Abstract N°: ID-46

Topic: Cutaneous oncology

Facial Basal Cell Carcinoma in a Young Adult: Beyond the Sun

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Introduction

Basal cell carcinoma (BCC) is the most common malignant epithelial tumor, accounting for nearly 75% of non-melanoma skin cancers.

BCC typically develops in older adults, with incidence rising sharply after the age of 50 and peaking between 60 and 65 years. Its pathogenesis reflects a complex interplay between environmental exposures, primarily chronic and cumulative ultraviolet radiation, and genetic factors, particularly alterations in key tumor suppressor and signaling pathway genes such as PTCH1 and TP53.

Within this context, the occurrence of facial BCC in a young patient without major environmental risk factors is highly unusual. Such cases underscore the need to maintain a high index of suspicion for BCC even outside the typical age range and highlight the importance of considering potential underlying genetic predispositions.

Here, we report the case of a young woman presenting with early-onset facial BCC in the context of a TYR gene mutation, illustrating the potential contribution of hereditary factors to BCC development in the absence of overt albinism.

Results

We report the case of a young female patient who presented with a persistent lesion of the upper lip. She had no personal or family history of albinism, skin cancers, or other dermatological disorders. The patient reported that the lesion had been evolving for several months, without spontaneous regression despite local care, which prompted further evaluation.

The lesion was ulcerated, measuring 10 mm in its largest dimension, painless, with regular borders, a clean base, and slight serous discharge. There were no pearly borders and no signs of secondary infection. Palpation of the regional lymph nodes revealed no lymphadenopathy. T

A dermoscopic assessment was performed, which did not reveal any features suggestive of malignancy.

The patient underwent a complete laboratory work-up, including routine biochemistry, inflammatory markers, and viral serologies, all of which were within normal limits. No systemic abnormalities or inflammatory processes were detected, confirming the lesion's isolated nature. Bacteriological swab cultures were sterile. Serologic tests for syphilis, including TPHA and VDRL, were negative. The persistence of the lesion and its progressive course raised concern for a malignant process. A biopsy was therefore performed, which confirmed the diagnosis of basal cell carcinoma (BCC).

Given the diagnosis, the case was presented at a multidisciplinary tumor board (MDTB). After discussion, the consensus was to proceed with surgical management, given the tumor's location and infiltrative nature. The recommended

approach was a wide local excision with 5 mm safety margins around the lesion, followed by reconstructive surgery to restore both the anatomical integrity and the aesthetic appearance of the upper lip. The procedure was successfully performed, and the postoperative course was uneventful. Reconstruction was achieved using a local advancement flap adjacent to the defect, allowing primary closure of most of the excised area. The remaining uncovered portion was repaired with a full-thickness skin graft harvested from the right retroauricular region, resulting in satisfactory aesthetic and functional outcomes.

Considering the tumor's localization and infiltrative character, a plan for close surveillance every six months was established, in order to detect any potential recurrence at an early stage.

Conclusions

The occurrence of facial basal cell carcinoma in a young adult without significant environmental or familial risk factors remains exceptional. This case underlines the importance of not only considering classical risk factors, such as chronic sun exposure, but also exploring the contribution of genetic predispositions, including TYR mutations, even when patients do not present with the overt phenotype of oculocutaneous albinism.

Abstract N°: ID-55

Topic: Cutaneous oncology

Alpha and gamma human papillomaviruses (α- and γ-HPV) seropositivity and the association with cutaneous squamous cell carcinoma - A systematic review and meta-analysis

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Introduction

Cutaneous squamous cell carcinoma (cSCC) is one of the most common non-melanoma skin cancers, with increasing incidence globally. While ultraviolet (UV) radiation is the primary etiological factor, the role of human papillomavirus (HPV) in cSCC pathogenesis remains uncertain. Although β-HPV types have been implicated in early carcinogenic events, the contribution of alpha and gamma HPV (α- & γ-HPV) genera remains unclear. This study aimed to evaluate the association between α- and γ-HPV seropositivity and the risk of cSCC.

Materials and Methods

A systematic literature search was conducted across PubMed, Embase, Scopus, and Cochrane Library up to January 2024. Eligible studies included case-control and cohort designs that assessed α- or γ-HPV seropositivity in individuals with and without cSCC. A random-effects meta-analysis was performed to calculate pooled odds ratios (ORs) and 95% confidence intervals (CIs) for overall and type-specific α- or γ-HPV subtypes. Heterogeneity and publication bias were assessed using the I^2 statistic, Egger's, and Begg's tests.

Results

Seven studies involving 1,745 cSCC cases and 847 controls were included. Pooled analyses demonstrated no significant association between seropositivity to α-HPV (OR 1.09; 95% CI 0.99–1.20) or γ-HPV (OR 0.92; 95% CI 0.82–1.07) and cSCC risk. Heterogeneity was low across all analyses (I^2 < 25%). Subgroup analyses of specific α- and γ-HPV groups similarly showed no significant associations.

Conclusions

This systematic review and meta-analysis found no evidence that seropositivity to α- or γ-HPV types is associated with increased risk of cSCC. Further large, longitudinal studies using standardized HPV detection methods are needed to clarify HPV's role in cutaneous carcinogenesis

Abstract N°: ID-64

Topic: Cutaneous oncology

RISK FACTORS AND BEHAVIORAL PATTERNS IN SKIN CANCER: INSIGHTS FROM A GREEK OUTPATIENT COHORT

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Introduction
With over 330,000 new cases diagnosed annually in Europe, skin cancer remains one of the most common—yet preventable—malignancies. Despite decades of public health efforts, high-risk behaviors and late seeking of medical help continue to burden healthcare systems. These trends highlight the need not only for early detection but also for a deeper understanding of individual risk profiles. Advances in molecular biology and immunology are opening the way for precision medicine, yet behavioral and environmental factors remain at the heart of skin cancer prevention.This study explores under-reported behavioral patterns and phenotypic traits among Greek skin cancer patients, using real-world data from the Euromelanoma questionnaire.

Materials and Methods
A total of 115 patients attending the Dermato-oncology outpatient clinic at the "Attikon" University General Hospital were enrolled. All had a confirmed diagnosis of BCC, SCC, or melanoma. Data were collected through structured Euromelanoma questionnaires, capturing: demographics and lifestyle factors (smoking, diet), sun exposure patterns and photoprotection habits, personal and family medical history, comorbidities, and phenotypic traits. Collected data were statistically analyzed to explore correlations between patient characteristics and skin cancer type.

Results
A consistent pattern emerged across all cancer types: insufficient photoprotection was prevalent, especially during midday sun exposure (11:00–16:00), often linked to professional activities, outdoor hobbies, or intentional tanning. It appears that the highest rates of sunburn took place during childhood and adolescence. The pattern of sun exposure seems to correlate with the type of cancer, as it seems that most melanoma cases were associated with sunbathing, tanning sessions, sunburns, and generally, intermittent exposure. SCC cases showed a strong association with chronic occupational sun exposure, emphasizing the role of cumulative UV damage. Phenotypic traits, such as hair color and the presence of freckles during childhood, appear to be linked to the risk of developing skin cancers, particularly in individuals with fair skin or sun sensitivity. A significant proportion of skin cancer patients, particularly those with SCC, were immunosuppressed.

Conclusions
Our findings reinforce the critical need for early, targeted education on sun safety—starting in childhood—and for

tailored public health interventions based on individual risk factors. Equally important is addressing the frequent delay in seeking medical help, which can compromise outcomes even in otherwise treatable cases. Dermatologists play a critical role not only in the early diagnosis, but also in risk communication and long-term surveillance of high-risk populations.

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Topic: Cutaneous oncology

Vulvar cell carcinoma due to low-risk HPV

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Introduction

Vulvar cancer is one of the uncommon gynecologic malignancies, accounting for 3–5% of gynecologic cancers, and the incidence is on the rise. In Albania its incidence is 1.7% of all new cancer cases. [2] The incidence of vulvar intraepithelial neoplasia (VIN) is also on the rise in women aged 50 years and above. In vulvar cancer associated with human papillomavirus (HPV) infection (mainly HPV 16 and HPV 18 types), VIN is the precancerous lesion. Due to its association with HPV infection, the incidence of vulvar cancer is increasing in young women, but in elder women it was rare. The appearance of vulvar cancer on low-risk HPV lesion is also rare.

Materials and Methods

Case Report: We want to present the case of a 71 years old woman, who came at our clinic complaining for a lesion on her vaginal region since 18 months. The lesion lied on the right part of the vulvar region, and was very itchy. It appeared like a little bump that gave her discomfort. There was no history of sexually transmitted infections or history of risky sexual relations in the patient or the patient's husband. The patient reported having had small lesions on that part of the vulva that afterwards disappeared.
On physical examination, the vital signs were within normal limits, normal weight, and no lymph node enlargement was found. On the venereological status of the vulva, a lesion was seen, irregular in shape, measuring 2 × 2.5 × 0.3 cm, well defined, raised, and dry in the form of a white tumor with a verrucous surface.
Routine hematological examination and serologic tests for syphilis, hepatitis B, and HIV were within normal limits. HPV PCR showed positive result for HPV type 11. The biopsy performed on the lesion showed the presence of squamous cell epithelium, and the patient was referred for surgery.

Results

The patient was diagnosed with squamous cell carcinoma in-situ, with only one focus of invasion of the tumor.
Vulvar cancer is a rare malignant tumor of the female reproductive system, accounting for 1% of all cancers in women and 4% of all gynecological cancers. It is most common in women aged 60–80 years. Our patient was 71 years old. Evaluating carefully the history, we came to the suspect of previous HPV lesions, which resulted to be caused by a low-risk HPV type.

Conclusions

SCC accounts for over 90% of all vulvar cancer cases and is most often preceded by dysplastic changes.
The VSCCs can be classified as HPV-associated and HPV-independent, and are usually preceded by noninvasive VIN. The majority of cases diagnosed in the elderly women are non-HPV depend tumors, but
there are a few cases when we meet the HPV type of vulvar cancer, and we should always check for the presence of HPV as it is directly related to its prognosis. The risk of developing cancer should be considered even with low-risk types of HPV.

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Topic: Cutaneous oncology

A case of Lentigo Maligna presenting as repigmentation of hair in a scalp that previously underwent radiotherapy for tinea capitis.

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Introduction
Lentigo maligna often presents as a slowly growing pigmented macule or patch that develops on chronically sun-damaged skin. It is melanoma in-situ and can become quite extensive and progress to invasive melanoma if left untreated. Lentigo maligna has occasionally been noted to have the capacity to invade and re-pigment gray hairs.

Materials and Methods
A retrospective review of patient history and histology was performed.

Results
We present a case of a 78-year-old male who presented with a patch of brown hair on the vertex of the scalp in an area of previously white hair. The patient had had previous radiotherapy to the site as a child for the treatment of tinea capitis. Histology revealed a lentigo maligna melanoma in situ subtype and the patient underwent surgical excision with split thickness skin graft.

Conclusions
This case highlights not only the rare entity of hair repigmentation as a sign of malignancy but also past scalp radiotherapy as a risk factor in the development of melanoma.

Abstract N°: ID-99

Topic: Cutaneous oncology

Histopathologic and Immunohistochemical Features of Scalp Metastasis from Breast Cancer

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Introduction

Cutaneous metastases from breast carcinoma are relatively uncommon and typically indicate advanced systemic disease. They may occur at various anatomical sites, most frequently on the chest wall, while involvement of the scalp is rare. Clinically, skin metastases can mimic benign dermatologic conditions, leading to delayed diagnosis. Their recognition is important, as they often reflect disease progression and may necessitate modification of systemic therapy.

Histopathological examination combined with immunohistochemical analysis is essential to confirm the metastatic nature of cutaneous lesions and to establish concordance with the primary tumor. Breast carcinoma is the most frequent source of cutaneous metastases in women, and markers such as cytokeratins, hormone receptors, and HER2 status are particularly useful. We present a case of scalp metastasis arising from a known history of HER2-positive invasive ductal carcinoma of the breast, highlighting the diagnostic process and clinical implications.

Materials and Methods

In 2017, a 56-year-old woman was diagnosed with invasive ductal carcinoma of the right breast (ER/PR-negative, HER2-positive, Ki-67 ~30%). She underwent neoadjuvant chemotherapy with Abraxane and carboplatin with G-CSF support, followed by breast surgery and radiotherapy. Her treatment course was complicated by an allergic reaction to carboplatin.

In 2020, the patient developed a violaceous, asymptomatic nodule on the scalp. Histopathological examination of the skin biopsy revealed dermal invasion by a moderately to poorly differentiated carcinoma composed of medium-sized atypical cells forming tubular, solid, and cribriform structures, with numerous mitotic figures. Immunohistochemical analysis demonstrated positivity for CK19 and E-cadherin and negativity for CK20, TTF-1, ER, and PR, with low HER2 expression (score 1).

