participants.

Samples were collected immediately following consent to prevent the hairdressers from non-routine cleaning of tools before sample collection. The number of samples per salon varied based on salon size and available hair clippers. If a cleaning brush for the electric clipper was present, it was also sampled. The sampling was done by swabbing the head of the electric clipper with a sterile cotton swab moistened with sterile saline water. It was thereafter inoculated onto Sabouraud dextrose agar supplemented with cycloheximide and chloramphenicol (Substratafdelingen, Herlev Hospital, Denmark) and incubated at 25–28 degree Celsius for four weeks. Plates with fungal growth were submitted for species identification based on macro- and micromorphological characteristics supplemented with molecular diagnostics at the National Reference Laboratory for Mycology, Statens Serum Institute, Copenhagen.

Results:

Between 21 February and 13 March 2025, a total of 82 hair salons in Copenhagen were visited. Among these, 57 provided consent to participate in the study and 25 declined. The most common reasons for declining were lack of time, shop owner not present to approve the study participation or unwilling to participate.

A total of 133 samples were collected from 57 different hair salons, of which 122 were from electric clippers and 11 were from brushes. The number of samples collected from each salon varied between 1-5 samples.

After four weeks of incubation, 8 of the 133 samples collected from five different salons were culture-positive for *T. tonsurans*. Of these, seven were confirmed by molecular diagnostics, while one result remains pending. Five of the positive samples were obtained from electric clippers and three from brushes.

Conclusion:

Hairdressing tools are a source of infection, and the recent outbreak of TC in Denmark is most likely spread through electric hair clippers and indirectly through cleaning brushes as 3/11 (27%) brush samples and 5/122 (4%) hair clipper samples from 5/57 (9%) hair salons were positive for *T. tonsurans*. Disinfection of tools between each customer is important to limit the transmission of dermatophytes.

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**Abstract N°: 7774****severe rickettsiosis complicated by Vasculitis (a case report)**

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¹UHC HASSAN II, dermatology, FES, Morocco

Introduction & Objectives:

Rickettsiosis is a bacterial infection caused by *Rickettsia conorii*, primarily affecting the endothelium. While usually benign, severe cases can mimic systemic diseases, such as post-rickettsial vasculitis which is a rare complication. We report a case of malignant rickettsiosis with systemic involvement.

Materials & Methods:

A case observational approach was used involving a 52-year-old male patient with confirmed diagnosis of malignant rickettsiosis .

Results:

A 52-year-old man, with a history of chronic tobacco and cannabis use, presented with a generalized febrile rash evolving over ten days. Initial symptoms included headache, arthralgia, and ocular redness, followed by non-pruritic red lesions on the lower limbs, later spreading to the trunk and extremities.

Physical examination revealed a diffuse morbilliform exanthem, infiltrated livedoid purpura on the limbs, conjunctival hyperemia, and tearing. Notably, there was no palmar-plantar involvement or escharotic lesions.

Laboratory findings showed leukocytosis with neutrophilia (WBC: 22,190/mm³; Neutrophils: 18,860/mm³), thrombocytopenia (98,000/mm³), hyponatremia (127 mmol/L), elevated C-reactive protein (86 mg/L), and liver cytolysis (4× normal). HIV and HCV serologies were negative, while past HBV infection was noted. *Rickettsia conorii* serology was highly positive (>2560; threshold: 320). Immunological tests for vasculitis (ANCA) were negative.

A skin biopsy of purpuric lesions revealed dermo-hypodermic vasculitis with perivascular inflammation, fibrinoid necrosis, microthrombi, and leukocytoclasia, consistent with rickettsial vasculitis. Ophthalmological examination confirmed bilateral active uveitis.

The patient was treated with doxycycline 200 mg/day and vitamin C 1 g/day for ten days. He showed significant improvement, with resolution of the rash, normalization of laboratory values, and residual pigmented scars.

Conclusion:

Malignant rickettsiosis should be considered in patients with widespread systemic symptoms and purpuric skin lesions resembling vasculitis. Early diagnosis and prompt treatment are essential for a favorable prognosis.



**Abstract N°: 7777****A silent invasion of actinomycetoma in non endemic soil**

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Introduction & Objectives:

Madura foot (mycetoma) is a chronic granulomatous infection caused by fungi (eumycetoma) or filamentous bacteria (actinomycetoma), typically presenting as a painless pseudotumor with progressive swelling, draining sinuses, and grain discharge. While endemic to tropical regions within the “mycetoma belt,” sporadic cases in temperate climates often remain underrecognized, leading to delayed diagnosis due to clinical mimicry. We report a case of actinomycetoma in a farmer from a non-endemic area, highlighting histopathological features and diagnostic challenges.

Materials & Methods:

We present the case of a 28-year-old male farmer with no significant past medical history, who presented with a two-year history of progressive left plantar swelling and intermittent whitish granular discharge following a soil-contaminated injury to his left foot. A detailed clinical examination was conducted to assess the extent and characteristics of the lesion. Radiological investigations, including computed tomography (CT) and magnetic resonance imaging (MRI), were performed to evaluate soft tissue and bone involvement. A deep incisional biopsy was obtained and sent for histopathological examination and microbiological culture to confirm the diagnosis and identify the causative organism.

Results:

Clinical examination revealed a subcutaneous mass over the calcaneus with multiple fistulae, fibrin-coated ulceration, and visible white granules. CT and MRI revealed soft-tissue hypertrophy, osteolytic changes, and calcaneal sequestra. A characteristic “dot-in-circle” sign central hypointense dots within hyperintense rings on T2-weighted MRI was observed. Histopathology showed dense neutrophilic infiltrates surrounding basophilic filamentous aggregates and grains, consistent with actinomycetoma. Culture identified *Actinomyces* spp., confirming the diagnosis. The patient was treated with a combination of amoxicillin-clavulanate (30 mg/kg/day), amikacin (15 mg/kg/day), and streptomycin (1 g/day), along with local wound care. At six-month follow-up, ulcer healing and marked clinical improvement were noted.

Conclusion:

The insidious progression and non-specific symptoms of mycetoma often hinder timely diagnosis in non-endemic areas. Actinomycetoma accounts for roughly 40% of cases and is typically confirmed via histopathology. This report highlights the need for greater awareness in temperate regions. The World Health Organization’s recognition of mycetoma as a neglected tropical disease underscores the importance of early biopsy and preventive strategies, such as protective footwear, to avoid debilitating outcomes.



**Abstract N°: 7864****Primary Measles Meningoencephalitis in an immunocompetent Adolescent : A Rare and Severe Complication**

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Introduction & Objectives:

Measles is a highly contagious airborne viral disease that can lead to serious neurological complications. Therefore, measles vaccination represents a major turning point in the history of public health and is of crucial importance for the prevention of neurological complications in children. Also, the effectiveness of vaccination goes beyond reducing encephalitis to include other neurological sequelae. We are presenting a clinical case of meningoencephalitis in an immunocompetent unvaccinated patient.

Materials & Methods:

We report the case of a 17-year-old unvaccinated male who was admitted for severe headache, photophobia, and projectile vomiting. Within 48 hours, his condition deteriorated with seizures, altered consciousness, and respiratory distress, necessitating hospitalization with mechanical ventilation. Notably, he had developed a maculopapular rash one week prior, initially on the face and progressively spreading caudally. CSF analysis showed mild hyperproteinorrachia and normal glucose, bacterial cultures and multiplex PCR were negative. Brain CT scan revealed no specific abnormalities. Empirical treatment with intravenous ceftriaxone, acyclovir, and antiepileptics was initiated. Serology confirmed acute measles infection (positive IgM and IgG). Extensive workup excluded other infectious, autoimmune, and systemic causes. The patient also received vitamin A supplementation. Clinical evolution was favorable, with full neurological recovery noted three weeks after onset.

Results:

Measles encephalitis is a rare but serious complication, primarily affecting unvaccinated individuals. Our patient presented with primary measles encephalitis, a direct viral invasion of the CNS typically occurring within days of the exanthema. Diagnosis was supported by the temporal association with rash onset, compatible CSF profile, and positive measles serology. Given the broad differential for encephalitis with rash, comprehensive exclusion of other infectious agents (e.g., HIV, EBV, CMV, syphilis) and autoimmune conditions such as lupus or Behçet's disease is essential. In our case, all autoimmune markers were negative, and neuroimaging was nonspecific. Early empirical antiviral and antibacterial treatment, alongside vitamin A per WHO guidelines, contributed to the favorable outcome. This case underscores the critical importance of measles vaccination, early recognition of neurological complications, and systematic etiological investigation.

Conclusion:

Measles meningoencephalitis is a life-threatening but preventable complication. Diagnosis hinges on clinical suspicion and serology. In patients presenting with encephalitis and rash, measles should remain a key differential, particularly in the context of inadequate immunization.

**Abstract N°: 7887****Association of psoriasis exacerbations and covid-19**Iryna Vozniak¹, Hennadiy Astsaturov¹, Marianna Dashko¹, Orysya Syzon¹¹Danylo Halytsky Lviv National Medical University, Dermatology, venereology, Lviv, Ukraine

Introduction & Objectives: Psoriasis is a chronic, non-infectious, inflammatory, relapsing immune-mediated skin disease affecting approximately 125 million people worldwide, including 14 million in Europe. Existing literature has mainly reviewed psoriasis exacerbations after COVID-19 vaccination, but relapses in patients currently on treatment and after COVID-19 infection have rarely been addressed.

Materials & Methods: A 46-year-old man diagnosed with psoriasis vulgaris, 2013 was well controlled with secukinumab (an interleukin-17A inhibitor).

Results: In May 2023, the patient contracted a COVID-19 infection, but recovered within a week with a mild fever. However, the rash gradually reappeared on the limbs and face, which showed no response to 2 consecutive doses of secukinumab at 300 mg/month. Blood tests showed elevated levels of interleukin-6 (IL-6), C-reactive protein and erythrocyte sedimentation rate. Analysis of the patient's psoriasis history and laboratory results, confirmed psoriasis exacerbation. The patient is currently continuing treatment with tocilizumab (8 mg/kg) every 4 weeks. Viral infection has been shown to be strongly associated with the onset or exacerbation of psoriasis. A possible mechanism is stimulation of viral Toll-like receptor 3 RNA, leading to dysregulation of the innate immune response, causing exacerbations of psoriasis associated with COVID -19 infection. Although a causal relationship between Covid-19 infection and psoriasis exacerbations cannot be definitively established in this case.

Zou Y., Meng Z. et al. described a case series justifying the use of biologic drugs in patients with psoriasis with short disease duration and highlighting the safety of these treatments during the Covid-19 pandemic. Several studies have shown that circulating IL-17 levels are elevated in the peripheral blood of Covid-19 patients, providing evidence to support treatment decisions for psoriasis patients treated with IL-17 inhibitors during the Covid-19 pandemic. Cases of well-controlled psoriasis with secukinumab that stopped responding to the prescribed therapy shortly after Covid-19 were also described, with elevated TNF-alpha levels noted in the patients' data and they were successfully switched to adalimumab.

Despite the patient's previous positive response to secukinumab, increasing psoriatic activity suggested possible resistance or tolerance to this IL-17A inhibitor. Our patient's blood tests showed elevated levels of IL-6, one of the key cytokines in psoriatic inflammation. Elevated IL-6 levels may suggest a compensatory mechanism or alternative pathway of psoriatic inflammation, warranting individualisation of the therapeutic approach. Patient experience with secukinumab followed by tocilizumab indicates the need for continuous evaluation and optimisation of therapeutic approaches in the treatment of psoriasis, particularly in the context of viral infections or other triggers.

Conclusion: Viral infection has been shown to be strongly associated with the onset or exacerbation of psoriasis.



**Abstract N°: 7976****tungiasis in a greek patient**

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Tungiasis in a Greek patient

Introduction & Objectives: Tungiasis, a cutaneous condition caused by the sand flea **Tunga penetrans**, is a significant health concern in poor urban and rural communities in endemic geographic regions, particularly in Africa and South America. The increased number of travelers visiting the endemic areas result to increasingly imported cases of tungiasis. Here, we report a case of a Greek patient who developed tungiasis after traveling to Uganda.

Materials & Methods: A 32-year-old Greek male presented with a slow-growing, pruritic, and painful nodule on his left sole. The lesion appeared three days after returning from a two-week volunteering trip to Uganda. Although he denied walking barefoot, he reported leaving his shoes outside his tent at night.

On clinical examination, a dark-reddish nodule with a central black dot was observed on the left sole. Photographs of the lesion during its evolution show the characteristic central pore and visible flea excrement (Figure 1 a-d)³. No signs of secondary infection or systemic symptoms were noted. His medical history was unremarkable, and he was not on any medications. The lesion was surgically excised, and histopathology confirmed the presence of *T. penetrans* within the epidermis (Figure 1e-f). The patient recovered fully without complications.

Results: Tungiasis is a neglected tropical disease, prevalent in impoverished communities with poor sanitation. The female flea burrows into the skin, feeding on blood and expanding to release eggs before dying. The feet are most commonly affected due to the flea's limited jumping ability.

Early lesions appear as white papules with a central black dot (the flea's respiratory opening). As the flea grows, symptoms progress from pruritus to pain, often complicated by bacterial infections. Severe cases may lead to ulcers, digit auto-amputation, or systemic infections like tetanus and sepsis.

Diagnosis is clinical and in non-endemic regions, travel history is crucial. Histopathology can aid in confirmation, revealing intraepidermal cavities with flea exoskeletons and eggs.

The WHO recommends sterile surgical extraction. Topical treatments (e.g., dimeticone) and parasiticides (e.g., ivermectin) show efficacy. Prevention includes wearing shoes, using insect repellents, and avoiding contact with infested soil.

Conclusion: With increasing travel to endemic regions, clinicians in non-endemic areas must consider tungiasis in patients with suggestive lesions and travel history. Early diagnosis and treatment prevent complications and improve outcomes.





Abstract N°: 8018

Epidemiological and Clinical Profile of Measles in Adults: A Series of 102 Cases

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Introduction & Objectives:

Measles is a viral infection caused by the paramyxovirus. It has become rare due to vaccination. However, recent cases in adults have increased. Our objective is to describe the epidemiological and clinical features of measles in adults.

Materials & Methods:

This was a prospective study conducted at University Hospital over three months, from November 2024 to March 2025. We included all adult patients with an acute rash. Pediatric cases and rashes caused by other diseases were excluded.

Results

A total of 102 patients were included. Most came from Casablanca (39.3%), Berrechid (17.6%), and Benslimane (11.8%). The average age was 33.8 years. Women were more affected, with a female-to-male ratio of 2.09.

Eighty-eight patients had no medical history. Others had hypertension (3), type 2 diabetes (2), type 1 diabetes (1), DRESS syndrome (1), Apert syndrome (1), uterine myoma (1), and rhabdomyosarcoma (1). Two patients were pregnant.

Vaccination status was unknown for 65% of cases. A total of 31.4% were vaccinated, while 2.9% were not. Prior contact with a measles case was reported by 24.5% of patients. The median consultation time was four days.

