Abstract N°: ID-37

Topic: Autoimmune disorders

Baffling Bullae: A Case Report of Pemphigoid Gestationis

Sabhya Sehgal*[1], Sharmila Patil[1]

[1]DY Patil Hospital, Navi Mumbai, Mumbai, India

Introduction

Pemphigoid gestationis (PG) is a rare autoimmune subepidermal blistering dermatosis that occurs exclusively in pregnancy. It is mediated by complement-activating IgG autoantibodies directed against hemidesmosomal proteins, most commonly BP180, leading to intense pruritus and subsequent blister formation. Although uncommon, PG carries important maternal and fetal implications, including severe discomfort, a risk of secondary infection, and potential associations with preterm delivery or small-for-gestational-age infants. Because its clinical presentation may overlap with other pregnancy-related eruptions, accurate diagnosis requires clinicopathologic correlation and confirmation with direct immunofluorescence. Early recognition and coordinated multidisciplinary management are essential to ensure maternal relief and optimise fetal safety.

Materials and Methods

A 30-year-old multigravida at 26 weeks of gestation presented with intensely pruritic erythematous plaques that evolved into tense, symmetrically distributed bullae over the trunk and limbs, with characteristic periumbilical involvement. The mucosa and scalp were spared. The bulla spread sign was positive, the Nikolsky sign was negative, and the Tzanck smear showed no acantholytic cells. Histopathology demonstrated a subepidermal blister with abundant eosinophils, while direct immunofluorescence revealed linear IgG and C3 deposition along the dermo-epidermal junction, confirming PG. Laboratory investigations showed leukocytosis and mild elevation of alkaline phosphatase, with a normal renal profile. Obstetric ultrasonography revealed a single live intrauterine fetus with normal amniotic fluid volume and Doppler parameters.

Results

The patient was initiated on oral prednisolone, escalated from 60 mg/day to 80 mg/day for disease control and later tapered to 40 mg/day. Adjunctive therapy included antihistamines, topical steroid–antibiotic combinations, calcium and iron supplementation, and amoxicillin–clavulanate for secondary infection. Supportive care comprised a high-protein diet, adequate hydration, physiotherapy, glucose and blood pressure monitoring, and obstetric fetal surveillance. Over 16 days, pruritus markedly subsided, new bullae ceased to form, erosions crusted and re-epithelialised, and healing progressed with post-inflammatory hyperpigmentation. Maternal and fetal conditions remained stable throughout hospitalization.

Conclusions

Early identification, supported by histopathology and direct immunofluorescence, combined with timely systemic corticosteroid therapy and multidisciplinary management, enables rapid disease control in PG and contributes to favourable maternal and fetal in-hospital outcomes.

Abstract N°: ID-101

Topic: Autoimmune disorders

Comprehansive Assessment of Pemphigus Activity: Correlation of clinical and Serological Parameters

Gaukhar Koylibaeva*[1], Ulugbek Sabirov[1]

[1]Republican Scientific-Practical Medical Center of Dermatovenerology and Cosmetology, Uzbekistan, Tashkent, Uzbekistan

Introduction
Pemphigus represents a group of chronic autoimmune blistering diseases characterized by intraepidermal blister formation due to acantholysis. Objective assessment of disease activity is critically important for treatment strategy selection and prognosis. Traditional diagnostic methods do not always provide comprehensive evaluation of pathological process activity, necessitating a complex approach utilizing modern serological markers in combination with clinical indices. Determination of anti-desmoglein antibodies by ELISA demonstrates high sensitivity and specificity, while the PDAI (Pemphigus Disease Area Index) provides standardized clinical severity assessment.

Materials and Methods
The study included 43 patients with pemphigus (14 males, 29 females; mean age 56.4 ± 12.8 years) examined during 2020-2024. Anti-desmoglein-1 and anti-desmoglein-3 antibodies were determined by ELISA (pathological values ≥12 ng/ml). Direct immunofluorescence (DIF) was performed to detect IgG and C3 deposits in intercellular spaces. Disease severity was assessed using PDAI index (mild ≤15, moderate 15-45, severe ≥45 points). Statistical analysis included Pearson correlation coefficient calculation using SPSS 23.0.

Results
Elevated anti-desmoglein antibody levels were detected in 95.3% of patients (41/43), positive DIF in 53.5% (23/43). All patients with positive DIF demonstrated elevated antibody levels by ELISA. Oral mucosa involvement was diagnosed in 55.8% of patients. According to PDAI index: mild severity—41.9% (18 patients), moderate—44.2% (19 patients), severe—14.0% (6 patients). Strong correlation was established between antibody levels and disease severity: mean antibody levels were 12.5 ± 4.1 ng/ml in mild cases, 15.2 ± 4.1 ng/ml in moderate cases, and 19.5 ± 3.7 ng/ml in severe cases ($r = 0.847$, $p < 0.001$).

Conclusions
ELISA demonstrates high diagnostic efficacy (95.3%) and superior sensitivity compared to DIF (53.5%). The strong correlation between anti-desmoglein antibody levels and PDAI index ($r = 0.847$, $p < 0.001$) validates the use of serological markers for objective disease activity monitoring and optimization of therapeutic approaches. Combined serological and immunohistological assessment enhances diagnostic accuracy and enables comprehensive evaluation of pemphigus activity.

Abstract N°: ID-118

Topic: Autoimmune disorders

Salt-and-Pepper Dyspigmentation as an Early Cutaneous Clue to Systemic Sclerosis: A Diagnostically Decisive Presentation

Samet Öner*[1], Semih Gülle[2], Sevgi Akarsu[1]

[1]Department of Dermatology, Dokuz Eylül University Medical Faculty, İzmir, Türkiye
[2]Department of Internal Medicine, Division of Rheumatology, Dokuz Eylül University Medical Faculty, İzmir, Türkiye

Introduction

Systemic sclerosis (SSc) is a chronic autoimmune disease characterized by microvascular injury and fibrosis. While skin thickening is the hallmark feature, pigmentary changes can precede sclerosis. "Salt-and-pepper" dyspigmentation, characterized by vitiligo-like depigmentation with sparing of perifollicular pigment, is a distinctive but often overlooked sign. We present a case where the recognition of this specific sign, occurring concomitantly with diffuse hyperpigmentation, led to the diagnosis of diffuse SSc with early interstitial lung disease (ILD), highlighting the important role of dermatologic evaluation in the preliminary diagnosis of rheumatic diseases.

Materials and Methods

A 36-year-old woman presented with a 4-month history of asymptomatic white spots on the upper back and concomitant swelling in the fingers. Physical examination revealed characteristic "salt-and-pepper" dyspigmentation on the upper back, manifesting as depigmentation mimicking the perifollicular repigmentation pattern of vitiligo. Distinctly, diffuse hyperpigmented patches were observed on the lower back and lumbar regions. Bilateral hand edema ("puffy fingers") was prominent. Notably, the patient reported a history of Raynaud's phenomenon. The diagnostic workup included serological profiling, skin biopsy, nailfold capillaroscopy, and high-resolution computed tomography (HRCT).

Results

Serological evaluation revealed strong positivity for Anti-Scl-70 and ANA (nucleolar pattern). Histopathologic examination of a skin biopsy from the upper back showed fibroplasia in the papillary dermis and thickened collagen bundles. Nailfold capillaroscopy demonstrated "giant capillaries," hemorrhagic foci, and avascular areas, confirming an active scleroderma pattern. Crucially, screening HRCT revealed ground-glass opacities and a nonspecific interstitial pneumonia pattern, indicating early ILD. Upon referral to the Department of Rheumatology, a diagnosis of early-stage diffuse cutaneous systemic sclerosis (dcSSc) was established and a treatment regimen comprising mycophenolate mofetil, low-dose prednisone, nifedipine, and aspirin was initiated. At the 1-month control visit, a regression of hand edema was noted.

Conclusions

This case underscores the importance of recognizing salt-and-pepper dyspigmentation as an early dermatologic indicator of systemic sclerosis. In this patient, subtle pigmentary alterations preceded overt skin induration and facilitated timely rheumatologic referral, confirmation of microvascular involvement, and detection of early ILD. The

prompt initiation of immunosuppressive and vasculoprotective therapy highlights the pivotal role of dermatologic assessment in accelerating diagnosis, preventing diagnostic delay, and improving long-term outcomes in dcSSc.

Abstract N°: ID-177

Topic: Autoimmune disorders

Clinical Management of Pemphigus Foliaceus: The Role of Dapsone in Steroid-Sparing Therapy

Gabriele Vengalyte*[1], Laura Rackauskaite[1], Jurgita Makstiene[2], Vesta Kucinskiene[1], Skaidra Valiukeviciene[1]

[1]Lithuanian University of Health Sciences (LSMU), Hospital of Lithuanian University of Health Sciences Kauno klinikos, Department of Skin and Venereal Diseases, Kaunas, Lithuania
[2]Lithuanian University of Health Sciences (LSMU), Hospital of Lithuanian University of Health Sciences Kauno klinikos, Department of Pathologic Anatomy, Kaunas, Lithuania

Introduction
Pemphigus foliaceus (PF) is a rare, acquired autoimmune blistering disease characterized by subcorneal blister formation. While systemic corticosteroids are the primary treatment, dapsone is commonly used as a first-line steroid-sparing agent. We present a clinical case of PF treated with dapsone, highlighting the challenges faced during treatment.

Materials and Methods
Case report.

Results
A 24-year-old female presented with painful, disseminated vesicular lesions initially localized to the lower abdomen in July 2024. The lesions regressed spontaneously but recurred, leading to treatment with 40 mg prednisolone. She was referred to our clinic with no significant medical history or medications. On examination, erythematous vesicles, reddish plaques with lichenification, and crusted erosions were observed on the face, trunk, and extremities. Mucosal involvement was absent, and Nikolsky's sign was negative. BSA was 32%, PDAI 28, and DLQI 16. Histopathology and direct immunofluorescence of a skin biopsy revealed subcorneal intraepidermal cleft bullae with granulocytes, along with IgG and C3 deposition between keratinocytes, confirming PF. Anti-desmoglein 1 antibodies were elevated at 13.13 U. Other lab results were unremarkable. A multidisciplinary team diagnosed PF, and treatment was initiated with dapsone 50 mg twice daily. After two weeks, lesions worsened, progressing to exfoliative plaques and targetoid lesions, with BSA increasing to 72% and DLQI to 30. Pulse methylprednisolone (250 mg) was administered, followed by 40 mg prednisone, and dapsone was increased to 100 mg twice daily. Topical therapy was added. Lesions improved over two months, steroids were discontinued, and dapsone was maintained with close monitoring.

Conclusions
PF is primarily managed with systemic immunosuppressants, especially corticosteroids, often combined with steroid-sparing agents like dapsone. While dapsone is generally well-tolerated and effective, clinicians should recognize that clinical improvement may require prolonged treatment, and close monitoring is essential for optimal outcomes.

Abstract N°: ID-182

Topic: Autoimmune disorders

Observational Outcomes of a Combined Oral Phytotherapeutic Approach in Patients with Vitiligo

C.K. de Montaxel*[1]

[1]Green Fields Overseas R&D, Jos, Nigeria

Introduction
Background: Vitiligo is a chronic depigmenting disorder characterised by melanocyte loss, immune dysregulation, and oxidative stress. Despite multiple available therapeutic options, many patients experience incomplete response, relapse, or treatment-limiting adverse effects, highlighting the need for supportive systemic strategies.

Materials and Methods
Objective: To present real-world observational outcomes of a combined oral phytotherapeutic supplementation approach in patients with vitiligo.

Methods: Patients with stable or progressive vitiligo were followed under a supervised care framework while receiving a combined oral phytotherapeutic regimen. No topical agents, phototherapy, or invasive interventions were introduced during the observation period. Clinical follow-up included assessment of treatment tolerance, patient-reported well-being, and visible changes in depigmented lesions. Serial visual examination and photographic documentation were used to monitor progression. A minimum observation period of six months was recommended to assess sustained response.

Results
Results: Across observed cases, all patients demonstrated visible clinical improvement, with early changes noted within the first two months of oral supplementation. Observed changes included softening of lesion borders, gradual repigmentation, reduction in contrast between affected and unaffected skin, and overall improvement in skin appearance. The degree and rate of response varied between individuals, but improvement was consistently observed. The oral regimen was well tolerated, and no serious adverse effects were reported. Due to the observational nature of the data, formal statistical analysis was not performed.

Conclusions
Conclusion: These preliminary real-world observations suggest that a combined oral phytotherapeutic approach may provide supportive benefit in the management of vitiligo when used under professional supervision. Early visible improvement within two months was observed, with continued progression over time. While promising, these findings require confirmation through controlled clinical studies to further evaluate efficacy, safety, and mechanisms of action.
Keywords: Vitiligo, oral phytotherapy, immune modulation, oxidative stress, observational study

Abstract N°: ID-191

Topic: Autoimmune disorders

A Neurologically Quiet Variant of Linear Morphea En Coup de Sabre Presenting with Frontal Scalp Alopecia

Ahmed Kordy[1], Mohamed Kordy[2], Sarah Almohammdi*[1], Ghaidaa Elemehallawy[3]

[1]King Salman Bin Abdulaziz Medical City, Dermatology Clinic, Dermatology, Madinah, Saudi Arabia
[2]Prince Mohammed Bin Abdulaziz Hospital, Dermatology Clinic, Dermatology, Madinah, Saudi Arabia
[3]MBBS, College of Medicine, Taibah University, Madinah, Saudi Arabia, Dermatology Clinic, Dermatology, Madinah, Saudi Arabia

Introduction
Linear morphea en coup de sabre (ECDS) is a localized form of scleroderma characterized by linear atrophic lesions of the frontoparietal scalp and forehead, with potential neurologic involvement. However, management of neurologically asymptomatic patients in late, inactive stages remains challenging,particularly regarding the need for invasive investigations and neuroimaging.

Materials and Methods
We report the case of a 26 year-old man who presented with a 10-month history of a progressively enlarging linear atrophic plaque involving the frontal scalp and upper forehead, associated with scarring alopecia. Clinical examination, neurologic assessment, and review of systems were unremarkable, with no systemic or neurologic warning signs. The diagnosis of late atrophic-phase ECDS was established clinically based on characteristic morphology.

Results
Given the absence of inflammatory activity or neurologic symptom-directed, conservative management approach was adopted, and no skin biopsy or neuroimaging was performed. Management consisted of topical tacrolimus, patient education regarding signs of reactivation, and serial photographic monitoring. At follow-up, the lesion remained stable with no progression or development of neurologic manifestations.

Conclusions
This case exemplifies a neurologically quiet, late-phase manifestation of ECDS, for which a conservative, individualized therapy strategy was appropriate. Finding stable atrophic lesions and tailoring the diagnostic assessment to them can help save unnecessary tests and provide patient-centered, effective care.

Figure 1. (A) Linear atrophic plaque involving the frontal forehead. (B) Scarring alopecia of the frontal scalp consistent with linear morphea en coup de sabre.

EA SYMPOSIUM DV 2026
ATHENS 7 - 9 MAY

Abstract N°: ID-221

Topic: Autoimmune disorders

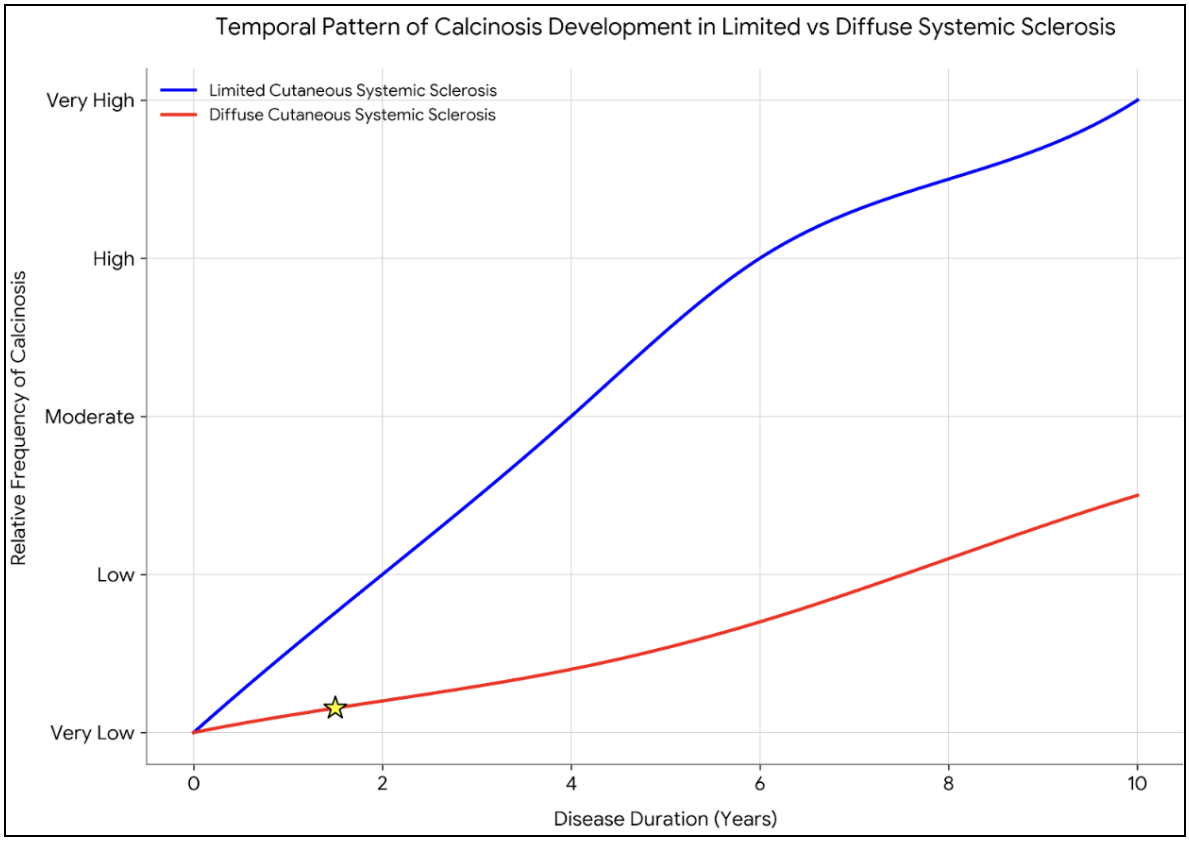
Atypical Young-Onset Extensive Multifocal Calcinosis in Diffuse Systemic Sclerosis with Overlap Autoimmune Antibodies.

Thayasre Babu*[1]

[1]Saveetha University, DEPARTMENT OF DERMATOLOGY,VENEREOLOGY,LEPROSY, Sriperumbudur, India

Introduction

Calcinosis cutis is a recognised manifestation of systemic sclerosis and is more commonly described in limited cutaneous disease and in patients with longer disease duration. Extensive multifocal calcinosis occurring in diffuse systemic sclerosis, particularly in young patients with overlap autoimmune antibody profiles, is less frequently reported. Such presentations may be associated with significant morbidity including pain, functional limitation, recurrent ulceration and risk of secondary infection, often posing therapeutic and reconstructive challenges. Early identification of atypical clinical evolution and associated serological patterns may help guide multidisciplinary management and improve functional and quality-of-life outcomes.



The star indicates the position of the present case, demonstrating early calcinosis in diffuse systemic sclerosis compared to typical temporal patterns.

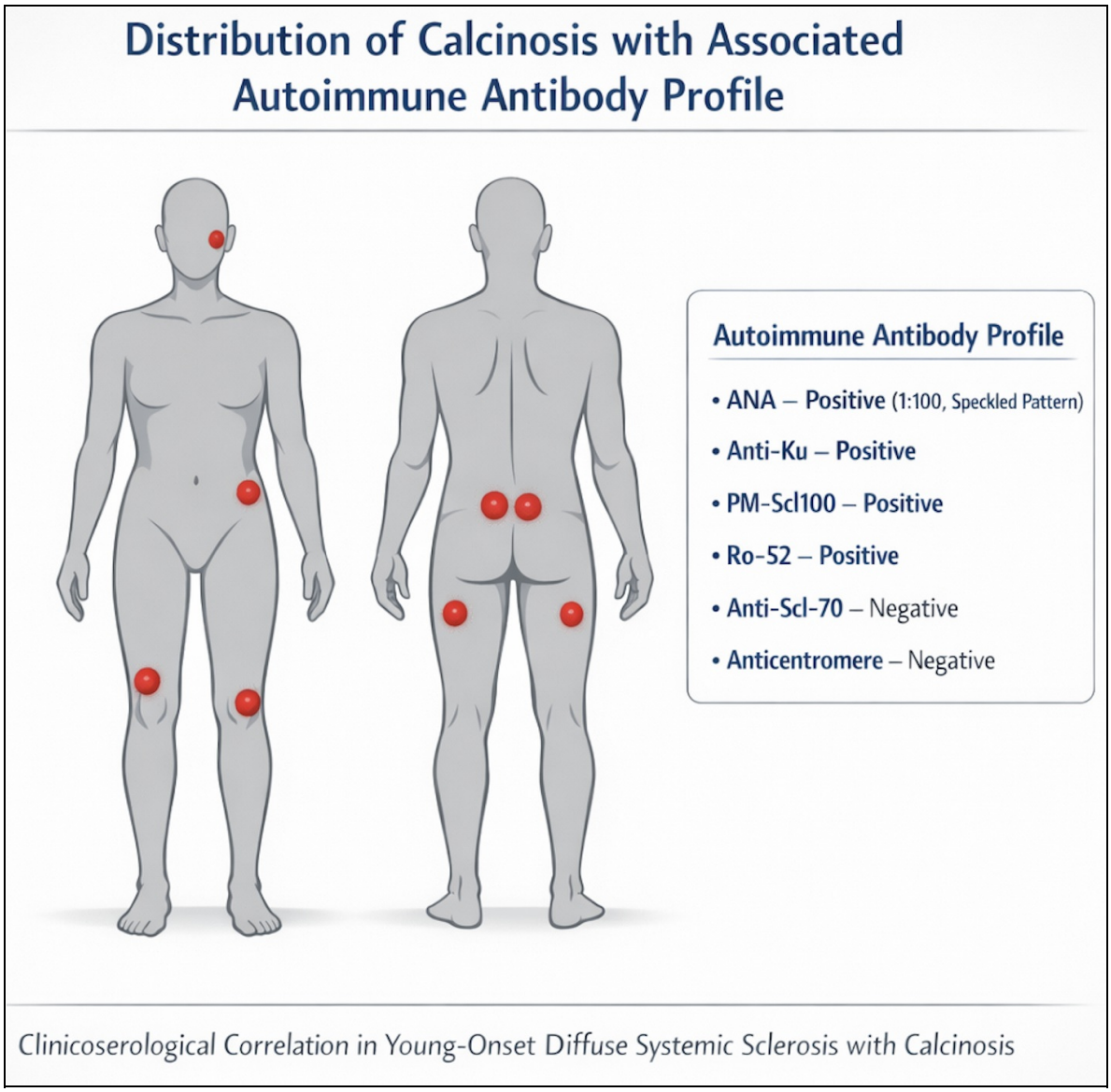
Materials and Methods

We report a case of a 19-year-old female who initially presented with progressive skin tightening involving acral and proximal sites over approximately 8–10 months, suggestive of diffuse cutaneous systemic sclerosis. Dermatological examination revealed indurated, bound-down skin with reduced pliability and associated functional restriction. Clinical dermatological evaluation was followed by systemic assessment including pulmonary evaluation with imaging and functional assessment. Extended autoimmune serology including systemic sclerosis–specific antibodies and overlap connective tissue disease antibody profile was performed. Following disease progression, histopathological examination was carried out on excised calcified nodules. Clinical course and response to combined surgical and systemic therapy were assessed during follow-up.

MONTH	EVENT
0	Progressive skin tightening noticed
4	Dermatology consultation + Autoimmune workup
6	Pulmonary evaluation + ILD screening
7-8	First calcinosis nodules appear
9-10	Multifocal extensive calcinosis
10-11	Surgical excision
11-12	Systemic therapy stabilisation

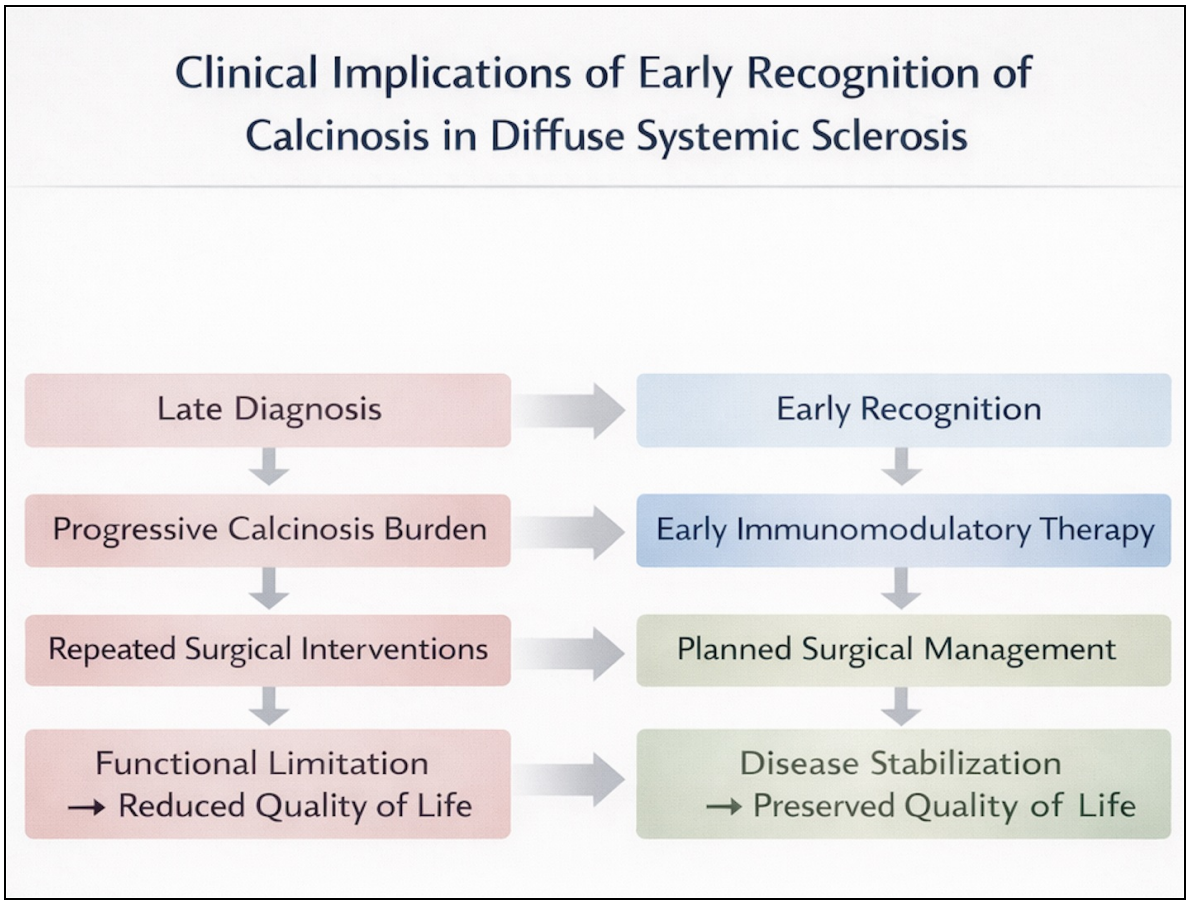
Results

The patient initially developed progressive cutaneous sclerosis with tightening and induration of skin, followed by development of painful subcutaneous nodules over subsequent months. She later presented with early-onset widespread multifocal calcinosis involving sacral region, posterior thigh, distal medial thigh, knee and facial regions, associated with pain, local tenderness and functional limitation affecting daily activities. Pulmonary evaluation demonstrated features suggestive of interstitial lung involvement. Autoimmune evaluation revealed ANA positivity (1:100, speckled pattern). Systemic sclerosis–specific antibodies including anti-Scl-70 and anticentromere antibodies were negative. Overlap connective tissue disease profile showed positivity for anti-Ku, PM-Scl100 and Ro-52 antibodies. Histopathology demonstrated extensive dermal and subcutaneous amorphous basophilic calcium deposition consistent with calcinosis cutis. Due to disease extent and symptoms, staged surgical excision with Limberg flap reconstruction was performed, followed by wound debridement and rotational flap with V-Y advancement for wound dehiscence. Adjunct systemic therapy with mycophenolate mofetil, vasodilators and supportive dermatological care resulted in symptomatic improvement and clinical stabilisation.