Results

The findings of the histology of the biopsy of the nodule of the scalp were consistent with cutaneous metastasis from the known ductal breast carcinoma. At that time, the patient also developed pleural effusion. In 2022, disease progression was noted with the development of brain metastases. The patient was treated with Sacituzumab govitecan (10 mg/kg), followed by gemcitabine and epirubicin/eudoxine. Despite treatment, her condition deteriorated, and she died three months later.

Conclusions

This case illustrates the significance of cutaneous metastases as a visible marker of systemic disease progression in breast cancer. Although rare, scalp metastases should be considered in patients with a history of breast carcinoma presenting with new skin lesions. Accurate histopathological and immunohistochemical correlation with the primary tumor is crucial for diagnosis. Additionally, the case highlights the challenges of systemic treatment sequencing in advanced disease, particularly in patients with hypersensitivity to standard chemotherapeutic agents.

Abstract N°: ID-137

Topic: Cutaneous oncology

Clinical Management and Outcomes of Nodular Malignant Melanoma Treated with Pembrolizumab

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Introduction

Amelanotic melanoma, a rare and aggressive cutaneous malignancy (2–8% of cases), lacks melanin pigmentation, often appearing as erythematous or pink lesions that resemble benign skin disorders, thereby complicating diagnosis. The nodular subtype is especially lethal due to rapid vertical progression and poor outcomes. Diagnostic accuracy is hindered by its atypical appearance; while dermatoscopy may aid suspicion, confirmation necessitates histopathology and immunohistochemistry. Prompt detection and surgical intervention are critical, particularly in cases with substantial tumor depth or vascular involvement.

Materials and Methods

A 77-year-old woman with a medical history including cardiac insufficiency, advanced chronic venous disease (CEAP C4), cystic breast changes, prior hysterectomy, and a familial predisposition to gastroesophageal cancer (offspring affected), presented with a newly developed, ulcerated, erythematous nodular lesion (~20 mm) on the lateral left forearm.

Dermatoscopy revealed a polymorphic vascular configuration with irregular linear and dotted vessels, milky-red clods, reticular hypopigmentation, and white, structureless zones. Biopsy and subsequent histopathological and immunohistochemical evaluation confirmed nodular, amelanotic malignant melanoma with ulceration, deep dermal infiltration, and vertical proliferation. The Breslow depth measured 4.8 mm (Clark level IV) with lymphovascular invasion.

Results

Comprehensive CT imaging showed no distant disease. Wide local excision and sentinel node biopsy (left axillary/supraclavicular) revealed nodal metastases. Based on NCCN criteria, the melanoma was classified as stage IIIC. The patient commenced Pembrolizumab immunotherapy (4 cycles) targeting PD-1 immune checkpoint inhibition, alongside supportive care with antiemetics, antisecretory agents, and antihistamines.

Conclusions

Amelanotic melanoma presents significant diagnostic and therapeutic difficulties due to its uncommon appearance and aggressive nature. This case underscores the necessity of heightened clinical awareness for rapidly progressing, non-pigmented skin lesions, particularly in older adults. Early detection relies on dermatoscopy and expedited histopathological and immunohistochemical assessment. Adverse prognostic indicators, including substantial tumor depth and vascular invasion, require coordinated multidisciplinary care involving wide excision, sentinel node evaluation, and systemic treatment. Immune checkpoint inhibitors such as Pembrolizumab play a pivotal role in managing advanced disease. Timely identification and treatment are vital to enhancing survival in this rare melanoma

subtype.

Abstract N°: ID-138

Topic: Cutaneous oncology

Metastatic Acral Melanoma: Diagnostic and Therapeutic Challenges in a Clinical Case

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Introduction

Acral melanoma (AM) is a rare subtype of melanoma that arises on non-hair-bearing skin, including the palms, soles, and nail beds. Unlike other cutaneous melanomas (CM), AM is not linked to common risk factors such as sun exposure or fair skin and has a lower tumor mutational burden due to its lack of ultraviolet radiation association. Its prognosis is generally worse than CM, likely due to late detection, and it has fewer *BRAF* mutations, limiting the effectiveness of *BRAF* inhibitors . However, frequent mutations in *KIT* and *CDK4/6* suggest potential benefits from targeted therapies. Wide local excision remains the primary treatment, while metastatic cases may require systemic therapies, including chemotherapy, immune checkpoint inhibitors, and mutation-targeted treatments. Despite advances in therapy, metastatic AM shows reduced responsiveness to immune checkpoint inhibitors due to a weaker immune response.

Materials and Methods

We present the case of a 50-year-old female patient with a known history of grade 2 hypertension and obesity. Six months prior to her admission to our clinic, she developed an adenopathic tumor mass in the left thigh, located in the Scarpa triangle, which was subsequently excised. Histopathological examination confirmed a massive lymph node metastasis of malignant melanoma. Immunohistochemical analysis demonstrated strong positive expression for S100, HMB-45, MART1, and Tyrosinase markers, with a Ki67 proliferation index of approximately 25% in atypical cells. No p.V600 mutations were detected in the BRAF gene.

A computed tomography (CT) scan of the thorax, upper abdomen, and pelvis, performed both without and with contrast, as well as a non-contrast cranio-cerebral CT scan, revealed no abnormalities. Soft-tissue ultrasound examination of the cervical, axillary, supraclavicular, and inguinal regions did not identify any ultrasonographically detectable lymphadenopathy, except for a well-defined, hyperechoic right inguinal lymph node. At the incision site on the medial aspect of the left thigh, a multiloculated, septated, transonic soft-tissue lesion with hyperechoic septa was observed, exceeding measurable limits.

The patient reported that approximately two years prior to the current presentation, she had undergone surgical excision of a bleeding pigmented tumor located on the left calcaneal region, though no histopathological report was available.

Results

Clinical examination revealed multiple junctional pigmented nevi across the body. At the site of the previous tumor excision on the left heel, pigmentation was observed on the surface of the scar, visible both clinically and dermatoscopically. Dermatoscopic examination showed a disorganized gray-blue pigmentation within the papillary ridges, in the periphery of the calcaneal scar. Surgical excision and histopathological analysis of the lesion were performed, confirming recurrent acral lentiginous melanoma and a dermal fibrous scar.

The patient was initiated on immunotherapy with Nivolumab and Ipilimumab; however, after two cycles, treatment was discontinued due to grade 4 toxicity. Consequently, chemotherapy with Dacarbazine (six cycles) was initiated, followed by Carboplatin and Paclitaxel. However, after five cycles, chemotherapy was discontinued due to hematologic toxicity.

Conclusions

In conclusion, acral melanoma presents unique diagnostic and therapeutic challenges due to its distinct molecular profile, delayed clinical detection, and poor response to conventional treatments. This case highlights the aggressive nature of metastatic AM and the limitations of current therapeutic strategies, particularly the reduced efficacy of immune checkpoint inhibitors and the toxicity associated with systemic chemotherapy. The patient's clinical course underscores the need for novel targeted therapies and personalized treatment approaches to improve outcomes in AM. Further research is essential to enhance early detection and optimize treatment strategies for this rare and aggressive melanoma subtype.

Abstract N°: ID-139

Topic: Cutaneous oncology

Dual Diagnosis of In Situ Squamous Cell Carcinoma and Nodular Melanoma: Clinical and Management Challenges

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Introduction
The simultaneous occurrence of two distinct primary skin cancers in a single patient is an unusual but increasingly recognized phenomenon, often attributed to shared risk factors such as cumulative UV exposure, immunosenescence, and genetic susceptibility. While melanoma and squamous cell carcinoma are individually common malignancies, their synchronous presentation poses unique diagnostic and therapeutic challenges. Early recognition and comprehensive management are critical for optimizing patient outcomes, particularly when aggressive tumor types, such as nodular melanoma, are involved.

Materials and Methods
We present the case of a 67-year-old patient with a history of ischemic stroke four years earlier, who developed two recent, asymptomatic tumoral lesions. Clinical examination identified a 20 mm elevated, nodular, brown-gray lesion with a bumpy surface, asymmetry, and irregular borders on the left pectoral region, evolving over two months (Lesion A). Dermoscopy revealed a disorganized, asymmetrical pattern with atypical vascular structures and blue-gray areas.

A second, slightly elevated gray lesion, approximately 5 mm in diameter, was noted in the left infraclavicular region (Lesion B), with dermoscopy showing clusters of rounded and coiled blood vessels, which had appeared concurrently with the first lesion.

Results
Histopathological examination of the biopsied lesions revealed a nodular melanoma with microsatellites, subcutaneous adipose tissue invasion (Clark level V), and a Breslow thickness of 8.5 mm (Lesion A), as well as a completely excised squamous cell carcinoma in situ (Lesion B).

Lesion A was surgically re-excised with a 20 mm safety margin, uncovering a satellite melanoma nodule. Sentinel lymph node biopsy confirmed metastatic melanoma in the left axillary region. Imaging studies (soft tissue ultrasound, thoracoabdominopelvic CT, brain MRI, and PET-CT) detected metabolically active supra- and subdiaphragmatic lymphadenopathies. LDH and S100 protein levels remained within normal limits. According to NCCN guidelines, the disease was classified as stage IIIC, with a negative BRAF mutation.

The patient underwent 16 cycles of nivolumab, maintaining a favorable clinical course without disease progression over a four-year follow-up, monitored by imaging and semiannual LDH and S100 assessments.

Conclusions
This case highlights the importance of thorough clinical and dermoscopic examination in identifying multiple concurrent

skin malignancies. The presence of both nodular melanoma and squamous cell carcinoma in situ in the same patient underscores the need for a high index of suspicion, particularly in elderly individuals with risk factors for skin cancer. Prompt biopsy, accurate histopathologic diagnosis, and individualized management strategies are essential to address the distinct biological behaviors of each malignancy and to improve overall prognosis.

Abstract N°: ID-161

Topic: Cutaneous oncology

Triple synchronous primary melanomas in a 48-year-old male: The critical role of total skin examination in early diagnosis

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Introduction
Multiple primary melanomas (MPM) occur in a small subset of melanoma patients, while triple synchronous primary melanomas are exceedingly rare. The number of reported 3PM cases in the literature remains limited, mostly consisting of isolated case reports involving elderly patients. Early detection is often contingent upon thorough total skin examination (TSE), as patients may remain unaware of additional lesions. To our knowledge, few cases of 3PM have been documented in patients under 50 years of age. Few similar cases, such as those by Karimi et al. and Castillo-Apitz et al., have emphasized the importance of full-body skin examination in detecting multiple synchronous melanomas. This report presents a 48-year-old male with three histologically distinct melanomas, all identified during a single dermatological visit.

Materials and Methods
A 48-year-old male with Fitzpatrick skin type II presented for evaluation of a pigmented lesion on his left upper arm. He denied any history of malignancy or familial cancer predisposition. During total skin examination, two additional suspicious lesions were noted on the right ankle and right scapular region. All three lesions were dermoscopically evaluated using a DermLite DL5 device (polarized mode) and subsequently excised for histopathological and immunohistochemical analysis.

Results

Three distinct melanocytic lesions were excised and confirmed histopathologically as primary melanomas.

The first lesion, located on the **left upper arm**, was a 6 mm blue-black papulonodule with a structureless blue-white veil and dotted vessels on dermoscopy. Histopathology revealed a **nodular melanoma** (Breslow 1.2 mm, Clark III, mitotic rate 3–4/mm^2, pT2a).
The second lesion on the **right medial ankle** appeared as a hyperpigmented papule with papillomatous surface and asymmetry. Dermoscopy showed a multicomponent pattern with irregular networks. It was diagnosed as **nodular melanoma** (Breslow 1.4 mm, Clark III, mitotic rate 0–1/mm^2, pT2a).
The third lesion on the **right scapular region** was an asymmetric macule with globules, blotches, and central regression features. Dermoscopy suggested superficial spreading melanoma, confirmed histologically (Breslow 0.4 mm, Clark II, pT1a).

All three melanomas showed strong expression of SOX10, HMB45, PRAME, and BRAF V600E, with focal loss of p16. D2-40 and CD31 were negative, excluding lymphovascular invasion. Pagetoid intraepidermal spread and nevoid components were observed. The patient was referred to plastic surgery and oncology; wide local excisions and staging are pending.

Conclusions
This case highlights the pivotal role of total skin examination in detecting clinically silent melanomas. Due to the scarcity of reported 3PM cases in the literature—especially in younger patients—our case adds valuable evidence to an

underexplored clinical phenomenon. The identification of triple synchronous melanomas in a 48-year-old patient with no known risk factors emphasizes the need for comprehensive skin evaluation beyond the presenting lesion. The histopathologic and molecular diversity among the tumors underscores the importance of a multidisciplinary approach, integrating clinical, dermoscopic, and immunohistochemical data for optimal management.