Fever was present in 98% of cases. All patients had a descending maculopapular rash. Two patients had purpura. Palmoplantar involvement was observed in 28.4%. Conjunctivitis, rhinorrhea, and Koplik spots were found in 76.5%, 36.3%, and 62.7% of cases.

Respiratory complications were most frequent (44.1%). Other complications included diarrhea (25.5%), otitis (16.7%), cervical lymphadenopathy (5.9%), eye complications (3.9%), and neurological disorders (2%).

Blood tests showed neutrophilic leukocytosis in 11.8%, lymphopenia in 18.6%, thrombocytosis in 25.5%, and liver cytolysis in 16.7%. Kidney function was normal in all cases.

Chest X-rays were performed in 86.2% of cases. Bilateral interstitial syndrome was found in 46.1%, bronchial syndrome in 5.9%, and pneumonia in 2.9%. A chest CT scan was performed on one patient and showed a bilateral alveolo-interstitial syndrome.

Measles was confirmed by IgM serology in 27.5% of cases. Suspected cases represented 72.5%. Ninety-four patients were treated as outpatients. Three were admitted to intensive care, three to dermatology, one to infectious diseases, and one to maternity.

Ninety-nine patients recovered. Two died. One pregnant woman had a premature delivery. No factors influencing disease progression were identified.

Conclusion

Measles is usually mild but can cause severe complications. A measles outbreak is ongoing in our setting. More epidemiological studies are needed.

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**Abstract N°: 8041****Case report of scabies with bullous and crustose elements**

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Introduction & Objectives: Scabies is a contagious disease that is accompanied by itching, especially at night. This disease is caused by *sarcoptes scabiei* and is characterized by polymorphic lesions. Vesiculo-bullous lesions in scabies are very rare.

Materials & Methods: We present the case of a 70-year-old patient who had a stroke many years ago and was aphasic since then. He presented himself for dermatological consultation as the family members reported that the patient had severe itching throughout the day. In the objective examination, erythema was observed in the upper anus and in the trunk, also 2-3 vesicular elements were observed in the trunk. The Nikolski phenomenon was negative. In the peripheral blood examination, eosinophilia was observed. Biopsy of one of the bullous elements suggested bullous pemphigoid. Under these conditions, the patient started therapy with systemic corticosteroids, but after 7 days no improvement was observed, so azathioprine 50 mg per day was added to the therapy. The patient presented after 3 days with generalized erythematous-squamous elements and the pruritus had become more intense. The clinical presentation was very similar to Norwegian scabies. Treatment with permethrin did not give results, so the patient was treated with 3 cycles of ivermectin, and then the erythema-crusted elements and pruritus were no longer present.

Results: The appearance of scabies with bullous elements is a very rare phenomenon and differential clinical and histopathological is difficult. Direct and indirect immunofluorescence are essential in establishing the diagnosis. The use of immunosuppressants in scabies turns it into a form resistant to topical therapy.

Conclusion: The dermatologist should be careful to suspect bullous scabies in cases that present with pruritic eruptions similar to bullous pemphigoid, especially when they do not respond well to immunosuppressive therapy. Bullous scabies should be included in the differential diagnosis of bullous diseases. Ivermectin is an effective alternative in resistant forms.





Abstract N°: 8055

Scabies Incognito: A Revealing Case Series of 16 Unusual Presentations

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Introduction & Objectives:

Scabies is a common cutaneous parasitic infection caused by *Sarcoptes scabiei*. It typically presents with nocturnal pruritus, vesicles, nodules, and characteristic scabietic burrows in specific anatomical sites. However, atypical forms that resemble other dermatological conditions may emerge, particularly after the use of topical corticosteroids or immunosuppressive therapies, potentially leading to diagnostic delays and therapeutic errors. We report a series of 16 such cases.

Materials & Methods:

This is a prospective descriptive study conducted over three years, from March 2022 to March 2025, in our department. All cases of scabies with atypical clinical presentations were included.

Results:

A total of 16 patients were included. The median age was 49 years, ranging from 4 months to 75 years, with a male-to-female ratio of 2.19. The median consultation delay was 3 months, ranging from 20 days to 2 years. Eight patients had no known medical history. One patient had asthma, one had type 2 diabetes, one had hypertension, one had SHARP syndrome, one had hypothyroidism, and one had a retroviral infection. The use of topical corticosteroids and immunosuppressive therapies was reported in 62.5% and 12.5% of cases, respectively.

Pruritus was present in all patients, with familial occurrence and nocturnal exacerbation in 62.5% of cases. Skin lesions included excoriated papules (81.3%), vesicles (37.5%), eczematous lesions (31.3%), nodular prurigo, erythroderma, and pustules (25%), palmoplantar keratoderma (18.8%), bullae, and hyperkeratotic lesions (6.3%).

Nail involvement was observed in 12.5% of cases, with subungual hyperkeratosis. The “delta-wing sign” was noted in 62.5% of patients. Satellite lymphadenopathy was found in three patients. The tape test was positive in 37.5% of cases. A skin biopsy performed on two patients showed non-specific parakeratosis.

Among the patients, 64.6% were treated with benzyl benzoate, and 35.4% with ivermectin. All patients showed a favorable outcome.

Conclusion:

This case series highlights the importance of diagnosing scabies incognito, a rare form of scabies that should be considered in any polymorphic pruritic dermatosis, especially when aggravated by topical corticosteroids and immunosuppressive therapies. Early recognition of this condition can help avoid misdiagnosis and inappropriate treatments, which may otherwise complicate the clinical picture.



**Abstract N°: 8079****Lymphangitis in Suspected Black Widow Spider Bite: A Case Report from Morocco**MOHAMED HOUBAYELI¹, Nouhaila Bourht¹, Mariem Aboudourib¹, layla bendaoud¹, Ouafa Hocar¹, Amal Said¹¹Mohammed VI University Hospital of Marrakech, Bioscience and Health Laboratory, Department of Dermatology-Venerology, Marrakesh, Morocco**Introduction & Objectives:**

Spider bites, particularly those from venomous species like the black widow spider (*Latrodectus* spp.), can present with a spectrum of clinical manifestations, including local and systemic symptoms. This case report describes a unique presentation of lymphangitis following a suspected black widow spider bite in a patient from Morocco.

Materials & Methods:

A 41 years -old male presented to the emergency department with complaints of cellulitis, severe pain, erythema, and swelling at the site of a spider bite on his right leg. Physical examination revealed lymphangitis extending proximally from the bite site, along with associated regional lymphadenopathy.

Given the clinical presentation and the analysis a presumptive diagnosis of black widow spider bite was made. The patient was managed with wound care, analgesics, and close monitoring for systemic symptoms. Antivenom therapy was considered but not administered due to the absence of severe systemic manifestations.

Results:

Over the course of hospitalization, the patient's symptoms gradually improved, with resolution of lymphangitis and local inflammation. Follow-up evaluation showed complete recovery without long-term complications.

Conclusion:

This case underscores the importance of considering black widow spider bites in the differential diagnosis of spider bites presenting with lymphangitis, especially in regions where the species is endemic like Morocco. Timely recognition, appropriate wound care, and vigilant monitoring for systemic complications are essential in the management of suspected black widow spider bites. Further studies are needed to enhance understanding of the epidemiology, clinical features, and optimal management of spider envenomations in Morocco.



**Abstract N°: 8094****Epidemiological and Clinical Profile of Childhood Leprosy: A Decade of Observations in a Tertiary Care Hospital in Delhi, India**sonikaa garg^{*1}, lekshmi p¹, krishna debbarman¹¹MAMC, Delhi, India**Title: Epidemiological and Clinical Profile of Childhood Leprosy: A Decade of Observations in a Tertiary Care Hospital in Delhi, India****Introduction & Objectives:**

Leprosy remains a public health challenge in India, particularly among socioeconomically disadvantaged populations. Childhood leprosy, defined as cases occurring in individuals under 15 years of age, serves as a key epidemiological marker for transmission within communities. Despite global efforts targeting elimination, new childhood cases persist, highlighting gaps in control measures.

Objective was to analyze the epidemiological trends, clinical characteristics, and treatment outcomes of childhood leprosy cases presenting to a tertiary care hospital in Delhi over a decade (2014–2024).

Materials & Methods: A retrospective analysis was conducted on 969 leprosy patients, including 44 children (4.5%) aged below 15 years, registered at the Leprosy Tertiary Care Hospital, Delhi. Clinical and demographic data, contact history, clinical features, slit skin smear, histopathological findings, and treatment details were collected and analyzed.

Results: Among the 44 pediatric patients, the majority were aged 11–15 years (47.7%), with a male-to-female ratio of 1.93. Multibacillary (MB) leprosy was more prevalent (57%) than Paucibacillary (PB) leprosy (43%). Borderline Tuberculoid (BT) was the predominant subtype (73%), followed by Borderline Lepromatous (11%). Hypopigmented patches (50%) were the most common lesions, primarily affecting extremities (68%). Nerve involvement was significant (84%), with the ulnar nerve being the most frequently affected (68%). Lepra reactions were observed in 16% of cases, all of which were Type 1 reactions. MDT completion was achieved in 68% of cases, while 32% defaulted. Disability, primarily claw hand, was noted in 20% of patients.

Conclusion: Childhood leprosy continues to be a challenge in endemic regions, with significant nerve involvement and disability risks. Despite a declining trend, sustained efforts in contact tracing, early detection, and community-based screening are critical for reducing transmission and preventing long-term sequelae. Strengthened surveillance and community education can bridge the gaps in timely diagnosis and treatment adherence.





Abstract N°: 8096

“Managing the Unexpected: Atypical ENL and Associated Comorbidities in Hansen’s Disease”

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Introduction & Objectives:

Hansen’s disease is an ancient infectious disease characterised by varied clinical presentations influenced by the host’s immune response. Here we report four cases of leprosy with uncommon disease presentations.

Materials & Methods:

Clinical data were collected from four patients with biopsy-confirmed Hansen’s disease who demonstrated atypical disease features or complications. Details regarding clinical presentation, treatment course, complications, and outcomes were documented and analysed.

Case 1: A 47-year-old female with a history of borderline leprosy, treated with MB-MDT in 2018, presented with fever, chills, and tender nodules over all limbs, along with pedal oedema. She was diagnosed with erythema nodosum leprosum (ENL) in a previously treated case of lepromatous leprosy. Initially managed with tapering oral corticosteroids, ENL recurred with steroid tapering. Methotrexate (15 mg/week) was initiated, leading to resolution. During therapy, she developed Ludwig’s angina, surgically managed by ENT specialists. Six months later, she presented with high-grade fever and weight loss and was diagnosed with pulmonary tuberculosis. Methotrexate was stopped, and anti-tubercular therapy with thalidomide for recurrent ENL was initiated, resulting in clinical improvement.

Case 2: A 30-year-old male diagnosed with lepromatous leprosy in reaction was started on MB-MDT with tapering steroids in October 2024. He presented with fever, erythematous plaques, proximal muscle weakness, and pedal oedema. Lab tests revealed elevated creatine phosphokinase (CPK), and skin biopsy confirmed ENL. Autoimmune screening was negative. He developed progressive anaemia and liver dysfunction, diagnosed as dapsone hypersensitivity syndrome, prompting dapsone withdrawal. He was treated with cyclosporine. Later, he developed erythroderma and liver dysfunction after starting cotrimoxazole for a febrile illness. Biopsy confirmed drug-induced erythroderma, again managed with cyclosporine. He subsequently developed slate-grey hyperpigmentation involving the skin and oral mucosa. Endocrinological evaluation revealed Addison’s disease, and he was initiated on steroid replacement therapy.

Case 3: A 56-year-old male who had completed MB-MDT for lepromatous leprosy one year prior developed recurrent ENL. Managed with tapering corticosteroids and methotrexate, he later presented with persistent fever, necrotic ulcers on the limbs and trunk, and multiple erythematous nodules. Skin biopsy confirmed necrotic ENL. He responded well to intravenous antibiotics followed by thalidomide, with resolution of symptoms and ulcer healing.

Case 4: A 28-year-old male with borderline lepromatous leprosy (diagnosed in 2024) developed tender nodules and recurrent orchitis. Skin biopsy confirmed ENL. Despite treatment with tapering steroids, recurrences were frequent. He was subsequently started on oral tofacitinib, with significant clinical improvement.

Results and conclusion:

Among the four cases, all exhibited complicated ENL presentations. Timely recognition and the judicious use of immunomodulatory therapies are essential for optimal outcomes. These findings emphasise the need for continued vigilance and individualised treatment approaches in managing leprosy reactions.

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**Abstract N°: 8140****Majocchi's Granuloma treated with anidulafungin. A non-hepatotoxic alternative to dermatophytosis. - A Case Report**

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Introduction & Objectives:

Majocchi's Granuloma is an uncommon, underdiagnosed deep dermatophytosis caused by the infiltration of the hair follicle and the dermis causing a clinical presentation often similar to a skin and soft tissue infection to which is frequently mistaken. It affects mainly young adults, mostly women and is deeply associated with immunosuppressed patients. We present the case of a 24 year old female, liver transplant recipient, with ischemic cholangitis and concomitant Majocchi's Granuloma, successfully treated with anidulafungin.

Materials & Methods:

A 24-year-old female with a history of chronic kidney disease and secondary biliary cirrhosis underwent liver transplantation two years prior and was on immunosuppressive therapy with tacrolimus and methylprednisolone. She was admitted with fever and jaundice and was diagnosed with cholangitis. Simultaneously had multiple violaceous nodules and hyperpigmented plaques on the front of the left leg which on ultrasound revealed two small collections. Skin and liver biopsies were performed, and empirical antibiotic therapy was initiated for both hepatic and skin infections. Hepatic biopsy confirmed ischemic cholangitis, and corticosteroid pulses were started. After no response with antibiotics, the patient was started on antifungal therapy. Due to hepatic dysfunction, terbinafine was contraindicated; therefore, amphotericin B was initiated, leading to removal from the transplant list. Direct microscopy later revealed septate hyaline hyphae and the biopsy showed mixed perifollicular and dermal inflammation, and PAS staining showed dermatophytes in the stratum corneum and dermis. Fungal culture confirmed *Trichophyton rubrum* as the causal agent. Given poor clinical response, systemic treatment with anidulafungin 200 mg/day was started, with planned therapy for 90 days with a successful response.

Results:

Majocchi's Granuloma presents often as grouped perifollicular papules and pustules in healthy individuals. In immunosuppressed patients, specially HIV, transplant recipients and those with long term use of corticosteroids, it acquires a more severe form with plaques and nodules. It requires due to lack of immune response. Diagnosis through histopathology and mycological culture is necessary for confirmation. While terbinafine and itraconazole are first-line systemic treatments, this case highlights the potential role of echinocandins in deep dermatophytosis when standard therapies are contraindicated.

Conclusion:

We report a case of Majocchi's granuloma in an immunosuppressed patient, that could not receive conventional antifungals and was successfully treated with anidulafungin. To our knowledge, this is the first documented case of dermatophytosis treated with this agent.