Conclusions

This case highlights evolution of extensive calcinosis cutis in young-onset diffuse systemic sclerosis associated with overlap autoimmune antibodies. Recognition of progressive cutaneous sclerosis followed by development of calcinosis may indicate an atypical disease trajectory requiring early multidisciplinary dermatology-led intervention. Management of extensive calcinosis remains challenging, and emerging therapeutic approaches targeting inflammatory and fibrotic pathways are being explored, although evidence remains limited. This case contributes to the expanding clinical spectrum of calcinosis in systemic sclerosis and supports integrated dermatological, rheumatological and surgical management in complex connective tissue disease presentations.



CLINICAL IMPACT OF EARLY RECOGNITION AND MULTIDISCIPLINARY MANAGEMENT IN CALCINOSIS ASSOCIATED WITH DIFFUSE SYSTEMIC SCLEROSIS

Abstract N°: ID-235

Topic: Autoimmune disorders

Moderate-Severe atopic dermatitis and alopecia totalis in adolescence: hair regrowth following Janus kinase inhibitor therapy

Klimentina Gospodinova*[1, 2], Dzhamile Kamber[1]

[1]MU Pleven, Pleven, Bulgaria
[2]Medical centre Cordis, Pleven, Bulgaria

Introduction

Atopic dermatitis (AD) and alopecia areata (AA) frequently coexist and may share overlapping immune pathways. Severe AA, including alopecia totalis (AT), is often refractory to conventional therapies, particularly in pediatric and adolescent populations. Janus kinase (JAK) inhibitors have emerged as targeted therapies for both moderate to severe AD and AA, yet real-life observations describing hair regrowth in patients treated primarily for AD remain limited. We report a case of adolescent-onset AT in the context of longstanding AD, with significant scalp hair regrowth following initiation of systemic JAK inhibition.

Materials and Methods

We report the clinical course of a 16-year-old female with moderate-severe, early-onset AD since infancy who developed progressive scalp hair thinning from the age of 12, rapidly evolving into complete scalp hair loss consistent with alopecia totalis. Eyebrows and eyelashes were not affected. Previous alopecia treatments included topical and intralesional corticosteroids, topical minoxidil, and microneedling, without significant response. Extensive laboratory investigations, including hematologic, endocrine, nutritional, and autoimmune screening, were unremarkable. Following a severe exacerbation of AD refractory to optimized topical therapy after a respiratory infection, systemic therapy with a JAK inhibitor was initiated for dermatologic control. Clinical assessment focused on AD severity and qualitative scalp hair regrowth during follow-up.

Results

Systemic JAK inhibition resulted in rapid and sustained improvement of AD. Unexpectedly, early signs of scalp hair regrowth became clinically evident after three months of therapy, with substantial progression by six months, including increased hair density and uniform coverage of previously alopecic areas. No regrowth of eyebrows or eyelashes was required, as these regions were unaffected at baseline. Treatment was well tolerated, and no clinically significant adverse events were observed. The clinical response is consistent with emerging evidence supporting the efficacy of JAK inhibitors in severe AA and AT, particularly in younger patients and those with concomitant atopic disease.

Conclusions

This case illustrates significant scalp hair regrowth in adolescent alopecia totalis following initiation of systemic JAK inhibitor therapy for severe atopic dermatitis. The observation supports the concept of shared immunopathogenesis between AD and AA and highlights the potential dual benefit of JAK inhibition in patients with overlapping inflammatory dermatoses. Further real-world and longitudinal studies are needed to better define predictors of response and long-term outcomes in pediatric and adolescent populations.

Abstract N°: ID-277

Topic: Autoimmune disorders

Milia (en plaque) following treated bullous pemphigoid: a case of post-blister sequelae.

Hannah Badawy*[1], Frederick Johnson[1], Ilona Blee[1], Simon Unter[1]

[1]Warwick Dermatology Centre, Warwick, United Kingdom

Introduction

Bullous pemphigoid is a common autoimmune subepidermal blistering disorder, affecting older adults. While post-inflammatory pigmentary changes are well recognised, the development of secondary milia following disease resolution is less frequently described and may cause diagnostic uncertainty and patient distress. Milia en plaque represents a rare variant characterised by grouped milia arising on an erythematous or hyperpigmented base. We report a case of milia en plaque arising at sites of healed bullous pemphigoid lesions and contextualise this finding within the existing literature.

Materials and Methods

This is a single-patient observational case report. Clinical findings, histopathology, immunofluorescence results, treatment course, and follow-up were reviewed. A focused literature review was conducted using PubMed to identify reports describing milia or milia en plaque occurring in association with bullous pemphigoid.

Results

A 75-year-old man presented with an acute blistering eruption involving the trunk and limbs. Histopathology demonstrated a subepidermal blister with moderate lymphocytic infiltrate with numerous eosinophils. Furthermore, direct immunofluorescence showed linear IgG and complement component C3 deposition along the basement membrane zone, confirming a diagnosis of bullous pemphigoid. He was treated with topical clobetasol propionate 0.05% and oral prednisolone, achieving gradual disease control and resolution of active blistering.

Five months after his initial presentation, while undergoing corticosteroid tapering, the patient reported asymptomatic, firm, white, papules developing exclusively at sites of previous bullae on the proximal thighs and upper limbs. Examination revealed clustered 1–2 mm papules within areas of post-inflammatory hyperpigmentation, forming plaques consistent with milia en plaque. No active blistering was present. Nail examination revealed transverse depressions consistent with Beau's lines, observed alongside the development of milia. Conservative management was initially adopted, followed by initiation of topical retinoid (0.05%) due to persistence.

Secondary milia have been reported in association with bullous pemphigoid in both cohort studies and case reports. Vernal et al. identified milia in 7.8% of patients with bullous pemphigoid, with associations including older age, raised serum IgE levels, and active or severe disease (1). Multiple case reports describe milia developing during the recovery phase following prolonged or refractory disease courses (2–4). The pathogenesis remains uncertain but is thought to relate to aberrant re-epithelialisation and regeneration of adnexal structures following basement membrane damage (5). Topical retinoids have been reported to result in clinical improvement in persistent cases (6).

Conclusions

Milia en plaque represents an uncommon but clinically relevant post-inflammatory sequela of bullous pemphigoid that

may arise months after apparent disease control. Recognition of this entity can prevent unnecessary investigation and allow appropriate patient reassurance. Awareness of this association is particularly important in patients with extensive or prolonged disease, and topical retinoids may be considered for persistent milia.

Abstract N°: ID-283

Topic: Autoimmune disorders

When Two Rare Dermatologic Entities Collide in the Same Patient: Rowell Syndrome and Bullous Systemic Lupus Erythematosus; A Diagnostic and Therapeutic Challenge

Sachithra Samarakoon*[1], Sanduni Thellambura Hettige[1], Chandani Udagedara[1], Hasini Jayasundara[1]

[1]National Hospital Kandy, Dermatology, Dermatology, Kandy, Sri Lanka

Introduction

Systemic lupus erythematosus (SLE) is a heterogeneous autoimmune disease with diverse cutaneous and systemic manifestations. Among its rare dermatologic variants are Rowell syndrome, characterized by erythema multiforme–like lesions in association with lupus, and bullous systemic lupus erythematosus (BSLE), an autoimmune subepidermal blistering disorder mediated by autoantibodies against basement membrane components. The coexistence of both entities in a single patient is exceedingly rare and poses diagnostic and therapeutic challenges. We report a unique adolescent case highlighting the dynamic evolution and collision of Rowell syndrome and BSLE, underscoring the importance of serial clinical, histopathological, and immunological assessment.

Materials and Methods

A 17-year-old girl presented with a one-week history of acral blistering lesions with bilateral eye redness and watery discharge. There was no history of infection, drug intake, or recent vaccination. Clinical evaluation included dermatologic and musculoskeletal examination. Laboratory investigations comprised complete blood count, peripheral smear, reticulocyte count, ESR, renal function tests, urine analysis with urine protein-to-creatinine ratio (UPCR), serum albumin, ANA, complement levels, rheumatoid factor, cultures, and viral screening. Skin biopsies for histopathology and direct immunofluorescence (DIF) were performed. Ophthalmology, nephrology, and rheumatology consultations were obtained, and the patient was monitored serially.

Results

Cutaneous examination revealed tense, blood-filled targetoid bullae over acral areas with associated inflammatory polyarthritis. Laboratory findings showed anemia (hemoglobin 8.9 g/dL) with hemolysis, reticulocyte count of 6.4%, elevated ESR, and sterile cultures. Urinalysis demonstrated proteinuria and hematuria with dysmorphic red blood cells; UPCR was 2483.20 mg/g and serum albumin 2.6 g/dL. Immunological workup revealed ANA positivity (1:320), low complement levels, and elevated rheumatoid factor (226 IU/mL). Initial skin biopsy favored erythema multiforme, consistent with Rowell syndrome. She was treated with intravenous methylprednisolone (500 mg/day for 3 days) followed by oral prednisolone, with partial improvement.

Subsequently, the bullae became flaccid and progressed to deep ulcers. Ten days later, new bullous lesions appeared over the trunk and upper limbs, sparing the face, along with painless oral ulcers. Repeat biopsy and DIF confirmed BSLE, showing linear IgG deposition along the dermoepidermal junction. The constellation of hemolytic anemia, nephritic-range proteinuria, arthritis, and mucocutaneous involvement indicated an active lupus flare.

Treatment included repeat intravenous methylprednisolone pulses, oral prednisolone, rituximab (1 g two doses two weeks apart), hydroxychloroquine, and mycophenolate mofetil. The patient showed marked improvement with cessation of new blister formation, ulcer healing, and stabilization of systemic disease.

Conclusions

This case illustrates the exceptionally rare coexistence of Rowell syndrome and BSLE in a single patient and highlights the evolving nature of lupus-associated blistering disorders. Serial laboratory evaluation, repeat histopathology, and DIF were crucial for accurate diagnosis. Early recognition and aggressive immunosuppressive therapy, including biologic agents, resulted in favorable outcomes, emphasizing the need for vigilant follow-up and multidisciplinary care in atypical cutaneous presentations of SLE.

EA DV SYMPOSIUM 2026
ATHENS 7 - 9 MAY

Abstract N°: ID-311

Topic: Autoimmune disorders

Hemiatrophia faciei – en coup de sabre: impressive manifestation in a Bulgarian patient

Simona Kordeva*[1], Konstantin Tchernev Jr[2], Valentina Broshtilova-Nikolova[3], Georgi Tchernev[1, 2]

[1]Medical Institute of Ministry of Interior, Department of Dermatology and Venereology, Sofia, Bulgaria
[2]Onkoderma- Clinic for Dermatology, Venereology and Dermatologic Surgery, Sofia, Bulgaria
[3]Sofia University Saint Kliment Ohridski, Faculty of Medicine, Department of Internal Diseases, Pharmacology and Clinical Pharmacology, Pediatrics, Epidemiology, Infectious Diseases, and Skin Diseases, Sofia, Bulgaria

Introduction

Scleroderma, whether diffuse or localized, is a rare autoimmune connective tissue disease. Linear sclerodermia type en coup de sabre is a form of localized scleroderma that manifests in most of the cases in the literature on the frontoparietal scalp or paramedian forehead area.

Serological testing with specific antibodies is recommended, along with histopathological verification of lesional tissue.

Materials and Methods

We present an extremely rare and impressive case of a 51-year-old female patient with a 21-year history of linear sclerodermia, type en coup de sabre, with progressive facial hemiatrophy and some signs of cicatricial alopecia areata (Fig.1a,b).

Fig.1a,b: Linear erythematous-infiltrative plaques, type „en coup de sabre", located on the left facial area and

capillitium. Fields of deforestation in the frontal region with a diameter of 1 cm. Single fields of cicatricial alopecia are appearing along the periphery of the indurative plaques.

Results

The initial routine immunological assessments revealed positive results for ANA; anti-dsDNA; anti-Sm; anti-RNP protein; anti-SS-A; and anti-Scl-70. Histological verification of linear sclerodermia, type “en coup de sabre”, was established (Fig.2ab).

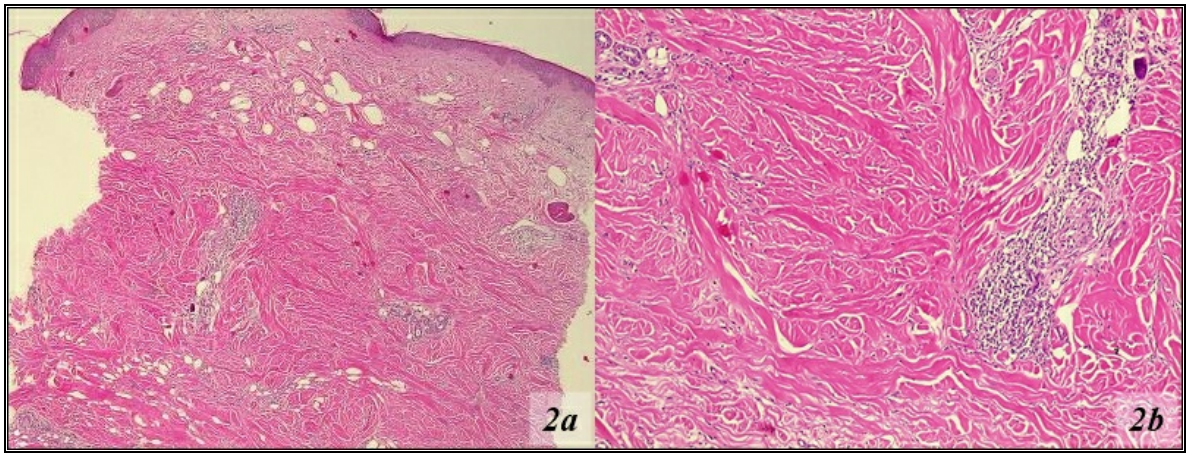


Fig.2a,b: Histopatological picture 2a: Sclx40 – orthohyperkeratosis, irregular acanthosis, dense collagen bundles arranged in coarse fascicles throughout the whole dermis 2b: Sclx100 – thickened collagen bundles in the reticular dermis with dense perivascular inflammatory infiltrate abundant of plasma cells

Conclusions

The disease was managed over the years with hydroxychloroquine, intravenous immunoglobulin infusions, and consistent hyaluronic acid injections for the facial defects. Improvement was observed for a short period of time also after the administration of D-penicillamine.

Abstract N°: ID-317

Topic: Autoimmune disorders

Eosinophilic fasciitis associated with Pemphigus Vulgaris : A Rituximab-resistant case

Meriem Mhiri*[1], Maha Lahouel[1], Denguezli Mohamed[1]

[1]Farhat Hached University Hospital, Sousse, Tunisia

Introduction

Eosinophilic fasciitis (EF) is a rare fibro-inflammatory disorder of the connective tissue, characterized by painful induration of the skin and subcutaneous tissue, most commonly affecting the limbs.

Materials and Methods

Herein, we report a case of EF occurring in a patient with pemphigus vulgaris (PV) with limited efficacy of rituximab in EF.

Results

A 68-year-old woman with a history of pemphigus vulgaris (PV) was followed in our dermatology department. The diagnosis of PV was established by histopathology showing suprabasal acantholysis, direct immunofluorescence with intercellular IgG and C3 deposits, and positive anti-desmoglein 3 ELISA. She was treated with oral prednisone (1.5 mg/kg/day) and rituximab following the rheumatoid arthritis protocol, allowing corticosteroid withdrawal after six months and achieving complete remission. Five months later, she developed painful, symmetric indurated and atrophic plaques of the lower limbs with an “orange peel” appearance and mild stiffness. Laboratory tests showed peripheral eosinophilia (1.2×10^3/µL) and elevated C-reactive protein (73 mg/L) with no other abnormalities. Imaging and immunological workup were unremarkable. Deep skin biopsy revealed a dense eosinophilic infiltrate extending to the fascia with inflammatory fibrosis, consistent with eosinophilic fasciitis. Reintroduction of systemic corticosteroids (0.75 mg/kg/day) led to clinical and biological improvement within several weeks.

Schulman’s fasciitis is associated with autoimmune disease in 5–6% of cases, most often autoimmune thyroiditis, Raynaud’s phenomenon, or rheumatoid arthritis, and is accompanied by antinuclear antibodies in approximately 42% of cases. To our knowledge, its association with pemphigus vulgaris has never been reported. Eosinophilic fasciitis may also occur as a paraneoplastic syndrome linked to hematologic malignancies or solid tumors, particularly melanoma. It can be drug-induced, notably by checkpoint inhibitors, statins, and anti-TNF agents. Optimal management of EF remains unclear due to its rarity, with no randomized controlled trials available to guide therapy. First-line treatment consists of systemic corticosteroids and methotrexate (15–25 mg/week), are considered in patients with an incomplete response or to minimize steroid exposure (5). Among biologic therapies, tocilizumab appears to be the most effective, followed by anti-TNFα agents and immunoglobulins, whereas rituximab shows only partial and delayed efficacy. In our case, the onset of fasciitis after corticosteroid withdrawal, despite rituximab therapy, highlights the corticosteroid sensitivity of this disease and suggests the limited efficacy of rituximab in this context.

Conclusions

This case highlights a previously unreported association between Shulman’s fasciitis and pemphigus vulgaris and underscores the central role of corticosteroids in controlling eosinophilic fasciitis, in contrast to the limited effectiveness of rituximab.

EADV Symposium 2026 – Athens
07 MAY - 09 MAY 2026
POWERED BY M-ANAGE.COM

Abstract N°: ID-366

Topic: Autoimmune disorders

Selective genetic modulation of IL-1Ra and TNF-alpha pathways in dermal and rheumatic diseases:A systematic review

Wael Aljuhani[1], Sarah Almohammdi*[1], Emad Alsaedi[2], Abdullah Almohammdi[3], Enas Alhabib[2]

[1]King Salman Bin Abdulaziz Medical City, Dermatology Clinic, Dermatology, MEDINAH, Saudi Arabia
[2]King Salman Bin Abdulaziz Medical City, Medicine, Internal Medicine, MEDINAH, Saudi Arabia
[3]University of Jeddah, College of Medicine, Medical Student, College of Medicine, Jeddah, Saudi Arabia

Introduction
Chronic inflammatory dermatological and rheumatic conditions, including psoriasis, rheumatoid arthritis, and osteoarthritis, often show inadequate responses and safety constraints with systemic biologic therapies targeting inflammatory cytokines. Recent progress in gene-based treatments offers the potential for localized and sustained modulation of key inflammatory pathways, providing new therapeutic opportunities in these diseases.

Materials and Methods
A systematic review was conducted in accordance with PRISMA criteria and registered in PROSPERO. English-language studies published between January 2015 and August 2025 were retrieved from PubMed, Scopus, Google Scholar, and ClinicalTrials.gov. Due to heterogeneity among included, findings were synthesized narratively.

Results
Eleven studies met the inclusion criteria, comprising two phase I human trials, six preclinical studies, and three high-quality reviews. Human trials reported favorable safety profiles and sustained localized expression. Preclinical models demonstrated persistent reductions in inflammation and structural tissue damage.

Conclusions
Targeted genetic modulation of inflammatory cytokine pathways shows significant therapeutic potential for dermatological and rheumatic diseases. However, further controlled clinical investigations are required to strengthen the evidence base and address current limitations.

Abstract N°: ID-490

Topic: Autoimmune disorders

Overlap of Generalized Morphea and Eosinophilic fasciitis

Çınar Yıldız*[1], Mehmet Buğra Toptan[1], Ece Gökyayla[1]

[1]Ege University, Department of Dermatology and Venerology, İzmir, Türkiye

Introduction

Eosinophilic fasciitis (EF) is a rare fibrosing disorder considered a limited form of scleroderma, first described by Shulman in 1975. It is characterized by the rapid onset of painful swelling and woody induration of the extremities, typically accompanied by peripheral eosinophilia. Early clinical manifestations include edema and pain of the involved extremities, which may rapidly progress to fibrosis, resulting in a dimpled or “pseudo-cellulite” appearance. The characteristic *groove sign* refers to linear depressions along superficial veins caused by tightening and induration of the overlying skin.[1]

Although EF is generally regarded as a distinct entity, overlap with localized scleroderma, particularly morphea, has been reported.[3] Herein, we present a case of eosinophilic fasciitis overlapping with generalized morphea in a postmenopausal woman.

Materials and Methods

A 67-year-old female patient with a medical history of hypertension, Hashimoto thyroiditis, chronic atrial fibrillation, and congestive heart failure presented to our dermatology clinic with a two-month history of progressive stiffness, pain, and restricted movement of both arms. Physical examination revealed bilateral induration of the forearms with limited hand mobility. A *peau d’orange* appearance and a positive groove sign were observed on the forearms. (Figure-1) In addition, well-demarcated morphea plaques were noted on the anterior and lateral abdominal regions. (Figure-2) Laboratory investigations demonstrated peripheral eosinophilia (1.62/11.25 Eos/L) and elevated acute-phase reactants (C-reactive protein: 10 mg/L). An incisional biopsy including the fascia and underlying muscle from the left pronator teres region was performed, and histopathological examination was consistent with fasciitis. A separate skin biopsy obtained from the abdominal lesions confirmed the diagnosis of morphea. Serological evaluation revealed antinuclear antibody (ANA) positivity at a titer of 1:1000. Rheumatological consultation was obtained; nailfold capillaroscopy findings were normal, and the patient had no history of Raynaud phenomenon. High-resolution computed tomography (HRCT) showed no evidence of internal organ involvement. Systemic sclerosis was excluded by the rheumatology.

Results

Treatment was initiated with systemic methylprednisolone (1 mg/kg/day) and methotrexate (15 mg/week). After one month of therapy, the patient showed improvement in joint mobility, and treatment is currently ongoing.

Conclusions

Concomitant conventional morphea has been reported in approximately 29%–40% of patients with eosinophilic fasciitis, supporting the concept of a clinical and pathological overlap within the spectrum of localized scleroderma.[4] Although eosinophilic fasciitis is most often considered idiopathic, several potential triggers and associated conditions have been described, including strenuous physical exercise, autoimmune diseases, medications, hematologic disorders,

malignancy, hemodialysis, Lyme disease and graft-versus-host disease.[5]

In our patient, no identifiable triggering factor or associated condition could be detected, consistent with previous reports describing truly idiopathic cases. The coexistence of generalized morphea and eosinophilic fasciitis in the absence of a clear precipitating factor underscores the heterogeneous nature of this disease spectrum. Reporting such cases may contribute to a better understanding of the pathogenesis and clinical variability of eosinophilic fasciitis and highlights the importance of careful dermatological examination for overlapping skin findings.

Abstract N°: ID-503

Topic: Autoimmune disorders

Assessment of the Safety and Tolerability of Combined Therapy with Calcipotriol and Microneedling in Patients with Vitiligo: A Prospective Study

Daryia Kairesheva*[1], Ouaili Nader[1], Konstfntin Lomonosov[1], Mohammad Almomani[1], Elizaveta Djahaia[1]

[1]Sechenov First Moscow State Medical University, Moscow, Russian Federation

Introduction
Vitiligo is a chronic dermatosis characterized by depigmented patches and significantly affecting the patient's psychoemotional state. The prevalence of vitiligo in dermatological practice is increasing, while the need for well-tolerated and effective combination treatment methods remains relevant. Given the limited data on the tolerability of emerging combination regimens, we investigated the safety and tolerability of microneedling combined with topical calcipotriol in patients with stable non-segmental vitiligo.

Materials and Methods
In a pilot prospective study, 15 patients (9 women and 6 men; mean age 18–60 years) with stable non-segmental vitiligo participated. All patients underwent microneedling once weekly, followed by daily application of calcipotriol throughout the entire treatment period. The total study duration was 16 weeks (12 weeks of therapy and 4 weeks of follow-up). The following assessments were used: Vitiligo Area Scoring Index (VASI), a visual analogue scale for repigmentation (G0–G4), Dermatology Life Quality Index (DLQI), and Numeric Rating Scale (NRS, 0–10 points) for pain intensity evaluation.

Results
After 12 weeks of therapy, the relative improvement in VASI was 44.4%, and repigmentation >25% was achieved in 86.7% of patients. A total of 38 adverse events were recorded in 73.3% of patients, all of mild severity (mainly transient erythema, itching, and pain). No serious adverse events were observed, and no patient discontinued treatment. Pain intensity during procedures was low (median NRS score of 2.0 points). A statistically significant improvement in quality of life was also noted: a reduction in DLQI score by 4 points (40%).

Conclusions
Combination therapy with microneedling and calcipotriol for the treatment of stable non-segmental vitiligo is an effective and safe method with good tolerability and patient adherence.

Abstract N°: ID-533

Topic: Autoimmune disorders

A Case of Bullous Pemphigoid associated with Pembrolizumab Treatmentin a Patient with Bladder Cancer

Sae Hee Kim*[1], Seungmin Park[1], Ji Won Lim[1], Yina Yoon[1], Jaeyoung Sung[1], Hyungseok Son[1], Changyong Kim[1], Da-Ae Yu[1], Yangwon Lee[1], Yongbeom Choe[1]

[1]Konkuk University School of Medicine, Seoul, Korea, Rep. of South

Introduction
N/A

Materials and Methods
N/A

Results

A 66-year-old man with a history of bladder cancer presented to the emergency department with multiple tense bullae and erosive ulcers involving the trunk and upper extremities. His medical history included type 2 diabetes mellitus, for which he had been treated with linagliptin for five years. In addition, he had been receiving pembrolizumab every three weeks for bladder cancer for the preceding 15 months. Several months before presentation, he had attended our clinic complaining of generalized pruritus and erythematous skin lesions without blister formation. Two weeks prior to the visit, he experienced worsening pruritus followed by the abrupt development of tense bullae, which rapidly evolved into painful, widespread erosions.

Bullous pemphigoid and toxic epidermal necrolysis were initially considered in the differential diagnosis. A 4-mm punch biopsy and direct immunofluorescence (DIF) study were therefore performed. Histopathologic evaluation demonstrated subepidermal blister formation accompanied by a dense eosinophilic infiltrate. DIF revealed linear deposition of IgG and C3 along the dermo-epidermal junction, confirming the diagnosis of bullous pemphigoid. The patient was treated with intravenous methylprednisolone at a dose of 80 mg daily for two weeks, followed by gradual tapering.

Drug-induced bullous pemphigoid is clinically and histologically indistinguishable from idiopathic disease, which often complicates diagnosis. Furthermore, symptom onset may be delayed for several months or even more than a year after exposure to the causative medication. Although more than 50 drugs have been reported as potential triggers of bullous pemphigoid, most evidence derives from isolated case reports. Recent case-control studies, however, have demonstrated a strong association with dipeptidyl peptidase-4 (DPP-4) inhibitors and immune checkpoint inhibitors, including pembrolizumab. In the present case, the patient had been exposed to both agents, and whether their concurrent use increases the risk of bullous pemphigoid remains to be determined.