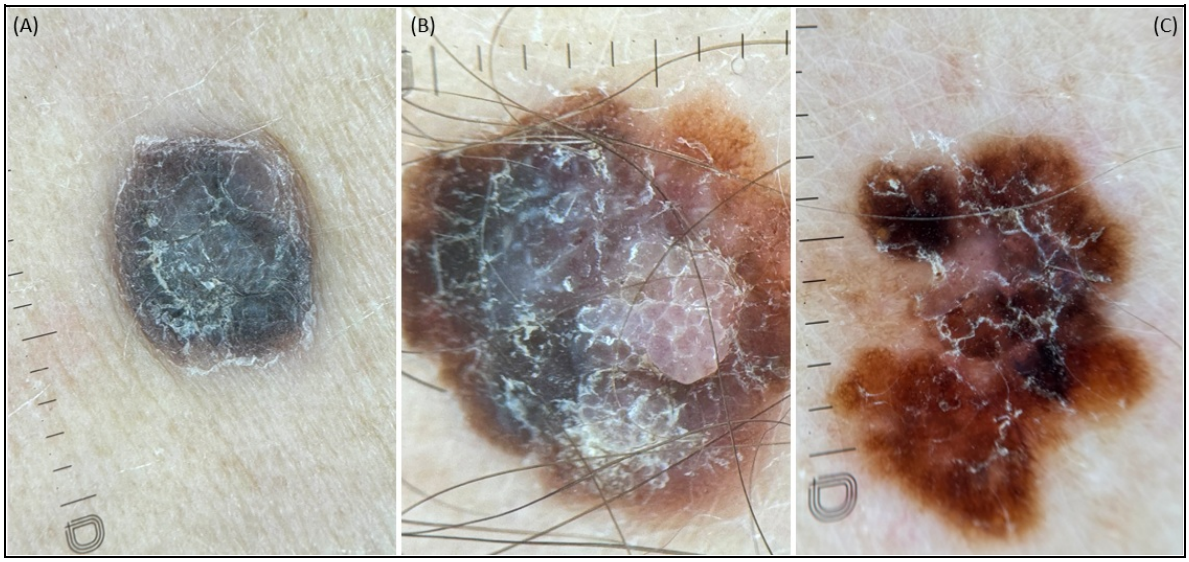

Figure 1. Dermoscopic images of three synchronous melanomas identified in a 48-year-old male. (A) Left upper arm – nodular melanoma with structureless blue-white veil (B) Right ankle – nodular melanoma with multicomponent pattern and irregular pigment network. (C) Right scapula – superficial spreading melanoma with regression structures and blotches.

Abstract N°: ID-166

Topic: Cutaneous oncology

Scrotal Melanoma in the Elderly: A Hidden and Under-Recognised Diagnosis

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Introduction

Genitourinary melanoma is a rare presentation of melanoma accounting for approximately 0.5% of all melanomas. Reports of male urethral and scrotal melanoma are even less common. (1) We describe a case of primary scrotal melanoma in an elderly man and hoping to draw attention to this rare but aggressive clinic entity.

Materials and Methods

Case Report:

An 83-year-old man presented with a rapidly growing, friable lesion on the right side of the scrotum, first noticed nine months earlier. Despite attempted cryotherapy in primary care, the lesion continued to grow without clinical improvement. He had a significant history of skin cancer, including 22 basal cell carcinomas, two melanoma in situ, and one squamous cell carcinoma. He had long-term sun exposure due to his occupation as a gardener.

Clinical examination revealed a 2.0 × 1.5 cm ulcerated, non-pigmented, soft nodule. Punch biopsy confirmed melanoma, and wide local excision was performed. Histology showed nodular melanoma (pT4b), a Breslow depth of 11 mm, ulceration, 25 mitoses/mm^2, no vascular or lymphatic invasion, and no microsatellites. BRAF, NRAS, and KIT were wild-type. Imaging showed no nodal or distant metastasis. The patient declined sentinel lymph node biopsy and adjuvant immunotherapy following multidisciplinary discussion. He remains recurrence-free at 12 months with routine surveillance.

Results

Discussion:

Scrotal melanoma is exceedingly rare, with fewer than 50 cases documented in the literature. [1]. While it often presents as a pigmented macule or papule, atypical forms may appear as non-pigmented, ulcerated nodules. [2]. This case aligns with prior reports highlighting that scrotal melanoma often presents late and at an advanced stage, with tumour thickness frequently exceeding 2 mm [1]. In our case, we believe diagnosis and definitive treatment were delayed due to both the concealed anatomical site and initial management in primary care.

Conclusions

This highlights the importance of proactive genital assessment, clinician awareness, and early referral for suspicious lesions to improve patient outcomes.

Abstract N°: ID-174

Topic: Cutaneous oncology

Post-scabietic Cutaneous Lymphoid Hyperplasia Resistant to Dapsone Successfully Treated with Methotrexate

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Introduction

Cutaneous lymphoid hyperplasia (CLH) is a benign reactive pseudolymphomatous condition characterized by polyclonal proliferation of lymphoid cells in the skin. It may closely mimic cutaneous lymphomas both clinically and histopathologically, making accurate diagnosis challenging. CLH typically presents as solitary or multiple slowly progressive papules or nodules, most commonly affecting the face, neck, and trunk. While various antigenic stimuli have been implicated, the etiology remains idiopathic in many cases. Pseudolymphomatous reactions following ectoparasitic infestations are rarely reported. We present a rare case of post-scabietic CLH that was refractory to dapsone but responded favorably to methotrexate.

Materials and Methods

A 73-year-old woman presented with a three-month history of persistent generalized pruritus and progressive papulonodular skin lesions. She had previously been diagnosed with scabies and treated with oral ivermectin; however, pruritus and skin lesions persisted despite treatment. Dermatological examination revealed multiple erythematous, firm, indurated papules and nodules on the back, lateral trunk, and lower extremities. No burrows, lymphadenopathy, or systemic symptoms were detected. Punch biopsies were obtained for histopathological examination and immunohistochemical staining. Systemic involvement was excluded through complete blood count and positron emission tomography.

Results

Histopathological examination demonstrated orthohyperkeratosis, focal parakeratosis, mild spongiosis, and irregular epidermal hyperplasia. A dense inflammatory infiltrate extending from the superficial to deep dermis with predominantly perivascular and interstitial distribution was observed, composed mainly of small lymphocytes with accompanying eosinophils and histiocytes. Immunohistochemistry showed preserved expression of pan-T-cell markers (CD2, CD3, CD5, CD7). CD4-positive T cells comprised approximately 55–60% and CD8-positive cells 40–45%, yielding a balanced CD4/CD8 ratio. CD20-positive B cells comprised less than 5% of the infiltrate. CD30-positive large atypical cells were absent, and the Ki-67 proliferation index was low (5–10%). These findings supported a diagnosis of reactive lymphoid infiltration consistent with post-scabietic CLH. Topical high-potency corticosteroids and oral dapsone (50 mg daily for five weeks) failed to achieve clinical improvement. Following dapsone discontinuation, methotrexate (15 mg weekly) was initiated, resulting in marked regression of lesions and significant reduction of pruritus after 12 weeks of treatment.

Conclusions

Post-scabietic cutaneous lymphoid hyperplasia is a rare diagnostic entity that may closely mimic cutaneous lymphoma both clinically and histopathologically. Comprehensive histopathological, immunophenotypic, and systemic evaluation is essential for accurate diagnosis and malignancy exclusion. In cases refractory to conventional therapies, methotrexate may represent an effective alternative treatment option. This case highlights the potential role of methotrexate in managing persistent, treatment-resistant CLH following scabies infestation.

Abstract N°: ID-204

Topic: Cutaneous oncology

Coexistence of Kaposi's Sarcoma and Psoriasis: a Case Report

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Introduction
Kaposi's sarcoma (KS) is a complex angioproliferative neoplasm affecting the extremities and caused by endothelium derived cells infected with human herpesvirus 8. A review of the literature reveals a few cases of KS accompanied by psoriasis, but in actual practice the coexistence of these two diseases is a diagnostic challenge. In regard to the pathogenetic relationship between these two diseases, one possibility under discussion is a common genetic basis due to predisposing HLA loci found in both entities (A1, DR5, DR7, DR11) [Erdoğan H.K., et al. 2017].

Materials and Methods
A case report.

Results
A 63-year-old male patient complained of a widespread lesion on his body. The patient had been diagnosed with psoriasis vulgaris for at least 30 years. Therefore, the patient treated his rashes as psoriatic and used topical steroids. Despite the administration of topical corticosteroids, the observed effect was minimal. In addition, the patient was frequently prescribed ultraviolet B (UVB) 311 nm phototherapy. No other comorbidities were identified. Clinical examination revealed reddish infiltrative plaques with white scaling on the trunk and upper extremities. Purplish plaques without scaling were observed on the patient's lower extremities. Furthermore, purplish-blue nodules approximately 10 mm in diameter were observed on the dorsal surfaces of the right popliteal region and left foot. The excised nodules were subjected to histologic examination, which revealed the presence of dermal tumor nests composed of cells that showed positive reactivity with HHV-8 immunohistochemical staining. This finding led to the diagnosis of Kaposi's sarcoma. The patient's HIV status was confirmed to be negative, and the results of RPR, TPHA, anti-HCV, HBsAg, ANA, ANCA were negative as well. The patient's partner was also tested for these infections and tests were negative. A computed tomography scan of the patient's chest, abdomen, and pelvis revealed a suspicious mass in the S7 liver segment. A multidisciplinary dermato-oncology team was consulted and chemotherapy was recommended as a potential treatment option. However, it was necessary to verify the nature of the mass in the liver prior to initiating this therapy. An abdominal MRI revealed the presence of a hemangioma. On October 20, 2024, the patient began treatment with paclitaxel administered intravenously at a dose of 100 mg/m^2 every two weeks. The patient received four cycles of chemotherapy and the lesions on the lower extremities showed gradual regression.

Conclusions
When HHV-8 positivity in histological examination is found, it is essential to exclude HIV infection and other possible

causes of immunosuppression - oncological diseases, hepatitis B and C, connective tissue diseases. In this case, all these causes were excluded and Kaposi's sarcoma could be associated with psoriasis. Although it is difficult to determine the exact nature of Kaposi's sarcoma and its relationship to psoriasis, it is often necessary to consider a number of factors to correlate these two conditions. These include regulation of the immune system and increased activation of T helper 1, levels of the pro-inflammatory cytokine interleukin-6, genetic predisposition of HLA factors, and immunosuppressive treatment of psoriasis vulgaris.

Abstract N°: ID-212

Topic: Cutaneous oncology

Papillary Eccrine Adenoma with Overlying Keratoacanthoma and Syringocystadenoma Papilliferum: A Rare Composite Adnexal Tumour

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Introduction

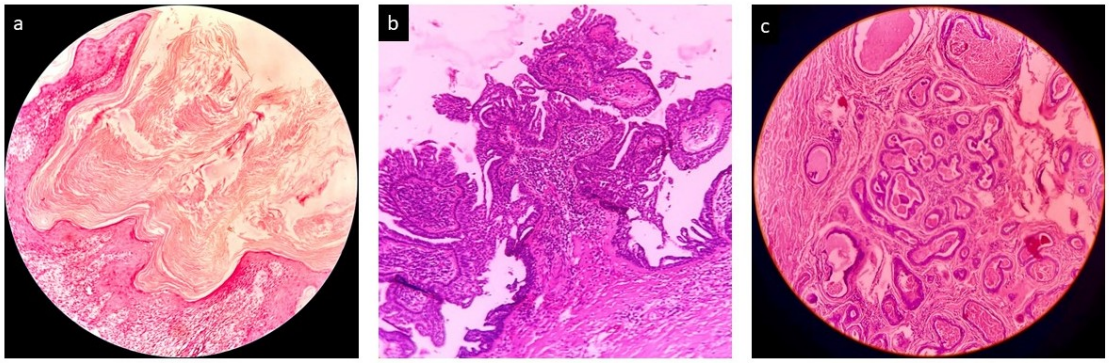
Papillary eccrine adenoma (PEA) and syringocystadenoma papilliferum (SCAP) are rare benign adnexal tumours, while keratoacanthoma (KA) is a rapidly growing epidermal neoplasm that clinically mimics squamous cell carcinoma. Although individual associations between adnexal tumours have been described, the coexistence of PEA, SCAP, and KA within a single lesion is exceedingly rare and, to our knowledge, unreported. We present a unique case highlighting the diagnostic challenges and histogenetic implications of composite adnexal tumours.

Materials and Methods

A man in his 60s presented with a 30-year history of a slowly enlarging, asymptomatic gluteal nodule, which recently developed pruritus and ulceration. Clinical examination revealed clustered, firm, exophytic nodules with a lobulated surface on the left mid-gluteal region. An excisional biopsy was performed. The specimen was processed as formalin-fixed, paraffin-embedded tissue and examined using hematoxylin and eosin (H&E) staining to assess epidermal and adnexal differentiation.