**Abstract N°: 8189****Erythema Induratum of Bazin with Unusual Features: A Case Report**

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Introduction & Objectives:

Erythema induratum of Bazin (EIB) is a rare tuberculid characterized by a hypersensitivity reaction to *Mycobacterium tuberculosis* antigens, manifesting as a chronic lobular panniculitis with vasculitis. The diagnosis remains challenging due to its clinical overlap with other forms of panniculitis and variable association with overt tuberculosis infection. We present a diagnostically challenging case of EIB with atypical anterior leg involvement, highlighting the essential role of clinicopathological correlation in its diagnosis and management.

Materials & Methods:

NA

Results:

A 49-year-old woman with multiple cardiovascular risk factors (hypertension, type 2 diabetes, morbid obesity) and chronic venous insufficiency presented with a 3-month history of progressive, painful, indurated plaques on both anterior and lateral legs. Her medical history was notable for spousal exposure to pulmonary tuberculosis (deceased husband). Cutaneous examination revealed multiple erythematous-violaceous plaques (3–8 cm) with central induration, focal ulcerations, and hyperpigmented borders bilaterally. Systemic review showed no fever, night sweats, weight loss, or lymphadenopathy. Laboratory investigations, including complete blood count, inflammatory markers, and renal/liver function, were unremarkable. Sputum and urine cultures for acid-fast bacilli (AFB) were negative. Tuberculin skin testing (TST) showed 14 mm induration, and interferon-gamma release assay (QuantiFERON-TB Gold) was positive. Histopathology of a biopsy demonstrated septolobular panniculitis with lymphocytic vasculitis, fat necrosis, and granulomatous inflammation, features diagnostic of EIB. Given the histopathological confirmation, positive TB immunoreactivity, and epidemiological context (high endemic region), a diagnosis of EIB was established. The patient was initiated on standard four-drug antitubercular therapy (ATT) with rifampicin, isoniazid, pyrazinamide, and ethambutol. Initial clinical improvement was evident at 4-week follow-up.

Conclusion:

This case highlights the diagnostic challenges of EIB with atypical anterior leg involvement in a patient with metabolic comorbidities. Histology showing lobular panniculitis with granulomatous vasculitis confirmed EIB, emphasizing biopsy's role in atypical presentations. Strong immunologic tests (TST/QuantiFERON) without microbiological evidence support EIB's classification as a tuberculid, a hypersensitivity reaction to mycobacterial antigens. Rapid response to antitubercular therapy (ATT) justifies empirical treatment in TB-endemic areas. Metabolic comorbidities may influence EIB's course, suggesting combined ATT and comorbidity management optimizes outcomes. EIB's varied presentations require a comprehensive approach integrating ATT and metabolic control, especially in high-risk patients.



**Abstract N°: 8212****HIV, leprosy and visceral leishmaniasis: A rare triad with complex diagnostic and therapeutic challenges**

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Introduction & Objectives:

Leprosy and visceral leishmaniasis are opportunistic infections that may affect individuals with advanced immunosuppression, especially those living with human immunodeficiency virus (HIV). While their association with HIV is well described, the simultaneous occurrence of all three conditions is exceptional. We present a case of triple co-infection to highlight the diagnostic complexity and the importance of early recognition and multidisciplinary management.

Materials & Methods:

We report a complex case of a 26-year-old male living with HIV who developed extensive papulonodular skin lesions twelve weeks after the initiation of antiretroviral therapy. Diagnostic evaluation included skin histopathology, dermal smear microscopy, bone marrow aspirate, and abdominal ultrasound. The patient was managed through a multidisciplinary approach in dermatology department.

Results:

The lesions initially affected the facial region, including eyebrow ridges, earlobes, and nasal bridge, then gradually extended to the trunk, back, and limbs. They were associated with nasal congestion, rhinorrhea, and progressive general deterioration.

Clinical examination revealed diffuse, bilaterally symmetrical infiltrated lesions over more than fifty sites, a leonine facies, ulcerated nodules on the lower limbs, generalized lymphadenopathy, and signs of pyramidal tract involvement. Histopathological examination of a skin biopsy showed dermal infiltration by histiocytic nodules surrounding neural and adnexal structures, with numerous Virchow cells and absence of epithelioid or giant cells, consistent with lepromatous leprosy. A dermal smear confirmed the presence of *Mycobacterium leprae*. In parallel, biological investigations revealed pancytopenia, and bone marrow aspiration identified *Leishmania* bodies, confirming visceral leishmaniasis. Parasitological analysis of the skin biopsy also revealed cutaneous *Leishmania* infection. Abdominal ultrasound showed hepatosplenomegaly, consistent with visceral involvement. The patient's immune status was compromised, with a CD4⁺ T-cell count of 70 cell/mm³. Treatment included rifampicin, clofazimine, and liposomal amphotericin B. Dapsone was excluded due to confirmed glucose-6-phosphate dehydrogenase (G6PD) deficiency. After two months, the patient showed marked clinical improvement. However, he was later lost to follow-up and subsequently reported deceased, with the exact cause of death remaining undetermined.

Conclusion:

This case illustrates the exceptional coexistence of HIV, lepromatous leprosy, and visceral leishmaniasis, a combination rarely described in the literature. Profound immunosuppression may lead to atypical and severe clinical presentations, complicating diagnosis and delaying treatment. Personalized therapeutic strategies are essential, particularly in the presence of comorbid conditions. Early recognition, multidisciplinary collaboration,

and close follow-up are crucial to improve outcomes in patients facing such complex co-infections.

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**Abstract N°: 8220****Tabetic arthropathy: A forgotten complication of Tertiary syphilis - A case report**

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Introduction & Objectives:

Tabetic arthropathy is a severe condition that has become exceptionally rare due to early diagnosis and management of syphilis. This study reports a new case of this uncommon pathology, for which treatment remains challenging.

Case report:

A 54-year-old male, a former smoker who had quit 16 years ago, was referred to the dermatology department for positive syphilis serology associated with painless right knee instability persisting for one year. Medical history revealed unprotected sexual behavior 30 years earlier. Dermatological examination was unremarkable. Rheumatological assessment showed freely mobile, non-tender joints with bilateral patellar ballottement. Neurological examination demonstrated a steppage gait, absent lower limb deep tendon reflexes, and multidirectional sway. Ophthalmologic funduscopy and cardiologic transthoracic echocardiography were normal.

In terms of paraclinical investigations:

- Blood tests: TPHA positive at 1/320; VDRL positive at 1/2.
- Cerebrospinal fluid : TPHA positive (titre to be specified), VDRL negative, protein concentration 0.46 g/L, glucose concentration 0.77 g/L, and white blood cell count <3 elements/mm³.
- Synovial fluid: TPHA positive 1/640 ; VDRL negative, 56 000 white blood cells/mm³ with 60% neutrophils, and negative bacterial culture.
- Viral serologies (HIV, HBV, HCV): Negative.
- Radiological evaluation of the right knee revealed mixed osteolytic and proliferative changes
- MRI of the knee showed a complete rupture of the anterior cruciate ligament (ACL), , depressed medial tibial plateau fracture with peripheral avulsion, ipsilateral meniscal tear, and large joint effusion.

Based on these findings, tabetic arthropathy was diagnosed. The patient received intravenous penicillin G (20 million IU/day for 14 days) with premedication (paracetamol and prednisolone 0.5 mg/kg/day) to prevent Jarisch-Herxheimer reaction. An orthopedic brace was applied, and arthroscopic intervention was planned.

Conclusion:

Tabetic arthropathy is a destructive neurogenic disorder secondary to treponemal infection. It typically appears at advanced stages, usually 20 to 30 years after primary syphilis. It affects 1 to 10% of patients with tabes dorsalis, primarily targeting the knee joint. Early forms, often unrecognized, may mimic simple osteoarthritis. Treatment is essentially medical, based on penicillin G administration. Early treatment of syphilis remains the only effective measure to prevent the progression to tabetic arthropathy.

**Abstract N°: 8231****Staphylococcal Infections of the Face: Clinical Challenges and Urgent Management of a Rare but Severe Condition**

kaouthar Ben Abdessalem¹, Bendaoud Layla¹, Mariem Aboudourib¹, Hocar Ouafa¹, Amal Said¹

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Introduction & Objectives:

Malignant facial staphylococcal infection (MFSI) is a rare but potentially life-threatening condition, typically caused by *Staphylococcus aureus*. It frequently arises after manipulation of lesions within the so-called “danger triangle” of the face, with the risk of severe complications such as cavernous sinus thrombosis, blindness, or meningitis. This study aims to describe the clinical presentation, underlying comorbidities, therapeutic approaches, and outcomes of 14 patients diagnosed with MFSI, while emphasizing the importance of early recognition and rapid management to prevent life-threatening complications.

Materials & Methods:

We conducted a retrospective analysis of 14 patients diagnosed with MFSI and hospitalized in our dermatology department. Data were collected regarding demographics, clinical features, suspected portals of entry, biological parameters, imaging findings, treatments received, and clinical outcomes. The diagnosis was based on clinical and laboratory findings, and treatment was initiated empirically with systemic antibiotics, adjusted according to clinical evolution and suspected etiology.

Results:

The study included 6 women and 8 men, with a mean age of 52.1 years (range: 17–89 years). Underlying comorbidities included hypertension (n=4), diabetes mellitus (n=3), cardiopathy (n=1), thyroid dysfunction (n=1), chronic obstructive pulmonary disease (n=1), recurrent herpes labialis (n=1), and chronic otitis media (n=1). A manipulated furuncle was identified as the presumed portal of entry in 6 patients; one patient had an intranasal foreign body, and in 7 cases no clear entry point was found.

All patients presented with a painful, erythematous, and warm plaque, affecting the entire face in 5 cases and one hemiface in 9 cases. Pustules and meliceric crusts were seen in 10 patients, vesicular clusters in 4, and bullae in 2 cases. One patient developed a necrotic plaque of the left nasal ala with ipsilateral nasal obstruction. Palpebral edema was noted in 9 patients (bilateral in 6, unilateral in 3), and fever was documented in 2 cases. No neurological signs were observed.

Laboratory tests revealed neutrophilic leukocytosis in all patients. CRP levels exceeded 200 mg/L in 5 cases, ranged between 100–200 mg/L in 4, and were below 50 mg/L in the remaining 5. Ophthalmologic assessments were normal in all patients. Facial scans revealed soft tissue infiltration in 3 cases, while 11 scans were unremarkable. Therapeutically, 4 patients received monotherapy, 6 required dual antibiotic therapy, and 3 were treated with triple regimens. Acyclovir was added in 4 patients where herpetic co-infection was suspected. The average treatment duration was 10 days. All patients improved clinically and biologically, except for one who died, representing the only fatal outcome in this series.

Conclusion:

MFSI represents a dermatologic and infectious emergency due to its potential for rapid and severe complications. While its clinical diagnosis is straightforward in most cases, the condition requires prompt initiation of empiric anti-staphylococcal antibiotic therapy and, when indicated, antiviral agents. Imaging plays a limited role unless complications are suspected. Our series underlines the importance of recognizing common risk factors especially skin manipulation within the facial danger triangle and managing patients urgently and aggressively.

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**Abstract N°: 8266****Uncommon varicelliform herpes zoster a clinical insight**Sofia El haitamy¹, Zakia Douhi¹, Meryem Soughi¹, Sara Elloudi¹, Hanane Baybay¹, Fatima Zohra Mernissi¹¹university hospital center hassan II, dermatology, Fez, Morocco**Introduction & Objectives:**

Herpes zoster (HZ), caused by the reactivation of the varicella zoster virus (VZV), typically manifests as a painful, vesicular rash localized to a single dermatome. However, when the rash spreads to form a diffuse varicelliform eruption (≥ 20 vesicles outside the primary dermatome), distinguishing between concurrent varicella and disseminated zoster (DZ) becomes clinically challenging. This study aimed to examine the clinical features, risk factors, and complications associated with this atypical presentation of HZ.

Materials & Methods:

A retrospective analytical study was conducted at our department over a period of six years, including patients diagnosed with varicelliform eruptions associated with HZ.

Results:

Thirteen patients were included, with a mean age of 46 years (range: 60–80 years) and a predominance of males (61.5%). Immunosuppression was identified in 77% of cases, encompassing HIV patients on antiretroviral therapy (ART), individuals with malignancies undergoing chemotherapy, and those with autoimmune diseases (lupus on mycophenolate mofetil, rheumatoid arthritis on methotrexate/corticosteroids). One case occurred in a pregnant woman with recent COVID-19 infection. Autoimmune diseases and malignancies were more frequently observed in younger patients (86% vs. 40% in the elderly), underlining the significant role of immunosuppression in VZV dissemination. Stress (39%) and immunosuppression (58.5%) were identified as common triggering factors, with malignancies increasing the risk of varicelliform HZ by fivefold (OR: 5.0). Neuropathic pain was the most common symptom (92.3%), with the rash initially confined to a single dermatome in 95% of cases. Dissemination occurred 2–6 days (mean: 4 days) after the rash onset, most frequently from thoracic (61.5%), trigeminal (23%), and lumbosacral (15.5%) regions. Cutaneous involvement included hemorrhagic and pustular vesicles, erosions, and necrotic lesions on an erythematous base, often extending to the trunk and limbs. Mucosal involvement (oral/genital) occurred in 31% of cases.

Complications included bacterial superinfection in 84% of patients, ocular involvement (superficial punctate keratitis, blepharitis) in 35%, and herpetic meningoencephalitis with cellulitis in 7.7%. Elderly patients experienced a higher frequency of complications, attributed to immunosenescence and tissue fragility. All patients were treated with intravenous acyclovir, resulting in favorable clinical outcomes.

Conclusion:

Varicelliform eruptions associated with herpes zoster are a key indicator of underlying immunosuppression and require prompt recognition to mitigate severe complications. Early intervention, including timely antiviral therapy and tailored vaccination strategies, is essential in improving outcomes for high-risk individuals, particularly those with immunosuppressive conditions.



**Abstract N°: 8292****Fungal Infections as Cutaneous Carcinogenic Amplifiers: A Retrospective Case-Control Analysis in the NIH All of Us Cohort**Mihir Kumar¹, Amritpal Kooner², Rawle Sekhon³, Selina Chang⁴¹Johns Hopkins University School of Medicine, Baltimore, United States²Chicago College of Osteopathic Medicine, Chicago, United States³Windsor University School of Medicine, Saint Kitts, Saint Kitts and Nevis⁴University of Pittsburgh School of Medicine, Pittsburgh, United States**Introduction & Objectives:**

Cutaneous squamous cell carcinoma (cSCC) is a keratinocyte malignancy driven by impaired immune surveillance, chronic inflammation, and tumor-induced barrier dysfunction. Opportunistic fungal infections—including *Candida* spp. and dermatophyte species such as *Trichophyton* and *Epidermophyton*—may exploit these perturbations, yet their epidemiologic relationship with cSCC remains poorly defined. We therefore aimed to quantify the association between common fungal skin infections (candida, tinea corporis, tinea pedis, tinea unguium, and tinea versicolor) and cSCC incidence in a large, demographically diverse cohort, to inform interdisciplinary strategies for surveillance and management in dermatologic oncology patients.