Conclusions
N/A

Abstract N°: ID-589

Topic: Autoimmune disorders

Burn-Induced Localized Bullous Pemphigoid: A Case Report

Petra Temelkova*[1], Katerina Damevska[1], Natasha Ichokaeva[1], Nora Pollozhani[1], Nevenka Adjievska[1], Anastasija Pesic[1], Simona Poposka[2]

[1]Faculty of Medicine "Ss. Cyril and Methodius" University, PHI University Clinic for Dermatology, Skopje, North Macedonia
[2]PHI City General Hospital 8th September, Skopje, North Macedonia

Introduction

Bullous pemphigoid (BP) is the most common autoimmune subepidermal blistering disease, typically observed in individuals over 60 years of age. The humoral immune response plays a central role, with tissue-bound and circulating autoantibodies directed against structural components of the hemidesmosomes at the basement membrane zone (BMZ). The major target antigens are BP180 (also known as BPAG2 or collagen XVII) and BP230 (BPAG1). The binding of these autoantibodies leads to complement activation, recruitment of inflammatory cells, and release of proteolytic enzymes, triggering an inflammatory cascade that ultimately causes separation of the epidermis from the dermis at the BMZ and formation of subepidermal blisters. Clinically, BP most often presents with tense, serous bullae in a generalized pattern, while localized forms are less common and usually associated with trauma. Thermal injury represents a rare but clinically relevant trigger that may initiate or amplify autoimmune activity at the BMZ. We report the case of a 65-year-old female patient who developed burn-induced localized bullous pemphigoid on the left lower extremity one month after a thermal injury caused by hot water.

Materials and Methods

Dermatologic evaluation, histopathologic examination, immunopathologic studies, laboratory tests, and microbiologic analysis were performed. Histology was obtained from an intact bulla, while direct immunofluorescence (DIF) was performed on perilesional skin. Indirect immunofluorescence (IIF), including salt-split skin testing, was used to detect circulating basement membrane zone autoantibodies and to exclude epidermolysis bullosa acquisita (EBA).

Results

A 65-year-old woman presented to the dermatology department with localized serous bullae on the left lower leg, developing one month after a thermal burn and associated with pruritus and mild edema at the site of injury. Dermatological examination revealed multiple tense, serous bullae on erythematous and edematous skin of the left knee and proximal lower leg. The surrounding non-burned skin also showed isolated blisters. No mucosal involvement was observed, and no signs of secondary infection. Laboratory tests were performed, and all results were within the normal reference range. Microbiological analysis excluded an infectious etiology. A skin biopsy was obtained, and histopathological examination demonstrated subepidermal blistering with a predominantly lymphocytic and eosinophilic dermal infiltrate. DIF revealed linear IgG and C3 deposits along the epidermal basement membrane. IIF was positive, and salt-split skin testing demonstrated IgG binding to the epidermal side of the split, supporting the diagnosis of bullous pemphigoid and excluding EBA. The diagnosis was established based on the correlation of clinical presentation, histopathology, and immunofluorescence findings. Treatment with systemic and topical corticosteroids resulted in rapid clinical improvement, with complete resolution of active blistering within 10 days, leaving only residual post-inflammatory hyperpigmentation. During four months of follow-up, no recurrence of bullous lesions was observed.

Conclusions

This case report highlights the importance of recognizing burn-induced localized BP, a rare but distinct and immunologically well-defined variant that should be considered in patients presenting with post-burn blistering. Early recognition is crucial, as this entity must be differentiated from post-burn bacterial infections and other subepidermal bullous diseases to ensure timely and appropriate management.

Abstract N°: ID-672

Topic: Autoimmune disorders

The Application of Dermoscopy and Ultraviolet-Induced Fluorescence Dermoscopy (UVFD) in Pemphigus Diseases: An issue probing study

Katarzyna Korecka*[1], Magdalena Jałowska[2], Bogusz Falkowski[2], Monika Bowszyc-Dmochowska[3], Marian Dmochowski[2]

[1]Department of Dermatology and Venereology, Poznan University of Medical Sciences, Poznan, Poland
[2]Autoimmune Blistering Dermatoses Section, Department of Dermatology, Poznan University of Medical Sciences, Poznan, Poland
[3]. Cutaneous Histopathology and Immunopathology Section, Department of Dermatology, Poznan University of Medical Sciences, Poznan, Poland

Introduction

Pemphigus is rare, chronic, and potentially life-threatening group of autoimmune blistering diseases that primarily affect the skin and/or mucous membranes. The major subtypes include pemphigus vulgaris, (PV) pemphigus foliaceus, andparaneoplastic pemphigus, with PV being the most prevalent. Final diagnosis integratates clinical assessment with direct immunofluorescence (DIF) of perilesional tissue and the serological quantification of circulating autoantibodies targeting desmoglein 1 (Dsg1) and desmoglein 3 (Dsg3) via multiplex enzyme-linked immunosorbent assay (ELISA) or mosaic indirect immunofluorescence (IIF).

While dermoscopy has been traditionally established as a pivotal tool for the diagnostic evaluation of melanocytic and non-melanocytic neoplasms, its utility has increasingly expanded to the assessment of inflammatory dermatoses. In this retrospective analysis, we evaluated the dermoscopic characteristics associated with various subtypes within the pemphigus spectrum.

Materials and Methods

This study was conducted at the Department of Dermatology of Poznan University of Medical Sciences from June 2024 to April 2025 on 10 patients (males and females) with pemphigus diseases. Clinical photos were taken and dermatoscopic images were captured with a handheld dermatoscope coupled to a smartphone camera (DermLite DL5, 10x magnification). Afterwards, the images were independently assessed by two evaluators (MJ, KK) within the following features: yellow hemorrhagic crusts, white scaling, white homogenous areas, pink homogenous areas, radial peripheral lines, dotted vessels, short linear vessels, linear branched vessels, hemorrhagic dots, sticky fiber sign, until a consensus was obtained.

Results

A total of 11 patients were analyzed, 10 females and 1 male patient, aged 41 to 82 years old (mean age 50). 7 patients were diagnosed with PV and 4 with PF. In 10 patients, skin lesions were assessed dermoscopically, and in one patient, lesions on the scalp were evaluated.

The frequency of the aforementioned features are presented in table below.

	PV (6) (%)	PF (4) (%)	total
Yellow hemmorrhagic crusts	6 (100%)	4 (100%)	10 (100%)
White scaling	6 (100%)	4 (100%)	10 (100%)
White homogeneous areas	1 ((16%)	3 (75%)	4 (40%)
Pink homogeneous areas	5 (83%)	3 (75%)	8 (80%)
Radial peripheral white lines	3 (50%)	2 (50%)	5 (50%)
Doted vessels	6(100%)	4 (100%)	10 (100%)
Short linear vessels	4 (66%)	1 (25%)	5 (50%)
Linear branched/serpentine vessels	2 (33%)	1 (25%)	3 (30%)
Hemorrhagic dots	6 (100%)	4 (100%)	10 (100%)
Sticky fiber sign	6 (100%)	3 (75%)	9 (90%)

Conclusions

Our findings suggest that dermoscopy serves as a valuable adjunct for the preliminary evaluation in autoimmune blistering diseases, particularly when located in atypical anatomical sites. Given that the initial clinical manifestations of these entities frequently mimic other bullous disorders, the integration of non-invasive imaging may enhance diagnostic sensitivity, thereby optimizing the selection of patients requiring direct immunofluorescence (DIF) examination.

However, a limitation of this study is the heterogeneity of the cohort regarding disease management. Furthermore, dermoscopic assessments were conducted on patients at varying stages of therapeutic intervention, which may confound the interpretation of specific patterns. Notably, the chronic application of potent topical corticosteroids can induce subclinical cutaneous atrophy, a dermoscopically characterized by the presence of linear vessels. In the subset of patients with a history of topical clobetasol application prior to examination, the dermoscopic morphology may have been altered by treatment, specifically resulting in an increased prevalence of linear vascular structures.

Dermoscopy, already widely used by clinicians in daily practice, could be a valuable tool for evaluating lesions in bullous diseases. However, further studies are needed, as the examined number of examined patients is relatively small. Considering the fact that PV and PF are rare conditions, a objective analysis of the described features would likely require a multicenter approach.

Abstract N°: ID-674

Topic: Autoimmune disorders

Periungual Injection of the Novel IL-17A Inhibitor Xeligekimab Combined with Tofacitinib for Acrodermatitis Continua of Hallopeau (ACH): A Prospective, Real-World, 12-Week Study

Anqi Liu*[1], Zhiying Yu[1], Meng Wang[1], Shaohui Geng[2], Ying Yang[1], Chen Li[1]

[1]Shenzhen People's Hospital(The First Affiliated Hospital, Southern University of Science and Technology;The Second Clinical Medical College,Jinan University), Department of Dermatology, Shenzhen, China
[2]Beijing University of Chinese Medicine, School of Life Science, Beijing, China

Introduction

Acrodermatitis continua of Hallopeau (ACH) is a localized clinical variant of pustular psoriasis that predominantly affects the distal phalanges of the fingers and toes. It is characterized by sterile periungual and subungual pustulation, paronychia, and onychodystrophy, which may progress to osteolysis, pain, and atrophy of the distal phalanx[1]. Due to the rarity of the disease, standardized therapeutic guidelines are currently lacking, rendering the management of ACH a significant clinical challenge.

Materials and Methods

This 12-week, single-center study enrolled 14 adults with ACH refractory to prior therapies, involving ≥ 3 nails. Exclusions included contraindications to xeligekimab or any ACH-directed treatments within the 4-week pre-enrollment washout period (covering all topical and systemic therapies). Participants received periungual injections of xeligekimab (0.1 mL per affected nail, biweekly) plus oral tofacitinib (5 mg twice daily). Assessments occurred at baseline and Weeks 2, 4, 6, 8, 10, and 12. Table 1 shows baseline cohort charateristics (n = 14). The study protocol was approved by the local Institutional Review Board (IRB), and written informed consent was obtained from all participants.
Treatment-emergent adverse events (TEAEs) were documented throughout the study period. At each visit, standardized clinical photography was performed to document morphological changes and evaluate the severity of nail damage. Clinical scoring was conducted by independent reviewers using the Nail Psoriasis Severity Index (NAPSI) and the ACH Physician's Global Assessment (ACHPGA). The ACHPGA scale ranges from 0 (clear) to 4 (very severe), with a score of 0 or 1 defined as 'clear' or 'almost clear.' The clinical improvement rate was calculated after each treatment session using the following formula: Improvement Rate=(Baselie NAPSI-Current NAPSI)/Baseline NAPSI.During the study, the use of any concomitant topical or systemic therapies was strictly prohibited. Efficacy endpoints included the proportion of patients achieving a ≥ 50% reduction (NAPSI 50) and a ≥75% reduction (NAPSI 75) in NAPSI scores at Week 12. Additionally, changes from baseline in ACHPGA scores and the Dermatology Life Quality Index (DLQI) were evaluated.

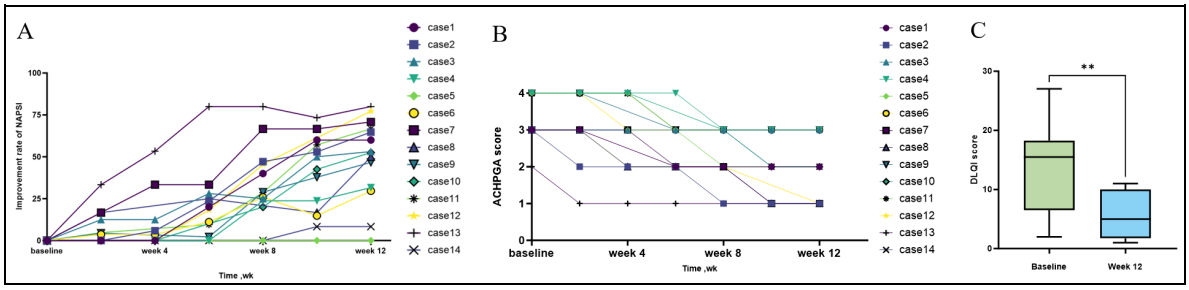
Table 1. Baseline Patient Characteristics

Patient No./sex/age of onset,y	Disease Duration, mo	Previous treatments	Comorbidities	Concomitant Psoriasis	No. of Affected Nails	NAPSI	ACHPGA	Smoking	Drinking
1/F/33	12	Topical ointments/creams	None	No	3	20	3	Yes	No
2/F/30	14	Topical ointments/creams	Rhinosinusitis	No	6	34	3	No	Yes
3/M/42	30	Topical ointments/creams; Tofacitinib; Upadacitinib	Diabetes mellitus; Pustulosis	No	7	62	3	Yes	No
4/F/39	12	Topical ointments/creams; Apremilast	Pustulosis; Dermatitis/Eczema	Yes	10	76	4	No	No
5/F/34	10	Acitretin; Cyclosporine; Topical ointments/creams; NB-UVB; Tofacitinib; Secukinumab	Otitis media	Yes	10	80	4	No	No
6/F/33	9	Acitretin; Topical ointments/creams	Rhinosinusitis	Yes	7	54	4	No	No
7/F/28	24	Topical ointments/creams	Pustulosis; Rhinosinusitis; Tonsillitis	No	4	24	4	No	No
8/F/35	9	Topical ointments/creams	Thyroid disease	No	4	18	3	No	No
9/F/44	24	Acitretin; Topical ointments/creams; Apremilast	Otitis media	No	7	36	4	No	No
10/F/22	38	Topical ointments/creams; Tofacitinib; Upadacitinib	Pustulosis	No	10	80	4	No	No
11/F/35	9	Methotrexate; Topical ointments/creams; Tofacitinib	None	Yes	5	40	4	No	No
12/M/33	42	Acitretin; Topical ointments/creams	None	No	3	22	3	Yes	No
13/F/22	144	Acitretin; Cyclosporine; Topical ointments/creams; Apremilast; Secukinumab	None	No	4	14	3	No	No
14/F/27	24	Acitretin; Topical ointments/creams; Apremilast; Upadacitinib	Pustulosis	No	3	24	4	No	No

Results

A total of 14 patients were enrolled in this study, comprising 12 females and 2 males. The mean age at disease onset was 32.5 years, and the median number of affected nails was 6. All participants had a definitive diagnosis of ACH. Regarding comorbidities, 4 patients presented with concomitant psoriasis, and 6 had a history of localized chronic inflammatory diseases.3 patients were active smokers, while only 1 reported alcohol consumption. In terms of treatment history, 6 patients were biologic-naïve, whereas 8 had previously received biologics or small-molecule inhibitors.

In this real-world study, all enrolled patients (n = 14) completed the 12-week follow-up. At week 12, 64.2% of patients (n = 9) achieved NAPSI 50, and 14.3% (n = 2) achieved NAPSI 75. Furthermore, 35.7% (n = 5) of patients achieved a ACHPGA score of 'clear' or 'almost clear'. The longitudinal improvement in clinical manifestations is illustrated in Figures 1A and 1B. Additionally, a significant reduction in DLQI scores was observed at week 12 following treatment ($P < 0.05$; Figure 1C).Regarding safety, no serious adverse events (SAEs) were reported during the study period. Among the 14 patients, adverse events were limited to upper respiratory tract infections in 3 cases and injection site pain in 1 case. The majority of participants reported either no pain or only mild discomfort at the injection site, and all demonstrated good adherence to the injection protocol.



(A) Improvement rate from baseline in Nail Psoriasis Severity Index(NAPSI) scores through weeks. (B) Change from baseline in ACH Physician Global Assessment (ACHPGA) scores through weeks. (C) Comparison of

Dermatology Life Quality Index(DLQI) scores between baseline and post-12-week treatment. Boxes include the median and interquartile range.**P<0.05 by Student's t-test

Conclusions

This preliminary study demonstrates that periungual xeligekimab combined with tofacitinib is an effective and well-tolerated therapeutic strategy for refractory ACH, offering significant improvements in both nail signs and quality of life.

Abstract N°: ID-706

Topic: Autoimmune disorders

Cutaneous lupus erythematosus in Korea: Nationwide incidence and increased risk of premalignant and malignant skin lesions

Seon Young Song*[1], Won Seob Lee[1], Jiyeong Kim[2, 3], Yu-Mi Kim[4, 5], Joo Yeon Ko[1, 6]

[1]Hanyang University Medical Center, Department of Dermatology, Seoul, Korea, Rep. of South
[2]College of Medicine, Hanyang University, Department of Pre-Medicine, Seoul, Korea, Rep. of South
[3]Biostatistics Laboratory and Medical Research Collaborating Center, Hanyang University, Seoul, Korea, Rep. of South
[4]College of Medicine, Hanyang University, Department of Preventive Medicine, Seoul, Korea, Rep. of South
[5]Graduate School of Public Health, Hanyang University, Seoul, Korea, Rep. of South
[6]College of Medicine, Hanyang University, Department of Dermatology, Seoul, Korea, Rep. of South

Introduction
Cutaneous lupus erythematosus (CLE) is a lupus erythematosus–specific cutaneous manifestation that may occur in isolation or in association with systemic lupus erythematosus (SLE). Although epidemiologic data on CLE have been well described in Western populations, population-based estimates in Asian countries remain limited. Accordingly, this study aimed to evaluate the incidence of CLE and to assess its association with premalignant and malignant skin lesions in the Korean population.

Materials and Methods
We conducted a nationwide retrospective cohort study using the Korean National Health Insurance Service–National Health Information Database from 2005 to 2020. Patients with CLE and SLE were identified using International Classification of Diseases (ICD) codes based on prespecified operational definitions. Demographic characteristics, disease subtypes, annual incidence trends, and age- and sex-specific incidence rates were analyzed. The occurrence of actinic keratosis (AK), non-melanoma skin cancer (NMSC), and melanoma was compared between patients with CLE and matched control subjects.

Results
A total of 32,337 patients with CLE (72.5% female; female-to-male ratio, 2.64) and 43,977 patients with SLE (86.4% female; ratio, 6.35) were identified. The mean (SD) age of patients with CLE was 42.9 (17.4) years. Discoid lupus erythematosus was the most prevalent subtype, followed by other/unspecified CLE and subacute CLE. The mean annual incidence of CLE was 3.98 per 100,000 person-years and showed a modest increasing trend over the study period (p for trend = .014), with the highest incidence observed among women aged 41–50 years. Compared with matched controls, patients with CLE showed significantly higher proportions of AK (2.7% vs 0.5%, $p < .001$), NMSC (0.5% vs 0.2%, $p < .001$), and melanoma (0.1% vs 0.02%, p = .005).

Conclusions
The incidence of CLE in Korea was comparable to that reported in Western populations and showed a gradual upward trend over time. Patients with CLE exhibited an increased risk of premalignant and malignant skin lesions, underscoring the importance of regular dermatologic surveillance and counseling on sun-protective behaviors in this population.

Abstract N°: ID-708

Topic: Autoimmune disorders

Upadacitinib for refractory discoid lupus erythematosus-associated scarring alopecia: a case report

Seon Young Song*[1], Kyung Mi Lee[1], Won Seob Lee[1], Yun Jung Huh[1], Mihn-Sook Jue[1], Jeong Eun Kim[1], Joo Yeon Ko[1]

[1]Hanyang University College of Medicine, Department of Dermatology, Seoul, Korea, Rep. of South

Introduction
Discoid lupus erythematosus (DLE), the most prevalent subtype of chronic cutaneous lupus erythematosus, frequently results in irreversible scarring alopecia and cosmetic disfigurement. Therapeutic responses to conventional systemic agents are often suboptimal. We report a patient with refractory DLE-associated alopecia who achieved sustained clinical improvement following treatment with upadacitinib.

Materials and Methods
A 27-year-old woman presented with a 4-year history of a progressive alopecic patch on the occipital scalp, with hyperpigmentation, erythema, and atrophic scarring. Dermoscopic examination showed follicular keratotic plugs and white structureless areas. Laboratory assessment showed positive antinuclear antibodies (1:160), anti-ribonucleoprotein, and anti-Ro antibodies; however, there was no additional clinical or laboratory evidence to support a diagnosis of systemic lupus erythematosus. Histopathologic examination of a scalp punch biopsy revealed diffuse dermal fibrosis, follicular atrophy, and mucin deposition, consistent with DLE. Previous treatments included hydroxychloroquine and methotrexate without meaningful response. Baricitinib (4mg daily) achieved partial improvement over 9 months; however, the emergence of new lesions prompted a switch to upadacitinib.

Results
Treatment with upadacitinib (15 mg daily, escalated to 30 mg as needed) led to sustained improvement in alopecia/hair density and marked improvement of post-inflammatory hyperpigmentation over a 22-month follow-up period. No treatment-related adverse events were observed. Disease activity remained controlled without the development of new alopecic lesions during maintenance therapy.

Conclusions
Dysregulated type I interferon signaling mediated through the JAK–STAT pathway is implicated in the pathogenesis of CLE and associated scarring alopecia. Consistent with emerging evidence supporting JAK inhibition in refractory cases, this case highlights the potential role of upadacitinib as a therapeutic option for DLE-associated alopecia. Larger studies are warranted to further evaluate its efficacy and long-term safety.

Abstract N°: ID-738

Topic: Autoimmune disorders

Post-Zoster Discoid Lupus Erythematosus: A Wolf's Isotopic Response

Malek Akid*[1], Samar Ben Naceur[2], Wissal Ben Yahia[2], Baya Chatti[2], Guiga Ahmed[2], Amira Atig[2], Maissa Thabet[2], Neirouz Ghannouchi[2]

[1]Charles Nicolle Hospital, Dermatology, Tunis, Tunisia
[2]Farhat Hached Hospiral, Internal Medicine, Sousse, Tunisia

Introduction
Wolf's isotopic response is defined as the occurrence of a new skin disorder at the site of a previously healed and unrelated dermatosis, most commonly following herpes zoster infection. A wide spectrum of secondary dermatoses has been reported, including granulomatous diseases, lichen planus, sarcoidosis, and, more rarely, lupus erythematosus. A number of factors including viral, neural, vascular, and immunologic factors have been implicated in the causation of this peculiar response but none has been proven conclusively. We report a case of discoid lupus erythematosus developing on a healed zoster scar in a patient with systemic lupus erythematosus.

Materials and Methods
Clinical data were collected during routine dermatological follow-up. Diagnosis was based on clinical history, physical examination, and characteristic lesion morphology. Photographic and dermoscopic documentation was obtained.

Results
A 51-year-old woman with a known history of systemic lupus erythematosus, treated with azathioprine, presented for routine consultation. She reported a previous episode of unilateral, painful vesicular eruption involving the left hemi-abdomen several weeks earlier, with subsequent neuralgia, consistent with herpes zoster, for which she did not seek medical care.
On examination, multiple erythematous, scaly, and atrophic plaques with residual post-inflammatory pigmentation were observed, strictly limited to the previous zoster distribution. The lesions followed a thoraco-abdominal dermatomal pattern corresponding to the T10 dermatome, with strict respect of the midline. No active vesicular lesions were present.
The clinical appearance of the lesions was highly suggestive of discoid lupus erythematosus occurring on the healed zoster scar. Given the characteristic topography, temporal relationship, and underlying autoimmune background, a diagnosis of Wolf's isotopic response was established, defined by the development of discoid lupus erythematosus on the site of a prior herpes zoster infection.

Conclusions
This case highlights a rare presentation of discoid lupus erythematosus occurring as a Wolf's isotopic response following herpes zoster. Patients with autoimmune diseases and immunosuppression may be particularly predisposed to this phenomenon. Persistent or atypical inflammatory lesions arising on healed zoster scars should prompt consideration of an isotopic response. Careful dermatological follow-up of immunocompromised patients is essential to ensure early recognition and appropriate management of secondary dermatoses.

Abstract N°: ID-767

Topic: Autoimmune disorders

Anti-MDA5–positive amyopathic dermatomyositis – diagnostic and therapeutic challenges. A case report

Anita Marcinkiewicz*[1]

[1]wojewódzki Szpital specjalistyczny we Wrocławiu, oddział dermatologiczny z pododdziałem dermatologii dziecięcej, wrocław, Poland

Introduction

Dermatomyositis associated with anti-MDA5 antibodies is a rare subtype of idiopathic inflammatory myopathies, frequently presenting in an amyopathic form. The disease may manifest with prominent cutaneous involvement in the absence of muscle symptoms and is associated with a high risk of severe, rapidly progressive interstitial lung disease.

Materials and Methods

We present the case of a 55-year-old man hospitalized due to painful subcutaneous inflammatory nodules in the gluteal region and progressive skin lesions.

The patient underwent comprehensive clinical, laboratory, imaging, and immunological evaluation, including assessment of inflammatory markers, chest computed tomography, autoantibody testing, and nailfold capillaroscopy. Immunosuppressive therapy was administered in accordance with current recommendations.

Results

The medical history revealed over six months of systemic symptoms, including intermittent arthralgia with fever, significant weight loss, and oral mucosal lesions. During the disease course, numerous cutaneous manifestations developed, including ulcerations of the fingertips, feet, and elbows, vascular changes, and Gottron’s papules, without clinical evidence of muscle involvement. Laboratory tests showed elevated erythrocyte sedimentation rate and ferritin levels with normal C-reactive protein. Chest computed tomography demonstrated features of interstitial pulmonary fibrosis. Anti-MDA5 and anti-RNP antibodies were detected, and nailfold capillaroscopy revealed abnormalities characteristic of connective tissue diseases. Previous treatment with glucocorticoids, mycophenolate mofetil, and a single dose of intravenous immunoglobulins was ineffective. Ultimately, anti-MDA5–positive amyopathic dermatomyositis was diagnosed. Treatment with rituximab resulted in a good clinical response.

Conclusions

Anti-MDA5–positive dermatomyositis represents a significant diagnostic challenge due to the absence of muscle involvement and predominance of cutaneous manifestations. Early diagnosis and prompt initiation of aggressive immunosuppressive therapy are crucial for prognosis, particularly in the context of the high risk of severe interstitial lung disease.

Abstract N°: ID-777

Topic: Autoimmune disorders

Clinical Evaluation of Low-Temperature Argon Plasma in the Treatment of Non-Segmental Vitiligo

Ouaili Nader[1], Karim Karray*[1], Daryia Kairesheva[1], Liliya Almakaeva[1], Konstfntin Lomonosov[1]

[1]Sechenov University, Dermatology and venerology, Moscow, Russian Federation

Introduction
Vitiligo is a chronic depigmenting skin disorder with substantial negative effects on patients' psychosocial well-being. Existing first-line treatments, such as prolonged topical corticosteroid use and phototherapy, present limitations including side effects and variable efficacy across different skin phototypes. These challenges underscore the need for novel, safe, and effective therapeutic alternatives. Low-temperature atmospheric-pressure plasma has emerged as a promising physical therapy modality in dermatology, with potential immunomodulatory and tissue-regenerative effects. This study aimed to clinically evaluate the efficacy and safety of low-temperature argon plasma in patients with non-segmental vitiligo.

Materials and Methods
A prospective, open-label, single-arm study was conducted at the Clinic of Skin and Venereal Diseases, Sechenov University. Twenty patients (aged 18–65 years) with a confirmed diagnosis of stable non-segmental vitiligo, affecting 1% to 10% of their body surface area (BSA), were enrolled. The intervention consisted of 24 treatment sessions administered three times per week over eight weeks, followed by a one-month post-treatment observation period. Treatments were delivered using the Plasmoran plasma-arc surgical device, which generates low-temperature argon plasma.

Efficacy was primarily assessed using the Vitiligo Extent and Treatment Fraction (VETF) index. Secondary outcomes included the percentage of depigmented BSA, the Dermatology Life Quality Index (DLQI), and the degree and pattern of repigmentation (categorized as complete [76-100%], severe [51-75%], moderate [26-50%], or minimal [1-25%]). Assessments were performed at baseline, week 4, week 8 (end of therapy), and one month post-therapy. Safety was monitored by recording all adverse events throughout the study period. Statistical analysis involved within-group comparisons relative to baseline

Results
All 20 enrolled patients completed the full treatment protocol and follow-up. Repigmentation outcomes were distributed as follows: complete in 4 patients, severe in 7, moderate in 6, and minimal in 3 patients. No patient was a non-responder.