Results

On clinical examination, multiple skin-coloured to erythematous, firm, non-tender clustered nodules were noted over the left mid-gluteal region. The lesions displayed an exophytic, lobulated surface with focal ulceration on a background of lichenified skin. Histopathological examination revealed three distinct tumour components within a single lesion. The overlying epidermis showed a crateriform architecture with lamellated keratin, prominent epidermal lipping, and bland squamous proliferation, consistent with keratoacanthoma. The superficial dermis demonstrated an exoendophytic papillary neoplasm lined by bilayered epithelium with apocrine decapitation secretion and a plasma cell–rich stroma, diagnostic of syringocystadenoma papilliferum. In the deeper dermis, well-circumscribed tubular structures with intraluminal micropapillary projections and eosinophilic secretions were identified, consistent with papillary eccrine adenoma. No cytological atypia or malignant transformation was observed. Complete excision was curative, with no recurrence at six-month follow-up.



(a) Histopathology (H&E, ×40) showing lamellated keratin overlying the crater lip with bland squamous cells, consistent with keratoacanthoma. (b) Histopathology (H&E, ×100) showing syringocystadenoma papilliferum with papillary projections lined by bilayered epithelium, decapitation secretion, and plasma cell–rich stroma. (c) Histopathology (H&E, ×100) showing papillary eccrine adenoma with dilated tubular structures, intraluminal micropapillary projections, and eosinophilic secretions.

Conclusions

This case describes a previously unreported composite adnexal tumour comprising keratoacanthoma, syringocystadenoma papilliferum, and papillary eccrine adenoma arising within a single long-standing gluteal lesion. It underscores the importance of complete excision and meticulous histopathological evaluation in clinically ambiguous or persistent nodules. Recognition of such rare composite adnexal tumours is essential to avoid misdiagnosis and offers insight into shared pathways of adnexal tumour histogenesis. Long-standing, slowly enlarging cutaneous nodules, even in uncommon non–sun-exposed sites such as the gluteal region, should therefore prompt thorough histopathological assessment.

Abstract N°: ID-214

Topic: Cutaneous oncology

Non-Acral Pigmented Eccrine Poroma Mimicking Melanoma: A Case Report

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Introduction
Eccrine poromas are benign adnexal tumours originating from the intraepidermal portion of the eccrine sweat gland duct (acrosyringium), most commonly affecting acral sites such as the palms and soles. Non-acral presentations are rare and may pose diagnostic challenges, particularly when pigmented, as they can clinically mimic malignant lesions, including melanoma and pigmented basal cell carcinoma. We present a rare case of pigmented eccrine poroma on the posterior shoulder, emphasizing the diagnostic importance of histopathological evaluation in atypical locations.

Materials and Methods
A 27-year-old male presented with a solitary, hyperpigmented nodule on the posterior left shoulder, present for over 10 years, with occasional serous discharge but no pain, bleeding, or systemic symptoms. Clinical examination revealed a well-circumscribed, 2 × 3 cm nodular lesion with an irregular surface and multiple punctate depressions; surrounding skin was normal. Considering the differential diagnoses of nodular melanoma, pigmented basal cell carcinoma, dermatofibroma, and seborrheic keratosis, an excisional biopsy was performed under local anaesthesia. The tissue was formalin-fixed, paraffin-embedded, and examined with hematoxylin and eosin (H&E) staining.

Results
Histopathology revealed a sharply demarcated epithelial neoplasm extending from the lower epidermis into the superficial and mid-dermis. The lesion consisted of broad, interconnected bands and cords of uniform poroid cells with round to oval basophilic nuclei, scant eosinophilic cytoplasm, and minimal pleomorphism. Scattered dendritic melanocytes within the tumour accounted for the pigmentation. Diagnostic ductal differentiation was present, confirming eccrine origin. No features of malignancy, including nuclear atypia, mitotic activity, or deep dermal invasion, were observed. Complete excision was performed, and the patient remained recurrence-free on follow-up.

Conclusions
This case illustrates a rare non-acral pigmented eccrine poroma clinically mimicking melanoma. It highlights the need for histopathological confirmation in atypical pigmented lesions to ensure accurate diagnosis and prevent overtreatment. Awareness of such uncommon presentations is essential for dermatologists and pathologists to avoid misdiagnosis and guide appropriate management.

Abstract N°: ID-252

Topic: Cutaneous oncology

PRIMARY CUTANEOS T-LYMPHOBLASTIC LYMPHOMA IN A PREGNANT WOMAN WITH CONJONCTIVAL INVOLVEMENT : A FIRST DESCRIPTION

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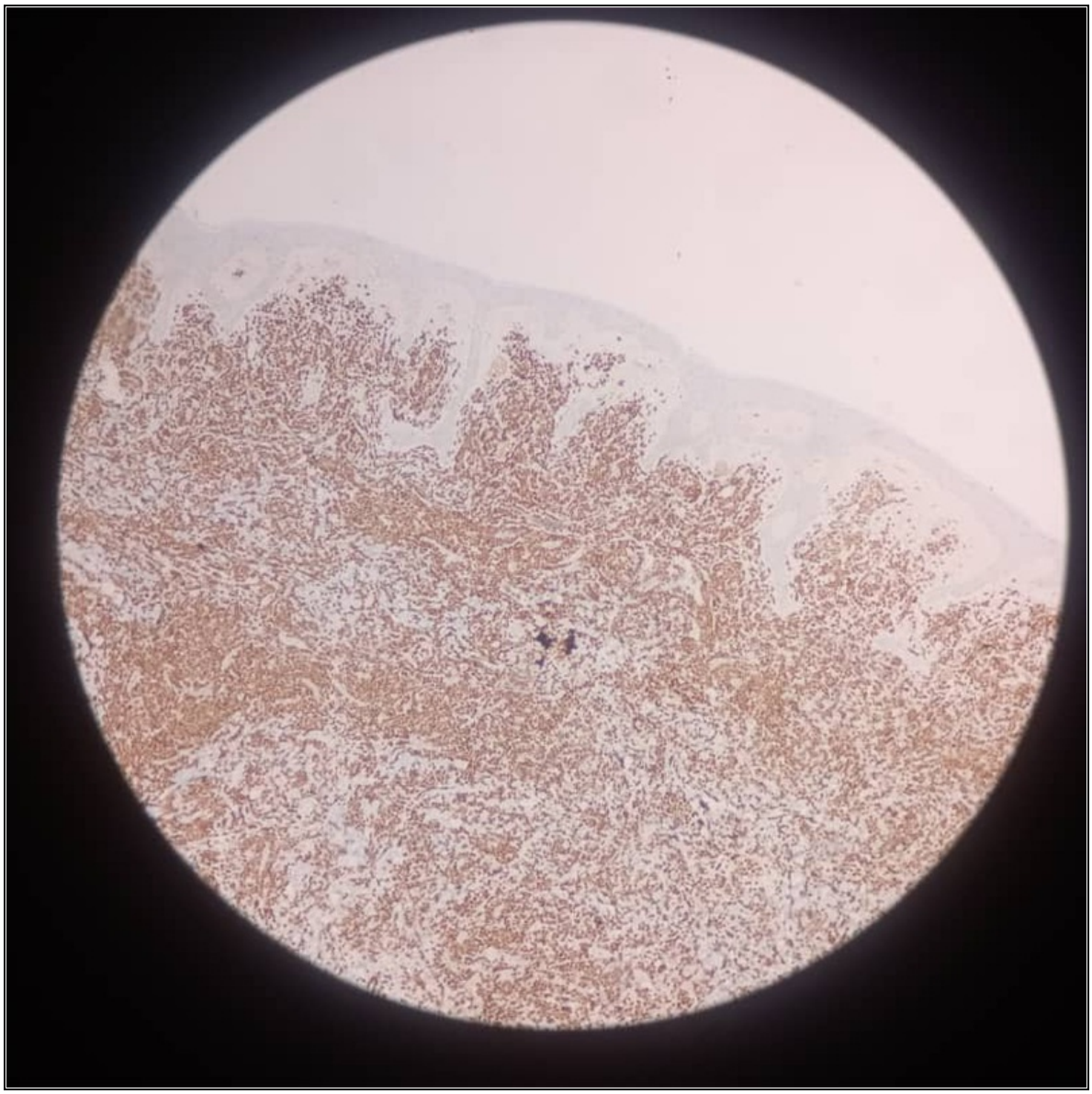
Introduction

T-lymphoblastic lymphoma (T-LBL) is a rare subtype of non-Hodgkin lymphoma, accounting for approximately 2% of adult cases. Cutaneous involvement is exceptional, with fewer than 20 cases reported, and only two described as primary cutaneous forms.

Materials and Methods

We report the case of a 23-year-old pregnant woman who presented with rapidly progressive violaceous macules evolving into multiple papulo-nodular and tumoral lesions predominantly involving the trunk, associated with bilateral conjunctival mucosal involvement. There was no peripheral lymphadenopathy. Histopathological examination revealed a monomorphic dermal infiltrate of small- to medium-sized lymphoid cells without epidermotropism. Immunohistochemistry demonstrated expression of CD3, CD5, and TdT, with a high Ki-67 index, confirming the diagnosis of primary cutaneous T-lymphoblastic lymphoma. Systemic staging did not reveal bone marrow or peripheral blood involvement. The patient was treated with a GRAALL-based chemotherapy regimen, with a favorable clinical outcome.



Intense and diffuse nuclear positivity of tumor cells Photomicrograph Immunohistochemistry (IHC), TdT-positive

Results

T-lymphoblastic lymphoma (T-LBL) is a rare non-Hodgkin lymphoma, accounting for approximately 2% of adult cases, and mainly affects adolescents and young adults. It classically presents with a mediastinal mass and peripheral lymphadenopathy. Cutaneous involvement is exceptional, with fewer than 20 cases reported in the literature, and only two cases described as primary cutaneous T-LBL. When present, skin lesions usually consist of multiple nodules involving the trunk, thoracic and abdominal walls, breast region, or cervical area.

The present case is remarkable due to disease onset through cutaneous lesions during pregnancy, associated with conjunctival mucosal involvement, a presentation not previously reported.

Histopathology typically shows a monomorphic dermal infiltrate of small- to medium-sized lymphoid cells without epidermotropism. Immunohistochemical analysis is essential to differentiate T-LBL from other cutaneous T-cell lymphomas, particularly the not otherwise specified (NOS) subtype. The characteristic immunophenotype includes expression of CD3 and CD5, together with TdT, a key marker of lymphoblastic lymphomas, positive in approximately 95% of T-LBL cases, as observed in our patient.

Conclusions

Primary cutaneous lymphoblastic lymphoma is a rare entity that requires careful clinicopathological correlation

Primary cutaneous lymphoblastic lymphoma is a rare entity that requires careful clinicopathological correlation, especially in atypical presentations such as the one reported here.

Abstract N°: ID-284

Topic: Cutaneous oncology

Dermatofibrosarcoma Protuberans Mimicking Benign Lesions: A Case Series Emphasizing Diagnostic Pitfalls and Molecular Challenges

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Introduction

Dermatofibrosarcoma protuberans (DFSP) is a rare, low-grade cutaneous sarcoma with infiltrative growth and a risk of local recurrence after inadequate excision. While DFSP often presents with characteristic protuberant features, early or non-classic DFSP can lack these features and clinically mimic benign conditions, such as cysts or keloids, leading to diagnostic delays and suboptimal management. PDGFB fluorescence in situ hybridization (FISH) is commonly used for molecular confirmation, but in some cases, reliance on this single test may lead to misdiagnosis, especially when the fusion is absent or occurs with alternative gene partners. This case series illustrates the clinical heterogeneity of DFSP and highlights diagnostic challenges associated with PDGFB FISH.

Materials and Methods

We retrospectively reviewed three patients with histopathologically suspected DFSP presenting with benign-appearing clinical phenotypes. Clinical, histopathologic, immunohistochemical, and molecular testing results were analyzed. Histology showed storiform spindle-cell proliferation involving the dermis and subcutaneous tissue. Immunohistochemistry included CD34, S100/SOX10, and smooth muscle markers. PDGFB FISH and COL1A1::PDGFB fusion testing were performed when material was available.

Results

All three lesions presented with clinically misleading features: (i) a cyst-like subcutaneous nodule, (ii) a keloid-like plaque, and (iii) a long-standing pigmented lesion clinically considered in the differential diagnosis of benign melanocytic/vascular entities. Histopathology in all cases revealed storiform spindle-cell proliferation with diffuse CD34 positivity and absence of melanocytic markers (S100/SOX10 negative). COL1A1::PDGFB fusion was identified in two cases, confirming DFSP (including a pigmented variant in one case). In one case, PDGFB FISH was negative despite classic morphology and immunophenotype, highlighting a diagnostic pitfall. As illustrated in Figure 1, this diagnostic workflow underscores the importance of clinicopathologic integration and highlights the need for broader molecular testing when PDGFB FISH results are negative. Broader molecular testing was recommended but limited by tissue availability.