Materials & Methods:

We conducted a retrospective case-control study using the NIH All of Us Research Program database. Individuals diagnosed with cSCC (SNOMED 254651007 or ICD-10 C44.92) were matched 1:4 to controls on sex, age, race/ethnicity, income, education, and smoking status via nearest-neighbor propensity-score matching. Univariate logistic-regression models estimated odds ratios (ORs) and 95% confidence intervals (CIs) for each fungal infection, and multivariate models adjusted for all matching covariates. Statistical comparisons employed Fisher's exact test for categorical variables and unpaired t-tests for continuous variables, with two-sided $P < 0.05$ denoting significance.

Results:

Among 3,755 cSCC cases (mean age 75.8 years; 57.0% male; 90.8% White) and 15,020 matched controls, univariate analysis revealed that prior diagnosis of candida infection was associated with a 1.51-fold increased odds of cSCC (95% CI 1.35–1.69; $P < 0.01$), while tinea corporis, tinea pedis, tinea unguium, and tinea versicolor were associated with ORs of 2.09 (95% CI 1.66–2.62; $P < 0.01$), 3.87 (95% CI 3.37–4.45; $P < 0.01$), 3.54 (95% CI 3.20–3.92; $P < 0.01$), and 1.45 (95% CI 1.02–2.06; $P = 0.05$), respectively. After adjustment for demographic and socioeconomic covariates, these associations remained significant, with adjusted ORs of 2.20 (95% CI 1.95–2.47), 1.99 (95% CI 1.58–2.49), 2.53 (95% CI 2.22–2.87), 2.11 (95% CI 1.92–2.32), and 1.61 (95% CI 1.12–2.28) for candida, tinea corporis, tinea pedis, tinea unguium, and tinea versicolor, respectively (all $P < 0.01$).

Conclusion:

Our findings demonstrate that both candida and dermatophyte infections are independently associated with a two- to four-fold increased risk of cSCC, suggesting that immune dysregulation and barrier compromise facilitate fungal colonization in malignantly transformed skin. These results underscore the importance of routine fungal surveillance and prompt treatment in patients with cSCC, and highlight the need for coordinated care between dermatology and infectious-disease specialists to mitigate secondary infection risk and improve oncologic

outcomes.

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Abstract N°: 8327

Tackling resistant dermatophytosis: A rising challenge

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Introduction & Objectives:

Dermatophytosis, superficial infections of the skin and its appendages, are a common and evolving pathology. The recent emergence of strains resistant to first-line antifungals, such as *Trichophyton indotineae*, is raising growing concern within the dermatological community.

Through these case reports, we aim to shed light on these resistant strains, their clinical features, and the therapeutic strategies to address this burgeoning public health crisis.

Materials & Methods:

Results:

Case 1:

A 39-year-old female patient presented with a pruritic skin eruption, initially on the trunk, aggravated by self-medication with corticosteroids, leading to lesion extension over a year. She reported contact with dogs and similar lesions in her son. Examination revealed multiple erythematous squamous lesions with centrifugal extension, annular arrangement, and circinate borders, affecting the face, trunk, large folds, and limbs. Extensive superficial dermatophytosis was suspected. Mycological testing of the skin scales successively isolated *Trichophyton rubrum* and *Trichophyton mentagrophytes*. A skin biopsy revealed nonspecific interface dermatitis with negative stains. The patient was initially put on local and oral Terbinafine 250 mg/d for 2 months, then switched to Griseofulvin 1 g/d, with no improvement, prompting the introduction of Itraconazole 400 mg/d. The outcome was favorable at the 15-day follow-up.

Case 2:

A 20-year-old male patient also presented with a pruritic, progressively spreading rash, evolving over 4 months. He reported regular contact with animals, as well as self-medication with topical corticosteroids and antifungals. Examination revealed erythematous squamous lesions similar to those in the 1st patient. Mycological testing isolated *Trichophyton interdigitale*. Initial treatment was similar to that of the 1st patient, with transition to itraconazole due to lack of response.

Case 3:

A 53-year-old female patient presented with a chronic rash treated with itraconazole for 1 year, with relapse after discontinuation. A skin biopsy, performed to rule out differential diagnoses, confirmed dermatophytosis, showing numerous mycelial filaments and microspores, along with a positive PAS stain. Mycological sample culture is still underway to isolate the resistant strain.

Conclusion:

Classic dermatophytosis manifest as erythematous squamous lesions, typically localized on the face, trunk, limbs, and

large folds. However, the emergence of *Trichophyton indotineae*, a terbinafine-resistant strain, complicates the diagnosis and treatment of these infections. Initially identified in India and Nepal, this species' resistance is due to mutations in the squalene epoxidase gene, leading to extensive and refractory dermatophytosis, often following inappropriate self-medication with corticosteroids and/or antifungals.

The treatment of resistant infections requires a more targeted approach. Itraconazole has proven effective, at doses of 200 to 400 mg/d for 1 to 12 weeks. Voriconazole has also demonstrated efficacy, while terbinafine has shown reduced response rates. Griseofulvin and fluconazole have proven ineffective. As for topical treatments, they are insufficient alone, but their combination with systemic antifungals has shown promising results. Future research should focus on expanding therapeutic options and improving antifungal sensitivity testing to better manage these infections.

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**Abstract N°: 8350****The dark side of fluffy - zoonotic tinea mentagrophytes misdiagnosed as psoriasis in a child**Jingyuan Xu¹, Christian Lowe²¹Countess of Chester Hospital NHS Foundation Trust, chester, United Kingdom²University College London Hospitals NHS Foundation Trust, London, United Kingdom**Introduction & Objectives:**

Zoonotic dermatophytosis, especially due to *Trichophyton mentagrophytes*, is increasingly encountered among individuals with small animal contact. Without relevant exposure history, these infections are frequently misdiagnosed as inflammatory conditions like psoriasis. This can lead to inappropriate treatments, such as topical corticosteroids, which exacerbate infection.

Results:

A 7-year-old child presented with a small erythematous, scaly lesion at the lateral hairline, diagnosed as psoriasis and treated with topical corticosteroids. Over time, the lesion expanded, involving the cheek, forehead, and scalp, accompanied by significant alopecia. Further history and review prompted skin scraping for fungal culture, confirming dermatophyte infection. Despite prolonged oral terbinafine therapy, clinical response remained incomplete. Subsequent investigation of further skin scraping from the child and family's pet guinea pig through hair-pluck sampling isolated the same causative organism, identified as *T. mentagrophytes* by PCR. Antifungal susceptibility testing guided subsequent management. Complete clinical resolution was achieved by 12 months, maintained at follow-up.

Conclusion:

This case illustrates important emerging trends and diagnostic challenges associated with zoonotic dermatophytosis. Guinea pigs are well-recognised reservoirs of *T. mentagrophytes*, with asymptomatic carriage rates reported between 20–30%. Topical steroid misuse commonly complicates and prolongs dermatophyte infections, emphasising the importance of early mycological investigation. Additionally, emerging antifungal resistance necessitates susceptibility testing to optimise treatment strategies. Clinicians must maintain vigilance by routinely enquiring about pet exposure, particularly to small mammals, when evaluating persistent and treatment-resistant inflammatory skin conditions in children. A comprehensive One Health approach, integrating veterinary and dermatological care, is pivotal to the effective management of zoonotic infections.



**Abstract N°: 8365****Exploring the diagnostic hurdles of Madura foot: insights from a case report**Aimane Zaim^{*1}, Zakia Douhi¹, Meryem Soughi¹, Sara Elloudi¹, Hanane Baybay¹, Fatima Zohra Mernissi¹¹Hassan II University Hospital, Dermatology Department, Fez, Morocco**Introduction & Objectives:**

Mycetoma is a neglected tropical infectious disease, often referred to as the “disease of the three P’s: Poverty, Peasants, and Prejudices”. It is distinguished by the formation of persistent, inflammatory pseudotumors that are typically polyfistulous, discharging grains of various colors. The condition most commonly affects the foot—hence the name “Madura foot”—and bone involvement significantly worsens the prognosis. Mycetoma can be caused by either fungal agents (eumycetomas) or bacteria (actinomycetomas), although in about 16% of cases, the causative organism remains unidentified. This case report aims to illustrate the diagnostic challenges associated with mycetoma, emphasizing frequent delays in diagnosis due to its rarity, slow progression, and lack of awareness in non-endemic regions.

Materials & Methods:

Herein, we report the case of a chronic polyfistulous swelling of the foot in an adult female patient. A comprehensive diagnostic approach—including clinical examination, histopathology, microbiological sampling, and imaging—was undertaken to establish the etiology and guide appropriate management.

Results:

A 57-year-old woman with a history of depression presented with a chronic, painful swelling on her right foot that had persisted for 43 years following a traumatic injury caused by a piece of glass. On dermatological examination, a significant, deformed, dyschromic pseudotumor was noted on the right foot. The mass was firm to hard in consistency, polyfistulous, and was discharging both pus and blood. Several white-yellowish grains were visible upon applying pressure to the fistulae. Additionally, ipsilateral inguinal lymphadenopathy was noted. Bacteriological and mycological cultures of the grains and skin tissue yielded no microbial growth, but histopathological examination revealed characteristics consistent with mycetoma, strongly suggesting an actinomycotic etiology. Magnetic resonance imaging (MRI) showed extensive bone destruction, with a pathognomonic “dot-in-circle” sign and fatty degeneration of the surrounding muscles. The patient was initiated on a triple antibiotic regimen consisting of cotrimoxazole, amoxicillin/clavulanic acid, and amikacin, leading to a favorable clinical outcome.

Conclusion:

Although mycetoma is typically endemic to rural tropical regions with hot and arid climates, it can also occur sporadically in non-endemic areas such as Morocco, often leading to delayed diagnosis. Transmission usually follows traumatic skin injury, with an incubation period ranging from several months to years. The classic clinical triad includes a painless, firm swelling, fistulization, and grain discharge—producing the characteristic “watering can” appearance. In advanced stages, deeper structures, including bone, may become involved. MRI is particularly valuable in these cases, especially when it reveals the pathognomonic “dot-in-circle” sign. This case underscores the diagnostic complexity of mycetoma in non-endemic settings and highlights the importance of histopathology and imaging when cultures are inconclusive. Early recognition through a multidisciplinary approach is essential to prevent complications and ensure optimal management.



**Abstract N°: 8389****Collected Erysipelas of the Elbow Mimicking Arthritis in an Immunosuppressed Patient**

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Introduction :

Skin infections such as erysipelas near articulations can sometimes mimic septic arthritis, particularly in immunocompromised patients. We report a case of elbow erysipelas simulating arthritis in a patient on corticosteroid and rituximab therapy.

Case report:

A 56-year-old man with pemphigus vulgaris treated with corticosteroids and rituximab presented with right elbow swelling persisting for one week without fever. Clinical examination revealed an erythematous, warm, and mildly painful plaque with a fistulous orifice draining pus but no joint stiffness or functional impairment. Radiography showed a normal elbow joint while soft-tissue ultrasound demonstrated significant infiltration with a 2 cm subcutaneous collection adjacent to the radial bone; joint ultrasound was normal.

Conclusion:

This presentation initially suggested septic arthritis but was ultimately diagnosed as erysipelas complicated by subcutaneous abscess given the absence of articular involvement on imaging and presence of cutaneous fistula. The case illustrates how skin infections in immunosuppressed patients may mimic joint infections and underscores the importance of imaging for accurate differentiation.



**Abstract N°: 8400****Misleading clinical presentation of scabies: the role of dermoscopy in the preconceived diagnosis**meryame hammouch¹, rachadi hanane¹¹CHU ibn rochd, dermatology, casablanca, Morocco**Introduction & Objectives:**

Scabies is a common parasitic skin infestation, typically characterized by nocturnal pruritus and specific lesions in predilection sites. However, certain atypical forms can delay diagnosis, particularly in young adults without relevant medical history or suggestive epidemiological context. We report an illustrative case. The objective is to highlight the contribution of dermoscopy in the early recognition and diagnosis of atypical presentations of scabies.

Observation:

A 20-year-old male with no prior medical history presented to the emergency department with intense pruritus lasting for four days. Initial clinical examination revealed erythematous papular lesions localized on the back, abdomen, and, to a lesser extent, on the limbs. There was no history of contact exposure or recent medication use. Infectious, inflammatory, and serologic workup returned unremarkable. Symptomatic treatment with antihistamines, topical corticosteroids, and emollients was initiated.

By day 4, the patient returned with marked worsening: the appearance of papulovesicular and pustular lesions, notably on the palms, soles, interdigital spaces, wrists, ankles, inguinal region, and anterior thighs, associated with pruritus so intense it caused insomnia and functional impairment. Diffuse erythematous papular lesions with central crusts were also observed across the body. Dermoscopy revealed characteristic scabetic burrows with the "delta wing" sign, confirming the diagnosis. Treatment with benzyl benzoate and management of household contacts led to rapid clinical improvement.

Discussion:

This case illustrates an atypical form of scabies, initially misleading due to the absence of known exposure and non-specific lesions, mimicking inflammatory or drug-induced dermatoses. Atypical scabies may present with pustular, eczematized, or bullous features, making diagnosis challenging without dermoscopy or parasitological confirmation. Lack of response to symptomatic treatment, involvement of characteristic areas, and severe pruritus should prompt clinicians to consider scabies, even without an obvious epidemiological context.

Conclusion:

Scabies should be considered in any case of diffuse pruritus affecting characteristic sites, even without known exposure. Dermoscopy is a valuable tool for early diagnosis, helping to avoid delays and prevent transmission.



**Abstract N°: 8403****Scrofuloderma arising from an osteoarticular foccus of tuberculosis.**

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Introduction & Objectives:

Scrofuloderma is an uncommon clinical form of cutaneous tuberculosis, usually produced by fistulization from an underlying affected adenopathy. However, it can also occasionally arise from other infected focci (e.g. joints).

Case presentation:

An 84-year-old man with a history of chronic obstructive pulmonary disease and a right-wrist traumatic arthritis during adolescence, presented with a 1-month history of multiple exudative ulcers on his right wrist. He lacked systemic symptoms or other mucocutaneous findings and had not previously responded to systemic antibiotherapy.

A biopsy yielded unspecific histological findings, whereas microbiological cultures of the sample were positive for *M. tuberculosis*. An MRI was performed, showing a cystic collection located at the radial and dorsal margin of the wrist. Chest X-ray and sputum smears ruled out pulmonary tuberculosis.

The diagnosis of scrofuloderma from an osteoarticular tuberculosis focus was reached and conventional antituberculous treatment along with surgical debridement led to the resolution of the lesions.

Discussion:

Scrofuloderma is a form of cutaneous tuberculosis that arises from the direct extension of an underlying tuberculous infection, typically from lymph nodes. When associated with osteoarticular tuberculosis, it presents as chronic, non-healing ulcers.

The diagnosis of scrofuloderma requires a high index of suspicion, especially in endemic areas or in patients with a history of tuberculosis, and is based on the isolation of *M. tuberculosis* in the affected tissue, either by culture or polymerase chain reaction. Histopathological study can support the diagnosis although it is sometimes nonspecific. Treatment involves the use of standard anti-tuberculosis therapy (generally isoniazid, rifampicin, pyrazinamide, and ethambutol), although in the case of scrofuloderma with osteoarticular tuberculosis, surgery is usually necessary as a complementary treatment.