A statistically significant reduction in the mean VETF score was observed, decreasing from 8.4 ± 3.6 at baseline to 6.8 ± 3.2 at week 4, 4.2 ± 2.8 at week 8, and 3.6 ± 2.4 at one month post-therapy ($p < 0.001$ for all time points vs. baseline). The mean area of depigmentation decreased from 4.6 ± 2.8% to 2.0 ± 1.8% BSA ($p < 0.001$). Quality of life improved significantly, with the mean DLQI score declining from 18.6 ± 5.4 at baseline to 14.2 ± 4.8, 9.8 ± 3.6, and 7.4 ± 2.9 at the subsequent assessments ($p < 0.001$).

Subgroup analysis revealed superior efficacy in patients with a disease duration of less than 3 years (mean repigmentation 68.5%) compared to those with a duration exceeding 7 years (mean repigmentation 32.3%). Lesions on the face, neck, and trunk responded better than those in acral locations (hands, feet). The predominant repigmentation pattern was follicular (16/20 patients), followed by peripheral (8/20) and diffuse (2/20). Repigmentation continued to progress during the one-month follow-up period after active therapy ceased.

The treatment demonstrated a favorable safety profile. Mild adverse events, such as erythema and a sensation of warmth, were reported in 12 patients. No serious adverse effects, were observed.

Conclusions

Therapy with low-temperature argon plasma system demonstrated high clinical efficacy and a safety profile in patients with non-segmental vitiligo. The treatment induced significant repigmentation, improved quality of life, and was associated with ransient side effects. These results substantiate the potential of low-temperature argon plasma as an effective, and safe physical therapy modality in the management of vitiligo, particularly for non-acral lesions and in patients with a shorter disease duration.

Abstract N°: ID-793

Topic: Autoimmune disorders

Acquired Epidermolysis Bullosa Mimicking Dermatitis Herpetiformis and Bullous Pemphigoid: A Case Report

Ilhame Jegoual*[1], Layla Bendaoud[1], Mariem Aboudourib[1], Ouafa Hocar[1], Said Amal[1]

[1]Mohammed VI University Hospital,, Arrazi Hospital,Biosciences Research Laboratory, FMPM, Cadi Ayyad University, Marrakech, Dermatology Department, Marrakech, Morocco

Introduction

Bullous pemphigoid (BP) and dermatitis herpetiformis (DH) are two autoimmune subepidermal blistering diseases, both characterized by intense pruritus. Although they are based on distinct pathophysiological mechanisms, several cases reported in the literature suggest the possibility of their coexistence.

In addition to these entities, acquired epidermolysis bullosa (EBA) is a rare autoimmune subepidermal blistering disease characterized by autoantibodies directed against type VII collagen. Although the clinical presentation of EBA may closely mimic that of bullous pemphigoid and dermatitis herpetiformis, its diagnosis relies on specific immunopathological criteria.

Materials and Methods

A 39-year-old patient with a medical history of **type 1 diabetes mellitus treated with insulin** and **ulcerative colitis** was admitted for **grouped vesicular lesions associated with diffuse tense bullae and erosions**, accompanied by **severe pruritus**.

A **skin biopsy with direct immunofluorescence** revealed a **subepidermal blister with neutrophilic microabscesses located in the dermal papillae**, along with **granular IgA deposits at the tips of the dermal papillae**, findings consistent with **DH**.

Laboratory investigations showed **neutrophilic leukocytosis** and an **elevated erythrocyte sedimentation rate**. Serological tests for **anti-gliadin and anti-transglutaminase antibodies were negative**.

The patient was started on a **gluten-free diet** and **dapsone at a dose of 100 mg/day**. Due to the development of **dapsone-induced anemia**, treatment was switched to **sulfasalazine at a dose of 3 g/day**.

In the absence of clinical improvement, a **second skin biopsy** was performed, showing a **subepidermal blister with linear deposits of C3 and IgG along the dermoepidermal junction**, suggestive of **bullous pemphigoid**, with **positive anti-BP180 and anti-BP230 antibodies**.

Systemic corticosteroid therapy was initiated at a dose of **1 mg/kg/day**. Given the lack of significant clinical response, the patient subsequently received **rituximab (1 g on day 0 and day 14)** in combination with **intravenous methylprednisolone pulses (1 g/day for 3 consecutive days)**.

Following this treatment, a **marked clinical improvement** was observed, with a **reduction in blister formation, decreased pruritus, and initiation of lesion healing with milia formation.**

Results

Bullous pemphigoid and dermatitis herpetiformis are two distinct autoimmune subepidermal blistering diseases with different immunopathological mechanisms, yet both are characterized by intense pruritus and vesiculobullous eruptions.

The rare association of these two entities, as reported in the literature, raises questions regarding possible shared or interconnected immunological mechanisms. Some reported cases suggest that DH may represent a predisposing factor for the subsequent development of BP, possibly through immune dysregulation or an epitope-spreading phenomenon.

The differential diagnosis relies on a careful correlation between clinical findings, direct immunofluorescence, and histopathological examination. Close follow-up of patients with DH is essential, particularly in cases of treatment resistance or the emergence of new or atypical lesions, in order to detect a possible transition toward BP.

Furthermore, the presence of **milia-like scarring lesions**, especially in areas exposed to friction or pressure (acral and pressure-prone sites), strongly suggests EBA. This entity can closely mimic both DH and BP, making the diagnostic process particularly challenging. Therefore, EBA should always be considered in atypical or refractory cases, given its distinct prognostic and therapeutic implications.

Conclusions

Our case highlights the importance of a **multidisciplinary approach** and heightened clinical vigilance when facing this rare presentation, which may carry **significant therapeutic and prognostic implications**. Early recognition and thorough immunopathological evaluation are essential to ensure accurate diagnosis and optimal management, particularly in atypical or treatment-resistant presentations.

Abstract N°: ID-815

Topic: Autoimmune disorders

Early Real-World Experience with Topical Ruxolitinib in Non-Segmental Vitiligo

Max-Wilhelm Brünger*[1], Alexander Zink[1]

[1]Technical University of Munich, Rechts der Isar Hospital, Department of Dermatology and Allergy, München, Germany

Introduction

Ruxolitinib cream is the first approved topical Janus kinase (JAK) inhibitor for the treatment of non-segmental vitiligo. Randomized controlled trials have demonstrated significant repigmentation and favorable safety outcomes, establishing this therapy as a novel, targeted treatment option. However, real-world data reflecting routine clinical practice remain limited. This study aimed to characterize the first 100 patients with vitiligo treated with ruxolitinib cream at a a tertiary care dermatology center in Germany and to evaluate early real-world treatment outcomes.

Materials and Methods

A retrospective cohort analysis was conducted including patients aged ≥12 years with non-segmental vitiligo who initiated treatment with ruxolitinib cream between March 2023 and March 2025. Demographic data, clinical characteristics, affected body areas, comorbidities, disease duration, and prior therapies were extracted from electronic medical records, including physician notes and photographic documentation. Treatment response was evaluated based on documented clinical repigmentation during follow-up visits. All data were analyzed in a pseudoanonymized manner.

Results

A total of 102 patients were included, with a mean age of 42.0 ± 18 years; 56% were female. Frequently affected sites included the face, hands, and genital region (each 34%). Most patients had received prior therapies, including topical calcineurin inhibitors (18.6%), narrowband ultraviolet B phototherapy (13.7%), and topical corticosteroids (11.8%), while 15% were therapy-naïve.

The mean age at disease onset was lower in men than in women (29.0 vs. 35.7 years). The interval from disease onset to initiation of ruxolitinib therapy was comparable between sexes (4.8 vs. 4.9 years, respectively). Repigmentation was documented in 53.9% of patients, while 9.8% showed no clinical response; outcome documentation was unavailable in 36%, reflecting real-world data limitations. Treatment response rates were similar between men (54%) and women (53%), and younger patients tended to demonstrate higher repigmentation rates.

Notably, a subgroup of 43 patients had chronic vitiligo of ≥15 years' duration, representing a population with long-standing, often therapy-resistant disease. Among those with documented outcomes, 85.7% achieved repigmentation, demonstrating that ruxolitinib cream is effective even in patients with long-standing disease who have exhausted prior therapies. While direct comparison is limited due to differences in study design, these real-world outcomes are consistent with the pivotal phase 3 trials of ruxolitinib cream (Rosmarin et al., 2022), supporting its effectiveness in chronic, previously treated vitiligo.

Conclusions

This real-world analysis provides valuable insights into patient characteristics and early treatment outcomes with ruxolitinib cream in routine clinical practice. More than half of patients with documented follow-up achieved repigmentation, with comparable responses between sexes and a trend toward improved outcomes in younger individuals. Importantly, clinically meaningful repigmentation was also observed in patients with long-standing, therapy-resistant disease. These findings support the effectiveness of ruxolitinib cream beyond controlled trial settings and highlight its potential role as a targeted therapy across diverse vitiligo populations.

Abstract N°: ID-871

Topic: Autoimmune disorders

Unilateral Onset of Subacute Cutaneous Lupus Erythematosus Mimicking Localized Dermatoses: A Case Report

Jonah Agatha Ilaya*[1], MA. Eleanor Cathryn Salonga[1], Katherine Joy Sayo-Aguiling[1], Angelito Flora Jr.[2]

[1]Jose R. Reyes Memorial Medical Center, Jose R. Reyes Memorial Medical Center, Dermatology, Manila, Philippines
[2]Bataan Doctor's Hospital, Bataan Doctor's Hospital, Internal Medicine, Balanga City, Philippines

Introduction

Lupus erythematosus (LE) is an inflammatory connective tissue disorder with diverse systemic and cutaneous manifestations. Subacute cutaneous lupus erythematosus (SCLE), a distinct subset of cutaneous lupus erythematosus (CLE), classically presents as hyperkeratotic papulosquamous or annular to polycyclic plaques distributed symmetrically over sun-exposed sites, including the upper trunk, shoulders, extensor surfaces of the arms, and the V-area of the neck. Facial involvement is less common and typically affects the lateral face with sparing of the central malar region. We report a rare and diagnostically challenging case of SCLE with an initial unilateral central facial onset.

Materials and Methods

A 59-year-old Filipino woman presented with a 1-year and 4-month history of progressive unilateral erythematous papules and plaques on the left face, later spreading to the contralateral forehead, V-area of the neck, upper back, and bilateral extensor arms. Clinical examination, dermoscopy, laboratory testing, and two skin punch biopsies were performed. Histopathology with H&E, Alcian blue, and PAS stains supported the diagnosis. Disease activity was evaluated using the Cutaneous Lupus Erythematosus Disease Area and Severity Index (CLASI). The patient was treated with topical corticosteroids, topical calcineurin inhibitors, oral prednisone, hydroxychloroquine, and strict photoprotection.

Results

Dermoscopy revealed white structureless areas, polymorphous vessels, brown dots, follicular plugging, and white scales. Histopathology demonstrated compact orthokeratosis, epidermal atrophy, basal vacuolization, basement membrane thickening, papillary dermal edema, superficial to mid-dermal perivascular and periappendageal infiltrates, dermal mucin deposition, and melanophages—findings consistent with SCLE. Laboratory evaluation showed ANA 1:80 (nucleolar pattern) and elevated CRP, with negative ENA panel. After treatment with topical desonide 0.05% cream alternating with tacrolimus 0.1% ointment, a tapering course of oral prednisone (20 mg), hydroxychloroquine 200 mg once daily, strict photoprotection, and adjunctive measures, lesions markedly improved with decreased erythema and thickness, resolution on the upper extremities, and a reduced CLASI activity score from 9 to 2 after six weeks, indicating a positive treatment response.

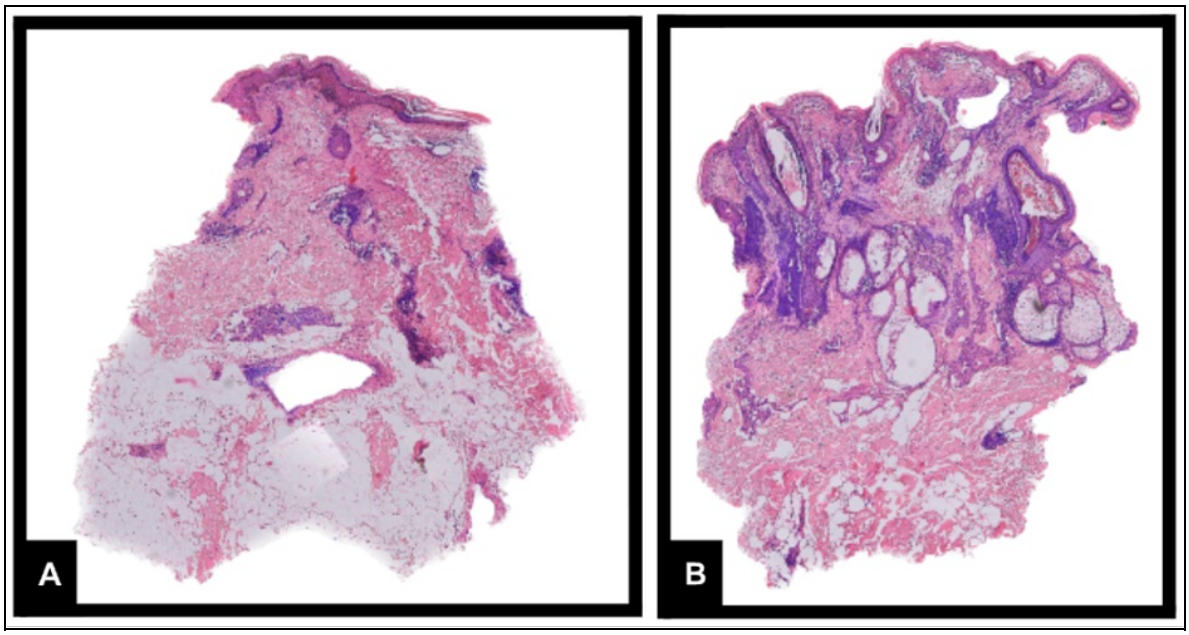
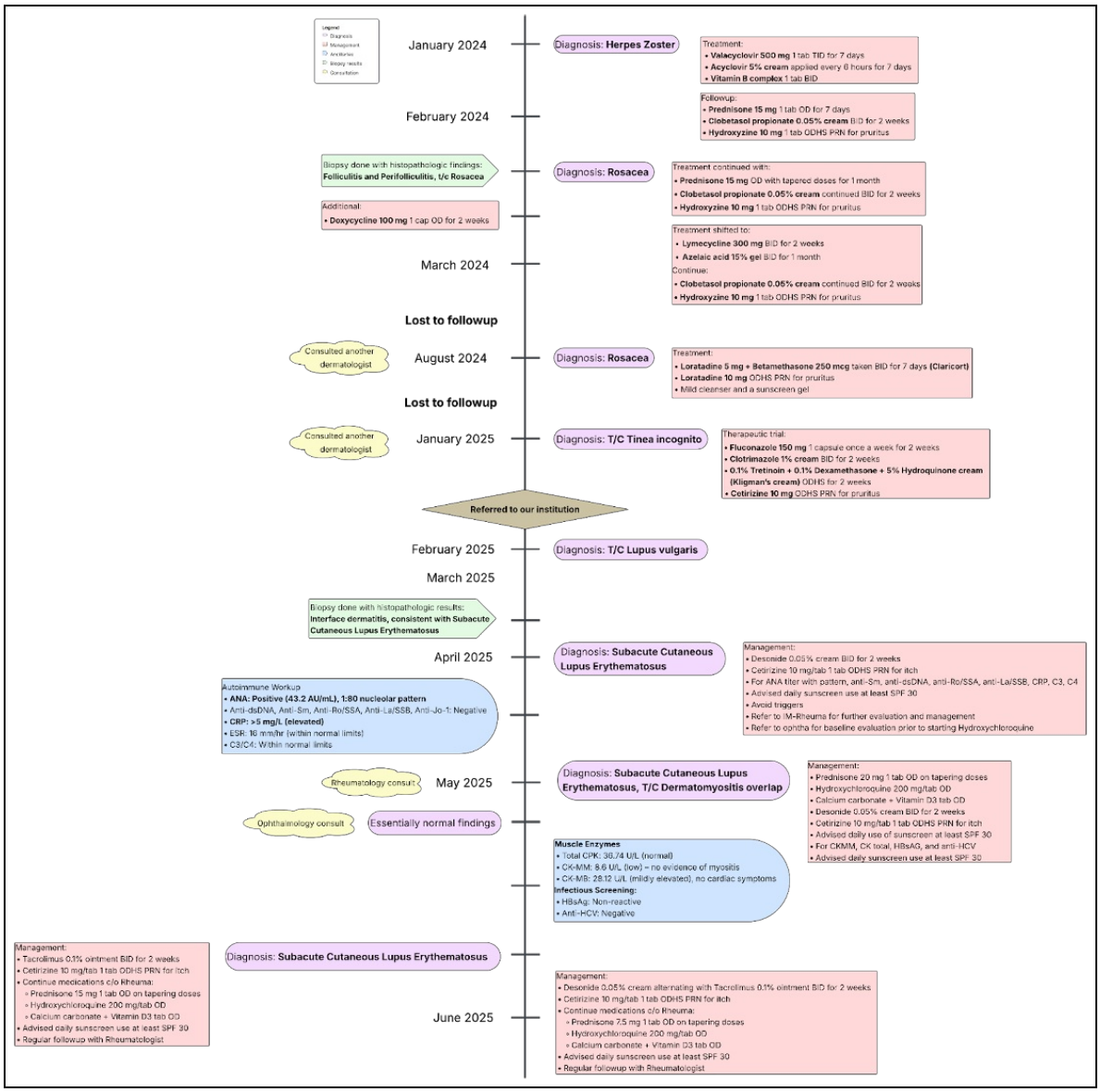


Figure 1. Histologic section of the specimens from the forehead (A) and left cheek (B) in scanning magnification.

Conclusions

This report documents the first known case of SCLE with unilateral onset on the face, subsequently evolving into a more typical photo-distributed pattern. The unusual presentation contributed to diagnostic delay due to initial misclassification as herpes zoster, rosacea, tinea incognito, and lupus vulgaris. No similar cases have been documented in the international literature to date, although unilateral facial presentations have been described in other CLE subtypes, including discoid lupus erythematosus, lupus profundus, and tumid lupus. This case underscores the importance of including SCLE in the differential diagnosis of persistent, unilateral erythematous papules and plaques of the central face, as early recognition is crucial to prevent disease progression and inappropriate treatment.



Timeline of Events

Abstract N°: ID-911

Topic: Autoimmune disorders

Dermoscopy in Lichen Amyloidosis: Insights from a Case Study

Sihame Alaoui*[1], Ahmed Alshbiti[1], Najoua Ammar[1], Syrine Hamada[1], Narjess Errachdy[1], Mariam Meziane[1], Laila Benzekri[1], Nadia Ismaili[1]

[1]University hospital center Ibn Sina, Department of Dermatology and Venereology, Rabat, Morocco

Introduction

Amyloid lichen is a localized form of cutaneous amyloidosis, characterized by amyloid deposits in dermal papillae without systemic involvement. It typically presents as pruritic hyperkeratotic papules, commonly affecting the lower limbs. Chronic scratching contributes to keratinocyte apoptosis, which leads to amyloid deposition. Diagnosis relies on histopathology, but dermoscopy can provide early and useful diagnostic clues.

Materials and Methods

A 58-year-old man presented with multiple bilateral hyperkeratotic papules on the legs, evolving over several years with severe pruritus, without mucosal involvement or systemic symptoms. Dermoscopic examination showed a heterogeneous brown-yellow background with multiple white structureless areas, diffuse white scales partially covering the lesions, numerous brown-red dots and globules indicating superficial hemorrhages and crusts, perifollicular scaling with hypopigmentation and a clear halo, and fine punctate or linear vessels within the inflammatory background. Skin biopsy demonstrated dermal papillary amyloid deposits, acanthosis, hyperkeratosis, papillomatosis, pigment incontinence, superficial lymphocytic infiltrate, and apoptotic basal keratinocytes, confirming the diagnosis of amyloid lichen.

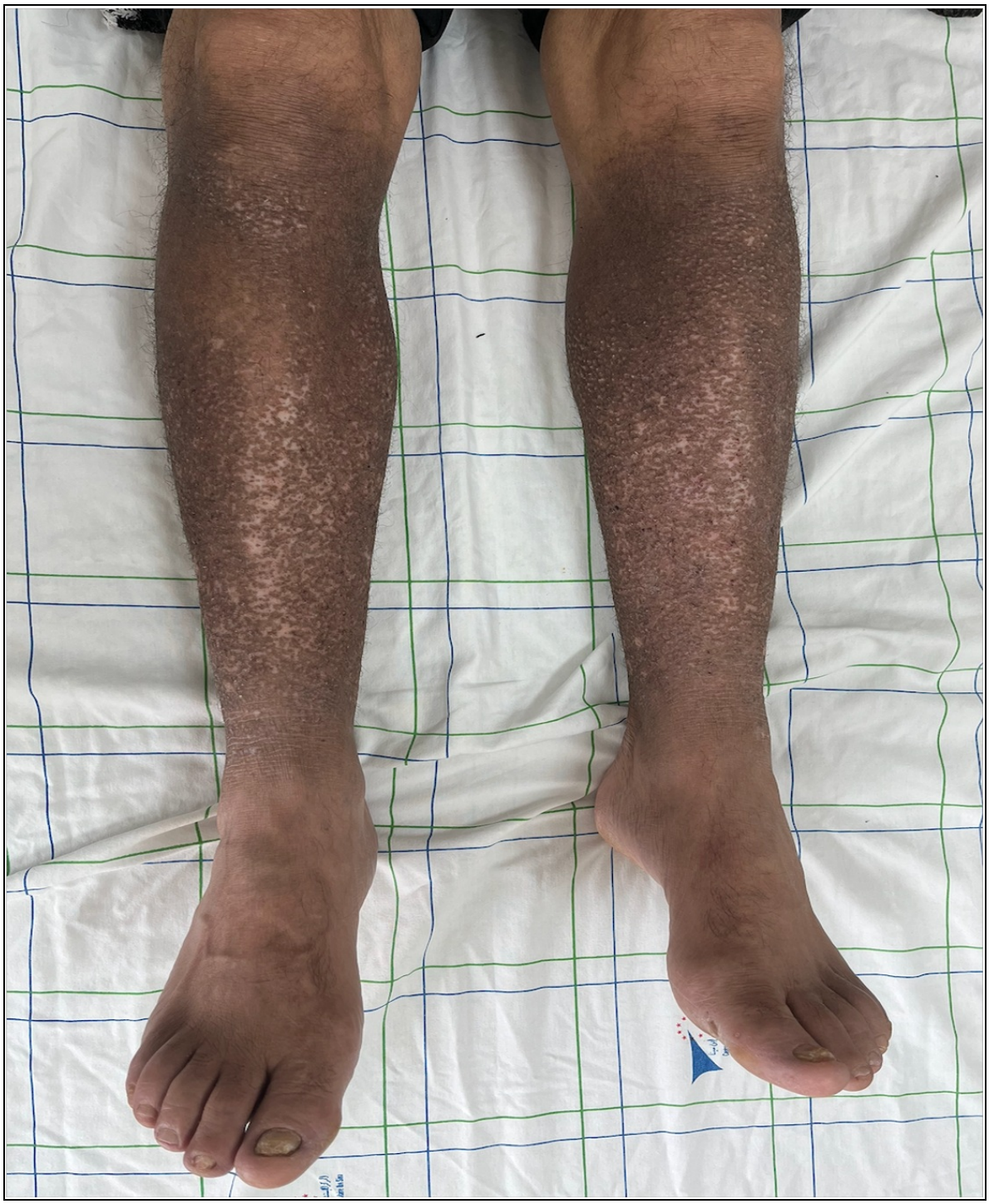


Figure 1: Bilateral keratotic papular lesions on the legs

Results

Symptomatic treatment with potent topical corticosteroids, emollients, and oral antihistamines was initiated, leading to partial pruritus improvement after several weeks. Dermoscopy allowed early orientation towards the diagnosis, facilitating timely confirmation by histopathology.

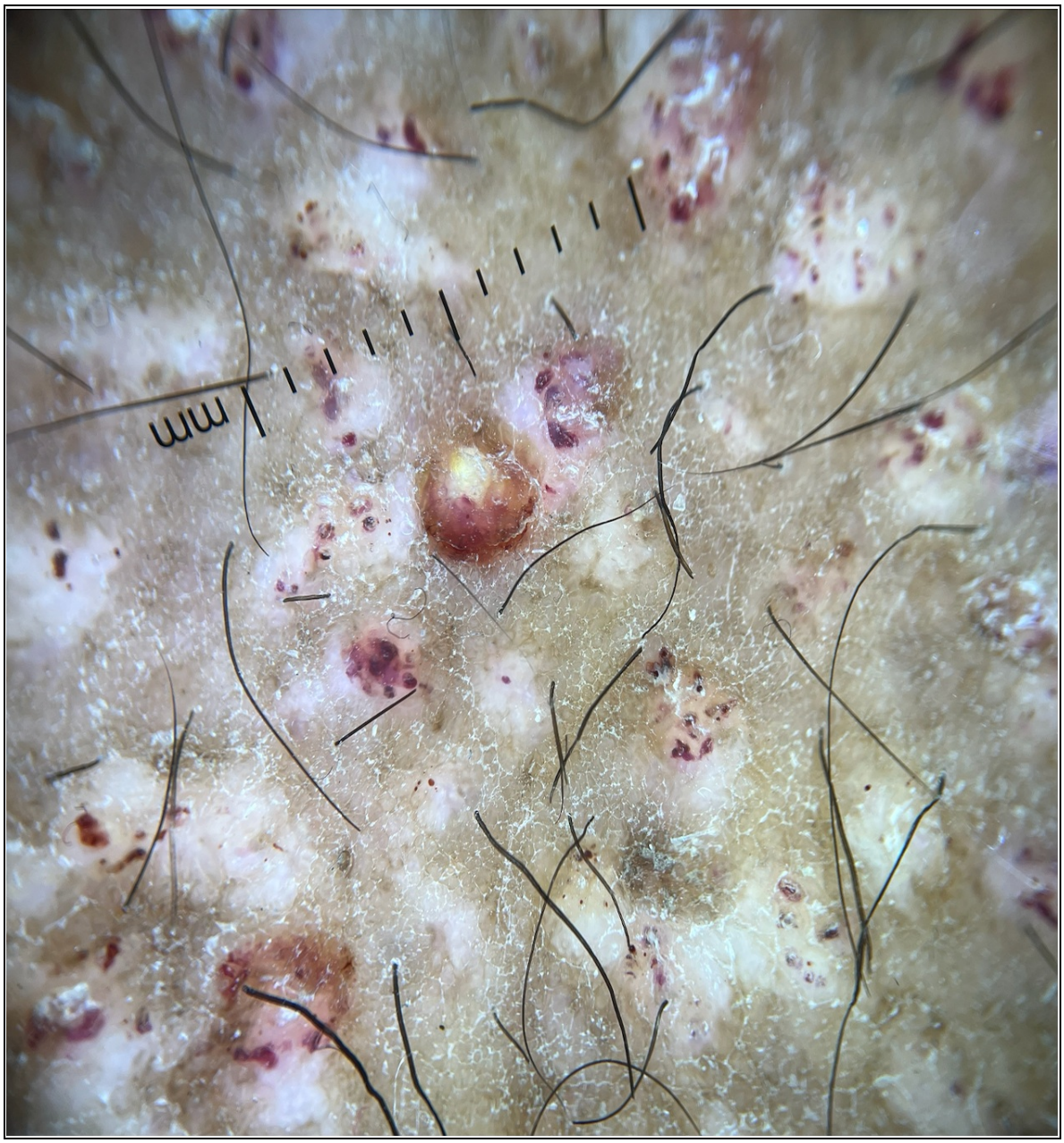


Figure 2: Dermoscopy of heterogeneous brown-yellow background with white scar-like areas, diffuse scaling, perifollicular hypopigmentation, hemorrhagic dots and crusts, and delicate dotted/linear vessels.