Conclusions

This three-case series underscores the clinical heterogeneity of DFSP, demonstrating that deceptively benign-appearing lesions (e.g., cyst-like, keloid-like, pigmented presentations) may conceal DFSP. Notably, negative PDGFB FISH results do not exclude DFSP when histopathologic and immunophenotypic features are consistent. An integrated diagnostic approach, incorporating clinicopathologic correlation and, when necessary, broader molecular profiling, is essential for accurate diagnosis and appropriate surgical management.

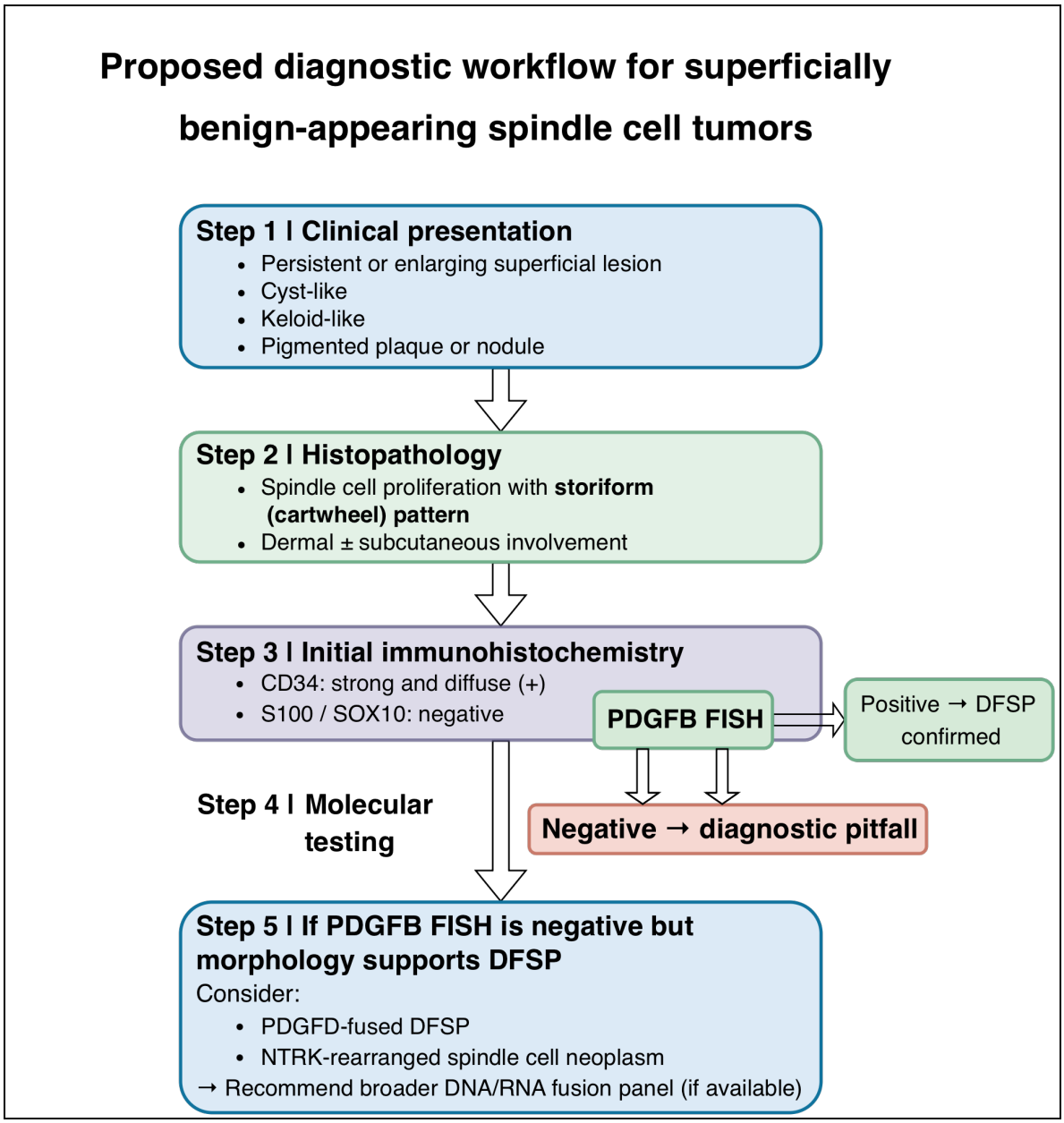

Figure 1. Proposed diagnostic workflow for benign-appearing lesions suggestive of DFSP. This workflow illustrates diagnostic steps for persistent or enlarging lesions with storiform spindle-cell proliferation and diffuse CD34 positivity, but negative melanocytic markers. PDGFB FISH is helpful when positive, but negative results may require consideration of alternative fusions (e.g., PDGFD, NTRK) and broader molecular profiling.

Abstract N°: ID-301

Topic: Cutaneous oncology

Pleomorphic dermal sarcoma presenting as a rapidly progressive facial tumour in a centenarian patient

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Introduction

Pleomorphic dermal sarcoma (PDS) is an uncommon cutaneous mesenchymal neoplasm with aggressive potential, predominantly affecting elderly individuals and arising on chronically sun-exposed skin. Its diagnosis relies primarily on histopathological assessment and immunohistochemical exclusion of major differential diagnoses, particularly atypical fibroxanthoma and other pleomorphic cutaneous tumours. Some authors regard PDS as a diagnosis of exclusion and propose that it may represent a dedifferentiated or spindle cell phenotype of ultraviolet-induced cutaneous malignancies, particularly squamous cell carcinoma and melanoma. Current soft tissue sarcoma guidelines emphasize appropriate risk stratification, staging and surveillance for high-risk lesions.

Materials and Methods

We report a case of PDS in a very elderly patient presenting with a rapidly progressive facial tumour. Clinical data, histopathological features and immunohistochemical findings were reviewed. Surgical excision was performed. The indication for staging investigations was assessed in accordance with soft tissue sarcoma management principles and tailored to patient-specific factors.

Results

A 101-year-old woman, fully dependent on all activities of daily living and with no social interaction, presented with a six-month history of a progressively enlarging cutaneous tumour on the right hemiface. Clinically, the lesion presented as a large exophytic and lobulated mass, measuring approximately 5 cm in greatest diameter, with a broad base and an irregular, friable and partially ulcerated surface. The lesion was surgically excised.

Histopathological examination revealed a dermal-based spindle cell neoplasm composed of intersecting fascicles with marked cytological pleomorphism and frequent atypical mitoses, with focal evidence of tumour necrosis.

Immunohistochemical analysis demonstrated strong CD10 expression, moderate positivity for smooth muscle actin and focal p63 positivity, while epithelial/squamous markers (AE1/AE3, CK5/6, 34βE12, p40), endothelial markers (CD31, CD34, ERG), melanocytic markers (S100, SOX10), desmin and CD117 were negative. The immunohistochemical profile supported a diagnosis of pleomorphic dermal sarcoma by excluding major differential diagnoses, including squamous cell carcinoma (CK5/6, 34βE12, p40), dermatofibrosarcoma protuberans (CD34), vascular tumours and angiosarcoma (CD31, ERG), leiomyosarcoma (desmin), and melanocytic neoplasms (S100, SOX10), with CD10, although nonspecific, supporting a pleomorphic spindle cell phenotype.

Complete excision was achieved, with the closest margin measuring approximately 0.5 mm at the deep margin. Although soft tissue sarcoma guidelines suggest that systemic staging may be considered for high-risk tumours, it was not performed owing to the patient's extreme age and functional status. No postoperative complications or evidence of local recurrence were observed during a six-month follow-up.

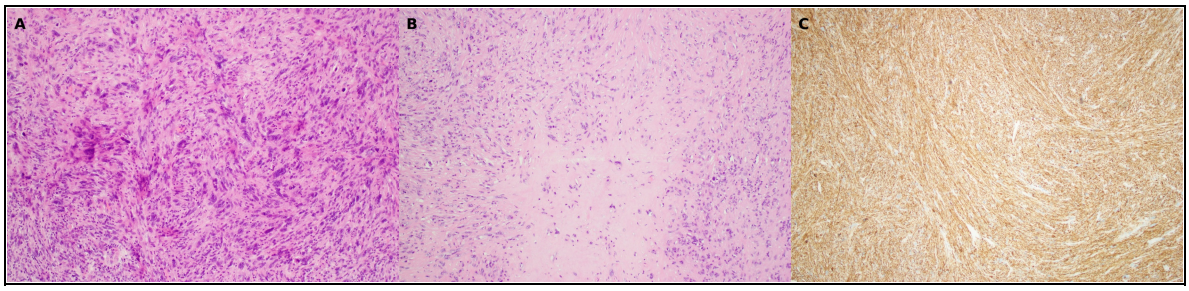

Figure 1. (A) Histopathology showed a dermal-based spindle cell neoplasm arranged in intersecting fascicles with marked cytological pleomorphism (H&E). (B) Areas of tumour necrosis, represented a high-risk histopathological feature supporting the diagnosis of PDS (H&E). (C) Tumour cells demonstrated strong and diffuse CD10 expression, consistent with a spindle cell phenotype.

Conclusions

This case highlights the diagnostic and therapeutic challenges posed by PDS, particularly in very elderly patients. Accurate histopathological evaluation, including careful interpretation of immunohistochemical markers and exclusion of major differential diagnoses is crucial. In particular, potential diagnostic pitfalls such as focal p63 expression should be interpreted in the context of a complete immunohistochemical panel, as the absence of p40 and cytokeratin expression (AE1/AE3, CK5/6) does not support epithelial differentiation. While soft tissue sarcoma guidelines advocate staging and close surveillance for high-risk lesions, clinical decision-making should be individualized, balancing oncological principles with patient-related factors, functional status and quality of life.

Abstract N°: ID-309

Topic: Cutaneous oncology

Radiotherapy-Associated Pleomorphic Dermal Sarcoma 33 Years After Basal Cell Carcinoma Treatment

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Introduction

Pleomorphic dermal sarcoma (PDS) is a malignant mesenchymal neoplasm of the skin that predominantly affects elderly individuals and typically arises on chronically sun-exposed areas of the head and neck. It is considered the aggressive end of the atypical fibroxanthoma spectrum, sharing histomorphological overlap while exhibiting adverse features such as infiltrative growth, deep tissue involvement, tumor necrosis, and an increased risk of local recurrence and distant metastasis. Radiotherapy is a well-recognized risk factor for secondary sarcomas arising within previously treated fields; however, this association has been primarily established for deep soft tissue sarcomas, and its relevance to cutaneous tumors, particularly PDS, remains insufficiently defined. Data regarding radiation-associated PDS, including latency periods and long-term behavior, are limited. Here, we report a patient who developed PDS within a previously irradiated cutaneous field more than three decades after radiotherapy for basal cell carcinoma (BCC).

Materials and Methods

A 63-year-old man presented with a rapidly enlarging lesion on the right side of his nose. His medical history was notable for a BCC diagnosed 33 years earlier at the same site. At that time, the patient was evaluated by a multidisciplinary tumor board and, due to concerns regarding surgical morbidity related to tumor location, declined surgical excision and underwent definitive external beam radiotherapy, delivered in a fractionated schedule to a cumulative dose of 45 Gy. According to the patient's history, no local recurrence, new primary skin tumors, or chronic ulceration developed within the irradiated field during the subsequent follow-up period. On current dermatologic examination, an infiltrative plaque with an irregular surface and focal crusting was observed, extending from the right medial canthus to the nasolabial fold (Figure 1).