Conclusion:

Scrofuloderma is a rare form of cutaneous tuberculosis specially arising from an infected osteoarticular foccus. Early diagnosis, in which dermatologists play an essential role, along with appropriate treatment are crucial to prevent complications such as deformities and to ensure complete resolution of the infection.



**Abstract N°: 8409****Nasal Borrelial Lymphocytoma cutis : A Rare Presentation with Dermoscopic Features**NADIA LAHMAMSI¹, oumaïma sbai¹, maria charaa¹, madiha el jazouly¹, soumiya chiheb^{1, 2}¹Cheikh Khalifa University Hospital, Dermatology and Venerology Department, Casablanca , Morocco²University Hospital Center Ibn Rochd, Dermatology Unit, Casablanca , Morocco**Introduction & Objectives:**

Borrelial lymphocytoma cutis is a rare cutaneous manifestation of early disseminated Lyme borreliosis, typically affecting the earlobe, areola, or genital area. Nasal localisation is rare and may mimic other dermatoses. While histopathology and serology are crucial for diagnosis, dermoscopy can provide additional diagnostic clues. However, its role in borrelial lymphocytoma remains underexplored. We present a rare case of nasal borrelial lymphocytoma cutis with contributive dermoscopic features, successfully treated with doxycycline.

Case report:

A 54-year-old woman with no significant medical history presented with a two-month history of an erythematous nodule on the nose, without systemic symptoms. She reported a trip to a rural area three months earlier. Clinical examination revealed a firm, erythematous, painless nodule without clinical signs of inflammation, measuring 22 mm × 15 mm on the nose. Examination of the rest of the skin and lymph nodes was unremarkable. Dermoscopy showed reticular whitish lines on an erythematous background, with a few linear vessels and follicular plugs. Histopathological examination of a biopsy revealed orthokeratotic epidermis and a dermis containing a moderately dense diffuse nodular infiltrate composed of medium-sized cells with abundant cytoplasm and slightly irregular nuclei. Immunohistochemical analysis was not performed. Borreliosis serology was positive for both IgG and IgM. The diagnosis of Borrelial lymphocytoma cutis, initially suspected based on clinical, dermoscopic, and histopathological findings, was further supported by positive Borrelia serology and confirmed by the complete resolution of the lesion following a 4-week course of doxycycline at 100 mg daily.

Discussion:

Borrelial lymphocytoma cutis is among the rarest cutaneous manifestations of Borrelia infection, accounting for around 5% of cases. More common in children, it usually appears weeks to months after a tick bite as a red-blue nodule or plaque, typically on the earlobe, nipple, or scrotum. Histologically, it presents with a dense lymphocytic and histiocytic dermal infiltrate, sometimes showing follicular patterns visible only by immunohistochemistry. In our case, the diagnosis was supported by serology and dermoscopic findings, despite the absence of immunohistochemistry. Dermoscopy of borrelial pseudolymphoma is infrequently reported. Described features include orange-yellow structureless areas, polymorphous vessels, and white lines, corresponding to dense infiltrates. Our case revealed reticular whitish lines, few linear vessels, and follicular plugs, also noted in prior reports, which may indicate folliculotropism.

Conclusion:

This case illustrates the rarity of nasal borrelial lymphocytoma and the diagnostic value of dermoscopy. Further reports are needed to better characterize its dermoscopic features.

**Abstract N°: 8450****When steroids fuel the fire: A case of a diagnostic pitfall in dermatophytosis**daghari douha¹, Mouna Korbi¹, Nesrine Ben Salah¹, Hichem Belhadj ali¹, Jamel eddine Zili¹¹University Hospital Monastir, Dermatology Department, monastir**Introduction & Objectives:**

Dermatophytosis, a superficial fungal infection of the skin, hair, or nails, is typically localized and responsive to topical antifungals. Thus, the aim of this case to illustrate extensive presentations, especially involving the face and trunk, due to corticosteroid use, which can mask inflammation and facilitate fungal spread.

Materials & Methods: NA**Results:**

We report the case of a 31-year-old female with medical history who presented with an acute five-week history of widespread, intensely pruritic skin lesions. The eruption began on her cheeks as erythematous scaly patches and was initially diagnosed as allergic dermatitis. She was prescribed topical corticosteroids and oral prednisone, resulting in rapid spread of lesions to the face, neck, chest, and back. On examination, she exhibited multiple large, annular, erythematous scaly plaques with sharply demarcated borders, distributed across the face, upper trunk, and lower limbs. Mucosal surfaces and nails were unaffected. A direct microscopic examination revealed numerous septate hyphae, confirming dermatophytosis. Culture grew *Microsporum canis*. The patient was treated with topical terbinafine. She was counseled on strict hygiene and avoidance of corticosteroids. Follow-up at four weeks showed marked improvement, with flattening of plaques and resolution of pruritus.

Conclusion:

Extensive dermatophytosis, sometimes termed “steroid-modified tinea” or “tinea incognito,” arises when corticosteroids mask inflammatory signs while promoting fungal growth. Recent reviews in *JAAD* and *JAMA Dermatology* emphasize the rising incidence of such cases, often linked to corticosteroid misuse and diagnostic delays. According to Gupta et al. systemic antifungals, particularly terbinafine, are first-line treatments in such extensive presentations, with cure rates exceeding 80%. Furthermore, a recent NEJM review stresses the importance of identifying tinea incognito early, especially in patients with sudden lesion expansion under corticosteroid treatment. Misdiagnosis and delayed treatment not only extend morbidity but increase the risk of chronic infection and transmission. This case underscores the critical need for clinicians to consider dermatophytosis in the differential diagnosis of inflammatory skin disorders, especially when lesions worsen under corticosteroids, and to confirm fungal infections via microscopy or culture before initiating immunosuppressive therapies.





Abstract N°: 8458

Cutaneous and Mucocutaneous Leishmaniasis in Tigray (Ethiopia)

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Introduction & Objectives

Cutaneous and muco-cutaneous leishmaniasis are endemic diseases in Tigray region,

the Northern part of Ethiopia. Still now specific treatments are not available in the rural areas and many people refer to the hospital when the illness is in a very late stage, after trying traditional treatment (application of leaves on the skin lesions). Control of leishmaniasis in Ethiopia is complicated by an inadequate supply of appropriate drugs. People are often unable to access medical treatment because of multiple factors such as poverty, lack of health education, and lack of health facilities.

Materials & Methods:

We analyzed the cases of cutaneous (CL) and muco-cutaneous leishmaniasis (MCL),

from January 2007 to December 2018, observed at the Italian Dermatological Centre (IDC) in Mekele, at the General Hospital of Adigrat and at the Maiani District Hospital of Sheraro, in Tigray (Ethiopia). 1,756 out of total medical visits were CL/MCL (1.98%), M:F ratio was 2:1, mean age was 21.4.

Results

We present some clinical cases of the different forms of CL and MCL, and some cases of coinfection with HIV.

Conclusion:

Specific and effective drugs were not available in the region since few years ago;

antimonial pentavalents are now available only in the main town, but we observed cases of

resistant leishmaniasis, mainly the diffuse cutaneous (DCL) and muco-cutaneous (MCL) type. People from the rural areas still seek for traditional medicine, this is leading to disfiguring and functional impairment of the affected regions of the body (usually face and extremities) if affected by DCL and MCL. Moreover, people with Leishmania/HIV coinfection need multiple cycles of

therapy, as the disease has chronic and relapsing course in these patients. **

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**Abstract N°: 8470****Prominent syphilitic secondary stage presenting clinical features of leprosy**

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Introduction: Secondary syphilis is the second stage of infection by *Treponema pallidum*, typically emerging weeks to months after the primary lesion. It is characterized by cutaneous manifestations, such as papular eruptions and mucosal lesions, in addition to systemic symptoms including fever, lymphadenopathy, and malaise.

Case report: A 50-year-old male presented to the dermatology outpatient clinic complaining of a facial rash, initially described as an “allergic reaction.” He reported that the lesions had appeared approximately 30 days earlier. On dermatological examination, the patient exhibited erythematous, infiltrated, ill-defined, and extensive plaques on the face, also involving the ears. Additionally, the scalp showed infiltrated areas interspersed with verrucous regions and zones of alopecia, giving the appearance of patchy hair loss. On the left upper limb, there were two infiltrated, circular plaques with peripheral scaling, suggestive of a possible Biett’s collarette. No lesions were observed in the genital area, and the patient denied any previous similar lesions. Based on the clinical presentation, the initial differential diagnoses included borderline leprosy, secondary syphilis, and cutaneous lymphoma. A 4 mm punch biopsy was performed on the right temporal region. Furthermore, serological testing returned positive results: VDRL 1:16, and both FTA-ABS IgM and IgG were reactive. These findings confirmed the diagnosis of secondary syphilis. The patient was treated with benzathine penicillin G, 2,400,000 IU once weekly for two weeks.

Conclusion: Given the nature of the lesions and the overall clinical picture, serological confirmation, in conjunction with clinical evaluation and histopathological findings, was essential in establishing the diagnosis of secondary syphilis. The polymorphic nature of syphilis is clearly demonstrated by the wide variety and intensity of cutaneous lesions, which in this case mimicked leprosy and cutaneous lymphoma. Accordingly, syphilis remains a key differential diagnosis in cases of infiltrated dermatoses with atypical presentation, underscoring its reputation as “the great imitator.”





Abstract N°: 8486

Oral Mucosal Involvement in Lepromatous Leprosy: A Case Report

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Introduction & Objectives:

Leprosy is a chronic infectious disease caused by *Mycobacterium leprae*, an acid-fast bacillus with a predilection for the peripheral nerves and skin. 1 Involvement of the oral mucosa is uncommon, most commonly affecting the hard palate. Such presentations are predominantly associated with the multibacillary spectrum of the disease. 2

We report a case of oral leprosy in a lepromatous patient.

Case report:

A 44-year-old male presented with a one-year history of diffuse erythematous plaques across the body. Dermatological examination revealed bilateral madarosis, infiltration of the ear lobes and nasal dorsum, as well as erythematous plaques on the trunk, upper and lower limbs. Intraoral examination showed an infiltrative nodular plaque on the hard palate.

Neurological evaluation demonstrated bilateral thickening of the ulnar and common fibular nerves. The patient also exhibited grade 2 disability, with a mobile ulnar claw affecting the left hand. Histopathological examination of a skin biopsy revealed features consistent with lepromatous leprosy. Specific multidrug therapy for leprosy was initiated, resulting in near-complete regression of the oral mucosal lesions within the first month of treatment.

Discussion:

Leprosy is a chronic infectious disease caused by *Mycobacterium leprae*, which has tropism for the skin and peripheral nerves. Most individuals are naturally resistant, and among those who are susceptible, the clinical manifestations vary along a spectrum according to the immune response. Patients with greater resistance develop paucibacillary forms, characterized by a low bacillary load and few skin lesions. At the opposite end, individuals with lower immunological resistance present with multibacillary forms, marked by a high bacillary load, widespread skin lesions, and involvement of multiple peripheral nerves.¹

Oral mucosal involvement in leprosy is uncommon and is typically associated with multibacillary forms, particularly lepromatous leprosy. The hard palate is the most commonly affected, with lesions presenting as infiltrative plaques, nodules, or, rarely ulcerations. 2 In this case, oral involvement was predominantly located on the hard palate, manifesting as infiltrative, non-ulcerated plaques.

Involvement of the tongue may present as erosions, ulcerations, and deep fissures. Labial manifestations include edema and ulcerative lesions, which in advanced cases may lead to microstomia due to tissue fibrosis. Gingival involvement may present as chronic gingivitis or periodontitis, while affection of the uvula is rare and typically associated with fibrotic changes in advanced disease.²

Untreated or advanced cases may result in fibrosis, leading to oropharyngeal dysfunction such as dysphagia and permanent structural alterations of the oral cavity.⁴ In the present case, the oral mucosal involvement demonstrated significant reversal within the first month of treatment, emphasizing the critical role of early

diagnosis and timely therapeutic intervention in preventing irreversible sequelae.

Conclusion:

Oral mucosal involvement in leprosy, though rare, is common in multibacillary forms like lepromatous leprosy. Early diagnosis and timely initiation of multidrug therapy are critical for effective management, as demonstrated by the rapid resolution of oral lesions in this case, emphasizing the importance of early intervention to prevent irreversible sequelae.

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Abstract N°: 8491

Epidemiological Profile of Bacterial Dermohypodermatitis in the Dermato-Venereology Department of Tlemcen University Hospital (2022-2024)

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Introduction & Objectives:

This infection is a type of SSTI (Skin and Soft Tissue Infection). At the beginning of the 20th century, it accounted for up to 12% of deaths; however, today its evolution is favorable in the majority of cases.

Materials & Methods :

A descriptive retrospective study, conducted on the records of 120 patients hospitalized for erysipelas during the period from June 2022 to February 2024.

Results:

In our population, we noted a predominance of females with a sex ratio of 0.76, whose average age was 59 years, with more than half of our patients being hypertensive. 73% of patients had risk factors, of which 38% had only one and 08% had 03 or more risk factors, and which were dominated by obesity with a percentage of 56.7. Interpretation of clinical and laboratory data showed a high frequency of a biological IFL syndrome and a pseudo-influenza syndrome found in half of the cases. The site was unilateral in 92% dominated by involvement of the lower limbs. The presence of a port of entry is noted in 54% of cases dominated by ITO in 83.3%. For our evolutionary data: 21% of patients were taking anti-inflammatory drugs following self-medication or under medical prescription. 40% of patients had presented signs of local severity such as bullae; purpura or necrosis among which 05% had presented the 03 signs, most of which progressed to necrotizing fasciitis which was present in 04% of cases, 11% presented cellulitis and 77% of patients presented no complications. The evolution was favorable in 3/4 of the cases while 25% either resisted or worsened even under antibiotics. Interpretation of the therapeutic data showed that 1st generation cephalosporins were prescribed in 57% of cases; in 2nd position Augmentin was prescribed in 40% of cases.

Conclusion:

Erysipelas remains a frequent pathology, the use of anti-inflammatory drugs and the presence of comorbidity favor complications and therapeutic failure.





Abstract N°: 8576

Cutaneous Infiltration and Diffuse Alopecia: A Rare Presentation of Leprosy

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Introduction & Objectives:

Leprosy is a chronic infectious disease caused by *Mycobacterium leprae*, often presenting with cutaneous and neurological signs.

Although peripheral neuropathy and hypopigmented skin lesions are well-known hallmarks of leprosy, the disease can occasionally present with atypical features, such as patterns resembling alopecia areata universalis.

This case aims to highlight a rare presentation of multibacillary leprosy initially mistaken for alopecia universalis,

Materials & Methods:

A 54-year-old woman with no notable medical background developed progressive, diffuse hair loss with complete loss of eyebrows and eyelashes, initially suggestive of alopecia areata universalis. No cutaneous or neurological signs were present at that time.

Over the following weeks, the patient began to experience progressive sensory loss in her hands and feet which was soon followed by the development of painful bilateral plantar ulcers. Dermatological examination revealed multiple infiltrated plaques with hypoesthesia, primarily located on the lower limbs. Neurological assessment confirmed peripheral nerve involvement, and a** slit-skin smear test was performed, revealing a high bacillary index with numerous acid-fast bacilli, thus confirming the diagnosis of multibacillary leprosy.