Conclusions

Amyloid lichen is a chronic pruritic dermatosis whose clinical presentation can mimic other hyperkeratotic papular disorders. Dermoscopy serves as a valuable non-invasive tool, providing early diagnostic clues and improving management strategies. Histopathology remains essential for definitive diagnosis, enabling targeted treatment and symptom control.

Abstract N°: ID-971

Topic: Autoimmune disorders

Pemphigus vulgaris and Squamous cell carcinoma of tongue: A rare association

Hasini Jayasundara*[1], Chandani Udagedara[1], Sachithra Samarakoon[1]

[1]Postgraduate Institute Of Medicine University Of Colombo, Dermatology, Colombo, Sri Lanka

Introduction

Pemphigus vulgaris (PV) is an autoimmune intraepidermal blistering disease caused by IgG autoantibodies against desmoglein 1 and desmoglein 3. It presents with flaccid blisters and painful mucocutaneous erosions. While paraneoplastic pemphigus is a recognized entity, an association between pemphigus vulgaris and solid tumors, including squamous cell carcinoma (SCC) of the oral cavity, is rare and sparsely reported.

Materials and Methods

This descriptive case report analyzes the clinical course, histopathology, and treatment outcomes of a patient diagnosed with pemphigus vulgaris in association with squamous cell carcinoma of the tongue. Clinical examination, skin and mucosal biopsies, and oncological evaluation were reviewed following informed consent.

Results

A 51-year-old man initially presented with extensive painful erosions of the skin and oral mucosa. Pemphigus vulgaris was diagnosed based on clinical features and histopathology. Disease remission was achieved with dexamethasone–cyclophosphamide pulse therapy, after which the patient was lost to follow-up.

He subsequently re-presented with a persistent painful tongue lesion in the absence of active skin disease. Examination revealed an indurated eroded plaque with irregular margins on the tongue, and biopsy confirmed moderately differentiated squamous cell carcinoma of tongue. Within weeks, the patient developed relapse of pemphigus vulgaris along with cutaneous metastasis of SCC in the neck region. Management included intravenous rituximab for control of pemphigus vulgaris combined with chemoradiotherapy for the underlying malignancy.

Conclusions

Paraneoplastic pemphigus is classically associated with hematological malignancies, while associations with solid tumors such as adenocarcinoma and squamous cell carcinoma are rare. Typical clinical features of paraneoplastic pemphigus, including severe intractable stomatitis involving the vermillion border and polymorphous cutaneous eruptions, were absent in this patient. Histopathological findings were also consistent with pemphigus vulgaris rather than paraneoplastic pemphigus.

However, the temporal relationship, parallel disease course, and relapse of pemphigus in association with progression of the underlying SCC suggest a paraneoplastic phenomenon. This case uniquely highlights pemphigus vulgaris as a possible paraneoplastic manifestation of squamous cell carcinoma of the tongue. It emphasizes the importance of vigilant follow-up and repeated biopsy of persistent oral lesions in patients with pemphigus vulgaris to enable early detection of underlying malignancy. Further studies are required to elucidate the molecular mechanisms linking pemphigus vulgaris with solid tumors.

Abstract N°: ID-992

Topic: Autoimmune disorders

Linear IgA Bullous Dermatosis Revealing Lymph Node Tuberculosis: A Case Report

Wijdane Tebbaai*[1], Layla Bendaoud[1], Kettam Manal[1], Aboudourib Maryem[1], Hocar Ouafa[1], Amal Said[1]

[1]Department of Dermatology and Venereology, Mohammed VI University Hospital, Marrakech, marrakesh, Morocco

Introduction

Linear IgA bullous dermatosis is a rare autoimmune subepidermal blistering disease characterized by neutrophil-predominant bullae.Lymph node tuberculosis is the most common extrapulmonary form of tuberculosis, often with a subacute and misleading clinical course. The association between LABD and tuberculosis is exceptional and deserves recognition, as cutaneous manifestations may constitute a revealing sign of an underlying systemic infection.

Materials and Methods

We report the case of a 23-year-old woman with no notable medical history, hospitalized for a generalized vesiculobullous dermatosis evolving for three months, intense pruritus, and impaired general condition. Dermatological examination revealed diffuse erythematous annular and grouped plaques involving the trunk, face, and all four limbs, surmounted by tense bullae, vesicles, pustules, and post-bullous erosions, with a negative Nikolsky sign. Mucosal examination was unremarkable. Lymph node examination revealed right submandibular cervical lymphadenopathy, firm, fixed, non-inflammatory, measuring approximately 4 cm. Skin biopsy showed a subepidermal blister containing abundant neutrophils, without acantholysis or keratinocyte necrosis. The dermis exhibited a polymorphous perivascular inflammatory infiltrate with neutrophilic and eosinophilic predominance. Direct immunofluorescence was negative . Cervico-thoraco-abdomino-pelvic CT scan revealed a conglomerate of necrotic right cervical lymph nodes without other localizations. Lymph node biopsy demonstrated epithelioid and giant-cell granulomatous inflammation with caseous necrosis, consistent with lymph node tuberculosis.The patient was treated with dapsone and antituberculous therapy, with good clinical improvement.

Results

Linear IgA bullous dermatosis is a rare autoimmune blistering disease with an estimated incidence ranging from 0.2 to 2.3 cases per million inhabitants per year. Histologically, it is characterized by a neutrophil-predominant subepidermal blister related to IgA autoantibodies most commonly directed against BP180/LAD-1. The originality of the present observation lies in its association with lymph node tuberculosis. Several reports have described LABD associated with disseminated or pulmonary tuberculosis, suggesting a possible pathophysiological link between chronic tuberculous infection and the onset of autoimmune blistering diseases. In our case, the clinical chronology is compatible with a parainfectious association. The first hypothesis relies on chronic antigenic stimulation induced by tuberculosis. Even when localized, lymph node tuberculosis represents a persistent infection capable of inducing prolonged immune activation. Such chronic stimulation may promote a breakdown of immune tolerance and the emergence of IgA autoantibodies directed against components of the dermoepidermal junction, particularly BP180/LAD-1. The second hypothesis concerns immunopathological coherence. In LABD, IgA deposition along the basement membrane leads to neutrophil recruitment responsible for subepidermal blister formation. Finally, persistence of tuberculosis infection may lead to nonspecific immune activation, known as bystander activation, promoting the activation of autoreactive lymphocyte clones and maintenance of cutaneous autoimmunity. This mechanism is classically evoked in autoimmune

diseases associated with chronic infections and constitutes a plausible pathophysiological explanation in our observation.

Conclusions

Beyond dermatological diagnosis, LABD should be considered an entity with multiple etiologies, including idiopathic, drug-induced, infectious, inflammatory, and neoplastic causes, requiring a rigorous and systematic etiological investigation. A multidisciplinary approach based on clinico-histological correlation and targeted exploration of associated signs, notably lymph node biopsy in cases of persistent lymphadenopathy, is essential to avoid diagnostic delay and initiate appropriate etiological management.

Abstract N°: ID-1006

Topic: Autoimmune disorders

When Digital Meets Clinical: The Influence of Online Content on Vitiligo Patient Expectations. A Qualitative Study with Vitiligo Patients and Dermatologists in Germany

Jana Riemer*[1, 2], Alexander Zink[2], Stefanie Ziehfreund[2, 3]

[1]Ludwig Maximilian University of Munich (LMU), Faculty of Medicine, Munich, Germany
[2]Technical University of Munich, School of Medicine and Health, Rechts der Isar Hospital, Department of Dermatology and Allergy Biederstein, Munich, Germany
[3]Pettenkofer School of Public Health, Munich, Germany

Introduction

Digital media have become a central source of health information for patients with chronic diseases. However, limited knowledge exists about how people with vitiligo use online resources and how this involvement impacts their expectations, treatment decisions and relationships with healthcare providers. This study explores patterns of digital media use among vitiligo patients and examines clinicians' perspectives on digitally informed patients in routine care.

Materials and Methods

A qualitative study design was applied using semi-structured, problem-centered interviews with adults diagnosed with vitiligo and practicing dermatologists. Participants were recruited through purposive sampling to ensure heterogeneity regarding age, gender, disease duration, and professional background. Interviews were conducted in person or via video conferences, audio-recorded, transcribed verbatim and pseudonymized. Data were analyzed using qualitative content analysis following Mayring's approach with support of qualitative analysis software. Categories were developed deductively and refined inductively. Intercoder reliability was assessed using Cohen's kappa.

Results

A total of 27 interviews were conducted, including 16 patients and 11 dermatologists. Six main themes emerged: frequency and pattern of digital media use, purposes of use, patient evaluation of online information quality, dermatologists' views on digitally informed patients, patients' perspectives on digital media and treatment decisions and perceived benefits and risks of digital media. Many patients reported intensive online information-seeking behavior shortly after diagnosis, which declined over time, often due to treatment initiation and disease acceptance. Digital media were mainly used to obtain general knowledge about vitiligo and to explore therapeutic options, while social media primarily served as a source for obtaining insights into other patients' experiences through personal narratives and testimonials. Information quality was frequently described as superficial, inconsistent and difficult to interpret. Dermatologists acknowledged that digital media can enhance patient knowledge but also contribute to misinformation and unrealistic expectations, particularly regarding novel therapies. Both groups highlighted the potential of trustworthy online resources to support informed clinical discussions.

Conclusions

Digital media play a key role in the early information behavior of vitiligo patients and influence expectations in clinical encounters. While online resources can promote informed patient engagement, variable information quality poses

challenges for shared decision-making. Developing reliable, context-sensitive digital health content and strengthening digital literacy in dermatological care are important steps to improve shared decision-making and support patients throughout their therapeutic journey.

Abstract N°: ID-1030

Topic: Autoimmune disorders

From Conventional Therapy to Natural Emollient: A Case of Guttate Psoriasis Successfully Maintained with Olive Oil

Suci Dewi Putri*[1], Andi Hardianty[1], Sri Malik[1], Khaeruddin Djawad[1], Ghea Anisah[1]

[1]hasanuddin university, -, dermatology,venereology and aesthetics, makassar, Indonesia

Introduction
Guttate psoriasis is an inflammatory dermatosis often triggered by streptococcal infection. While conventional systemic and topical therapies are effective, their long-term use can be limited by access and safety concerns. Natural emollients with anti-inflammatory properties, such as olive oil, present a potential alternative, though robust clinical evidence is lacking.

Materials and Methods
A 25-year-old male presented with extensive guttate psoriasis (Psoriasis Area and Severity Index/PASI 18.7, Body Surface Area >10%). Initial management consisted of a 2-week course of oral methotrexate (7.5 mg/week) and combination topical therapy (salicylic acid, liquor carbonis detergens, corticosteroids, fusidic acid, and emollients). Following this period, treatment was switched to exclusive twice-daily application of topical virgin olive oil for 45 days.

Results
The initial conventional therapy reduced the PASI score to 8.9. Subsequent monotherapy with virgin olive oil yielded further significant improvement over 45 days, with marked reduction in erythema and scaling. The final PASI score was 4. The oil, rich in oleic acid (Omega-9), was well-tolerated with no adverse effects reported.

Conclusions
This case demonstrates that topical virgin olive oil, primarily containing oleic acid with its proposed anti-inflammatory and barrier-repair properties, can serve as an effective and safe maintenance therapy for guttate psoriasis. It contributed to sustained clinical improvement after initial conventional treatment, highlighting a potential role for natural emollients in long-term management. Further controlled studies are warranted to validate these findings.

Abstract N°: ID-1033

Topic: Autoimmune disorders

Combination Therapy of Phototherapy, Topical 1% Pimecrolimus, and Topical Antioxidants in Pediatric Segmental Vitiligo: A Case Report

Suci Dewi Putri*[1], Nurelly Waspodo[1], Farida Tabri[1], Andi Hardianty[1], Suci Budhiani[1]

[1]hasanuddin university, -, dermatology,venereology and aesthetics, makassar, Indonesia

Introduction
Segmental vitiligo (SV) in children presents a therapeutic challenge due to its often rapid onset and limited response to monotherapy. Emerging evidence highlights the role of oxidative stress and localized inflammation in its pathogenesis, supporting the potential benefit of combining treatments that target these distinct pathways.

Materials and Methods
A 3-year-old girl presented with progressive, asymptomatic, milky-white macules on the left cheek, periorbital area, and parietal scalp. Diagnosis was confirmed clinically and with Wood's lamp and dermoscopic examination. The patient was treated with a triple combination regimen for 60 days: narrowband UVB phototherapy (initial dose based on minimal erythema dose testing), topical 1% pimecrolimus cream twice daily, and a once-daily topical antioxidant containing Superoxide Dismutase (SOD).

Results
Clinical assessment at day 30 showed initial repigmentation, particularly on the zygomatic region. By day 60, further significant repigmentation was observed with a noticeable reduction in macule size. Dermoscopic follow-up revealed fading perifollicular depigmentation. The treatment was well-tolerated with no reported adverse effects.

Conclusions
The combination of NB-UVB phototherapy, topical pimecrolimus 1%, and topical antioxidants (SOD) resulted in satisfactory and progressive repigmentation in this pediatric SV case. This regimen was designed to target the pathophysiology synergistically: SOD to neutralize oxidative stress damaging melanocytes, pimecrolimus to inhibit calcineurin-mediated local inflammation without skin atrophy, and NB-UVB to provide local immunosuppression and stimulate melanocyte migration. Concurrently targeting oxidative stress, immune-mediated inflammation, and local immunosuppression, appears to be a safe and promising strategy for managing SV in children.

Abstract N°: ID-1069

Topic: Autoimmune disorders

Clinical Features of Vitiligo and Alopecia Areata in Patients after COVID-19

Iryna Chaplyk-Chyzho[1], Orysya Syzon[1], Marianna Dashko*[1]

[1]Danylo Halytsky Lviv National Medical University, Dermalogy, venereology department, Lviv, Ukraine

Introduction

Vitiligo and alopecia areata are chronic autoimmune skin diseases in which autoimmune disorders and psychoemotional stress play a key role in pathogenesis. SARS-CoV-2 infection is associated with systemic immune dysfunction and a pronounced inflammatory response, which may act as a trigger for the onset or exacerbation of autoimmune dermatoses. In routine clinical practice, an increasing number of patients with vitiligo and alopecia areata have been observed following laboratory-confirmed COVID-19, highlighting the relevance of this study.

Objective. To retrospectively assess the impact of laboratory-confirmed COVID-19 on the course of vitiligo and alopecia areata, as well as to analyze clinical changes and quality of life in patients with these conditions.

Materials and Methods

Outpatient medical records of patients with vitiligo (n = 38, aged 18-55 years) and alopecia areata (n = 42, aged 19-58 years) who had experienced mild or moderate COVID-19 were analyzed. Previous SARS-CoV-2 infection was laboratory confirmed by a positive PCR test during the acute phase and/or the presence of IgG antibodies to SARS-CoV-2. The control group consisted of patients with vitiligo (n = 32) and alopecia areata (n = 35) who had not had COVID-19, as confirmed by the absence of clinical symptoms, negative serological testing, and no history of positive PCR results.

Disease activity was assessed prior to infection and over a 6-12-month period following COVID-19. The Vitiligo Area Scoring Index (VASI) was used in patients with vitiligo, while disease severity in alopecia areata was evaluated using the Severity of Alopecia Tool (SALT). Quality of life and psychoemotional status were assessed using questionnaires. Statistical analysis was performed using the chi-square (χ^2) test; differences were considered statistically significant at $p < 0.05$.

Results

In the post-COVID vitiligo group (n = 38), disease progression was observed in 24 patients (63.2%), compared with 9 patients (28.1%) in the control group (n = 32). This difference was statistically significant ($p < 0.01$). A stable course of vitiligo was observed in 14 patients (36.8%) in the post-COVID group and in 23 patients (71.9%) in the control group ($p < 0.01$).

Among patients with alopecia areata who had recovered from COVID-19 (n = 42), disease exacerbation was identified in 29 patients (69.0%), whereas only 11 patients (31.4%) in the control group (n = 35) experienced exacerbation. These differences were statistically significant ($p < 0.001$). Progression to the subtotal form of alopecia areata was observed in 7 patients (16.7%) in the post-COVID group and was not recorded in the control group ($p < 0.05$).

A decrease in quality of life, increased anxiety, and emotional exhaustion were reported by 52 of 80 patients (65.0%) who had experienced COVID-19, compared with 18 of 67 patients (26.9%) in the control group ($p < 0.001$).

Conclusions

Laboratory-confirmed COVID-19 represents a significant triggering factor for exacerbation of vitiligo and alopecia areata. SARS-CoV-2 infection is associated with a more frequent and more severe course of autoimmune dermatoses, as well as a marked reduction in patients' quality of life. These findings substantiate the need for dynamic dermatological follow-up, comprehensive treatment, and psychological support for patients in the post-COVID period.

Abstract N°: ID-1108

Topic: Autoimmune disorders

Adult-Onset Purpura Revealing Cryoglobulinemia Secondary to Early Rhupus Syndrome: A Case Report

Ouissal Laadime*[1], Layla Bendaoud[1], Houda Azour[1], Maryem Aboudourib[1], Ouafa Hocar[1], Said Amal[1]

[1]mohammed VI university hospital, dermatology and venereology, marrakesh, Morocco

Introduction
Adult-onset vascular purpura is a common reason for consultation and may represent the first clinical manifestation of an underlying systemic disease. Among its etiologies, cryoglobulinemia occupies a particular place due to its strong association with autoimmune disorders.Rhupus syndrome, a rare overlap condition combining features of systemic lupus erythematosus (SLE) and rheumatoid arthritis (RA), is an uncommon entity. Its association with cryoglobulinemia has only exceptionally been reported. We describe a case in which vascular purpura was the inaugural manifestation of cryoglobulinemia secondary to early rhupus syndrome.

Materials and Methods
A 61-year-old woman with no significant past medical history was hospitalized for vascular purpura associated with inflammatory arthralgia.

Results
Skin biopsy revealed leukocytoclastic vasculitis, and direct immunofluorescence showed IgA deposits, consistent with IgA vasculitis. Immunological investigations demonstrated positive cryoglobulinemia (typing pending), polyclonal hypergammaglobulinemia, positive antinuclear antibodies, positive anti-Sm antibodies, and positive anti-cyclic citrullinated peptide (anti-CCP) antibodies.The patient was treated with colchicine at a dose of 1 mg/day, resulting in marked improvement of purpuric lesions, and was subsequently referred to the internal medicine department for further management of cryoglobulinemia.

Conclusions
This case highlights that adult-onset vascular purpura may reveal cryoglobulinemia secondary to rhupus syndrome. It demonstrates that this rare overlap condition can initially present with vascular complications before classical lupic or articular manifestations become evident.
Systematic screening for underlying autoimmune diseases should be performed in cases of vascular purpura associated with positive cryoglobulinemia, including rare overlap syndromes such as rhupus.

Abstract N°: ID-1117

Topic: Autoimmune disorders

Diagnostic Pitfalls in an Atypical Presentation of Pemphigus Foliaceus: a case report

Gresa Agaj*[1], Shkendije Dobruna[1], Lekë Muhaxheri[1]

[1]DermaD Clinic, DermaD Clinic, Dermatology, Pristina, Kosovo

Introduction
Pemphigus foliaceus often presents deceptively with mild scaling with or without blistering, which can make early recognition challenging. Because it can resemble more common dermatoses such as Seborrheic dermatitis or even Dermatophytosis, appropriate therapy can be delayed. We report a patient managed as Tinea asbestina whose persistent, non-responsive condition led to re-evaluation and ultimately to the diagnosis of Pemphigus foliaceus. The case emphasises the need to align clinical findings with histopathology and serology and to question the initial diagnosis when treatment fails.

Materials and Methods
Clinical examination, dermoscopy, and review of prior treatments were performed. Two punch biopsies were taken for histopathologic evaluation. Additionally laboratory assessment with C3 complement levels and ELISA testing for anti–desmoglein 1 and anti–desmoglein 3 antibodies were done.

Results
An 42-year-old male presented with erythematous plaque with superficial fissures underneath yellow scaling along the frontal hairline and lateral face. The patient mentioned previous physical trauma in the affected region before thick scales appeared. Medical records indicated that the patient was treated by other dermatologists two years prior to evaluation at our clinic with working diagnoses of Eczema, Superficial Tinea, and ultimately Tinea asbestina as lesions presented with thick crusts. A smear was previously taken that had resulted as a superficial fungal infection, and topical antifungal therapy had been initiated alongside topical corticosteroid therapy. As lesions progressed despite treatment, the patient came to our clinic to re-evaluate the treatment. Dermoscopy showed diffuse erythematous background, yellowish-whitish scales and dotted vessels. Differential diagnoses were DLE and LPP when skin biopsy was performed. Histopathology demonstrated features of pemphigus vulgaris (PV), with suprabasal acantholysis. The distribution of lesions and clinical morphology, absence of mucosal lesions, lack of bullae and presence of superficial scaling, was more suggestive of PF than PV, raising concern for a potential clinicopathologic mismatch. Additional testing was performed to clarify the diagnosis: C3 Complement was decreased, whereas ELISA testing demonstrated markedly higher anti-desmoglein 1 antibodies compared to the minimal positivity of desmoglein 3, establishing a final diagnosis of Pemphigus foliaceus. Systemic corticosteroid therapy was initiated as well as local immunomodulatory treatment with calcineurin inhibitors. Systemic immunosuppressants are being considered pending further follow-up. Even though treatment had only been started shortly before this report, the case already shows what can happen when clinicians stay anchored to an initial impression when the presentation imitates frequent dermatoses.

Conclusions
What resembles common dermatosis may in fact be an underlying autoimmune blistering disorder. When the condition persists or fails to respond to appropriate therapy, it is crucial to proceed to biopsy and further testing if necessary to prevent delayed diagnosis of Pemphigus foliaceus. The case underlines the importance of diagnostic skepticism and the need of correlating the clinical presentation with histopathology and serology findings.

Abstract N°: ID-1121

Topic: Autoimmune disorders

Comorbidities in Discoid Lupus: A Systematic Review and Meta-Analysis of Prevalence and Association

Jl Sanz-Cabanillas*[1, 2], Francisco Gomez-Garcia[1, 2], Jesus Gay-Mimbrera[1, 2], Elena Beatriz Sanz Cabanillas[1], Juan Ruano-Ruiz[1, 2]

[1]Hospital Universitario Reina Sofia, Córdoba, Spain
[2]Instituto Maimónides de Investigación Biomédica de Córdoba (IMIBIC), Córdoba, Spain

Introduction
Discoid lupus erythematosus (DLE) is a chronic inflammatory scarring alopecia that may be accompanied by a broad range of systemic and extracutaneous comorbidities. However, the prevalence and magnitude of these associations have not been comprehensively quantified. Objectives: to systematically evaluate the prevalence and associated risk of comorbidities in patients with discoid lupus erythematosus.

Materials and Methods
We conducted a systematic review and random-effects meta-analysis in accordance with PRISMA 2020 guidelines, prospectively registered in PROSPERO (CRD420250656067). MEDLINE and Embase were searched from inception to June 2025. Observational studies reporting comorbidities in patients with DLE were included. Pooled prevalence estimates and pooled odds ratios (ORs) with 95% confidence intervals (CIs) were calculated using random-effects models. Between-study heterogeneity was assessed using the I^2 statistic. Sensitivity analyses excluding small studies (n<50) were performed for prevalence outcomes, whereas robustness of association analyses was assessed qualitatively owing to the limited number of contributing studies. Methodological quality was evaluated using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist.

Results
Twenty-five studies were included. Pooled prevalence estimates indicated a high frequency of systemic lupus erythematosus (SLE) (22.0%), hypertension (24.3%), depression (38.8%), and hypothyroidism (12.4%) among patients with DLE. Sensitivity analyses showed stable prevalence estimates for SLE and hypertension, with moderate variability for hypothyroidism and depression. Meta-analyses of case-control studies demonstrated significant associations between DLE and cardiovascular disease (OR 3.85, 95% CI 1.67-8.88), hypothyroidism (OR 2.55, 95% CI 1.79-3.61), hypertension (OR 2.22, 95% CI 1.91-2.58), depression (OR 2.21, 95% CI 1.71-2.85), and anxiety (OR 2.40, 95% CI 1.40-4.11). Associations with type 2 diabetes were more modest, while smoking was not significantly associated. Most association analyses were based on a limited number of studies.

Conclusions
Patients with discoid lupus erythematosus exhibit a substantial burden of systemic, cardiometabolic, endocrine, and psychiatric comorbidities. While prevalence estimates were generally robust, associations should be interpreted cautiously due to limited available evidence. These findings highlight the importance of comprehensive clinical assessment and multidisciplinary management of patients with DLE.

Abstract N°: ID-1136

Topic: Autoimmune disorders

ANTI-NXP2 POSITIVE DERMATOMYOSITIS INITIALLY PRESENTING AS CHRONIC URTICARIA: A DIAGNOSTIC CHALLENGE

Georgia Kliampa*[1], Vasiliki Drantaki[1], Vasiliki Chasapi[1], Alexander Stratigos[1], Maria Gerochristou[1]

[1]Andreas Sygros Hospital of Venereal and Dermatological Diseases, Athens, Greece

Introduction

Dermatomyositis (DM) is an idiopathic inflammatory myopathy characterized by proximal muscle weakness and characteristic skin findings. Myositis-specific autoantibodies are associated with distinct clinical phenotypes. Anti-NXP2 antibodies are linked to severe muscle disease and increased malignancy risk. Atypical cutaneous presentations may delay recognition of the disease.

Materials and Methods

A clinical case was evaluated through detailed clinical examination, laboratory testing, histopathological assessment, autoimmune screening, and a myositis-specific antibody panel. Imaging studies were performed to investigate possible associated malignancy.

Results

A 34-year-old woman presented with persistent urticarial lesions and recurrent angioedema unresponsive to antihistamines, without muscle weakness. Initial laboratory tests, including muscle enzymes, were within normal limits. Autoimmune testing revealed positive ANA and anti-RNP antibodies. Repeated skin biopsies demonstrated non-specific interface dermatitis. Due to the atypical clinical course, a myositis-specific antibody panel was performed and showed positivity for anti-NXP2 antibodies. Based on the immunological findings and clinical evolution, a diagnosis of anti-NXP2 positive dermatomyositis was established. Given the known association with malignancy, extended cancer screening was performed, revealing a pulmonary nodular lesion requiring further evaluation.

Conclusions

This case illustrates that dermatomyositis may initially manifest with atypical skin features such as chronic urticaria and angioedema, accompanied by non-specific histopathology and normal muscle enzymes. Awareness of such presentations facilitates timely diagnosis. In patients with anti-NXP2 antibodies, comprehensive malignancy screening is an essential part of the clinical assessment.

EA SYMPOSIUM DV 2026
ATHENS 7 - 9 MAY

Abstract N°: ID-1168

Topic: Autoimmune disorders

A rare case of dermatomyositis revealing nasopharyngeal carcinoma.