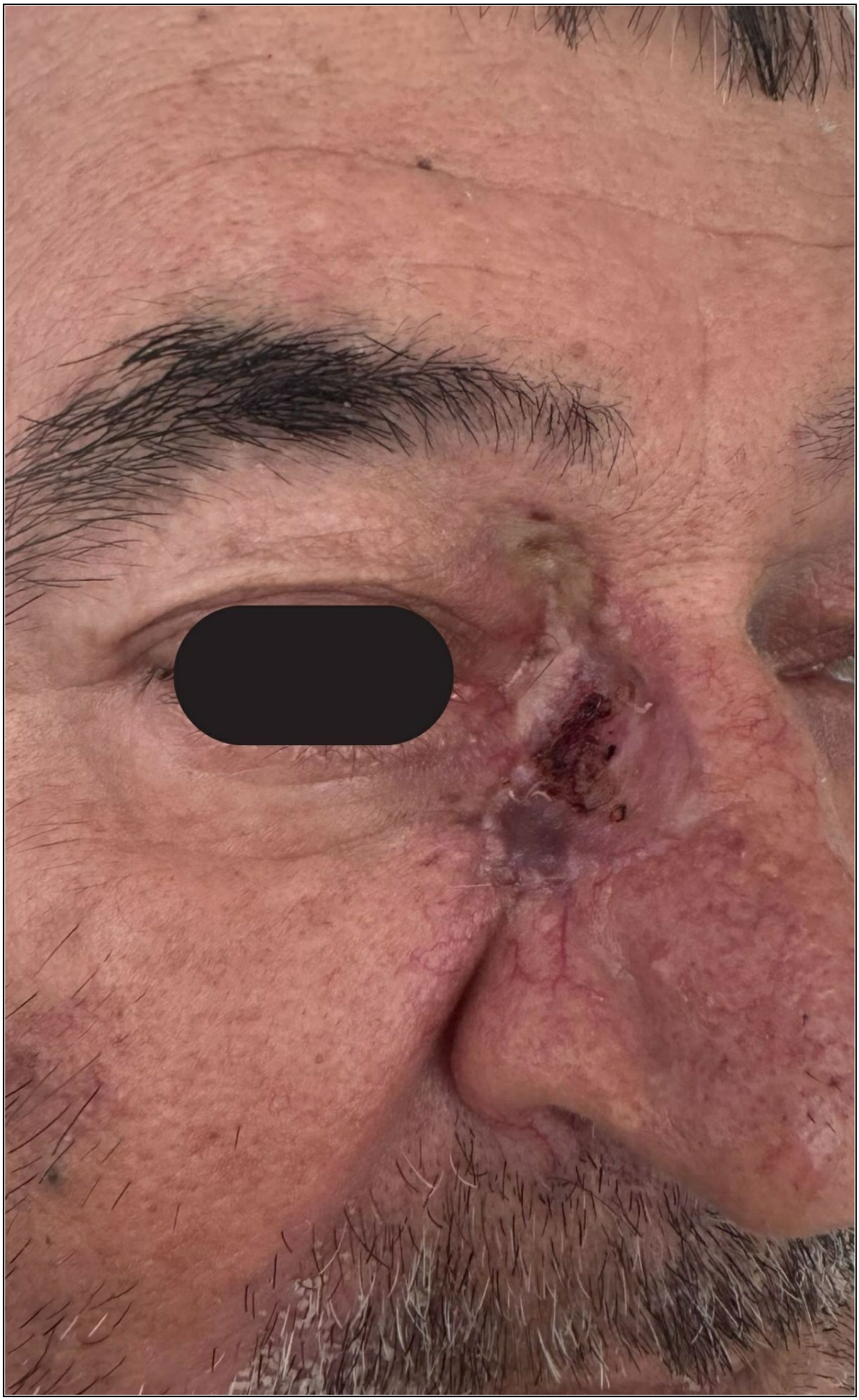

Figure 1. An infiltrative plaque with an irregular surface and focal crusting, extending from the right medial canthus to the nasolabial fold.

Results

Given the rapid growth and clinical suspicion of malignancy arising in a previously irradiated area, a biopsy was performed. Histopathological examination demonstrated a dermal-based malignant neoplasm composed of markedly pleomorphic spindle cells arranged in an infiltrative growth pattern, with invasion into underlying muscle tissue (Figure 2). The tumor showed pronounced nuclear atypia and frequent mitotic figures. Immunohistochemical analysis revealed a Ki-67 proliferation index of approximately 18% and negativity for epithelial, melanocytic, vascular, and myogenic markers, as well as CD10, thereby excluding atypical fibroxanthoma and supporting a diagnosis of PDS.

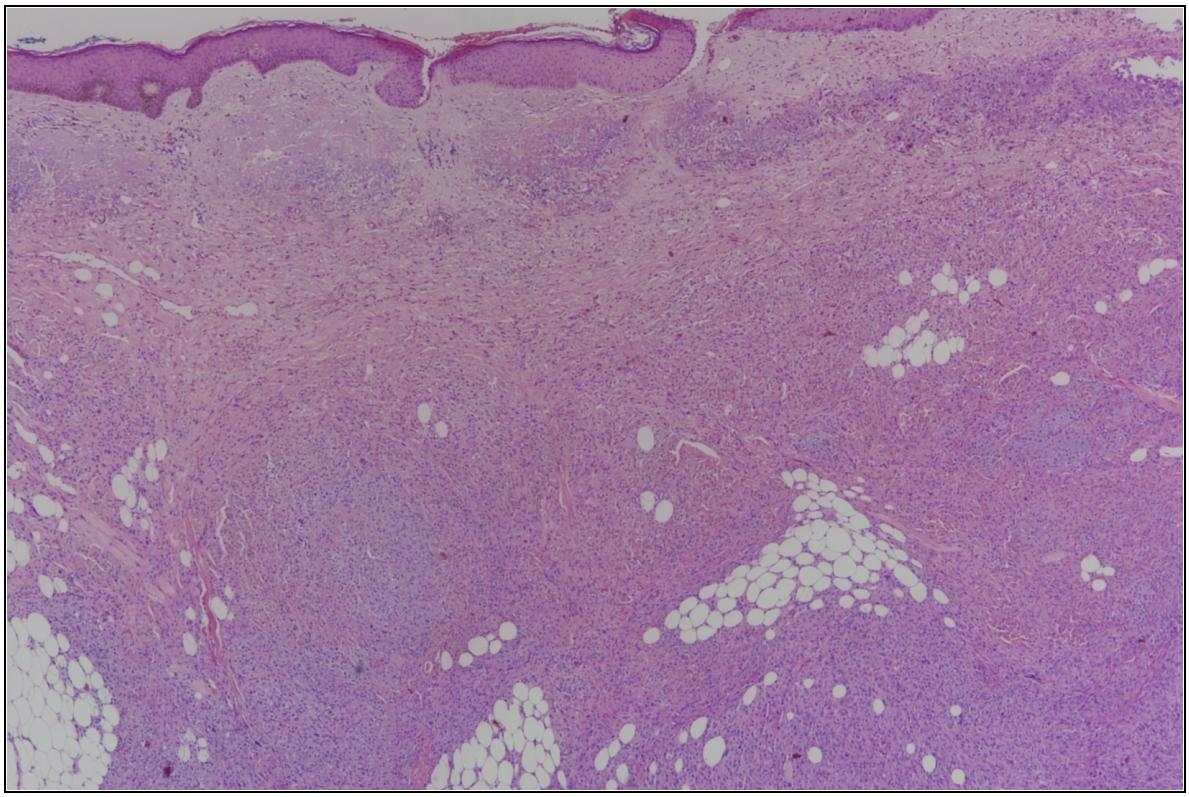

Figure 2. A dermal-based malignant neoplasm composed of pleomorphic spindle cells arranged in an infiltrative growth pattern (Haematoxylin & eosin, x40).

Conclusions

Although a definitive causal relationship cannot be established, the strict topographic concordance between the tumor and the previously irradiated field supports a possible association with prior radiotherapy. The exceptionally long latency period of 33 years lies at the upper end of those reported for radiation-associated sarcomas and underscores the persistent oncogenic potential of ionizing radiation on cutaneous mesenchymal tissues.

This case highlights that the latency period of radiation-associated sarcomas may extend up to 33 years. PDS should be recognized as a potential radiation-associated sarcoma that may arise long after radiotherapy. In the management of indolent cutaneous tumors such as BCC, radiotherapy should be reserved for carefully selected patients, with consideration of possible long-term complications. Finally, patients who have received radiotherapy for any indication require long-term dermatologic follow-up, as sustained surveillance of irradiated fields is essential for the timely detection of secondary malignancies.

Abstract N°: ID-323

Topic: Cutaneous oncology

Clinical and Health System Impact of Teledermatology in Suspected Skin Cancer Pathways: A Systematic Review

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Introduction
The incidence of skin cancer continues to rise, placing increasing pressure on dermatology services and contributing to high referral volumes and delays in specialist assessment. Teledermatology has emerged as a strategy to support early triage, improve access to specialist input, and reduce demand on face-to-face clinics within suspected skin cancer pathways. However, evidence regarding its clinical effectiveness, impact on patient outcomes, and system-level benefits remains heterogeneous. A synthesis of real-world evidence is therefore needed to define the role of teledermatology in contemporary skin cancer care.

Materials and Methods
A systematic search of major databases was performed in accordance with PRISMA guidelines, identifying 23 eligible studies from 294 screened records. Risk of bias was assessed using the Cochrane RoB 2 tool for randomised trials and the Newcastle-Ottawa Scale for observational studies.

Results
Across included studies, teledermatology demonstrated high diagnostic performance for suspected skin cancer, with diagnostic accuracy comparable to face-to-face assessment in most evaluations. Where dermoscopy was incorporated, concordance with in-person diagnosis was consistently higher. Several studies reported sensitivities comparable to conventional pathways. However, specificity was variably lower, reflecting more conservative triage strategies and higher biopsy or referral rates in some services.

Teledermatology was associated with more efficient use of healthcare resources. Approximately 40-70% of referrals were managed remotely. Furthermore, multiple services reported increased clinic capacity, with up to 4 times more patients assessed per session compared with traditional clinics. Waiting times for initial assessment were reduced or equivalent, supporting earlier triage and treatment initiation.

Economic analyses frequently demonstrated cost savings or cost-effectiveness, driven by reductions in outpatient visits, patient travel, and clinician time. Although some teledermoscopy models incurred higher upfront or operational costs, overall system-level savings were maintained.

Patient outcomes were preserved or improved. Timely diagnosis was maintained, with evidence of expedited melanoma detection in some pathways. Surgical management and follow-up adherence were comparable between models. Patient satisfaction was consistently high, with over 75% reporting positive experiences, particularly regarding convenience and accessibility. However, challenges persisted for older patients and those with limited digital literacy.

Conclusions
Teledermatology demonstrates comparable diagnostic performance to face-to-face assessment within suspected skin cancer pathways, while delivering substantial gains in service efficiency, accessibility, and cost-effectiveness. The ability

to manage a large proportion of referrals remotely supports its role as an effective triage tool. However, variability in specificity, service models, and study design highlights the need for standardised implementation and further prospective evaluation. This will help ensure safe and equitable integration into routine skin cancer care.

Abstract N°: ID-329

Topic: Cutaneous oncology

Polypharmacy, drug related nitrosocontamination and the link to lichen planus/subsequent development of keratinocyte and mucosal cancer/oral leukoplakia: presentation of a case and update on the new pathogenetic vision

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Introduction

The association between drug-induced lichen planus - whether oral/mucosal or solely cutaneous - involves a diverse range of drugs, including ACE inhibitors, diuretics, and beta blockers, as well as quinidine, NSAIDs, hydroxychloroquine, antiretroviral medications for HIV, penicillamine, TNF inhibitors, and certain medications for type 2 diabetes. The natural course of lichen planus has been also linked in certain cases to the development of squamous cell carcinoma, affecting both mucous membranes and skin, as extensively documented in the literature.

Materials and Methods

However, little attention has been given to the fact that many of the medications associated with lichen planus - such as ACE inhibitors, diuretics, and beta blockers - are listed by the FDA as contaminated with carcinogenic and mutagenic nitrosamines. These compounds exhibit photocarcinogenic, carcinogenic and mutagenic properties. Their potential role in the progression of lichenoid lesions to oral leukoplakia, oral carcinomas and squamous cell carcinoma, but also strictly cutaneous located tumour has not been previously explored, yet it appears both plausible and significant.

Results

We present for the first time in the medical literature, a case of a 91-year-old patient with a 2-year history of oral lichen planus and subsequent oral leukoplakia (Fig.1a-c) following 2-year beta-blocker (bisoprolol) and/or anti-arrhythmic (propafenone) administration, with no history of smoking and alcohol consumption, and discuss the possible role of nitrosamines as a cofactor in the malignant transformation of ulcerative lichenoid lesions to oral leukoplakia/mucosal carcinoma.