Results:

Atypical presentations of leprosy—particularly those marked by diffuse hair loss—can significantly delay diagnosis, as they may mimic more common conditions such as alopecia areata. Similar cases in the literature have reported eyebrow and** body hair loss as initial manifestations, especially in multibacillary or diffuse variants such as Lucio and Latapí leprosy. **In** our patient, the scalp was notably spared, a feature frequently observed and likely related to the higher temperature of the scalp, which is less favorable to *Mycobacterium leprae* proliferation.

The progression to peripheral neuropathy and the development of plantar ulcers subsequently revealed hallmark features of leprosy. This case underscores the need to consider leprosy in the differential diagnosis of atypical forms of alopecia, particularly in endemic regions or in the presence of neurological symptoms.

Conclusion:

Leprosy can exceptionally present as generalized alopecia, mimicking alopecia areata universalis.

The development of sensory deficits and neuropathic ulcers should prompt consideration of leprosy in the differential diagnosis.



**Abstract N°: 8581****When taking care of a simple diagnosis unveils an unexpected one**AYA TADLAOUI^{*1}, Hanane Baybay¹, Zakia Douhi¹, Meryem Soughi¹, Sara Elloudi¹, Fatima Zahra Mernissi¹¹CHU HASSAN II, DERMATOLOGY, FEZ**Introduction & Objectives:**

This case report aims to inform and educate healthcare professionals that, despite the perception of leprosy as eradicated in some areas, it remains a possibility due to its long incubation period. This highlights the importance of performing an exhaustive clinical examination, from scalp to toes, in order not to overlook a potentially unidentified condition despite any symptoms.

Clinical case:

A 66-year-old Moroccan male who was admitted for the treatment of dermohypodermatitis of the right lower limb was found to have leprosy after a preliminary clinical examination revealed neurological and dermatological symptoms suggestive of leprosy. The diagnosis of borderline leprosy was confirmed by a skin biopsy after a negative bacilloscopy. The patient was subsequently put on treatment and followed up in his region

Results:

A patient was diagnosed with leprosy after gathering anamnestic, clinical and paraclinical evidence in favor of this diagnosis. Physical examination of the skin lesions revealed borderline tuberculoid leprosy. Bacilloscopy was negative. Skin biopsy revealed the presence of red intracytoplasmic bacilli corresponding to Acid-fast stain resistant bacilli .

The patient lives in a region where leprosy has been virtually eradicated, with no new cases reported.

The most likely cause of his infection was his close contact with a colleague who had similar lesions all over his body and died without apparent cause over 10 years ago.

Conclusion:

This report describes a rare case of leprosy discovered incidentally while treating a dermohypodermatitis of the right lower limb.

This information serves as a reminder to healthcare professionals that leprosy is not obsolete, and that the national leprosy control program still has a crucial role to play in ensuring careful surveillance of leprosy, even in areas where the disease has been declared eradicated.



**Abstract N°: 8620****Skin Diseases in Displaced Individuals**

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Introduction & Objectives:

As of June 2024, an estimated 122.6 million people worldwide are forcibly displaced due to conflict. This figure has nearly doubled over the past decade, resulting in over 1 in every 67 people being displaced globally. Among these, the 1.9 million displaced in Gaza face particularly dire conditions, with many living in overcrowded camps prone to flooding and inadequate sanitation. The prevalence of cutaneous diseases in these environments is alarmingly high, driven by a combination of overcrowding, environmental exposure, and the breakdown of healthcare infrastructure. Understanding the unique challenges faced by displaced populations—including refugees, migrants, asylum seekers, and internally displaced persons—is critical for addressing their health needs effectively.

Materials & Methods:

To understand the scope of skin diseases, images and case studies obtained from medical associations at frontlines were obtained, with consent. In addition, a review of previous studies on skin diseases among displaced individuals was conducted by searching PubMed using keywords such as “skin,” “disease,” “displaced,” and “refugee.” Key findings and conclusions from this analysis are presented below.

Results:

The World Health Organization reports over 103,000 cases of lice and scabies in Gaza, and 65,000 cases of skin rashes since October 2023. Additionally, there are 9,274 cases of chickenpox and 10,038 cases of impetigo, which has led to kidney failure for some. Alopecia and achromotrichia are also common across all age groups. Inflammatory and communicable skin disorders dominate among displaced populations, along with issues related to heat and cold injuries and nutritional deficiencies. Médecins Sans Frontières (MSF) warns of the potential emergence of leishmaniasis.

In Benghazi, Libya, among 480 internally displaced persons, common skin conditions include infections, xerosis, eczema, and acne. In the Kutupalong refugee camp in Bangladesh, fungal infections, particularly dermatophytes, were the most frequent diagnosis among 380 Rohingya patients, with infections making up over two-thirds of diagnoses.

In Syrian refugee camps in Jordan, dermatitis was the most common skin condition, though higher rates of atopic dermatitis were observed compared to the contact dermatitis seen in the Rohingya camps, likely due to exposure to wet cement and nickel.

Conclusion:

Dermatologists treating asylum seekers must be aware of the high prevalence of skin conditions in these populations. With the increasing need for healthcare access, teledermatology can play a vital role in bridging

gaps. Understanding the unique skincare needs of this vulnerable group is essential for future healthcare planning.

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**Abstract N°: 8641****A Diagnostic Pitfall: Varicella Infection Mimicking Gestational Dermatoses in the Third Trimester**

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Introduction & Objectives

Dermatologic eruptions during pregnancy can present a diagnostic challenge due to the overlap between gestational dermatoses and infectious conditions. Disorders such as pemphigoid gestations and PUPPP are commonly considered in the third trimester. However, infectious etiologies like varicella zoster virus (VZV) must also be included in the differential diagnosis, particularly in the presence of vesiculopapular lesions and systemic symptoms. This case aims to emphasize the importance of early recognition of varicella infection during pregnancy and the diagnostic value of the Tzanck smear in such scenarios.

Materials & Methods

A 21-year-old primigravida at 30 weeks of gestation presented with fever, vomiting and a widespread pruritic rash that originated from the periumbilical area and spread to the chest, face, and back. Dermatological examination revealed pruritic, erythematous, scattered papules and plaques, some with central vesicles, originating from the umbilical region and spreading sequentially to the shoulders, neck, and face. According to the patient's medical history, the rash began simultaneously with fever. The morphology and distribution were suggestive of gestational dermatoses, for which a punch biopsy was planned with the preliminary diagnoses of (1) pemphigoid gestationis and (2) pruritic urticarial papules and plaques of pregnancy (PUPPP). Prior to biopsy, a Tzanck smear was performed from a fresh vesicle.

Results

The Tzanck smear revealed multinucleated giant cells, suggestive of herpesvirus infection. Despite negative varicella serologies, IgM and IgG, and since there was no prodromal phase, varicella was not initially considered as the primary diagnosis. However the clinical presentation and cytologic findings supported a diagnosis of disseminated varicella. The patient was promptly referred to infectious diseases and obstetrics for further evaluation. Intravenous acyclovir was initiated and lesions showed progressive improvement with crust formation. The patient later delivered a healthy full-term infant without any maternal or neonatal complications.

Conclusion

This case illustrates the importance of maintaining a broad differential diagnosis for pruritic eruptions in pregnancy. Varicella may clinically mimic gestational dermatoses, and misdiagnosis can delay life-saving antiviral treatment. Tzanck smear remains a valuable, rapid diagnostic tool in dermatologic evaluation, especially when serologic tests are inconclusive. Despite negative VZV serologies (IgM and IgG) and since there was no prodromal phase, varicella was not initially considered as the primary diagnosis. However the clinical presentation and cytologic findings supported a diagnosis of disseminated varicella.





Abstract N°: 8665

Quality of Life in Patients with Scabies:

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Introduction & Objectives:

Scabies is a widespread parasitic dermatosis caused by the mite *Sarcoptes scabiei* var. *hominis*. It is transmitted through direct skin contact or, less frequently, via contaminated textiles. Clinically, scabies presents with intense pruritus, often worsening at night, and characteristic lesions including papules, excoriations, vesicles, and burrows, primarily in interdigital spaces, wrists, genital areas, and other warm body folds. Beyond its physical symptoms, scabies can be a source of social embarrassment, sleep disturbance, and psychological distress, particularly in resource-limited settings or among vulnerable populations.

This study aimed to evaluate the impact of scabies on patients' quality of life using the Dermatology Life Quality Index (DLQI), and to identify clinical or demographic factors associated with greater impairment.

Materials & Methods:

This is a descriptive retrospective study conducted over a period of 4 years from January 2021 to January 2025, including patients with scabies. Quality of life was assessed using the Dermatology Life Quality Index (DLQI) questionnaire. The total score ranges from 0 to 30 and is divided into five classes: 0-1 (no effect), 2-5 (mild effect), 6-10 (moderate effect), 10-20 (significant effect), 20-30 (extremely significant effect).

Results:

A total of 82 patients were enrolled, with a mean age of 27.5 ± 13.2 years (range: 6–82 years). There was a slight male predominance (56%). The mean duration of symptoms before diagnosis was 3.1 ± 1.9 weeks. The overall mean DLQI score was 13.4 ± 6.5 , reflecting a significant impairment in quality of life.

- 13 patients (12.5%) reported an extremely significant impact
- 50 patients (48%) reported a significant impact
- 32 patients (30.7%) reported a moderate impact
- 9 patients (8.8%) reported a mild impact

The most affected domains were **symptoms and feelings** (particularly pruritus and embarrassment), followed by **leisure activities** and **sleep quality**. Among school-aged children and adolescents, performance and concentration at school were notably affected. Patients living in crowded households, dormitories, or with limited access to hygiene facilities reported significantly higher DLQI scores ($p < 0.05$). Women and younger patients, especially those under 30 years old, tended to report greater emotional and social distress.

Conclusion:

Our findings confirm that scabies significantly impairs patients' quality of life across multiple dimensions. The

intense itching, sleep disruption, and social stigma associated with the disease contribute to both physical discomfort and psychological burden. These results are consistent with previous studies from endemic and non-endemic regions, underlining the universal psychosocial impact of scabies. The higher burden observed in younger patients and those in overcrowded settings suggests that social and environmental determinants play a central role in the disease's impact.

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Abstract N°: 8674

Triple Minimycetoma by *Nocardia brasiliensis* treated with Linezolid and TMP/SMX

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Triple Minimycetoma by *Nocardia brasiliensis* treated with Linezolid and TMP/SMX

Introduction & Objectives:

Mycetoma is a chronic granulomatous infection of the skin and subcutaneous tissues caused by fungi (eumycetoma) and filamentous aerobic bacteria (actinomycetoma). It is considered a neglected tropical disease, particularly affecting rural populations in endemic regions such as Mexico. *Nocardia brasiliensis* is the leading cause of actinomycetoma in this region. While mycetoma classically presents as a single lesion, multifocal or disseminated forms are rare.

This case report aims to describe a patient with triple minimycetoma, emphasizing the diagnostic challenges, rarity of presentation, and management complexities. # **Materials & Methods:** A 33-year-old woman from Coyuca de Catalán, Guerrero, Mexico (225 km south to Mexico City), with a history of working in the agricultural sector, presented with a 1.5-year history of a nodular lesion on her right arm, followed by similar lesions on the left gluteal and posterior thigh regions. She denied trauma or inoculation events. An initial biopsy interpreted as a soft tissue abscess led to empirical treatment with cephalexin, itraconazole, and topical agents without clinical improvement. She was referred to our dermatology department for further evaluation. # **Results:** On examination, the patient exhibited three separate nodular-plaque lesions with erythematous-violaceous borders and surface scaling. A direct mycological examination revealed a grain compatible with *Nocardia* sp. Histopathologic analysis of a skin biopsy showed a mixed granulomatous infiltrate. Biochemical testing using casein hydrolysis was positive, and PCR confirmed the presence of *Nocardia brasiliensis*. A diagnosis of triple actinomycetoma due to *N. brasiliensis* was made. Treatment was initiated with linezolid 600 mg once daily and trimethoprim/sulfamethoxazole (TMP/SMX) 160/800 mg twice daily. After 8 weeks of treatment, the patient developed right flank pain and subjective fever. A urology consultation and laboratory workup suggested crystal-induced nephritis, likely secondary to prolonged TMP/SMX exposure. Both antibiotics were discontinued. A month later, the skin lesions were non-suppurative and showed cicatricial changes. Renal symptoms had resolved, and no new lesions had appeared. Therefore, 6 months after the last visit, the patient was found to be clinically and microbiologically cured. # **Conclusion:** Triple minimycetoma by *Nocardia brasiliensis* is an exceedingly rare clinical presentation. While isolated lesions are the norm, the simultaneous involvement of three distinct anatomical sites is highly unusual and poses diagnostic and therapeutic challenges. This case underscores the importance of maintaining a high index of suspicion in endemic areas, employing a stepwise diagnostic approach that includes microbiological and molecular tools. Early identification and coordinated multidisciplinary care are essential to optimize outcomes and manage potential treatment-related complications. In this patient, timely diagnosis and

targeted antimicrobial therapy led to clinical resolution within a short period, highlighting the potential for rapid cure when appropriate treatment is promptly instituted.

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**Abstract N°: 8675****Pyemotes ventricosus Dermatitis in a European Child Visiting Morocco: A Case Report**

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Introduction & Objectives:

Pyemotes ventricosus is a parasitic mite known to cause dermatitis in humans following exposure to infested materials, often wood or straw. The resulting skin eruption, typically pruritic and characterized by central vesicles with surrounding erythema and serpiginous tracks, can resemble a “comet sign.” Although rare, travel-associated cases can occur outside endemic areas.

Case Presentation: A 7-year-old female of European origin, with no notable medical history, presented three days after hospital admission with a history of intensely pruritic skin lesions. She was vacationing with her family in Morocco and denied any direct outdoor exposure or contact with vegetation or animals.

Physical examination revealed multiple erythematous papules and macules located on the trunk and abdomen. Several lesions displayed a central punctum and serpiginous extensions radiating outward, consistent with the “comet sign” typically associated with *Pyemotes ventricosus* dermatitis. The diagnosis was made clinically based on the morphology, distribution, and evolution of the lesions, alongside the absence of other systemic symptoms. Treatment consisted of topical corticosteroids and oral antihistamines. The patient responded gradually, with complete resolution of the lesions over the following days.

Conclusion:

This case highlights the importance of considering ectoparasitic etiologies in pruritic dermatoses acquired during travel. Prompt recognition and symptomatic management can lead to full recovery without complications.



**Abstract N°: 8711****Scrofuloderma With Retractable Scarring in a Young Moroccan Child: A Rare Cutaneous Form of Tuberculosis**

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Introduction & Objectives:

Cutaneous tuberculosis (CTB), a rare form of extrapulmonary tuberculosis (EPTB), constitutes less than 2% of all TB cases globally. Scrofuloderma, the most common type of CTB, results from direct extension of tuberculosis from underlying lymphadenitis to the skin. In endemic countries such as Morocco, where TB remains a major public health concern, pediatric scrofuloderma remains underdiagnosed and underreported. This case highlights the clinical presentation, diagnostic challenges, and therapeutic outcome of inguinal scrofuloderma in a 3-year-old child, emphasizing the need for early recognition to prevent disfiguring sequelae.