Ikbal Fikri*[1], Bendaoud Layla[1], Mariem Aboudourib[1], Ouafa Hocar[1], Said Amal[1]

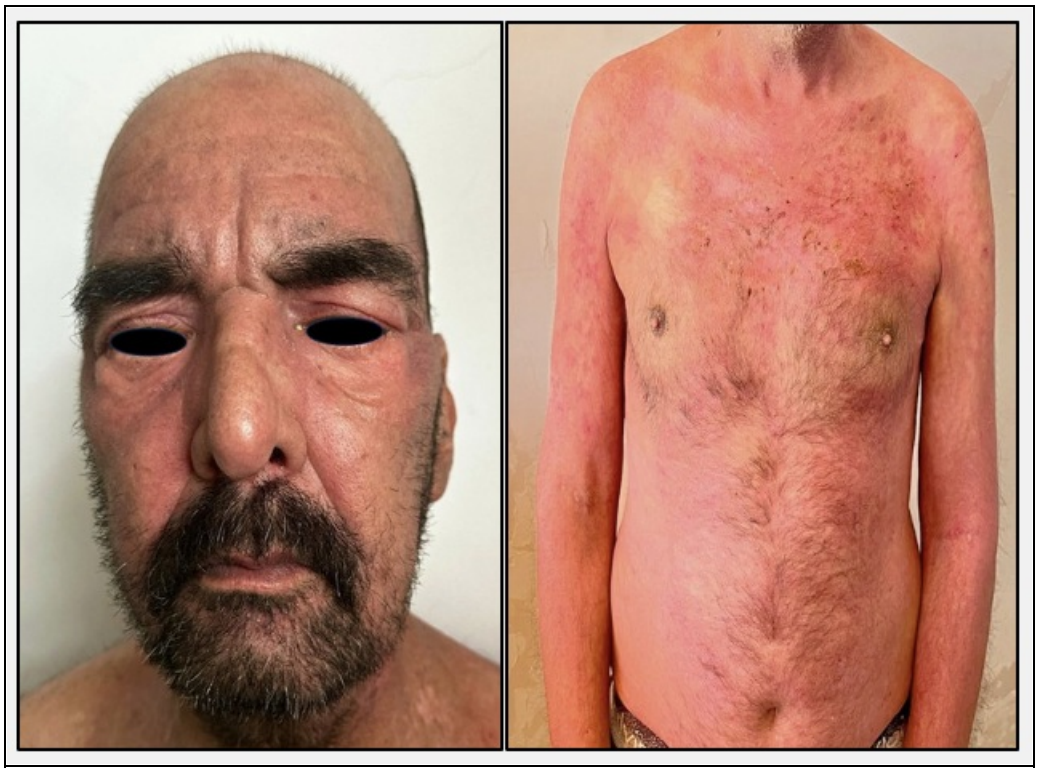
[1]Chu Mohammed VI Marrakech, Dermatology and Venerology, Marrakech, Morocco

Introduction

Dermatomyositis (DM) is a rare autoimmune disease characterized by mainly skin involvement, but which also affects the muscles. It can be associated with an underlying malignant tumor, thus serving as a paraneoplastic marker. Nasopharyngeal carcinoma (NPC) is a malignant tumor that is particularly prevalent in East Asia. We report a rare case of DM revealing NPC.

Materials and Methods

A 60-year-old man of North African origin was referred for dermatological lesions associated with dysphagia to solids. Clinical examination revealed heliotrope erythema on the face, shawl erythema on the abdomen and hands, and a manicure sign. Neurological examination revealed proximal muscle fatigue with a positive stool sign. Laboratory tests revealed an increase in muscle enzymes to 11 times the normal level, and EMG showed myogenic syndrome. Dysphagia and paraneoplastic testing revealed a nasopharyngeal mass, which biopsy confirmed as undifferentiated nasopharyngeal carcinoma (UCNT). The patient was placed on prednisone 1mg/kg/day and hydroxychloroquine 400mg/day. For his UCNT, he was placed on radio-chemotherapy. The course of the disease was marked by skin and muscle improvement and tumor remission.



Clinical photos illustrating erythema of the face and on the abdomen and the shawl sign

Results

Various malignant tumors have been described in relation to DM, including NPC, adenocarcinoma of the lung, breast, pancreas, stomach, colon, and ovary. 15 to 24% of DM cases are thought to reveal underlying cancer. A screening panel is used, including tumor markers (CA125, CA19-9, carcinoembryonic antigen, and prostate-specific antigen) and other tests such as mammography and transvaginal ultrasound. NPC is a rare malignant squamous cell tumor, and although it is one of the tumors most commonly associated with DM, its prevalence in DM remains unknown as prevalence rates vary between studies. The incidence of DM associated with NPC is rare, estimated at 1/1000 cases, but this association is thought to be more common in countries where SCC is endemic. This link between NPC and DM suggests that SCC may increase susceptibility to DM, while DM may serve as a predictive marker for NPC. Patients with DM associated with NPC generally present with skin changes followed by proximal muscle weakness, which is the case for our patient. Corticosteroids and immunosuppressants are the standard treatment for DM, with prednisone used at a dose of 1mg/kg/day. Cancer-associated myopathies are generally more resistant to treatment and have a poorer prognosis than non-cancer-related myopathies.

Conclusions

NPC associated with DM is a rare entity. We report a case of DM that revealed NPC, highlighting the importance of rigorous diagnostic and therapeutic approaches when dealing with these rare associations.

Abstract N°: ID-1188

Topic: Autoimmune disorders

Lupus panniculitis in a young patient associated with COVID-19 vaccination: a diagnostic challenge

Ioana Rățoiu*[1], Miruna Ioana Cristescu[1], Diana-Elena Gosav[1], Irina Tudose[1], Vlad-Mihai Voiculescu[1, 2]

[1]Elias Emergency University Hospital, Dermatology, Bucharest, Romania
[2]"Carol Davila" University of Medicine and Pharmacy, Bucharest, Romania

Introduction

Panniculitis represents a heterogeneous group of inflammatory disorders involving the subcutaneous adipose tissue, characterized by variable etiologies, clinical presentations and histopathological findings. Lupus panniculitis is a rare manifestation within the spectrum of chronic cutaneous lupus erythematosus and may pose significant diagnostic challenges due to its overlap with other inflammatory and sclerosing conditions of the hypodermis. In recent years, sporadic reports have described inflammatory and autoimmune-mediated cutaneous reactions occurring after COVID-19 vaccination. We report the case of a young female patient who developed chronic panniculitis with clinical, immunological and histopathological features suggestive of lupus panniculitis, with onset reported shortly after mRNA COVID-19 vaccination.

Materials and Methods

We present the case of a 23-year-old female patient, smoker, with a history of polycystic ovary syndrome and osteopenia, with no prior autoimmune disease, who reported the appearance of a painful, indurated erythematous plaque on the lateral aspect of the right upper arm in 2022, shortly after the second dose of mRNA COVID-19 vaccine, followed by progressive evolution toward atrophy.

Evaluation included repeated clinical examinations, laboratory investigations and imaging studies. Dermatological exam revealed a poorly demarcated, painful, indurated, atrophic plaque located on the lateral aspect of the right upper arm, with hyperpigmented borders and a central ivory-white area, associated with progressive skin retraction and cicatricial changes; a visible reduction in arm diameter due to extensive loss of fat tissue was also noted at this level, accompanied by functional impairment, especially of the triceps muscle. A discreet atrophic plaque was also observed in the right malar region. Based on the clinical aspect, differential diagnoses considered included lupus panniculitis, localized scleroderma, traumatic panniculitis, subcutaneous panniculitis-like T-cell lymphoma, and dermatomyositis-associated panniculitis. Blood tests revealed persistent antinuclear antibody positivity, weakly positive anti-SS-A and anti-Ro52 antibodies and strong positivity for DFS70 antibodies. Inflammatory markers were mildly elevated. Soft tissue ultrasound of the affected arm demonstrated localized atrophic changes of the subcutaneous tissue. A skin biopsy performed in 2023 initially described lobular panniculitis and was subsequently subjected to histopathological reevaluation in 2025.

Results

Histopathological reevaluation demonstrated features consistent with mixed panniculitis, predominantly lobular, without evidence of vasculitis, lymphoid follicle formation or fungal elements. Correlating the morphology and localisation of the lesions, the chronic clinical course, immunological profile and histopathological findings, a diagnosis of lupus panniculitis was established.

Systemic treatment with glucocorticoids followed by hydroxychloroquine resulted in a moderately favorable evolution, characterized by stabilization of lesion progression and partial improvement of pain and inflammatory activity. Additional management included topical corticosteroids, emollients and initiation of medical rehabilitation procedures aimed at improving upper limb functionality.

Conclusions

This case illustrates a rare presentation of lupus panniculitis in a young patient, with disease onset reported after mRNA COVID-19 vaccination. Although a causal relationship cannot be established, this unusual association highlights the importance of comprehensive clinical, immunological and histopathological evaluation of chronic panniculitis. Increased awareness of such presentations may facilitate earlier diagnosis, appropriate management and improved patient outcomes.

Abstract N°: ID-1208

Topic: Autoimmune disorders

YKL-40 expression in lichen planus

Reham Doss*[1], Mona Abdellatif[1]

[1]Beni Suef University, New Beni Suef, Egypt

Introduction
Lichen planus (LP) is an idiopathic chronic inflammatory disease of the skin, mucous membranes, and nails. The exact pathogenesis of LP is still unclear. YKL-40 is one of the 18 glycosyl hydrolases, but lacks enzymatic activity. Recent studies have shown that YKL-40 is present at sites of inflammation and tissue remodeling, triggers immune responses, and attracts eosinophils and T cells.

Materials and Methods
This case–control study included 30 cutaneous LP patients and 30 healthy volunteers serving as controls. About 4-mm punch-skin biopsies were taken from skin lesions in LP patients and healthy skin from controls. Skin biopsies were examined for YKL-40 using PCR technique.

Results
The expression of YKL-40 in LP lesions (5.12±1.02 pg/ml) was significantly higher than their expression in control-tissue biopsies (1.02±0.05 pg/ml) (F<0.001). No significant relation was detected between the expression of YKL-40, type of LP, and the disease duration.

Conclusions
upregulation of YKL-40 could point to a possible role in the pathogenesis of LP.

Abstract N°: ID-1231

Topic: Autoimmune disorders

Pemphigoid Gestationis in a Patient with Celiac Disease: Association or Coincidence?

Kenza Benothmane*[1], Nouha Touhami[1], Yasmine Zekraoui[1], Narjess Errachdy[1], Najoua Ammar[1], Syrine Hamada[1], Mariame Meziane[1], Nadia Ismaili[1], Laila Benzekri[1]

[1]Ibn Sina University Hospital Center, Rabat, Rabat, Morocco

Introduction

Pemphigoid gestationis (PG) is a rare autoimmune subepidermal blistering disease of pregnancy driven by autoantibodies against BP180. Celiac disease (CD) is an autoimmune enteropathy confirmed by serology and duodenal biopsy, and may involve systemic immune activation beyond the gut. Co-occurrence of PG and CD is rarely reported. We present a case of PG arising during pregnancy in a woman with established CD, notable for tapering-dependent relapses and a postpartum flare.

Materials and Methods

A 38-year-old woman at 29 weeks' gestation, with a 2-year history of CD controlled on a strict gluten-free diet (serology- and biopsy-confirmed), developed a one-month intensely pruritic eruption starting as periumbilical erythematous papules and rapidly evolving into urticarial plaques and tense serous bullae involving the trunk and limbs, with palmoplantar extension.
Histology showed a subepidermal split with an eosinophil-rich infiltrate. Direct immunofluorescence demonstrated linear IgG and C3 deposition along the basement membrane zone. Anti-BP180 ELISA was positive (8.8; laboratory cut-off >0.5).

Oral corticosteroids were initiated at 0.5 mg/kg/day with partial response, requiring escalation to 0.7 mg/kg/day for improved disease control. The patient experienced recurrent relapses during tapering; corticosteroids were maintained until clinical improvement and then gradually tapered. Delivery occurred at 39 weeks by caesarean section. The newborn was in good condition with no neonatal blistering. A postpartum flare occurred and was controlled with oral corticosteroid therapy.

Results

This case is relevant for both pathophysiology and practice. First, it illustrates the concept of **autoimmune clustering**: patients with one organ-specific autoimmune disease such as CD may be predisposed to additional antibody-mediated disorders, including PG. A plausible explanation is a shared immunogenetic background and heightened systemic immune reactivity that may facilitate BP180-directed autoantibody responses during pregnancy.
Second, it underlines a key management challenge: PG commonly relapses during tapering and may flare postpartum. In a patient with autoimmune comorbidity, clinicians should anticipate the need for **early treatment optimization, slower tapering**, and close dermatology–obstetric follow-up, while monitoring maternal and neonatal outcomes.

Conclusions

We report immunopathologically confirmed PG in a pregnant woman with confirmed celiac disease, characterized by tapering-dependent relapses and postpartum exacerbation. Further case reporting is needed to clarify whether CD is

associated with a more recalcitrant PG phenotype and to refine management strategies.

Abstract N°: ID-1234

Topic: Autoimmune disorders

Deep morphea of the scapular region with diffuse non-fungal leukonychia: a clinicopathologic case and practical nail pitfall

Kenza Benothmane*[1], Sihame Alaoui[1], Yasmine Zekraoui[1], Narjess Errachdy[1], Najoua Ammar[1], Syrine Hamada[1], Mariame Meziane[1], Nadia Ismaili[1], Laila Benzekri[1]

[1]Ibn Sina University Hospital Center, Rabat, Rabat, Morocco

Introduction
Deep morphea is a localized scleroderma subtype involving the deep dermis and subcutis, potentially causing functional impairment. Diffuse nail whitening is frequently misinterpreted as onychomycosis, leading to unnecessary antifungal therapy.

Materials and Methods
A 40-year-old woman presented with a left scapular lesion evolving from swelling to a mildly sclerotic atrophic plaque (~4 cm) with functional impact (upper-limb strength 4/5). There were no clinical features of systemic sclerosis and autoantibodies were negative. Skin biopsy showed thickened collagen bundles in the dermis and hypodermis, with vessels displaying thickened walls and narrowed lumina, variably surrounded by a mononuclear leukocytic infiltrate—findings consistent with deep morphea. Systemic treatment (methotrexate and oral corticosteroids) resulted in clinical stabilization of the plaque.

Subsequently, the patient developed diffuse leukonychia of all toenails with onycholysis. Two consecutive mycological examinations were negative and there was no history of repetitive trauma.

Results
This case highlights two practical points. First, deep morphea may present with functional symptoms and requires clinicopathologic correlation and targeted work-up to exclude systemic disease. Second, diffuse leukonychia/onycholysis in an immunomodulated patient should not be assumed to be fungal: a negative mycology supports a non-infectious nail dystrophy and helps avoid inappropriate antifungals. A temporal relationship with immunosuppressive therapy may be discussed, but causality cannot be inferred.

Conclusions
Deep morphea can be functionally relevant. Diffuse toenail leukonychia warrants systematic mycological testing and consideration of non-fungal causes, particularly in patients receiving systemic therapy.

Abstract N°: ID-1253

Topic: Autoimmune disorders

Lichen Sclerosus- a registry study

Leonie Kahlert*[1], Sarah Heyer[1], Katharina Tropschuh[2], Tilo Biedermann[1], Alexander Zink[1]

[1]Technical University of Munich, Klinikum Rechts der Isar, Dermatology and Allergy, Munich, Germany
[2]Technical University of Munich, Klinikum Rechts der Isar, Gynaecology, Munich, Germany

Introduction

Lichen sclerosus (LS) is a chronic inflammatory skin disease. It is characterised by atrophy and scarring of the vulva or penis, which can progress to introital stenosis. It is also associated with a higher risk of genital squamous cell carcinoma. Adult women are most commonly affected, less frequently also men and children. Symptoms include pruritus, burning, dysuria and dyspareunia.

Materials and Methods

The aim of this cross-sectional study is to create a clinical registry to examine the impact of LS on quality of life and to record sociodemographic and clinical characteristics of those affected. Five questionnaires, among them the Dermatology Life Quality Index (DLQI), and a clinical score are used. In several cases the skin condition is also recorded with photographic documentation. Men and women aged 18 and over with a diagnosis of LS (clinical and/or histological) are included. The study is being conducted since May 2025 and is scheduled to continue until the end of May 2026.

Results

To date, 85 patients have been included (88% female, mean age 55 years (SD 15.6 years)). The average age at onset of the disease was 46 years old (SD 17.5). The first contact with a doctor took place 42 weeks (SD 94.5) after first symptoms appeared. The correct diagnosis of LS was made on average 3.9 years (SD 6.3 years) after onset of symptoms.

In 72% of the cases, initial contact with a doctor was with a gynaecologist, 19% with a dermatologist and 8% with other specialists or general practitioners. Regarding the first contact, 41% received the correct diagnosis of LS, 21% received a diagnosis of vaginal candidiasis and 38% received a different diagnosis (e.g. cystitis or dry skin), or none at all.

On the visal analogue scale (VAS), the mean values were 2.5 (SD 2.7) for itching, 2.5 (SD 3.0) for burning, 2.2 (SD 2.4) for pain and 1.3 (SD 2.3) for sleep disturbances. The mean DLQI score was reported as 7.8 (SD 6.4). 75% of sexually active participants reported having experienced an impairment of their sexual life during the last 7 days. Furthermore, 60% claimed a disease-related strain on their partnership.

Satisfaction with healthcare regarding LS was 6.4 out of 10 (SD 2.6).

Conclusions

The results show a significant delay between the onset of symptoms and the diagnosis of LS. Many affected individuals initially receive an incorrect diagnosis or no diagnosis at all, which delays adequate treatment. Despite medical care,

relevant symptoms and a moderate reduction in quality of life persist. Satisfaction with medical care is moderate. These results underscore the need for earlier diagnosis and improved education and awareness in clinical practice.

Abstract N°: ID-1256

Topic: Autoimmune disorders

Acute pediatric lupus mimicking varicella complicated by orbital cellulitis: a diagnostic pitfall

Romaissaa Boufetama*[1], Kawtar Diaa[1], Fatima Zahra Sassine[1], Narjess Er-Rachdy[1], Najoua Ammar[1], Syrine Hamada[1], Nadia Ismaili[1], Laila Benzekri[1], Mariame Meziane[1]

[1]Mohammed V University / Ibn Sina University Hospital (CHU Ibn Sina), Department of Dermatology, Dermatology, Rabat, Morocco

Introduction

In children, systemic lupus erythematosus represents a formidable clinical mimicker, capable of imitating common viral or bacterial infections. When it initially presents with isolated cutaneous and mucosal manifestations without obvious visceral involvement, it may easily be mistaken for benign conditions, leading to diagnostic delay.

We report a case of acute pediatric lupus mimicking varicella complicated by orbital cellulitis, illustrating a classic yet challenging diagnostic pitfall. This case highlights the need for a high index of suspicion in the presence of atypical febrile eruptions.

Materials and Methods

N/A

Results

A 12-year-old girl with no significant medical history was admitted for a febrile eruption evolving over twelve days. The eruption initially involved the face and progressively spread to the trunk and upper limbs. Outpatient treatment with amoxicillin–clavulanic acid and antihistamines was prescribed without clinical improvement.

The clinical course was marked by bilateral facial and eyelid edema associated with fever (38.5°C). Physical examination revealed malar erythema covered by vesicles and honey-colored crusts, target-like lesions on the trunk and back, confluent purpura on the limbs, digital pulpitis, and oral erosions with cheilitis. Painful bilateral cervical lymphadenopathy was also noted.

Laboratory investigations showed pancytopenia (hemoglobin: 10 g/dL, leukocytes: 3400/mm^3, platelets: 99,000/mm^3). Cervicofacial CT scan demonstrated bilateral preseptal orbital cellulitis (Chandler stage I) without abscess formation. Ophthalmological examination was normal in the left eye but difficult to perform in the right eye due to marked edema.

Given the atypical progression and lack of response to anti-infective therapy, an autoimmune workup was performed and revealed positive antinuclear antibodies (ANA) and anti–double-stranded DNA antibodies. Skin biopsy and direct immunofluorescence findings were consistent with acute lupus erythematosus.

Conclusions

Pediatric systemic lupus erythematosus, although uncommon, represents a major diagnostic challenge due to its misleading initial presentations. In children, clinical expression may be dominated by isolated cutaneous and mucosal signs mimicking frequent infectious conditions, increasing the risk of delayed diagnosis.

Our observation highlights a particularly misleading presentation in which acute lupus manifested as a vesiculocrusted

eruption suggestive of varicella combined with orbital edema suggestive of bilateral preseptal cellulitis. This dual diagnostic misdirection emphasizes the ability of lupus to masquerade as apparently benign conditions, especially in the absence of overt systemic involvement.

This case underscores the importance of not limiting diagnostic reasoning to infectious etiologies in the presence of atypical febrile eruptions, particularly when associated with hematological or mucosal abnormalities. Early recognition of subtle signs such as digital pulpitis, confluent purpuric lesions, or oral erosions, combined with targeted immunological testing, allows rapid reorientation toward an autoimmune etiology.

Pediatric lupus erythematosus may present with misleading initial manifestations mimicking common infectious diseases. This case emphasizes the importance of heightened clinical vigilance when evaluating atypical febrile eruptions in children in order to reduce diagnostic delay and ensure timely specialized management.

Abstract N°: ID-1259

Topic: Autoimmune disorders

A Turning Point in Refractory Pemphigus Vulgaris: The Role of Rituximab in Severe Pemphigus Vulgaris with Long-Term Corticosteroid Toxicity

Maria Dragomir*[1], Carmen Curea[1], Alexandra Alexe[1], Bianca Ivascu[1], Anca Popescu[1]

[1]Colentina Clinical Hospital, Dermatovenerology, IInd Department of Dermatovenerology, Bucharest, Romania

Introduction

Pemphigus vulgaris (PV) is a rare, chronic, potentially life-threatening autoimmune blistering disease caused by autoantibodies against desmogleins (Dsg3 and Dsg1) affecting the skin and the mucous membranes. Although mortality rates for PV decreased significantly after the introduction of systemic corticosteroids and immunosuppressants, management of refractory disease remains challenging, particularly in patients with severe corticosteroid-related adverse effects. Biologic therapy comes to the rescue with Rituximab (anti-CD20 monoclonal antibody) providing PV patients with long term remissions and disease-modifying effects. We report a case of severe pemphigus vulgaris resistant to conventional therapies, aggravated after vertebral surgery for corticosteroid-induced fragility fracture, highlighting the therapeutic role of Rituximab (RTX).

Materials and Methods

We present the case of a 54-year-old woman with a 4-year history of PV (histologically and direct immunofluorescence confirmed) without other comorbidities, admitted for a severe generalized bullous eruption. Clinical findings included widespread flaccid blisters, post-bullous erosions, extensive post-inflammatory hyperpigmentation (PDAI= 80) and painful ulcerations of the oral mucosa, significantly impairing swallowing and speech. The disease worsened markedly over the preceding three months following vertebral cement augmentation surgery performed for a corticosteroid-induced vertebral fragility fracture.

At admission, the patient also exhibited clinical stigmata of long-term systemic corticosteroid therapy, including facial erythema, moon facies, dorsocervical fat pad (“buffalo hump”), red striae on the trunk and hypertrichosis. She reported profound weight loss (>10 kg in one month), fatigue, palpitations, insomnia and severe impairment of quality of life, being unable to work (DLQI= 25).

Previous therapies included systemic corticosteroids, azathioprine and repeated plasmapheresis sessions (2–3 per year), which resulted only in transient improvement without sustained remission. Maintenance therapy with low-dose methylprednisolone, azathioprine and nicotinamide was discontinued due to corticosteroid-related complications, leading to disease exacerbation.

Given refractoriness to conventional therapy and cumulative adverse effects, Rituximab was initiated according to the international guidelines. The patient received two intravenous infusions of RTX 1 g, administered two weeks apart, during a 30-day inpatient stay.

Results

One week after the second RTX infusion, partial clinical remission was observed with marked reduction of new blisters and improvement of mucosal lesions. At three month follow-up, the patient achieved further disease control, with resolution of active lesions and persistence only of post-inflammatory hyperpigmentation. Corresponding clinical severity (PDAI=11) and (DLQI= 4) scores showed marked improvement. Maintenance therapy with RTX 1 g was initiated at month 6, with planned infusions at 12 and 18 months and every six months thereafter, according to clinical response.

No adverse events were reported.

Conclusions

This case highlights the therapeutic challenges posed by severe, refractory pemphigus vulgaris in a patient exposed to prolonged systemic corticosteroid therapy and its associated complications. The occurrence of corticosteroid-induced vertebral fragility fracture further limited the use of conventional immunosuppressive regimens and contributed to disease exacerbation. Rituximab demonstrated a favorable safety profile and resulted in rapid and sustained clinical improvement, with reduction of disease activity and substantial restoration of quality of life. These findings support the role of RTX as an effective disease-modifying therapy in refractory PV and emphasize the importance of early biologic intervention to minimize cumulative corticosteroid toxicity and prevent irreversible treatment-related morbidity.

Abstract N°: ID-1284

Topic: Autoimmune disorders

Clinical, serological and flowcytometric predictors of pemphigus relapse after rituximab: A retrospective study

Simone Liguori*[1], Francesca D'elia[1], Dario Didona[2], Maddalena Raia[3], Michele Davide Mignogna[1], Stefania Leuci[1]

[1]University of Naples Federico II, Department of Neuroscience, Reproductive and Odontostomatological Sciences, Naples, Italy
[2]Istituto Dermopatico dell'Immacolata-IRCCS, Rare Skin Diseases Center, Rome, Italy
[3]Centre for Advanced Biotechnology Franco Salvatore, Naples, Italy, Clinical and Experimental Cytometry Unit, Naples, Italy

Introduction
Rituximab (RTX) has significantly improved pemphigus vulgaris (PV) management. Nonetheless, the risk of post-RTX flare is high. This study aimed to identify clinical, serological, and immunological predictors of relapse after RTX therapy.

Materials and Methods
Forty-four PV patients treated with RTX were enrolled. Baseline clinical characteristics were collected and anti-Dsg antibodies levels were evaluated before and after therapy. Peripheral blood flowcytometry was used to assess CD20+ and CD4+ cell frequencies at baseline, at 3-month intervals until B-cell repopulation, at B-cell repopulation time, at 6 and 12 months after repopulation and at the end of follow-up or at relapse.

Results
Relapsing patients reported lower levels of CD4+ cells at B-cell repopulation time and increasing post-repopulation T-cell values compared to patients experiencing remission. Post-RTX T-cell course was found to correlate with anti-Dsg antibodies titers with the maximum increase of anti-Dsg3 value coinciding with the peak in CD4+ T-cell frequency. Additionally, patients initially responding to conventional immunosuppressants reported higher CD4+ T-cell levels both at baseline and at B-cell repopulation time and a significantly lower risk of post-RTX relapse.

Conclusions
Post-RTX CD4+ T-cell values were found to predict patients' clinical response and to correlate with autoantibodies levels. Flowcytometric T-cell immunophenotyping could be proposed as an additional prognostic marker.

Abstract N°: ID-1292

Topic: Autoimmune disorders

Real-World Psychiatric Outcomes in Pemphigus: Rituximab vs. Conventional Immunosuppression

Justin Baroukhian*[1], Kristina Seiffert-Sinha[1], Animesh Sinha[1]

[1]Jacobs School of Medicine & Biomedical Sciences, Dermatology, Buffalo, United States

Introduction
Emerging evidence across multiple immune-mediated disorders including rheumatoid arthritis and hidradenitis suppurativa have shown that disease-targeted biologic therapies decrease the risk of downstream psychiatric morbidity. Analogous evidence regarding treatment-specific effects on subsequent psychiatric disease risk is lacking in pemphigus. To address this gap, we analyzed de-identified electronic medical record data to evaluate the risk of incident psychiatric disease following the initiation of mechanistically-distinct, mutually exclusive systemic treatment regimens among pemphigus patients.