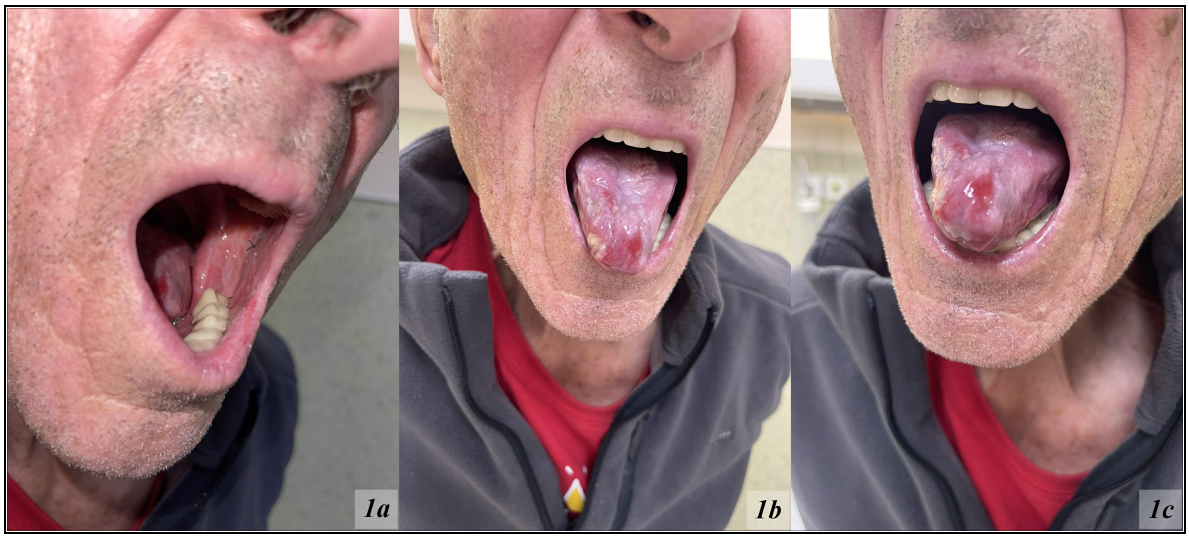

Figure 1a-c: Dermatological findings 1a: Fine, band-shaped, slightly raised gray-whitish plaques on the buccal mucosa, characteristic of Wickham's striae, positioned above the surrounding mucosa and with tendency to merge into a network-like pattern 1b,c: Single erosions and erythematous papular changes on the tongue, accompanied by papillary loss and whitish plaque covering the affected areas.

Conclusions

The histological findings were consistent with lichen planus (Fig.2a,b) and tongue leukoplakia (Fig.2c,d).

The adverse effects of these medications may be categorized into those related to 1) the active substance - potentially triggering lichen planus and those 2) linked to contaminants/carcinogens/mutagens, such as nitrosamines, which may act as primary or contributory factors in skin carcinogenesis in direction development of oral leukoplakia and oral/cutaneous carcinomas.

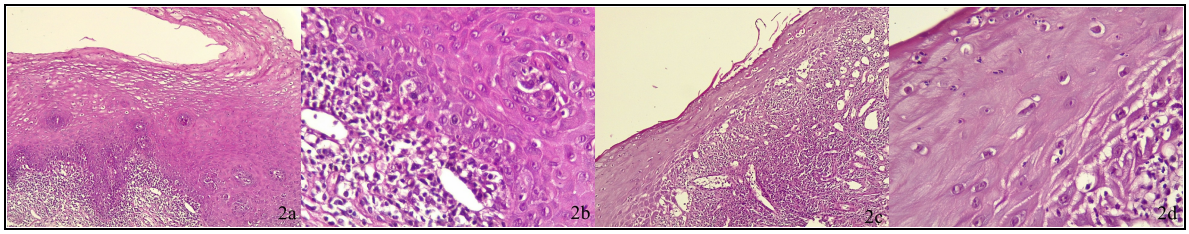

Figure 2a,b: Histology panel lichen planus: abundant parakeratosis, patchy acanthosis, and vacuolar degeneration of the basal keratinocyte layer, with obscuration of the dermo-epidermal border by a lichenoid lymphoplasmacytic inflammatory infiltrate lining the tunica propria. 2a: lichen planus x HE x 100 2b: vacuolar degeneration of the basal cell layer x HE x 200 Figure 2c,d: Histology panel leukoplakia: orthohyperkeratosis with filiform and oval hematoxylin-stained inclusions, patchy acanthosis with dyskeratosis, binucleated keratinocytes, and disrupted epithelial architecture throughout the epithelial segment. The segment is demarcated by an abundant lichenoid round-cell stroma, prominent among collagen fibers throughout the tunica propria. 2c: full thickness intraepithelial dysplasia x HE x 100 2d: dyskeratotic cells and irregular keratinocytic arrangement x HE x 200

Abstract N°: ID-346

Topic: Cutaneous oncology

CD8+ Primary Cutaneous Peripheral T-Cell Lymphoma in a 64-Year-Old Male: A Case Report and Diagnostic Insight

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Introduction

Primary cutaneous peripheral T-cell lymphoma, not otherwise specified (PC-PTCL-NOS), is a rare and aggressive subtype of cutaneous T-cell lymphoma. $CD8^+$ variants are particularly uncommon and may present with nonspecific clinical features that resemble benign inflammatory dermatoses, leading to diagnostic delay. Early recognition is essential due to the risk of rapid progression and extracutaneous involvement.

Materials and Methods

This report describes the clinical, histopathologic, and immunophenotypic findings of a patient with persistent, treatment-refractory cutaneous lesions. Clinical evaluation, skin biopsy, slit-skin smear test, culture, histopathologic examination, immunohistochemical staining, and baseline systemic assessment were performed. Infectious and inflammatory conditions were excluded using appropriate laboratory investigations and special stains.

Results

A 64-year-old male presented with multiple, progressively enlarging erythematous plaques and nodules involving the trunk and extremities, evolving over several months. The lesions were persistent and refractory to treatment with topical corticosteroids and empiric oral medications, with no significant clinical improvement observed.

Histopathologic examination of lesional skin demonstrated a dense, diffuse infiltrate of atypical lymphoid cells occupying the dermis and extending into the subcutaneous tissue, with relative sparing of the epidermis. The infiltrate consisted predominantly of medium- to large-sized lymphoid cells with irregular nuclear contours and increased mitotic activity. No significant epidermotropism or angiocentricity was identified.

Microbiologic evaluation, including bacterial and fungal cultures, yielded negative results. Slit-skin smear examination did not demonstrate acid-fast bacilli. Special stains for infectious organisms were likewise negative, effectively excluding infectious etiologies.

Immunohistochemical studies showed that the atypical lymphoid cells were positive for CD3 and CD8, with loss of CD4 and CD7 expression. Staining for CD30 and CD56 was negative. A high proliferative index was observed, supporting the diagnosis of an aggressive T-cell lymphoproliferative disorder. These findings were consistent with primary cutaneous peripheral T-cell lymphoma, not otherwise specified, $CD8^+$ phenotype.

Baseline systemic evaluation revealed markedly elevated serum lactate dehydrogenase levels. Initial staging investigations showed no evidence of extracutaneous involvement; however, subsequent follow-up demonstrated the development of regional lymphadenopathy, indicating disease progression beyond the skin.

Marker	Result	Diagnostic Relevance
CD3	Positive	T-cell lineage
CD8	Positive	Cytotoxic phenotype
CD4	Negative	Excludes helper T-cell CTCL
CD7	Negative	Supports neoplastic T-cell process
CD30	Negative	Excludes $CD30^+$ LPD
CD56	Negative	Excludes NK/T-cell lymphoma
Ki-67	~60%	High proliferative index

Conclusions

$CD8^+$ PC-PTCL-NOS represents a diagnostic challenge due to its clinical resemblance to benign dermatoses. Persistent or progressive lesions that fail standard therapy should prompt early biopsy and comprehensive immunophenotypic analysis. Timely diagnosis and multidisciplinary management are crucial given the aggressive clinical behavior of this rare cutaneous lymphoma.

Abstract N°: ID-351

Topic: Cutaneous oncology

Drug related nitrosogenesis, nitroso- photocarcinogenesis and the sertraline induced nevus associated cutaneous melanoma: spotlight on the nitrosocontamination as possible key triggering factor in relation to skin cancer pathogenesis

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Introduction

The carcinogenic action of nitrosamines in rats under experimental conditions was demonstrated as early as the early 1960s (1954) by Barnes and Magee. The series of subsequent experiments in their numerous research studies was strongly indicative of a pathogenetic role of nitrosamines / dimethylnitrosamine / in the development of liver cancer and kidney cancer. Starting from the fact that contact with nitrosamines is of primary importance for the development of tumours in animals, there is practically no circumstance that would lead us to believe that the intake of the same mutagens in man would have a different carcinogenic effect from that already known to us (as was found under experimental conditions as early as 1954, but in animals). On the contrary, to this day the incidence of cancer is increasing every year and, according to global statistics, it is projected to increase by nearly 50% or 18 million new cases by 2040. The intake of (un)identified nitrosamines found in drugs as contaminants is increasing analogously to the shared breakneck cancer incidence. In addition to the number of identified carcinogens or NDSRIs, the number of affected drug classes is also progressively growing and in mid-2026 this number amounts to over 250 drugs according to the official data of the FDA bulletin. In practice, the population/patients have been in a continuous, still ongoing, multicentric prospective study since 1954. Cancer incidence is skyrocketing (according to Globocan/Cancer Journal for the Clinicians), and not a single worldwide study has commented on its potential link to actual contamination of the most commonly used drugs worldwide with nitrosamines/NDSRIs. For the past 5 years, the team of the Bulgarian Society of Dermatological Surgery has been committed to formalizing the final results of these prospective nationwide observational studies and providing full transparency on the relationship between the intake of actual/potential nitrosamine-contaminated drugs and the development of skin cancer. Over 95% of newly reported skin cancers during this period (2016-2026) were associated with prior intake of drugs listed in the 2026 FDA as potentially nitrosamine/NDSRIs contaminated or carcinogens. Melanoma is one of the most significant patterns of tumor arising after potential contact of the human body with nitrosamines.

Materials and Methods

We report the occurrence of another case of nevus associated cutaneous melanoma (Fig.1a) and multiple dysplastic nevi (Fig.1b) after taking the antidepressant Sertraline. A drug declared according to the official FDA bulletin as potentially contaminated with class 2 nitrosamines/ NDSRIs: having similar to completely identical carcinogenic potency as that of NDMA and NNK. Or reciprocal to that in valsartan, irbesartan, olmesartan, repeatedly described already as possible melanoma inducers.

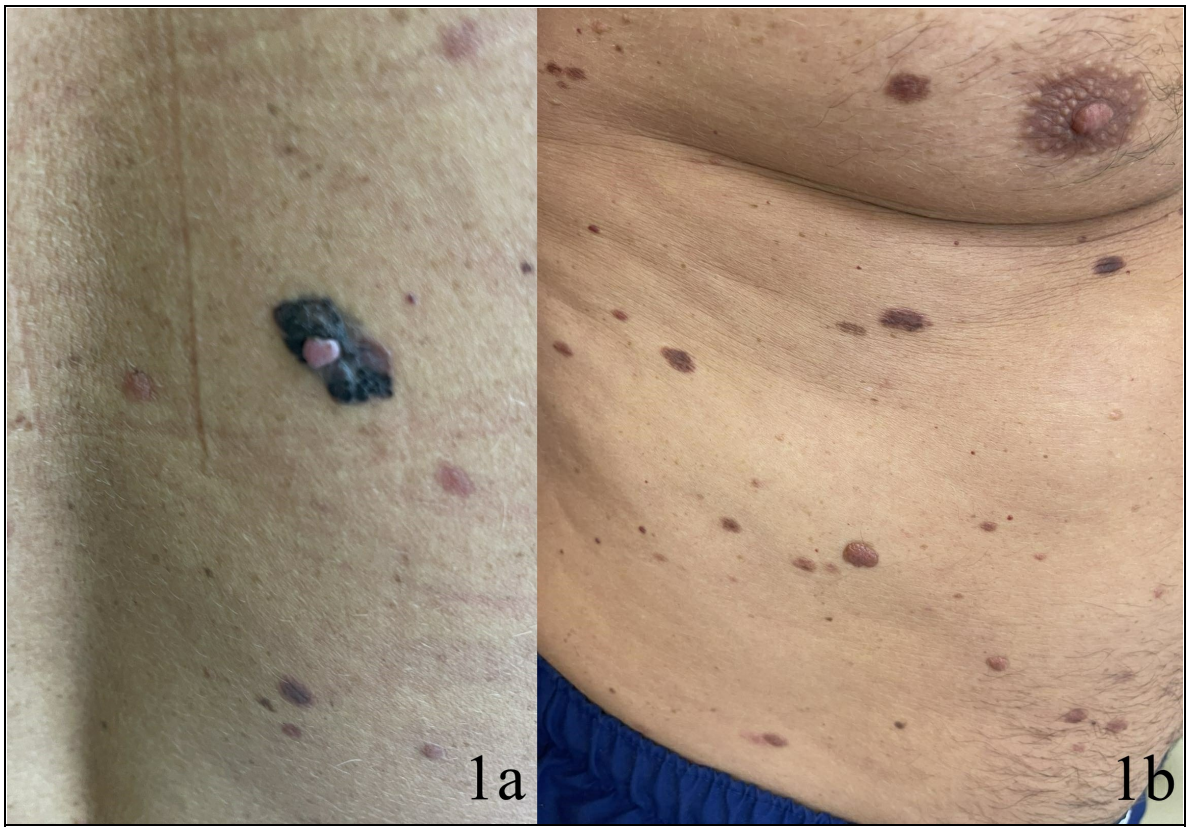

Figure 1a,b: Clinical findings in a patient with subsequently histopathologically proven nevus-associated cutaneous melanoma (a). Multiple dysplastic nevi within concurrent intake of nitrosamine contaminated drugs (b).