Materials & Methods:

A 3-year-old Moroccan boy presented with a 4-month history of multiple indurated, ulcerated nodules in the right inguinal area, evolving into retractile, atrophic scars. There was no history of trauma, BCG site reactivation, or known TB contact. Clinical examination revealed multiple linear and nodular scars with central retraction and hyperpigmentation, suggestive of healed scrofuloderma. Regional lymphadenopathy was palpable. Tuberculin skin test was strongly positive (15 mm). Ultrasonography showed hypoechoic lymph nodes with necrotic centers. Histopathology of a nodular lesion revealed granulomatous inflammation with caseation. GeneXpert on biopsy confirmed *Mycobacterium tuberculosis*, sensitive to rifampicin. HIV serology was negative.

Results:

The patient was started on standard anti-TB therapy (2HRZE/4HR) with favorable evolution; lesions healed without recurrence, but retractile scarring persisted. Scrofuloderma typically affects the cervical region; inguinal involvement, though uncommon, should raise suspicion in TB-endemic areas. According to the Moroccan Ministry of Health, tuberculosis remains a public health priority, with over 30,000 new cases annually and 45% being extrapulmonary in nature (Programme National de Lutte Antituberculeuse, 2022), and scrofuloderma representing a minor yet important subset. Pediatric forms may be missed due to nonspecific signs and lack of awareness. Early diagnosis aided by histology and molecular testing, as in our case, is essential for prompt treatment and minimizing sequelae. Literature supports the value of GeneXpert in CTB, with sensitivity reaching 80–90% in tissue samples (Barbagallo et al., *J Eur Acad Dermatol Venereol*, 2020).

Conclusion:

Scrofuloderma remains a diagnostic challenge, especially in children in endemic settings. This case highlights the importance of clinical vigilance, the utility of histological and molecular diagnostics, and the need for timely treatment to prevent irreversible scarring. Improving awareness of CTB's variable presentations can enhance early diagnosis and reduce the burden of disfigurement and morbidity in children.





Abstract N°: 8716

Butterfly-Shaped Tinea Faciei: A Diagnostic Pitfall

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Introduction & Objectives: Tinea faciei is a superficial dermatophytosis affecting the glabrous skin of the face. Its clinical presentation can be highly variable, sometimes mimicking other facial dermatoses such as lupus erythematosus, rosacea, perioral dermatitis, or annular psoriasis. Atypical features, especially in cases involving hair-bearing areas like the eyebrows, can lead to diagnostic delays or misdiagnosis, particularly when lesions adopt a butterfly distribution pattern suggestive of malar rash in lupus.

Materials and Methods : We report a case of tinea faciei with an unusual butterfly-shaped presentation, initially raising suspicion for lupus erythematosus, and highlight the value of trichoscopy and mycological evaluation in reaching the correct diagnosis.

Results : Case Presentation A 32-year-old woman with no significant medical history presented with a two-month history of itchy, erythematous-squamous facial plaques. The lesions were arranged in a butterfly-shaped pattern involving the cheeks, nasal bridge, periorbital region, and forehead. She denied photosensitivity or systemic symptoms. Dermatologic examination revealed poorly demarcated erythematous plaques with active borders, scattered follicular pustules, and localized alopecia of the lateral eyebrows, without skin atrophy.

Trichoscopic examination of the eyebrows showed signs suggestive of fungal infection: erythema, black dots, yellow dots, perifollicular scaling, and comma hairs—indicative of fungal invasion of hair shafts. Direct microscopic examination of eyebrow hairs in potassium hydroxide (KOH) preparation revealed ecto-endothrix fungal elements. Fungal culture subsequently identified *Trichophyton rubrum* as the etiologic agent.

A diagnosis of tinea faciei with eyebrow involvement was confirmed. The patient was treated with oral terbinafine (250 mg/day) for one month, along with topical ciclopiroxolamine. The lesions resolved completely, with regrowth of eyebrow hair and no residual inflammation or scarring.

Conclusion : This case underscores the potential for tinea faciei to present in a misleading butterfly distribution, mimicking autoimmune or inflammatory facial dermatoses. Trichoscopy provided key diagnostic clues, including comma hairs and perifollicular scales, which supported a fungal etiology. KOH preparation and culture remain essential for definitive diagnosis. Involvement of hair-bearing areas, such as the eyebrows, requires systemic antifungal therapy. Early recognition and appropriate management can lead to complete resolution and prevent complications.



**Abstract N°: 8743****The Scabies Surge: Rising Cases and Evolving Treatment Strategies in the UK and Europe**Nabiah Malik¹, Sarah El Gamma², Narin Shareef³¹Imperial College Healthcare NHS trust, London, United Kingdom²University Hospitals of Leicester NHS trust, Leicester, United Kingdom³Kingston Hospital, London, United Kingdom**Introduction & Objectives:**

Scabies, a parasitic skin infestation caused by *Sarcoptes scabiei*, has seen a significant resurgence across Europe. The United Kingdom has reported a sustained increase in cases, with general practice surveillance data indicating rates consistently above the five-year average and a notable rise in recent years. Similar upward trends have been observed in Germany, France, the Netherlands and Ireland, with outbreaks increasingly reported in communal settings such as care homes and student residences. This resurgence has raised concerns regarding treatment availability, public health responses and the effectiveness of current therapeutic regimens.

Materials & Methods:

This review draws on literature published between 2020 and 2024, as well as national surveillance reports and updated clinical guidelines from the UK and other European countries. Data were gathered from PubMed, Embase and official public health websites, focusing on epidemiological trends, treatment protocols and emerging alternative therapies. The search used keywords including 'scabies', 'epidemiology', 'treatment guidelines', 'Europe', 'United Kingdom', and 'alternative therapies'.

Results:

Scabies cases in the UK have risen sharply, with recent rates around 3.1 per 100,000-well above previous averages. Similar increases have been seen in Ireland and other European countries, especially in communal settings like care homes and student housing. The main treatment remains topical permethrin 5%, applied twice about a week apart. Oral ivermectin is now more widely used, particularly during outbreaks or in institutions, following recent UK licensing changes. Treating all close contacts and thorough cleaning are vital to stop reinfestation. However, shortages of permethrin and malathion have made controlling outbreaks harder. There are also concerns about possible resistance and incorrect use of treatments. Alternative options such as benzyl benzoate and the oral drug moxidectin are gaining interest, but strong clinical evidence is still lacking. Across Europe, treatment approaches vary, with some countries favouring oral ivermectin while others stick to topical creams.

Conclusion:

The resurgence of scabies in the UK and Europe has led to updated clinical guidance and highlighted the need for coordinated, assertive management strategies. While standard treatments remain effective when correctly applied, supply issues and possible resistance pose emerging challenges. Alternative therapies show potential but require further clinical evaluation. Harmonised public health responses and standardised treatment protocols across Europe are essential to effectively address this growing public health concern.



**Abstract N°: 8746****Disseminated Fusariosis - Management Conundrum - a fatal case in an immunocompromised patient**

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Introduction & Objectives:

Disseminated fusariosis is a rare but often fatal opportunistic fungal infection that predominantly affects immunocompromised individuals with a mortality rate of over 80%. Prognosis is determined by the degree of immunosuppression and extent of infection.

A 55-year-old caucasian female was admitted to the haematology unit after seeing her GP for fatigue, bruising, recurrent pyrexia and mouth ulcers. She was found to be profoundly cytopenic hence requiring admission and further investigations. The haematology team diagnosed this patient with aplastic anaemia following a bone marrow aspirate. She was commenced on a prophylactic course of acyclovir, levofloxacin and posaconazole. She developed a suspected drug rash shortly thereafter which was attributed to the posaconazole and therefore this was switched to fluconazole resulting in a resolution of the rash.

The underlying cause of the aplastic anaemia was unclear prompting further investigations including an autoimmune panel which revealed a positive ANA and dsDNA, positive crithidia with normal complement levels (C3 and C4). An early CT thorax, abdomen and pelvis showed no acute abnormal findings except for a large pericardial effusion which was aspirated showing macrophages and no evidence of malignancy. The patient was treated with a short course of high dose oral steroids (60mg once daily) by the rheumatology team for suspected systemic lupus erythematosus. Following the completion of the one-week course of oral steroids, an acute rash was observed with erythematous papules, nodules with areas of central necrosis and haemorrhagic crust.

A skin biopsy was performed revealing the presence of short, branching, septate fungal hyphae within the superficial and mid-dermis. On deeper sectioning, there were occasional vessels within the superficial dermis showing fibrin thrombi and possible infiltration by fungal hyphae. The patient was commenced on high dose antifungal - Amphotericin B (5mg/kg) following involvement of the microbiology team. A tissue culture confirmed the presence of *Fusarium* species which was resistant to all anti-fungals except for Amphotericin B.

Despite two weeks of treatment with high-dose Amphotericin B, the patient continued to develop new cutaneous lesions. She was persistently cytopenic and the rheumatology team intermittently treated her with low doses of methylprednisolone to try and treat her underlying likely autoimmune-related cytopenia. A further skin biopsy revealed fungal hyphae in the dermis once more with evidence of angio-invasion. The patient deteriorated with systemic sepsis and required ITU admission and despite inotropic support, treatment with IVIG and GCSF, she did not recover and subsequently died from systemic disseminated fusariosis.

Conclusion:

This case highlights the rare but serious complication of disseminated fungal infections and the complexity of treating such in a patient with suspected systemic lupus erythematosus (SLE) and confirmed aplastic anaemia.



**Abstract N°: 8747****Masked by Immunity: Recognizing Breakthrough Varicella in the Vaccinated Population**Beatriz Ganzella¹, Dafne Bromberg¹, Rebeca Shida¹, Kaique Arriel¹, John Veasey¹¹Santa Casa de Misericórdia de São Paulo, São Paulo**Introduction & Objectives:**

Varicella (chickenpox) is a highly contagious disease caused by primary infection with the varicella-zoster virus (VZV). Since the development of the live-attenuated vaccine derived from the Oka strain, global vaccination programs have significantly reduced the incidence and severity of varicella. The vaccine is highly effective, with a two-dose regimen providing enhanced and sustained immunity. However, breakthrough varicella—defined as infection occurring more than 42 days after vaccination—remains a recognized phenomenon. These cases are typically milder and may lack classical features, making diagnosis more challenging, particularly in the absence of a clear epidemiological link or typical prodromal symptoms. Our aim is describing the clinical, histopathological, and laboratory findings of a breakthrough varicella case in a fully vaccinated adolescent and highlight the diagnostic challenges associated with attenuated presentations of the disease.

Materials & Methods:

Clinical data, photographic documentation, and imaging findings were retrieved from the patient's medical records. No statistical analysis was performed, as this is a descriptive case report.

Results:

A 16-year-old male adolescent was referred for evaluation of erythematous papules and vesicles, some with crusting, distributed diffusely over the body. Two months prior, he had undergone surgery for sigmoid volvulus detorsion. The cutaneous lesions (Figure 1) had emerged four days before presentation, with no associated fever, myalgia, or other systemic symptoms. The patient reported no known contact with individuals with varicella and confirmed receipt of two doses of the quadrivalent MMRV vaccine, with the last dose administered in 2014. Histopathological examination (Figure 2) revealed keratinocyte apoptosis, a mixed inflammatory infiltrate, ballooning degeneration of the epidermis, and intraepidermal vesicle formation with reticular degeneration. Absence of nuclear inclusions suggested a subclinical or abortive viral process. The Tzanck smear (Figure 3) was positive, demonstrating multinucleated giant cells. Serological testing showed a markedly elevated VZV IgG level, more than three times the upper limit of normal. IgM was 1.8, and C-reactive protein (CRP) was 0.5 mg/dL.

Conclusion:

This case illustrates how breakthrough varicella may present diagnostic challenges, particularly in vaccinated individuals, where classical signs can be attenuated or misinterpreted. Despite immunization, characteristic cytopathic findings such as multinucleated giant cells and markedly elevated VZV IgG titers, alongside detectable IgM, may indicate active infection. Accurate interpretation of cytological and serological data, in conjunction with clinical context, is critical to avoid underdiagnosis. Awareness of breakthrough varicella as a distinct clinical entity is essential to guide appropriate management and limit transmission.



**Abstract N°: 8760****Recalcitrant Fungal Skin Infections and Possible Links with Topical Corticosteroid and Antiseptic Misuse in Nigeria: A Case Series**Olufolakemi Cole*¹, Ehiaghe Anaba¹, Olutomidimu Afolabi¹, Afolabi Obe²¹Lagos State University Teaching Hospital (LASUTH), Dermatology Unit, Department of Medicine, Ikeja, Nigeria²Lagos State University College of Medicine,, Medical Microbiology, Pathology, Lagos, Nigeria

Introduction & Objectives: Antifungal-resistant dermatophytoses are increasingly reported and pose a significant clinical and public health challenge, especially in low-resource settings. In Nigeria, the widespread misuse of topical corticosteroids (TCS) and antiseptic soaps and solutions may be a contributing factor. This case series aims to highlight potential associations between such misuse and difficult-to-treat fungal infections.

Materials & Methods: Clinical data of patients with recalcitrant fungal infections were collected over 6 months, including history of TCS and/or antiseptic use, lesion characteristics, mycological findings, antifungal susceptibility (where available), and treatment outcomes. Findings were compared with similar reports in the literature.

Results: Six patients aged 22 to 50 years presented with persistent or recurrent superficial fungal skin infections unresponsive to standard antifungal therapy. Skin lesions were atypical and extensive. All six patients had a documented history of prolonged topical corticosteroid misuse, and five had used antiseptics frequently. Fungal cultures predominantly yielded *Trichophyton rubrum*, *T. interdigitale*, and *T. mentagrophytes*. Reduced response to terbinafine was observed in four cases, and to azoles in two cases. The infections resolved slowly after prolonged treatment with oral itraconazole and topical azoles.

Conclusion: This case series suggests a link between TCS/antiseptic misuse and treatment-resistant dermatophytoses. There is an urgent need for regulation of topical corticosteroids, increased public education on TCS use, and antifungal stewardship. Dermatologists should maintain a high index of suspicion for resistance in chronic or recalcitrant cases and request fungal culture and sensitivity testing when possible, to guide appropriate therapy.

Keywords: Antifungal resistance, corticosteroid misuse, dermatophytosis



**Abstract N°: 8764****verrucous syndrome**

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Introduction & Objectives:

An 81-year-old male patient from Nova Iguaçu presented with back ulcers. Two years prior, he noticed the onset of painless, erythematous papules with progressive growth in the thoracolumbar region. The lesions evolved with a fetid odor and serosanguineous discharge. His medical history included hypertension, diabetes mellitus, and prostatic hyperplasia. He denied contact with pets, recent travel, or handling of plants.