Materials and Methods
Within the TriNetX Global Collaborative Network, we identified adults with ≥2 instances of ICD-10 codes for any subtype of pemphigus and excluded any individuals with codes for bullous pemphigoid. Two mutually exclusive exposure cohorts were then assembled: a rituximab (RTX)-only cohort (RTX exposure with no record of exposure to any other systemic immune-directed agents, e.g. mycophenolate, azathioprine, IVIg, etc.) and a conventional-therapy cohort (≥1 traditional systemic immunosuppressant with no exposure to RTX). Systemic glucocorticoids were permitted in both. After 1:1 propensity-score-matching for demographic factors, baseline substance use, known pemphigus trigger factors (HSV 1/2 infections), obesity, and exposure to systemic corticosteroids, each cohort comprised n=902 patients.

Results
RTX-only exposure was associated with a significantly lower risk of incident diagnoses of anxiety-spectrum nonpsychotic disorders (e.g. GAD, OCD, dissociative and somatoform disorders) [RR 0.779, (0.665–0.915)]. Furthermore, RTX-only exposure was also associated with a significantly lower risk of incident diagnoses of the “reaction to severe stress and adjustment disorders” group of psychiatric diseases (e.g. PTSD) [RR: 0.471, (0.262–0.847)]. Both associations remained significant after Benjamini-Hochberg correction for multiple hypothesis testing. By contrast, there were no significant differences between cohorts in subsequent mood/affective disorders [RR 0.723, (0.479–1.090)] or substance use disorders [RR 0.917, (0.571–1.472)]. As expected, no significant differences were observed between cohorts for our falsification endpoints: hernia [RR 0.697, (0.430–1.132)] and chronic obstructive pulmonary disease (COPD) [RR 0.586, (0.288–1.192)].

Conclusions
These findings mirror trends in other autoimmune conditions wherein targeted biologic therapy is associated with reduced subsequent psychiatric morbidity. Whether this reflects improved disease control, attenuated inflammatory burden, or altered patient experience of illness warrants further investigation. Recognizing mental-health benefit as a measurable therapeutic outcome may refine treatment selection and better align pemphigus care with patient priorities.

Abstract N°: ID-1360

Topic: Autoimmune disorders

A Systematic Review of Case Series and Clinical Trials Investigating Regenerative Medicine for the Treatment of Vitiligo

Alireza Jafarzadeh*[1]

[1]Iran University of Medical Sciences, Tehran, Iran

Introduction
Vitiligo is a chronic autoimmune disorder that leads to depigmented patches on the skin. While various treatment modalities have been proposed over the years, their efficacy and recurrence rates vary. Regenerative medicine, including cell therapy, platelet-rich plasma (PRP), and stem cell therapies, has gained significant attention for its potential in treating vitiligo. This systematic review explores the efficacy, safety, and patient outcomes of regenerative medicine approaches for vitiligo.

Materials and Methods
A comprehensive search was conducted across major databases, including PubMed, Scopus, and Web of Science, to identify studies involving regenerative treatments for vitiligo. Fifty-four studies were reviewed, including randomized clinical trials, case series, and open-label studies. The primary focus was on the use of stem cell-derived therapies, PRP, and melanocyte-keratinocyte transplantation. Data was extracted on treatment modalities, repigmentation rates, and side effects. Risk of bias was assessed using the Cochrane Risk of Bias 2.0 tool.

Results
Out of the 48 included studies involving 2186 patients, regenerative treatments such as autologous melanocyte-keratinocyte transplantation and PRP injections showed significant repigmentation, particularly when combined with phototherapy. The average repigmentation rate for PRP was 58.7%, and for melanocyte-keratinocyte transplantation, it was over 50%. Other regenerative methods, including adipose-derived stem cells and exosomes, also demonstrated promising outcomes, though the evidence for these methods remains less robust. Side effects such as pain were reported in 21 studies, though no serious adverse events were observed. The risk of bias was moderate across the studies, with many lacking long-term follow-up data.

Conclusions
Regenerative medicine represents a promising approach to treating vitiligo, with autologous melanocyte-keratinocyte transplantation and PRP emerging as the most effective treatments. While these therapies show significant potential, further clinical trials with larger sample sizes and standardized protocols are needed to confirm long-term efficacy and safety. Regenerative treatments could be used as monotherapy or in combination with traditional treatments to enhance outcomes for vitiligo patients.

Abstract N°: ID-1369

Topic: Autoimmune disorders

Biologic therapies in autoimmune blistering diseases: current evidence and future directions

Sofiia Tymchuk*[1]

[1]Saint-Petersburg State University, Medical faculty, Department of Dermatovenerology, and Cosmetology, Saint-Petersburg, Russian Federation

Introduction
Autoimmune blistering diseases (AIBDs) are rare, chronic, and potentially life-threatening conditions that significantly impair patients' quality of life. Conventional therapies, such as systemic corticosteroids and immunosuppressants, often achieve disease control but are associated with considerable toxicity and relapses. The emergence of biologic therapies has started to redefine treatment standards in AIBDs, offering targeted, more effective, and safer alternatives.

Materials and Methods
A structured search and analysis of original research articles, systematic reviews, and clinical guidelines published between 2019 and 2024 was conducted using PubMed, ScienceDirect, Scopus, and Elsevier databases. The focus was placed on efficacy, safety, and clinical applicability of novel biologic agents in the management of pemphigus vulgaris, bullous pemphigoid, and other AIBDs.

Results
Rituximab has become the gold standard for pemphigus, showing high remission rates and superior steroid-sparing effects compared with conventional therapy. In bullous pemphigoid, biologics such as omalizumab, dupilumab, and emerging anti-FcRn agents demonstrate promising efficacy and favorable safety, particularly in refractory cases. Early-phase studies on complement inhibitors and JAK inhibitors highlight new therapeutic directions. Despite encouraging results, treatment access, long-term safety data, and head-to-head comparisons remain limited.

Conclusions
Biologic therapies are transforming the therapeutic landscape of AIBDs, shifting from broad immunosuppression toward precise immune modulation. These advances hold the potential to improve outcomes and reduce treatment-related morbidity. However, multicenter randomized controlled trials and international consensus are urgently needed to establish evidence-based guidelines and optimize patient care.

Abstract N°: ID-1370

Topic: Autoimmune disorders

Cutaneous lupus-dermatomyositis overlap: diagnostic pitfalls and therapeutic challenges

Sofiia Tymchuk*[1]

[1]Saint-Petersburg State University, Medical faculty, Department of Dermatovenerology, and Cosmetology, Saint-Petersburg, Russian Federation

Introduction

The overlap between cutaneous lupus erythematosus (CLE) and dermatomyositis (DM) represents a rare but clinically significant phenomenon, affecting fewer than 5% of patients with autoimmune myopathies and cutaneous autoimmune disorders. These cases illustrate a diagnostic and therapeutic grey zone, where heterogeneous presentations and the lack of consensus criteria create substantial uncertainty in clinical practice.

Materials and Methods

A structured review was conducted using PubMed, Scopus, ScienceDirect, and Elsevier databases, focusing on original research and reviews published between 2018 and 2023. Studies addressing clinical features, immunological profiles, and therapeutic approaches in CLE–DM overlap were included.

Results

Evidence highlights three major challenges in overlap patients: atypical serological profiles (anti-Mi-2, anti-MDA5, ANA),blended cutaneous features (discoid lesions with heliotrope rash, photosensitivity, vasculitis), reduced responsiveness to conventional regimens (glucocorticoids, hydroxychloroquine). Management frequently requires combination therapy (methotrexate, mycophenolate mofetil, azathioprine). Recent reports also point to emerging benefits of biologics, including rituximab and JAK inhibitors, in refractory disease.

Conclusions

CLE–DM overlap remains a diagnostic and therapeutic grey zone in dermatology and rheumatology. Early recognition is crucial for accurate risk stratification, timely multidisciplinary involvement, and the implementation of targeted therapies. Consensus-driven guidelines and multicenter studies are urgently needed to provide clarity and improve outcomes for this challenging patient group.

Abstract N°: ID-1404

Topic: Autoimmune disorders

Bullous pemphigoid associated with rapidly progressive acute kidney injury: a rare concomitant presentation

Mohamed Houbayeli*[1], Layla Bendaoud[1], Nouhaila Bourht[1], Maryem Aboudourib[1], Ouafa Hocar[1], Said Amal[1]

[1]Mohammed VI University hospital of Marrakech, Bioscience and health laboratory, Dermatology-Venerology, MARRAKECH, Morocco

Introduction

Bullous pemphigoid (BP) is the most common autoimmune subepidermal blistering disease, mainly affecting elderly patients. It is characterized by autoantibodies directed against hemidesmosomal proteins of the basement membrane zone. BP is usually confined to the skin; however, rare systemic associations have been described. The concomitant occurrence of BP and acute kidney injury (AKI), particularly with rapid progression, remains uncommon and poorly documented.

Materials and Methods

A 60-year-old man with a recent diagnosis of arterial hypertension was hospitalized in the nephrology department for rapidly progressive acute kidney injury. Dermatological consultation was requested for a diffuse pruritic bullous eruption evolving for two weeks, associated with asthenia and impaired general condition. A history of medicinal plant intake was reported two months earlier.

Cutaneous examination revealed multiple urticarial plaques and tense bullae filled with clear or hemorrhagic fluid, predominantly involving the trunk and limbs. Nikolsky sign was positive on plaques. Secondary lesions consisted of post-bullous erosions, hemorrhagic crusts, and excoriations. Mucosal involvement was absent.

Laboratory investigations showed normocytic normochromic anemia, inflammatory syndrome, and acute renal failure. Autoimmune work-up, including antinuclear antibodies, anti-double stranded DNA, ANCA (anti-MPO and anti-PR3), and anti-glomerular basement membrane antibodies, was negative, with normal complement levels.

Skin biopsy demonstrated a subepidermal blister with an eosinophil-rich inflammatory infiltrate. Direct immunofluorescence revealed linear granular IgG (+++) deposits along the basement membrane zone, confirming the diagnosis of bullous pemphigoid. Renal biopsy was performed but was non-conclusive.

Results

Renal involvement is not considered a classical manifestation of bullous pemphigoid. Unlike systemic autoimmune diseases such as lupus or vasculitis, BP rarely presents with kidney disease. Only isolated cases of BP associated with renal impairment have been reported, often related to drug exposure, systemic inflammation, or paraneoplastic contexts. In the present case, extensive immunological investigations were negative, and renal biopsy failed to identify a specific immune-mediated nephropathy, suggesting a functional or inflammatory mechanism rather than direct autoimmune renal involvement.

The temporal association between the onset of BP and rapidly progressive AKI raises the hypothesis of a shared trigger, including drug exposure or medicinal plant intake. Management was challenging, as systemic corticosteroids are the cornerstone of BP treatment but require careful consideration in patients with renal impairment, highlighting the importance of multidisciplinary management.

Conclusions

This case illustrates a rare concomitant presentation of bullous pemphigoid and rapidly progressive acute kidney injury with a non-conclusive renal biopsy. Awareness of such associations is essential to optimize diagnostic evaluation and therapeutic decisions. Multidisciplinary collaboration is crucial, and further studies are needed to clarify the pathophysiological links between bullous pemphigoid and renal involvement

Abstract N°: ID-1420

Topic: Autoimmune disorders

Lupus Profundus Mimicking Parry–Romberg Syndrome: A Case Report

Diana Dinulescu*[1], Livia Băicoianu-Nițescu[1], Corina Ionescu[1], Ioana Stoenica[1], Alexandra Roman[1], Andreea Radu[1], Ana-Maria Forsea[1], Florica Șandru[1]

[1]Carol Davila University of Medicine and Pharmacy, Elias Emergency University Hospital, Dermatologic Oncology, Dermatology, Bucharest, Romania

Introduction

Lupus profundus (lupus panniculitis) is a rare variant of chronic cutaneous lupus erythematosus characterized by lobular inflammation of the subcutaneous adipose tissue, potentially leading to fibrosis, tissue retraction, and permanent atrophy. Facial involvement is uncommon and may clinically mimic other causes of progressive hemifacial atrophy, particularly Parry–Romberg syndrome. In this case, Parry–Romberg syndrome was considered due to the progressive unilateral facial atrophy; however, the presence of active inflammatory changes and histopathologic findings typical of lupus profundus, together with the patient's late age of onset, excluded this diagnosis. We report a case of facial lupus profundus presenting with progressive hemifacial atrophy in the absence of systemic lupus erythematosus.

Materials and Methods

A 54-year-old woman with a long-standing history of epilepsy treated with carbamazepine and lamotrigine for approximately 40 years and controlled hypertension presented with a progressive erythematous-cicatricial plaque involving the left hemiface. The lesion was associated with telangiectasias, marked subcutaneous tissue retraction, and extension to the lateral cervical region, with an evolution of approximately 1.5 years. Dermatological evaluation was followed by laboratory investigations including antinuclear antibodies (ANA), anti-SSA/Ro antibodies, complement levels (C3, C4), and 24-hour urine protein assessment. Imaging studies and a deep skin biopsy from the atrophic plaque were performed. Direct immunofluorescence was not performed. No temporal relationship was identified between lesion onset and antiepileptic therapy.

Results

Clinical examination revealed an erythematous-cicatricial plaque on the left hemiface with pronounced subcutaneous atrophy, telangiectasias, and lateral cervical extension. Laboratory tests showed normal C3 and C4 levels, negative ANA, mildly elevated anti-SSA/Ro antibodies, and normal 24-hour urine protein. Imaging studies were unremarkable. Histopathological examination demonstrated lobular panniculitis with abundant hyaline adipocyte necrosis, dystrophic calcifications, sclerosis, and small intralobular lymphohistiocytic aggregates, consistent with lupus profundus. Systemic lupus erythematosus was excluded according to the EULAR/ACR 2019 classification criteria.

Parry–Romberg syndrome and deep morphea were considered in the differential diagnosis but excluded based on the presence of inflammatory clinical features and characteristic histopathologic findings. Treatment with hydroxychloroquine and intravenous corticosteroids, followed by gradual tapering, resulted in clinical stabilization without further progression during follow-up.

Conclusions

Lupus profundus should be considered in the differential diagnosis of progressive hemifacial atrophy, even in the absence of systemic lupus erythematosus. Careful clinicopathologic correlation is essential to distinguish this inflammatory condition from non-inflammatory entities such as Parry–Romberg syndrome. Early recognition and prompt initiation of systemic therapy may limit disease progression and prevent irreversible facial atrophy.

Abstract N°: ID-1427

Topic: Autoimmune disorders

Seronegative Pemphigus Vulgaris presenting as varicella zoster: A diagnostic pitfall

Shubham Kumari*[1], Swagata Tambe[1], Kirti Jangid[1]

[1]Seth V C Gandhi & M A Vora Municipal General Hospital, dermatology, Mumbai, India

Introduction
Pemphigus vulgaris is a rare autoimmune blistering disease characterized by intraepidermal acantholysis. While it typically presents with flaccid bullae and mucosal involvement, atypical morphologies may lead to diagnostic delay. Varicella is a common vesicular eruption, and clinical mimicry by autoimmune blistering disorders is rare. We report an unusual case of pemphigus vulgaris presenting with a varicella-like eruption, emphasizing the need for careful clinicopathological correlation.

Materials and Methods
Hereby, presenting a case of seronegative pemphigus vulgaris mimicking as varicella in our out patient department.

Results
A 49-year-old male presented with painful oral erosions and bilateral ocular redness for four months, followed by the acute onset of fluid-filled skin lesions over the trunk and back for eight days. The oral lesions initially involved the buccal mucosa and gingiva and gradually progressed to affect the lips, palate, tongue, and nasal mucosa, leading to difficulty in eating and speaking. Concurrently, the patient developed bilateral eye redness, burning sensation, and excessive watering, without history of trauma or visual disturbance.
Eight days prior to presentation, the patient developed multiple itchy erythematous macules over the trunk and back, which rapidly evolved into vesicles and bullae, clinically resembling varicella. The patient reported a weight loss of 10–12 kg over four months.
The patient had received multiple treatments including systemic corticosteroids, azathioprine, and acyclovir over the preceding months without symptomatic improvement. Varicella serology showed positive IgG and negative IgM antibodies. Desmoglein 1 and 3 antibodies were negative. PET scan revealed no abnormal hypermetabolic activity.
Cutaneous examination revealed multiple vesicles and bullae on an erythematous base over the trunk, back, and upper extremities, with erosions and central crusting at sites of rupture. Nikolsky sign was positive. Oral examination showed haemorrhagic crusting of the lips and widespread mucosal erosions. Bilateral conjunctival congestion with watering was present. Anal mucosa showed maceration with erosion, while genitalia, nails, palms, and soles were spared.
Skin biopsy demonstrated a suprabasal blister consistent with pemphigus vulgaris. Direct and indirect immunofluorescence studies confirmed the diagnosis. The patient was admitted under dermatology care and managed with multidisciplinary consultations, including ophthalmology, ENT, and internal medicine, and was evaluated for rituximab therapy. Patient was given Injection rituximab as per RA protocol and show significant improvement.

Conclusions
Pemphigus vulgaris (PV) is an autoimmune blistering disorder. Atypical presentations may mimic infectious vesiculobullous disorders, leading to diagnostic delay and inappropriate therapy.

In the present case, the patient initially had persistent oral and ocular involvement for several months, which is characteristic of PV. The subsequent acute eruption of pruritic vesicles and bullae on an erythematous base, resembling varicella, posed a diagnostic challenge. Pemphigus vulgaris may rarely present with **varicella-like vesicular lesions. Mucosal predominance and chronicity** help differentiate PV from viral infections. **Negative desmoglein ELISA does not**

exclude PV. Histopathology and immunofluorescence are crucial for diagnosis. Early clinicopathological correlation prevents misdiagnosis and treatment delay.

Abstract N°: ID-1436

Topic: Autoimmune disorders

Pemphigus Herpetiformis Misdiagnosed and Inappropriately Treated for Six Months: A Case Report

Araksya Manasyan*[1], Gegham Barseghyan[1], Lilit Meliksetyan[2], Hovhannes Hovhannisyan[1], Aram Shahverdyan[1], Astghik Ghaltakhchyan[1]

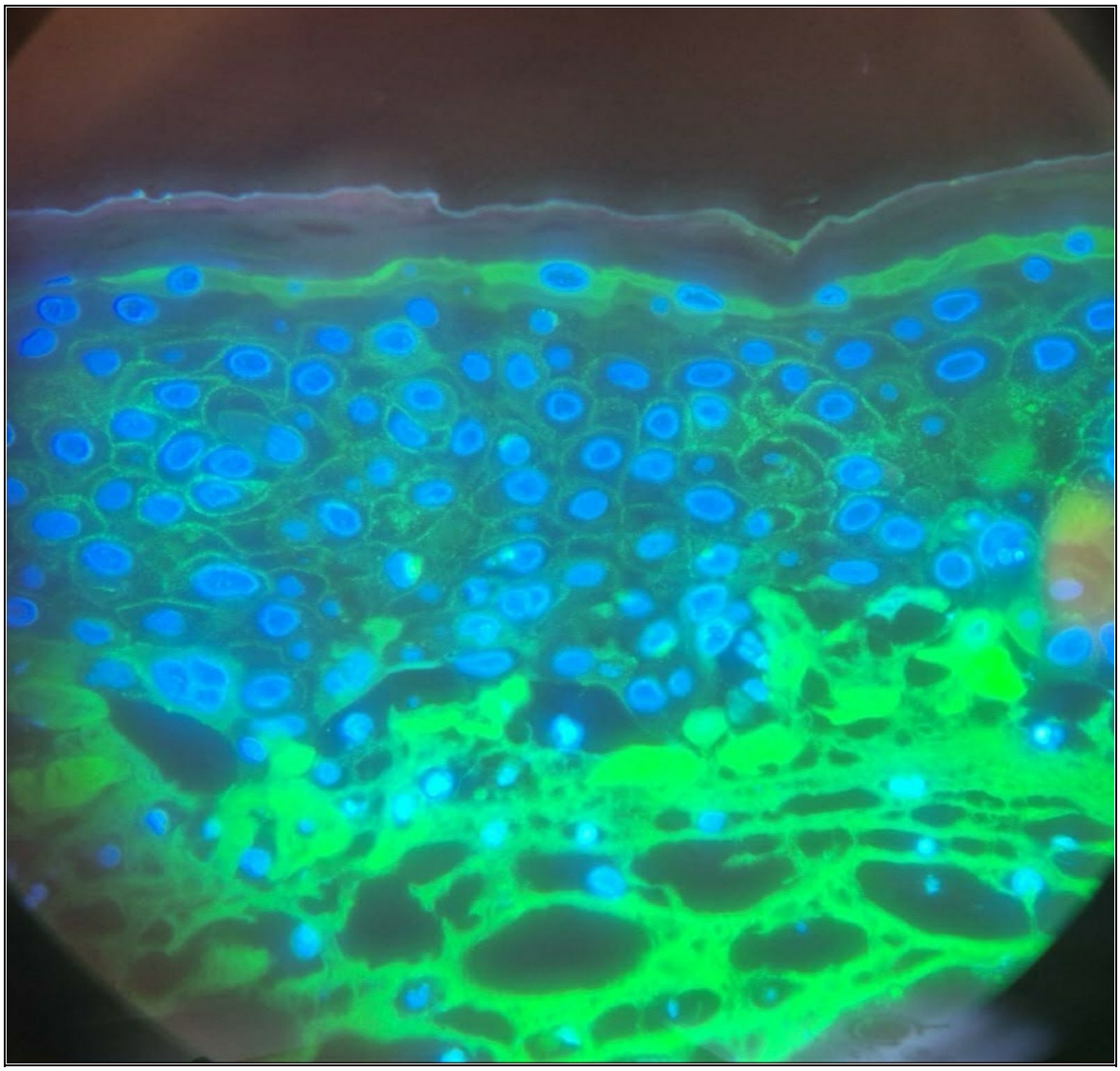
[1]National Center Of Dermatology, Yerevan, Armenia
[2]HISTOGEN ARMENIAN-GERMAN SCIENTIFIC-PRACTICAL CENTER OF PATHOLOGY, Yerevan, Armenia

Introduction

Pemphigus herpetiformis is a rare variant of pemphigus, accounting for approximately 6% to 7.3% of all pemphigus cases, and is characterized by intensely pruritic papulovesicular eruptions. Owing to the polymorphic nature of the rash, particularly during the non-bullous stage, the condition may be misdiagnosed as scabies or eczema, resulting in inappropriate treatment and delayed diagnosis. In this report, we present a case of pemphigus herpetiformis in a patient who underwent six months of ineffective therapy before the correct diagnosis was established.

Materials and Methods

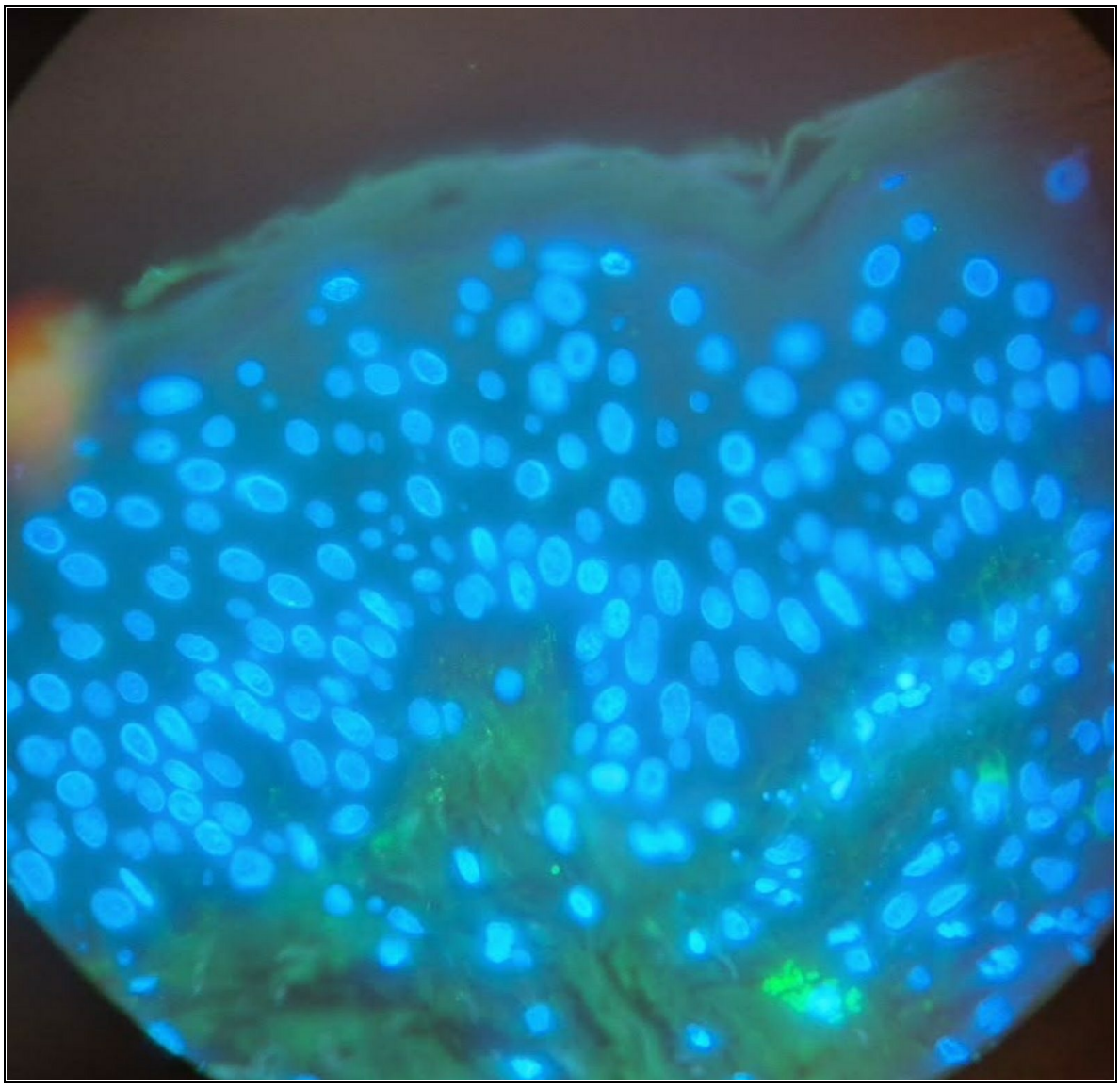
A 38-year-old male presented with symmetrically distributed, grouped erythematous papules and excoriated crusted lesions involving the extensor surfaces of the extremities, neck, eyebrows, and coccygeal/gluteal region. Lesions were herpetiform in pattern, with secondary excoriations from intense pruritus and scattered small vesicles on the chest. Prior treatments included repeated topical benzyl benzoate and intramuscular corticosteroid injections, which provided only temporary relief. A skin biopsy from a vesicular lesion was submitted for direct immunofluorescence (DIF). Routine laboratory tests and autoimmune screening (ANA, anti-dsDNA, complement C4) were performed.



Direct immunofluorescence of a vesicular lesion showing intercellular IgG deposition in a “chicken-wire” pattern, consistent with pemphigus herpetiformis.

Results

DIF revealed intercellular IgG deposition in the epidermis with a “chicken-wire” pattern, while IgA was negative, confirming pemphigus herpetiformis. Laboratory investigations were within normal limits. The patient was treated with oral prednisolone 30 mg daily and dapsone 100 mg daily. After 10 days, marked improvement of symptoms and lesions was observed.



Direct immunofluorescence of a vesicular lesion showing negative IgA deposition.