On physical examination, erythematous, vegetative lesions with a verrucous surface were observed in the posterior thoracic region, accompanied by small black dots and seropurulent discharge. Differential diagnoses included verrucous syndromes such as paracoccidioidomycosis, cutaneous leishmaniasis, sporotrichosis, squamous cell carcinoma/chromoblastomycosis, and cutaneous tuberculosis.

Materials & Methods:

A skin biopsy was performed and sent for histopathology and culture. Histological analysis revealed pseudoepitheliomatous hyperplasia with chronic granulomatous inflammation, suggestive of deep mycosis. The biopsy specimen was inoculated into specific culture media. No growth was observed for fungi or mycobacteria in standard media. However, in NNN (Novy-MacNeal-Nicolle) medium, typically used for *Leishmania* investigation, there was growth of *Sporothrix sp.*

Results:

Macromorphologically, the culture showed filamentous fungal colonies. Microscopic examination revealed hyaline, septate, branched hyphae ending in conidia arranged in a “daisy-like” pattern, consistent with *Sporothrix sp.* This confirmed the organism in the NNN medium as the etiological agent. The absence of growth in Sabouraud agar was attributed to bacterial contamination.

Despite the exuberant lesions, the patient showed excellent response to **Itraconazole 200 mg/day**. Healing progressed with characteristic “candle wax drop” scars—atrophic and hypertrophic in nature. After full re-epithelialization, treatment was continued for an additional 4–6 weeks under supervision to ensure clinical cure.

Conclusion:

Clinical significance: This case highlights an atypical presentation of verrucous sporotrichosis, demonstrates the utility of NNN medium as an alternative culture method for isolating *Sporothrix sp.*, and underscores that fungal growth in an unexpected culture medium should not be immediately dismissed as contamination—it may represent the actual pathogen



**Abstract N°: 8794****Disseminated Molluscoid Lesions in an Immunocompromised Patient – A Diagnostic Challenge**

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Introduction & Objectives:

Histoplasmosis, caused by the dimorphic fungus *Histoplasma capsulatum*, is an opportunistic infection that can become disseminated in immunocompromised individuals, with potential multisystem involvement, particularly affecting the lungs and central nervous system

Materials & Methods: Case report and review of articles in Medline

Results:

We report the case of a 33-year-old male, Fitzpatrick phototype IV, originally from Brazil and residing in Portugal for four years, who presented to the dermatology emergency department with a three-month history of hard, painful cutaneous nodules initially on the face, spreading caudally to the upper limbs and trunk. The patient also reported fever, weight loss, epistaxis, and cough. On examination, he exhibited countless firm, elastic nodules, some with central umbilication and others with ulceration, displaying a molluscoid appearance and coalescing in the centrofacial region, causing significant facial deformity. His medical history was notable for a recent diagnosis of HIV infection (AIDS stage) two months prior, for which antiretroviral therapy had been initiated, and spent 1 month in the intensive care unit for an atypical pneumonia, diagnosed as pulmonary aspergilosis (with galactomanan antibody positive). He had

The differential diagnosis included deep mycosis (histoplasmosis), poxvirus infection (giant molluscum or mpox), and immune reconstitution inflammatory syndrome with cutaneous expression of atypical mycobacteriosis (Hansen's disease). Etiological investigation with CT, skin and nasal mucosa biopsies and cultures confirmed infection by *Histoplasma capsulatum* with cutaneous, pulmonary, and sinonasal involvement, while other diagnoses were excluded. The patient was treated with amphotericin B for 15 days, resulting in marked clinical improvement, and was discharged on itraconazole, which will be maintained until resolution.

Conclusion:

This case highlights the critical importance of recognizing cutaneous manifestations of this infection in immunocompromised patients, as they may signal underlying multisystem disease and guide the diagnostic process. A broad differential diagnosis and targeted etiological investigation are essential, given the potential for concurrent pathologies. Additionally, this case underscores the emerging epidemiological trend of histoplasmosis in non-endemic countries, reflecting increased global migration and immunosuppression rates. Early recognition and appropriate management of disseminated histoplasmosis are vital to improve patient outcomes in this vulnerable population.



**Abstract N°: 8826****Disseminated Tinea Incognita simulating erythema annulare centrifugum**

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Introduction & Objectives:

A 21-year-old white male presented to the General Dermatology outpatient clinic reporting asymptomatic erythematous macules disseminated across the body since 2023. He associated the onset with the use of high-dose prednisone (80 mg/kg/day) prescribed by the Nephrology team for the treatment of Berger's disease (IgA nephropathy), started two months prior to symptom onset. Some lesions had evolved into hypopigmented macules. The patient reported previous empirical treatment for *tinea corporis* with isoconazole nitrate cream for 30 days one year ago, with no resolution.

On physical examination, the patient exhibited annular erythematous macules with central hypopigmentation and mild scaling at the elevated borders, as well as well-demarcated hypopigmented macules disseminated on the face, neck, trunk, and limbs. Differential diagnoses included erythema annulare centrifugum and extensive dermatophytosis. He was referred for two 4 mm punch biopsies from the lesion borders on the abdomen and right arm, in addition to laboratory tests and direct mycological examination with fungal culture (Sabouraud agar) from skin scrapings of the cervical, facial, and abdominal regions.

Use of systemic or topical corticosteroids and immunosuppression can obscure the clinical presentation of dermatophytoses. Tinea incognita is a superficial fungal infection altered by corticosteroid use, commonly presenting with atypical features, such as widespread distribution and minimal pruritus.

Materials & Methods:

Ten days later, the patient returned with histopathological and laboratory results. The biopsy showed mild spongiosis in the epidermis and a superficial perivascular mononuclear infiltrate in the upper dermis, consistent with erythema annulare centrifugum. Laboratory tests, rheumatologic panels, and serologies were negative.

Pending culture results, the patient was referred for phototherapy. Fungal culture later revealed a powdery, filamentous, sulfur-yellow colony with a central furrow and reddish-brown reverse pigmentation. Microscopic examination showed microconidia aligned along the hyphae in a "birds on a wire" pattern, suggestive of *Trichophyton tonsurans*. Phototherapy was discontinued, and terbinafine 250 mg/day was initiated for six weeks, with follow-up in the Mycology outpatient clinic.

Results:

Trichophyton tonsurans is an anthropophilic dermatophyte often associated with tinea corporis and tinea incognita in immunosuppressed patients. It is a slow-growing fungus, with macromorphology ranging from white to brown. Micromorphologically, it features drop-shaped microconidia aligned along hyphae, resembling birds perched on a wire.

Conclusion: Dermatologists must consider tinea incognita in immunosuppressed patients presenting with disseminated, asymptomatic skin lesions, as timely identification of the fungal etiology is crucial for proper management

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Abstract N°: 8843

Erythema nodosum leprosum, a rheumatologic simulator

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Introduction & Objectives:

Erythema nodosum (EN) is a type of panniculitis affecting the subcutaneous fat of the skin, clinically manifested by painful erythematous nodules (1). It represents a hypersensitivity reaction that may be associated with various etiologies (2).

Among clinically relevant infectious causes of EN is leprosy, a disease caused by *Mycobacterium leprae*, with a variable clinical spectrum (3). One of its most distinctive presentations is erythema nodosum leprosum (ENL), a type II reaction that can appear in patients with multibacillary forms. Is characterized by fever, malaise and painful erythematous nodules, similar to classic EN, which can make its initial diagnosis difficult (3). This presentation can be easily confused with rheumatologic diseases if a broad diagnostic approach is not considered.

Materials & Methods:

A 28-year-old man presented with a 3-month history of erythematous nodules on the thighs, arms, and face. These skin lesions were accompanied by systemic symptoms including malaise, unintentional weight loss, fever, lymphadenopathy, and arthralgia of the left limb. There was no involvement of other joints, and no other symptoms were reported.

Laboratory investigations revealed elevated transaminases, increased inflammatory markers, and a negative autoimmune panel. A skin biopsy demonstrated a non-vasculitic urticarial pattern. Thoracoabdominal computed tomography revealed hepatosplenomegaly. The initial differential diagnoses included adult-onset Still's disease and Sweet's syndrome.

An inguinal lymph node biopsy showed the presence of globi, and slit-skin smears from the ear and elbows confirmed the diagnosis of multibacillary Hansen's disease with associated type 2 leprosy reaction.

Results:

Erythema nodosum leprosum (ENL) is a type 2 leprosy reaction, an immunological complication of *Mycobacterium leprae* infection, in patients with multibacillary leprosy (4,5). Which complicates the course of Hansen's disease in approximately 30%–50% of patients, especially during treatment.

They occur because multidrug therapy does not completely clear the bacteria, leaving behind cell remnants that trigger acute inflammation, often leading to cutaneous and systemic small vessel vasculitis (3,6). However, they may occur in the regular course of the disease even without the intervention of treatment (5).

ENL, a panniculitis characterized by inflammation of subcutaneous fat, typically appears as symmetrical nodules on the face, back, and upper limbs (6). Furthermore, there may be signs of systemic involvement such as fever, inflammation of lymph nodes, joint involvement, hepatic, among others (5), which can lead to misdiagnosis as rheumatologic entities like Sweet's syndrome or even rheumatoid arthritis (7,8).

Conclusion:

This case highlights the importance of including Hansen's disease and its immunological reactions, in the differential diagnosis of systemic inflammatory syndromes that mimic rheumatologic conditions.

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Abstract N°: 8860

Secondary cutaneous blastomycosis; a case resulting from migration.

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Introduction & Objectives:

Blastomycosis is a systemic infection caused by *B dermatitidis*, an endemic North American dimorphic fungus found in the Ohio and Mississippi River valleys, Midwestern states, and Canadian provinces. Infection has been associated with outdoor recreational activities or occupations, given that *Blastomyces* usually resides in decaying wood and soil. Cutaneous blastomycosis presents in 2 forms, verrucous and ulcerative. Lesions often start as pustules that evolve into necrotic ulcers or verrucous plaques on sun-exposed areas of the extremities and face but can appear anywhere.

We present the case of a 60-year-old male patient with no significant illnesses, who lived in Chicago and worked as a baker, presented with a two-year history of dermatosis in the chin region, which began after shaving his beard. He had previously been treated with countless antibiotics at other hospitals, under the clinical diagnosis of tuberculosis verrucosa cutis, but showed no improvement. During the interview, the patient reported having been diagnosed and treated as pulmonary tuberculosis, with no improvement. The first CT scan showed bilateral mediastinal infiltrates; CT scan were repeated at our hospital, but no activity was observed.

The physical examination revealed a dermatosis affecting the chin, and the lower lip, presented as a well-defined, warty-like plaque with whitish scales, bloody crusts, and hemorrhagic spots, with raised and irregular borders. Presumptive clinical diagnosis: Tuberculosis verrucosa cutis vs. Fixed cutaneous sporotrichosis.

The objectives of this work are:

- To recognize the lesions of cutaneous blastomycosis
- To know the treatment of the cutaneous blastomycosis

Materials & Methods:

Biopsy revealed suppurative granulomas, and multinucleated giant cells, also thick-walled blastoconidia (8-15 µm), with double contours and budding.

The direct examination (KOH) and Giemsa and Wright staining revealed multiple broad-based, double-contour blastoconidia, suggestive of *Blastomyces* spp. Fungal culture was negative.

PCR reported *Blastomyces dermatitidis*.

Results:

We give the diagnosis of: Secondary cutaneous blastomycosis.

Treatment was initiated with itraconazole 400 mg daily and prednisone 50 mg daily (to prevent fibrotic disease). Prednisone was discontinued after four months, and itraconazole was continued for another 10 months, resulting in complete resolution of the lesion. The patient was considered clinically and mycologically cured.

Conclusion:

Cutaneous blastomycosis is a rare disease, the endemic places of the fungus are in North America, which is the importance and the diagnostic difficulty of this case, because it's presentation in our country is exceptional. It is of utmost importance to make a timely diagnosis, as the patient's prognosis will depend on it.

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Abstract N°: 8888

Itraconazole-resistant sporotrichosis: case report, determination of susceptibility and sequencing of *Sporothrix brasiliensis*Amadeu José Rodrigues Queiróz^{*1}, Eduardo Coronato Nogueira Constantino¹, Maria da Gloria Sousa Stafocker²¹Faculty of Medicine of São José do Rio Preto, São Paulo, Brazil, São José do Rio Preto²University of São Paulo, São Paulo

Introduction & Objectives: One of the great challenges in terms of therapeutics today is related to the emergence of strains resistant to several classes of antimicrobials and the low potential for the development of new drugs that can counterbalance these developed resistance patterns. This is widely observed in bacteria, mycobacteria, viruses, and fungi. Sporotrichosis is a subcutaneous mycosis caused by dimorphic organisms of the genus *Sporothrix sp.* Sporotrichosis is most commonly acquired from cutaneous inoculation, especially by vegetation such as thorns and wood. With the exception of *S. brasiliensis* from cats, animal-to-human transmission is rare. Multiple inoculations may occur simultaneously, not to be confused with spread of a single primary lesion. The presentation and course of sporotrichosis depends on the host immune response as well as the size and virulence of the inoculum. We report a severe case of sporotrichosis resistant to itraconazole and potassium iodide.

Materials & Methods: Case report.

Results: A 46 years-old female patient with dermatomyositis and epilepsy, using methotrexate, valproic acid and carbamazepine had suffered cortocutaneous trauma per cat 2 months ago in left forearm and left hemiface. Evolved with left ocular chemosis and nodules in left forearm and left hand; and cervical adenomegaly (figure 1). She was admitted to the service already using itraconazole, without microbiological proof. We hypothesize bacillary angiomatosis, sporotrichosis and Parinaud oculoglandular syndrome due to cat scratch disease. Tomography showed intraparotid lymph nodes (figure 2). Skin biopsy showed irregular acanthosis, moderate spongiosis, hyperkeratosis, epithelioides in dermis with multinucleated giant cells, mixed inflammatory infiltrate areas (figure 3) and positive culture for *Sporothrix sp.* In conjunctiva biopsy, granulomatous pattern with negative growth in culture. The presence of *Bartonella henselae* was not microbiologically proved. Because we cannot exclude cat scratch disease, treatment with itraconazole, potassium iodide, rifampicin and doxycycline. We adjusted treatment of epilepsy changing carbamazepine for levetiracetam and maintaining valproic acid. Suspended methotrexate. Patient had no toxicities, but showed no response.

Performed new samples on same positive culture tissues for *Sporothrix sp.* that at the sensitivity to antifungal test that included *Candida krusei* ATCC 6258 and *Candida parapsylos* ATCC 22019 as controls, the MICs of the isolates were: itraconazole > 8 mg/l; Terbinafin 0.12 mg/L; and amphotericin B 0.5 mg/l. Sequencing proved to be *Sporothrix brasiliensis*. Patient treated with liposomal amphotericin and get improvement without relapse in the follow-up (figure 4).

Conclusion: When initiating any antimicrobial treatment, there must be a strong clinical basis combined with microbiological evidence of the presence of a certain causative agent. Non-response to usual treatments should prompt susceptibility testing and review of the disease agent. The use of PCR and metagenomics is cost-effective and faster than isolation in habitual cultures. Rational use is essential in the context of drug scarcity in the face of emerging resistant strains.