Conclusions

Lesions at characteristic anatomical sites with severe, prolonged pruritus and vesicles resembling herpetic lesions, but with atypical features, should prompt consideration not only of common conditions but also of autoimmune blistering diseases such as dermatitis herpetiformis or pemphigus herpetiformis. Clinical presentation alone may be misleading; skin biopsy with direct immunofluorescence is essential to confirm the diagnosis. This case underscores the importance of including autoimmune bullous diseases in the diagnostic workup, even when vesicles are minimal, to avoid misdiagnosis and delayed treatment.

Abstract N°: ID-1437

Topic: Autoimmune disorders

Genetic and flowcytometric profile in pemphigus vulgaris patients: what about hypoimmunity?

Simone Liguori*[1], Lucia Mele[1], Giuseppe Castaldo[2], Michele Davide Mignogna[1], Stefania Leuci[1]

[1]University of Naples Federico II, Department of Neuroscience, Reproductive and Odontostomatological Sciences, Naples, Italy
[2]University of Naples Federico II, Department of Molecular Medicine and Medical Biotechnologies, Naples, Italy

Introduction
The aim of this study was to characterize the immunological and genetic phenotype of pemphigus vulgaris (PV) patients evaluating the correlations between cellular subsets, gene variants and patients' clinical characteristics.

Materials and Methods
A comprehensive panel of lymphocyte subpopulations, including B naïve, B memory, Th naïve, Th memory, and Th17 cells, was investigated through flowcytometry. Next-generation sequencing (NGS) was used to analyze 386 genes associated with autoimmune diseases, autoinflammation and primary immunodeficiencies. Clinical and immunological patients phenotype were evaluated trough Pemphigus Disease Area Index (PDAI) and ELISA testing for anti-Dsg1 and anti-Dsg3 antibodies titer.

Results
Thirty-two patients were recruited: we identified 16 genetic variants in 13 patients. Of these, 4 were classified as pathogenic, 6 as likely pathogenic, and 6 as variants of uncertain clinical significance. A correlation was found between SNPs and clinical characteristics with patients who displayed genetic mutations reporting lower PDAI and Dsg1 levels. Patients with identified gene mutations had lower levels of activated Th17 cells and memory helper and cytotoxic T-cell subsets. Higher levels of memory helper, cytotoxic T cells and higher frequency of activated Th17 cells were associated with higher PDAI scores.

Conclusions
Hyperimmunity and hypoimmunity-related gene variants predispose to the development of PV. Different cellular phenotypes reflect disease extent and clinical severity.

Abstract N°: ID-1448

Topic: Autoimmune disorders

Skin manifestations associated with chronic lymphopenia

Imane Hakim*[1], Bendaoud Layla[1], Mariem Aboudourib[1], Hocar Ouafa[1], Amal Said[1]

[1]Faculty of Medicine and Pharmacy, Mohammed VI University Hospital, Bioscience and health laboratory, Dermatology department, Marrakech, Morocco

Introduction
Chronic lymphopenia is a heterogeneous condition reflecting immune dysregulation, systemic disease, or iatrogenic causes. Cutaneous manifestations are common yet often underestimated, as they may precede systemic involvement or remain non-specific. Dermatologists play a key role in recognizing early skin clues of underlying immune deficiency, but the lack of standardized diagnostic pathways frequently results in delayed diagnosis.
The objective of this review is to examine cutaneous manifestations associated with chronic lymphopenia and to propose a structured, reasoning-based diagnostic framework for clinical practice.

Materials and Methods
A mini-systematic narrative review was conducted using PubMed databases. Articles published between January 2000 and December 2024 were included. Search terms combined lymphopenia, cutaneous manifestations, skin infections, immune deficiency, and dermatology. Eligible publications included observational studies, case series, and review articles describing dermatological findings in patients with confirmed chronic lymphopenia. Data extraction focused on type of skin involvement, associated systemic conditions, diagnostic delay, and proposed investigative strategies. Findings were synthesized qualitatively to identify reproducible diagnostic patterns.

Results
The literature indicates that cutaneous manifestations frequently represent the earliest clinical expression of chronic lymphopenia. Reported findings include recurrent viral infections, chronic or atypical eczema-like eruptions, persistent fungal infections, and non-specific inflammatory dermatoses. In several studies, dermatological involvement preceded hematological diagnosis by months or years. Etiologies associated with lymphopenia included primary immune deficiencies, autoimmune diseases, chronic infections, malignancies, and drug-induced immune suppression. This review highlights the importance of dermatological reasoning in the early detection of chronic lymphopenia. Skin manifestations should not be viewed in isolation but interpreted as potential markers of underlying immune dysfunction. A structured diagnostic approach beginning with confirmation of persistent lymphopenia, followed by evaluation of infectious patterns, autoimmune context, medication history, and hematological abnormalities, allows rational prioritization of investigations. Dermatologists thus play a pivotal role in initiating multidisciplinary evaluation and reducing diagnostic delay.

Conclusions
Cutaneous manifestations are frequent and often early indicators of chronic lymphopenia. Structured diagnostic reasoning integrating dermatological findings with systemic evaluation improves early detection and patient outcomes. Dermatologists should maintain a high index of suspicion for immune dysfunction in patients presenting with recurrent, atypical, or treatment-resistant skin lesions.

Abstract N°: ID-1457

Topic: Autoimmune disorders

Interrupting the Hormonal Loop in Autoimmune Progesterone Dermatitis with Therapeutic Response to Omalizumab

Maria Dragomir*[1], Carmen Curea[1], Alexandra Alexe[1], Anca Popescu[1]

[1]Colentina Clinical Hospital, Dermatovenerology, IInd Department of Dermatovenerology, Bucharest, Romania

Introduction

Autoimmune progesterone dermatitis (APD) is a rare immunologically mediated hypersensitivity disorder characterized by recurrent, progesterone-dependent cutaneous eruptions occurring during the luteal phase of the menstrual cycle. Clinical manifestations of APD are polymorphic and can include urticaria, eczema, erythema multiforme and rarely, anaphylaxis. APD may occur following exposure to exogenous progesterone, such as intrauterine devices (IUDs) or oral contraceptives, which may sensitize the immune system, though the pathogenic mechanism remains incompletely understood. Due to the rarity of the condition and its variable presentation, diagnosis is often delayed and may be overlooked in patients with chronic urticaria. We report a distinctive case of chronic spontaneous urticaria induced by levonorgestrel IUD placement, subsequently diagnosed as autoimmune progesterone dermatitis and successfully treated with Omalizumab.

Materials and Methods

A 43-year-old woman presented with a generalized pruritic urticarial eruption without angioedema, fever or arthralgias, first appearing 10 days after insertion of a levonorgestrel-releasing intrauterine device, inserted to manage metrorrhagia. Although the IUD was removed one week after symptom onset, urticaria persisted with minimal response to escalating antihistamine therapy, systemic corticosteroids and dietary modification over six weeks. Notably, the patient reported exacerbations in the perimenstrual period, consistent with cyclical hormonal influence. We calculated an UAS7 score of 28.

Her medical history included ulcerative colitis treated with mesalazine (discontinued at rash onset). Family history was significant for atopic dermatitis in her daughter. Workup was notable for absence of obvious triggers: patch testing was negative for relevant sensitizers; parasitologic evaluation was unremarkable; endocrinologic evaluation excluded thyroid disease but was consistent with perimenopause; acute phase reactants, renal and hepatic panels, serum IgE levels, viral serologies and Helicobacter pylori antibodies were within normal limits. Given the temporal association with exogenous progesterone, cyclical exacerbations prior to menstruation and excluding alternative diagnoses, autoimmune progesterone dermatitis was suspected. A progesterone intravaginal challenge provoked significant exacerbation of urticaria, supporting hormone-driven hypersensitivity.

Results

Diagnosis of APD was established based on clinical correlation with the menstrual cycle, temporal association with exogenous progesterone exposure and positive hormone challenge response. Traditional therapies, including high-dose antihistamines and corticosteroids provided only transient response. Considering the refractory nature of her symptoms and evidence of immunologic hypersensitivity, we initiated Omalizumab 300 mg subcutaneously monthly. During follow-up, no new lesions appeared including in the perimenstrual period (UAS7= 0). This durable clinical response, maintained with ongoing monthly Omalizumab, highlights the potential efficacy of anti-IgE therapy in hormonally mediated autoimmune dermatologic conditions.

Conclusions

APD is an underrecognized and rare cause of chronic cyclical dermatoses with urticaria being a frequent presentation. Exogenous progesterone exposure may trigger sensitization and subsequent autoimmune hypersensitivity. The

diagnosis should be considered in women with chronic urticaria that worsens premenstrually and persists despite removal of hormonal triggers and conventional therapy. Hormone challenge testing may aid diagnosis. Traditional treatment modalities range from antihistamines and corticosteroids to hormonal suppression and oophorectomy in refractory cases; however, this case demonstrates that Omalizumab may offer rapid and sustained remission in patients with hormonally mediated urticarial autoimmune phenomena. Further research is warranted to elucidate the immunopathogenesis of APD and to optimize therapeutic strategies.

Abstract N°: ID-1466

Topic: Autoimmune disorders

Lupus erythematosus–lichen planus overlap syndrome

Ofeliya Kercheva*[1], Kamelia Kukova[1], Dimitrina Serafimova[1], Elia Valeva[1], Slavyan Tamnev[1], Snejina Vassileva[1], Kossara Drenovska[1]

[1]University Hospital "Alexandrovska", Medical University – Sofia, Sofia, Bulgaria, Department of Dermatology and Venereology, Sofia, Bulgaria

Introduction
Lichen planus and cutaneous lupus erythematosus are chronic immune-mediated inflammatory dermatoses with heterogeneous clinical and histopathological presentations. Both conditions may mimic each other and, in rare cases, may coexist as an overlap syndrome, causing significant diagnostic difficulties. The objective of this report is to present a rare case of lupus erythematosus–lichen planus overlap and to emphasize the importance of the clinicopathological correlation.

Materials and Methods
We report a 69-year-old woman admitted for diagnostic clarification of a chronic pruritic dermatosis. The patient complained of widespread, intensely itchy skin lesions of a several-month duration. Her medical history was notable for ischemic stroke, post-traumatic epilepsy, and multiple comorbidities. Upon dermatological examination, the skin lesions were symmetrically distributed over the dorsal aspects of the upper and lower extremities, trunk, and partially the chest, consisting of multiple round to irregularly-shaped hyperkeratotic and verrucous plaques with erythema and hyperpigmentation in the peryphery. Dyschromic patches with predominant leukoderma and a few ulcerated verrucous plaques involved the dorsal hands. Routine laboratory investigations, extended immunological tests, skin biopsies for histopathology, and multidisciplinary consultations were performed.

Results
Laboratory investigations demonstrated high-titer antinuclear antibodies (ANA >1:1280) and positive anti-dsDNA antibodies. Histopathological examination revealed features consistent with both lupus erythematosus and lichen planus. Direct immunofluorescence (DIF) on lesional skin demonstrated numerous ovoid IgM deposits within the papillary dermis along the dermoepidermal junction. The pattern is compatible with either lupus erythematosus or lichen planus. Based on the clinical, histological, and immunological findings, a diagnosis of lupus erythematosus–lichen planus overlap syndrome was suggested. Treatment with methylprednisolone 20mg/24h, chloropyramine hydrochloride 1amp/24h, topical keratolytics and corticosteroids resulted in clinical improvement of the skin lesions.

Conclusions
The presented case confirms the rarity and diagnostic challenge of lupus erythematosus–lichen planus overlap, particularly in their hypertrophic variants, with only a few cases reported in the literature. Clinically, the patient had lesions compatible with both dermatoses, although the intense pruritus was interpreted as a feature characteristic of lichen planus rather than lupus erythematosus. Histology showed overlapping features of both entities, and DIF further provided crucial confirmatory evidence. The coexistence of these disorders - an uncommon clinical phenotype with mixed histopathological and immunopathological findings, underscores the need for thorough clinicopathological correlation to achieve an accurate diagnosis and administer appropriate therapy for simultaneous control of both conditions.

Abstract N°: ID-1494

Topic: Autoimmune disorders

When blistering meets depigmentation: bullous pemphigoid associated with vitiligo in advanced age

Oumaima Berradi[1], Kenza Benothmane*[1], Narjiss Errahdy[1], Najwa Ammar[1], Syrine Hamada[1], Meriame Meziane[1], Nadia Ismaili[1], Laila Benzekri[1]

[1]CHU Ibn Sina – Université Mohammed V, service de dermatologie, rabat, Morocco

Introduction

Bullous pemphigoid (BP) is the most common autoimmune subepidermal blistering disease in older adults. Vitiligo is an autoimmune depigmenting disorder that may coexist with other immune-mediated diseases, but the concomitance of BP and vitiligo is rarely reported. We report a severe BP in an elderly patient with vitiligo and discuss diagnostic and therapeutic considerations in advanced age.

Materials and Methods

An 87-year-old man with functional dependence and cognitive impairment presented with a 4-month history of generalized pruritus followed by widespread blistering. Clinical examination assessed lesion morphology, distribution, mucosal involvement and Nikolsky sign. Severity and quality of life were recorded using BPDAI and DLQI. Diagnosis was confirmed by skin biopsy and direct immunofluorescence (DIF). Baseline laboratory work-up and infection screening were performed before systemic immunosuppression.

Results

The patient had multiple tense, clear-fluid bullae on an erythematous/urticarial base, associated with widespread post-bullous erosions and hemorrhagic crusts, symmetrically involving all four limbs and the trunk. Mucous membranes were spared and Nikolsky sign was negative. BPDAI was 63 and DLQI was 20. Concomitant well-demarcated depigmented macules consistent with vitiligo were noted. DIF demonstrated a linear, continuous C3 deposition along the dermoepidermal junction, supporting BP. Chronic medications included sertraline, donepezil, bromazepam and acetylsalicylic acid; there was no exposure to frequently reported BP triggers such as loop diuretics, dipeptidyl peptidylase-4 inhibitors, angiotensin-converting enzyme inhibitors, amiodarone or immune checkpoint inhibitors. Laboratory tests showed leukocytosis (12.9 ×10^9/L), eosinophilia (0.9 ×10^9/L) and markedly elevated C-reactive protein (186 mg/L), with urinary abnormalities raising concern for intercurrent infection. Given advanced age and suspected infection, systemic corticosteroids were initially deferred. A steroid-sparing approach combining doxycycline 200 mg/day and high-potency topical corticosteroid (clobetasol propionate) with wound care and antibiotics was initiated. This strategy is supported by randomized trial data showing improved safety of doxycycline-based initial treatment compared with oral prednisolone, albeit with slightly reduced short-term blister control. Active disease persisted with >10 new bullae/day at discharge, and further investigations were planned to guide escalation once infection was controlled.

Conclusions

This case highlights an uncommon autoimmune overlap between BP and vitiligo and reinforces the need to consider autoimmune clustering in late life. In severe BP in very elderly or neurologically comorbid patients—an association reported in the literature—systematic infection screening and an initial steroid-sparing strategy may be particularly

relevant before systemic immunosuppression.

Abstract N°: ID-1502

Topic: Autoimmune disorders

Vogt-Koyanagi-Harada Syndrome: Listening to the Skin to Save the Sight

Wydad Boudi[1], Yasmine Farai*[1], Mohamed El Amraoui[1], Youssef Zemmez[1], Jjawad El-Azhari[1], Rachid Frikh[1], Hjira Naoufal[1]

[1]Mohamed V Military Hospital Rabat, Morocco, Dermatology, Rabat, Morocco

Introduction

Vogt-Koyanagi-Harada (VKH) syndrome is a rare multisystem autoimmune disorder targeting melanocyte-rich tissues, including the eyes, meninges, skin, and inner ear. Because early clinical manifestations are often subtle, they can easily be overlooked. Identifying these signs promptly is crucial to preventing irreversible ocular complications. This report illustrates how a dermatological consultation for vitiligo led to the diagnosis of early-stage VKH, facilitating life-changing intervention.

Materials and Methods

Patient Profile & Initial Symptoms Mrs. A, a 54-year-old woman with Type 2 diabetes (well-controlled via oral antidiabetics), presented with the progressive appearance of depigmented patches on her face, trunk, and hands. During the clinical interview, she reported experiencing bilateral blurred vision for several days, marked photophobia, and frontal headaches.

Clinical Findings Physical examination confirmed areas of vitiligo and revealed a mild meningeal syndrome. Given the multisystem nature of these symptoms, an urgent ophthalmological referral was initiated.

Diagnostic Investigations The ophthalmological assessment revealed:

- **Bilateral posterior uveitis** with papillary edema.
- **Serous retinal detachment** confirmed by OCT (Optical Coherence Tomography).
- **Multifocal choroiditis.**

Further testing showed moderate lymphocytic pleocytosis in the cerebrospinal fluid via lumbar puncture. Infectious serologies were negative, while HLA typing confirmed the presence of the **HLA-DR4** allele, solidifying the diagnosis of Vogt-Koyanagi-Harada syndrome.

Therapeutic Management High-dose corticosteroid therapy was immediately initiated (methylprednisolone pulses followed by an oral taper), leading to a steady recovery of visual acuity. Concurrently, her diabetes management was adjusted to mitigate the risk of glycemic instability associated with systemic steroid use.

Results

VKH typically progresses through three distinct phases: a **prodromal phase** (flu-like symptoms), an **ophthalmic phase** (bilateral uveitis), and a **convalescent/integumentary phase** (cutaneous depigmentation).

In this specific case, the skin depigmentation served as the primary clinical gateway, prompting a targeted investigation and rapid referral. This scenario underscores the vital importance of an interdisciplinary approach and "active listening"

toward patient complaints, even when they appear peripheral to the initial reason for consultation.

Conclusions

This case highlights the essential synergy between dermatologists and ophthalmologists in the early diagnosis of rare systemic diseases. The sudden onset of vitiligo paired with visual disturbances should immediately raise suspicion of a broader autoimmune process. Rapid, coordinated care is the cornerstone of preserving vision and improving the overall long-term prognosis for these patients.

Abstract N°: ID-1503

Topic: Autoimmune disorders

UNUSUAL MANIFESTATION OF SUBACUTE CUTANEOUS LUPUS ERYTHEMATOSUS AS ISOLATED NON-SCARRING PATTERNED HAIR LOSS: A RARE CLINICAL PRESENTATION AND DIAGNOSTIC CHALLENGE

Yulia Romanova*[1], Aida Gadzhigoroeva[1, 2], Oksana Katunina[1]

[1]Moscow Research and Practical Center of Dermatovenerology and Cosmetology, Moscow, Russian Federation
[2]Peoples' Friendship University of Russia (RUDN University), Moscow, Russian Federation

Introduction

Subacute cutaneous lupus erythematosus (SCLE) is a subtype of cutaneous lupus erythematosus. It typically presents as widespread symmetric non-scarring rash (annular or psoriasiform) on sun-exposed areas (upper trunk, shoulders, extensor surfaces of arms). While variants of cutaneous lupus erythematosus (acute, subacute, and chronic) can cause hair loss, scalp involvement is uncommon in SCLE and is usually accompanied by body lesions.

Materials and Methods

N/A

Results

A 47-year-old woman presented with a more than 6-month history of hair loss (in March 2025). The condition began acutely in August 2024 with profuse diffuse shedding, accompanied by general malaise but no fever. The patient associated the onset with significant stress. Initial dermatological assessment resulted in a diagnosis of acute telogen effluvium: it was prescribed a cosmetic hair lotion and multivitamins. Four months later, persistent thinning predominantly in the androgen-dependent zone led to re-evaluation.

Physical examination revealed reduced hair density on the vertex and crown, resembling female pattern hair loss (Ludwig stage III). The hair pull test was negative. No overt scarring or visible inflammation was observed. There were no subjective complaints. Eyebrows, body hair, facial and body skin, and nails were unaffected. Past medical history was unremarkable. No family history of alopecia or autoimmune disease was reported. The patient denied traction hairstyles, chemical treatments, or medications known to cause hair loss.

Trichoscopy demonstrated decreased hair density, predominance of single terminal and vellus hairs in follicles (some with mild perifollicular hyperkeratosis), preserved follicular ostia with mildly hyperkeratotic small yellow dots, and areas of mildly accentuated arborizing/interconnecting vessels in the interfollicular zone.

A 4-mm punch biopsy showed atrophic epidermis with mild loose orthokeratosis, follicular infundibular keratotic plugs, accentuated basement membrane zone, and scattered atrophic hair follicle fragments in the reticular dermis. Moderate perivascular and periadnexal lymphohistiocytic infiltrate was present, together with mild basophilic degeneration of upper dermal collagen and mucin deposition between collagen bundles. No concentric perifollicular fibrosis or loss of sebaceous glands was identified. The diagnosis of subacute cutaneous lupus erythematosus (SCLE) was established based on clinical and histopathological findings.

Laboratory investigations corresponding to the obtained findings (including antiphospholipid antibodies, anti-dsDNA, lupus anticoagulant, C3/C4, complete blood count, biochemistry, protein fractions, C-reactive protein, and urinalysis) were within normal reference ranges.

Treatment consisted of intralesional betamethasone injections (once monthly for 6 months), oral hydroxychloroquine at

5 mg/kg daily, and topical 5% minoxidil foam applied once daily. Follow-up at 11 months demonstrated marked improvement with visible hair regrowth.

Conclusions

This case illustrates the diagnostic difficulty of SCLE in case isolated non-scarring patterned scalp hair loss presentation. The scarcity of specific clinical and trichoscopic signs, along with strong clinical similarity to other non-scarring alopecias (androgenetic alopecia, diffuse alopecia areata), often leads to misdiagnosis. Histopathological examination is essential for confirmation. Timely diagnosis is particularly important given that approximately 50% of patients with SCLE eventually meet criteria for systemic lupus erythematosus, even if initially skin-limited.

Abstract N°: ID-1598

Topic: Autoimmune disorders

A systematic review of case series and clinical trials investigating systemic oral or injectable therapies for the treatment of vitiligo

Alireza Jafarzadeh*[1]

[1]Iran University of Medical Sciences, Tehran, Iran

Introduction
The purpose of this study is to investigate the effectiveness and safety of oral and injectable systemic treatments, such as methotrexate, azathioprine, cyclosporine, tofacitinib, baricitinib, corticosteroids, statins, zinc, apremilast, etc., for treating vitiligo lesions.

Materials and Methods
Databases including PubMed, Scopus, and Web of Science were meticulously searched for studies spanning from 2010 to August 2025, focusing on systemic oral and injectable therapies for vitiligo, using comprehensive keywords and search syntaxes tailored to each database. Key data extracted included study design, treatment efficacy, patient outcomes, patient satisfaction, and safety profiles.

Results
In a total of 42 included studies, oral mini-pulse corticosteroid therapy (OMP) was the subject of six studies (14.2%). Minocycline was the focus of five studies (11.9%), while methotrexate, apremilast, and tofacitinib each were examined in four studies (9.5%). Antioxidants and Afamelanotide were the subjects of three studies each (7.1%). Cyclosporine, simvastatin, oral zinc, oral corticosteroids (excluding OMP) and injections, and baricitinib were each explored in two studies (4.8%). Azathioprine, mycophenolate mofetil, and Alefacept were the subjects of one study each (2.4%).

Conclusions
Systemic treatments for vitiligo have been successful in controlling lesions without notable side effects. OMP, Methotrexate, Azathioprine, Cyclosporine, Mycophenolate mofetil, Simvastatin, Apremilast, Minocycline, Afamelanotide, Tofacitinib, Baricitinib, Antioxidants, and oral/injectable corticosteroids are effective treatment methods. However, oral zinc and alefacept did not show effectiveness.

Abstract N°: ID-1613

Topic: Autoimmune disorders

Suspected linear lichen planus/cutaneous lupus overlap mimicking striae, clinically improved with Tacrolimus 0.1% ung

Shakira Brathwaite*[1], Juthika Thakur[2]

[1]University of Toronto, Toronto, Canada
[2]Elevate Dermatology, Pickering, ON, Canada

Introduction
Elements of discrete auto-immune diseases can exist together within “overlap syndromes”; however, it is unusual for a solitary primary skin morphology to reflect features of both distinct conditions. Here, we present a unique case of multiple atrophic linear plaques with prominent peripheral hyperpigmentation in a patient with profoundly positive ANA. We suggest that this may represent a distinct clinical entity where a lichenoid reaction within microchimeric skin may provoke localized chronic cutaneous lupus erythematosus (CCLE) in a highly susceptible patient.

Materials and Methods
We present a case report of suggestive clinical, laboratory, dermoscopic and histological features suggestive of this.
A man of East Asian descent in his 40s presents for skin check due to incidental finding of ANA > 1:1280. He is not known for any rheumatologic disease or systemic symptoms. Routine labs are unremarkable, as are inflammatory markers and complement levels. He is not known for any lupus-specific rash; however, he notes the presence of “abnormal stretch marks” on the right flank that developed in his 20s. On exam, multiple pink-brown linear atrophic plaques with peripheral brown border were seen on the right flank. Dermoscopy showed white pink structureless areas with peri-follicular white halos, polymorphic vessels, rosette sign and peripheral pigmentation. Histology showed an interface dermatitis, and alcian blue and PAS ultimately showed increased mucin and basement membrane thickening respectively.

Results
A presumed diagnosis of CCLE was made, and he was treated with tacrolimus 0.1% ung BID, with good improvement in colour initially.

Conclusions
Lichen planus/lupus overlap syndrome is a known entity; however, the typically cutaneous exam features multiple primary skin lesions that reflect the two diseases. It is highly unusual to see clinical features of both within the same skin lesions. The linearity may reflect koebnerization or microchimerism. Overall, this case suggests a distinct activating mechanism for localized connective tissue disease in a genetically-susceptible individual.

Abstract N°: ID-1614

Topic: Autoimmune disorders

A systematic review of procedural modalities in the treatment of lichen planopilaris, frontal fibrosing alopecia, and discoid lupus erythematosus

Alireza Jafarzadeh*[1]

[1]Iran University of Medical Sciences, Tehran, Iran

Introduction

Lichen planopilaris (LPP), frontal fibrosing alopecia (FFA), and discoid lupus erythematosus (DLE) are lymphocytic cicatricial alopecias that result in irreversible follicular loss. Procedural therapies have been proposed to manage inflammation, remodel scarred tissue, and occasionally promote hair regrowth.

Materials and Methods

We performed a PRISMA-guided systematic review of studies from PubMed/Medline, Ovid Embase, and Scopus up to July 28, 2025. The review focused on original studies investigating procedural interventions for LPP, FFA, and DLE. We assessed the methodological quality of the included studies using tools from the NIH and Murad et al. A total of 38 studies with 411 patients were included in this review.

Results

The studies reported various procedural interventions including lasers/light therapies, platelet-derived products, adipose/exosome injections, low-level light therapy (LLLT), intralesional corticosteroids (ILCS), carboxytherapy, microneedling, and hair transplantation. The outcomes measured included both subjective (patient-reported symptom changes, global physician assessments) and objective (activity scores, terminal hair counts, hair shaft diameter, and photographic density) improvements. Platelet products most consistently reduced activity scores and improved symptoms, with some studies documenting increases in terminal hair counts or hair shaft diameter. LLLT led to improved patient-reported outcomes and modest increases in hair counts/thickness. ILCS reliably stabilized disease and reduced activity scores but had inconsistent regrowth outcomes. Hair transplantation resulted in good early cosmetic density in quiescent patients, though graft loss occurred after 3-5 years. Adipose and exosome injections showed promising results in case-level increases in density/thickness, though the findings were preliminary.

Conclusions

Procedural modalities may serve as useful treatments for symptom control and limited regrowth in selected patients with scarring alopecia. These treatments are best considered as adjuncts to medical therapy, pending further standardized and controlled trials. Adverse events were generally mild and specific to the procedure, with long-term graft durability remaining a concern in hair transplantation.