Results

An elliptical excision was performed for the lesion suggestive ofmelanoma with a surgical margin of certainty of 0.2 cm, and the histopathological verification of the lesionwas showed thin melanoma, Clark 2, Breslow 0.58 mm.

Re-excision was performed with an additional surgical margin of 1cm, with no evidence of residual cells in the re-excision, staged as 1a (T1aN0M0) (Figures 2a-c).

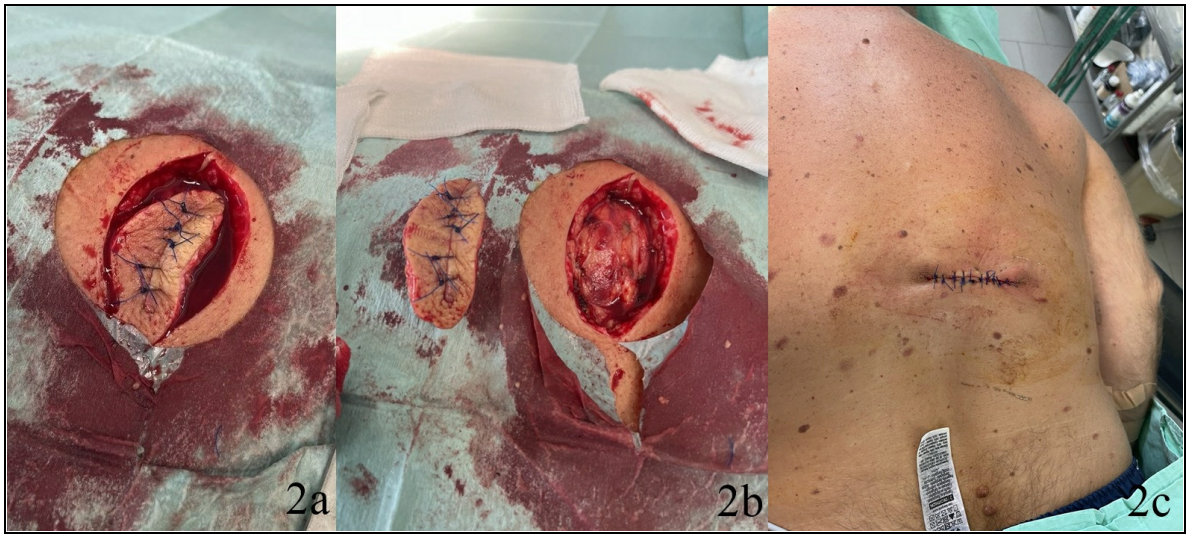

Figure 2a-c: g: Intraoperative view: Tissue resection next to the muscular fascia (a,b). The defect is closed with single interrupted sutures (c).

Conclusions

According to the literature search, this is also the first case in the world of Sertraline-induced nevus associated cutaneous melanoma, and we share the view/ thesis that the possible real inducer of the tumor is in fact the impurities in the medication in the form of contaminants or nitrosamines: the so-called NDSRIs. The drug related nitrosogenesis/ Nitroso Photocarcinogenesis of skin cancer seems to be a more than significant concep regarding the pathogenesis of skin cancer that has been cleverly concealed by the scientific community until recently.

Abstract N°: ID-353

Topic: Cutaneous oncology

(N-nitroso) Propafenone induced advanced nodular melanoma and the potential pathogenetic relationship to nitroso photo carcinogenesis

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Introduction

Onco-pharmacogenesis or pharmaco-oncogenesis of skin cancer is a concept , which could also be considered as an "end product" of drug-mediated Nitrosogenesis or of the permissive regime for carcinogens to be (un)controlled released in drugs. Their controlled distribution remains until 2025 as a forced and non-alternative and there is no indication of any possibility to introduce a full elimination regime against the already mentioned carcinogenic availability.

There are three main worrying facts that determine the need for these elimination regimes: 1) the clinicopathological correlations concerning the intake of a heterogeneous class of drugs and the subsequent development of relatively homogeneous tumours/ such as melanoma, 2) the recently proven mutagenic/ carcinogenic action of certain nitrosamines, but this time directly on human DNA, and 3) the fact that some of the nitrosamines are potent photocarcinogens that exert their genotoxic effects only after irradiation with UVA/ also recently proven/. In addition to the rhetoric mentioned above, there is also an overlap in mutational patterns between the genes previously generally accepted to affect melanomas - p53 / RAS oncogenes , with those identified as target genes, but being affected "mutationally", by certain nitrosamines.

Materials and Methods

We report an 80-year-old woman hospitalized for advanced melanoma of the skin (Fig.1a,b), in the terminal stage.

Clinical and dermatoscopic findings were in favor of nodular melanoma, localized preauricularly on the left: lesion diameter of 3.5 cm, soft-elastic consistency, clear differentiation from healthy tissue, exophytic growth, lack ofinfiltration of bony structures in the immediate vicinity, gray-white areas of regression/disturbed, disintegrated melanocytic network.

Figures 1a,b: Advanced metastatic nodular melanoma with preauricular localization

Results

The processes of photocarcinogenesis, nitrosogenesis and oncopharmacogenesis of skin cancer are inextricably linked and should not be considered and analysed unilaterally or in a semi-invasive manner. Cataloguing the type of nitrosamines and their precise concentration on drug leaflets and prescription/official websites with permanent access to clinicians and end-users remains the only safe and effective weapon in the fight against (un)controlled contamination.

Conclusions

Clinicians in the face of dermatologists/ dermatological surgeons remain the analysers and identifiers of these globalization processes. Once again, we present a patient who took the antiarrhythmic (nitroso-) drug propafenone and developed a relatively short-term nodular melanoma with a subsequent fatal outcome. We comment on the role of drug-mediated nitrosogenesis and its relationship to Nitroso -photocarcinogenesis and onco-pharmacogenesis.

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Abstract N°: ID-363

Topic: Cutaneous oncology

Nitrosamine-related phototoxicity/photocarcinogenicity, drug contamination and melanoma development: facts and/or controversies based on two new cases

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Introduction

Although phototoxicity as a chemical phenomenon is well-researched and understood, its occurrence in certain drug batches remains somewhat elusive. The uncertainty surrounding why certain drug batches are affected while others are not extends to the associated risk of photocarcinogenicity, underscoring the need for focused and comprehensive research. Unfortunately, these occurrences are often overlooked, with greater emphasis placed on addressing the substantial financial burden of managing the side effects – phototoxicity and its potential progression to photocarcinogenicity. The wide range of contamination with nitrosamines creates prerequisites for easy follow-up in the context of so-called clinicopathological correlations. Assuming that the linking link is the phototoxicity and genotoxicity of these substances, it could be easily established after the intake of which substances skin tumors develop.

Materials and Methods

We present two consecutive patients with melanomas who developed them against the background of taking a potentially/actually nitrosamine-contaminated medication: 1) in patient 1 (Fig.1a-d), the medications were valsartan, nebivolol, and hydrochlorothiazide, each of which is available on the FDA list for possible photo/ carcinogen contamination, and 2) in patient 2 (Fig.1e), the patient developed melanoma on a background of taking bisoprolol, metformin, and lercanidipine.

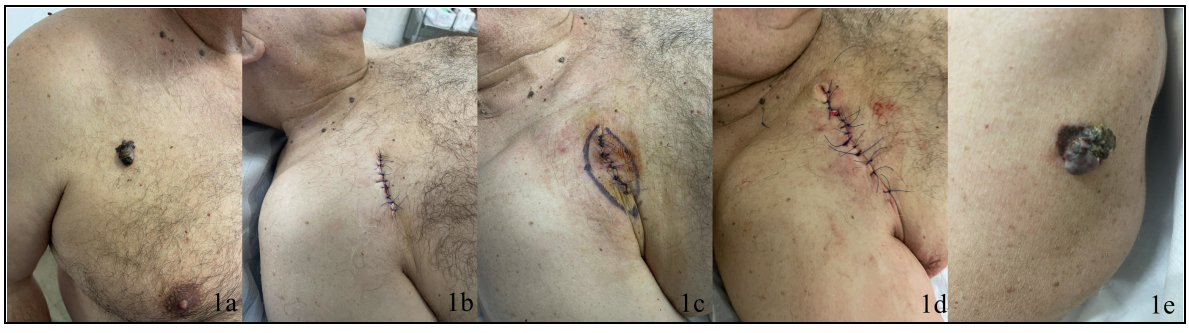

Fig.1a-e: Two patients: 1a: Patient 1: First surgical session (a,b) - Preoperative view: a polypoid-like pigmented lesion with irregular borders and black color located on the right anterior chest area. Intraoperative view: The wound defect is closed with single interrupted sutures (b). Second surgical session (c,d) - Intraoperative view: 2 cm surgical margin was achieved followed by defect closure with single interrupted sutures 1e: Patient 2: Preoperative view: a polypoid-like tumor formation with irregular borders and black, brown, and red pigmentation located on the left upper extremity.

Results

The possible new thesis of melanoma pathogenesis, known as photo/nitroso carcinogenesis or oncopharmacogenesis, is commented in detail.

Conclusions

We live in an era of “cancer pandemic”, reducing cancer rates must be a shared priority – not only for clinical physicians but also for the pharmaceutical companies. The first step toward a solution is acknowl- edging the problem. The current issue is evident and necessitates acknowledgment through careful observation and analysis of the clinicopathological correlations.

Abstract N°: ID-367

Topic: Cutaneous oncology

Pseudoepitheliomatous keratotic and micaceous balanitis/vulvitis revisited: recurrence, vulvar involvement, and malignant transformation - A case series.

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Introduction
Pseudoepitheliomatous keratotic and micaceous balanitis is an exceptionally rare non-infectious dermatosis affecting primarily older men, with a characteristic presentation of thick hyperkeratotic plaques and mica-like scaling on the glans penis. Although initially considered benign, emerging evidence suggests potential for malignant transformation.

Materials and Methods
To describe the clinicopathological profile of pseudoepitheliomatous keratotic and micaceous balanitis and vulvitis (PKMBV), highlight common clinical mimics and treatment outcomes, and emphasize the need for close long-term follow-up with repeat biopsies in recurrent or persistent lesions to enable early detection of malignant transformation and timely escalation of therapy. Clinical and histopathological data were collected for six patients presenting with hyperkeratotic lesions involving genitalia. Data analyzed included demographic details, lesion characteristics, treatment modalities, response to therapy, follow-up outcomes, recurrence, and evidence of malignant transformation.

Results
The series included six cases with male to female ratio of 2:1, aged 28 to 70 years. Lesions most commonly involved the glans penis and penile shaft in 66% cases, and rest 33% involved the vulva. Histopathological findings consistently demonstrated hyperkeratosis, acanthosis, and pseudoepitheliomatous hyperplasia. Primary treatment modality used was topical 5-fluorouracil in 5 patients (>80%) and complete surgical excision in 1 case, leading to complete clearance in 33% and only partial control in rest. Recurrence was noted in 50% cases with incomplete therapeutic response. Further the recurrent cases on frequent biopsies showed malignant transformation to verrucous carcinoma and squamous cell carcinoma.

Conclusions
This case series highlights the need for early histopathological confirmation, regular long-term surveillance with repeat biopsies in recurrent lesions, and timely escalation from topical to surgical treatment to improve patient outcomes and prevent progression. Further it broadens the clinical spectrum of PKMBV by documenting its recurrent nature, vulvar involvement and potential of malignant transformation.

Abstract N°: ID-379

Topic: Cutaneous oncology

Melanoma in situ and phototoxic drug reaction appearing simultaneously after antihypertensives intake: Photo Nitroso carcinogenicity of drugs as possible risk factor for the development of cutaneous melanoma

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Introduction

Drug-mediated nitrosogenesis or oncopharmacogenesis of skin cancer in general and melanoma skin cancer development in particular could be pathogenetically determined/ explained by the presence of photocarcinogens in drugs. These photocarcinogens are also known as nitrosamines. A number of studies in the scientific literature have linked the intake of antihypertensive drugs from heterogeneous groups to the generation of phototoxicity and the subsequent development of cutaneous melanomas. However, these particular groups of antihypertensive drugs belong at the same time to those declared by regulatory authorities worldwide (FDA/EMA) as affected by contamination with photocarcinogens. According to the most recent literature, 1) the number of potentially nitrosamine-contaminated antihypertensive drugs taken and 2) exposure to ultraviolet radiation could correspond to the severity of the clinical picture.

Materials and Methods

We report a patient who developed a melanoma in situ (Fig.1a) and phototoxic reaction (Fig.1a,b) in the context of a relatively short-term use of the four types of antihypertensive drugs: lisinopril/ amlodipine, followed by valsartan/ hydrochlorothiazide.

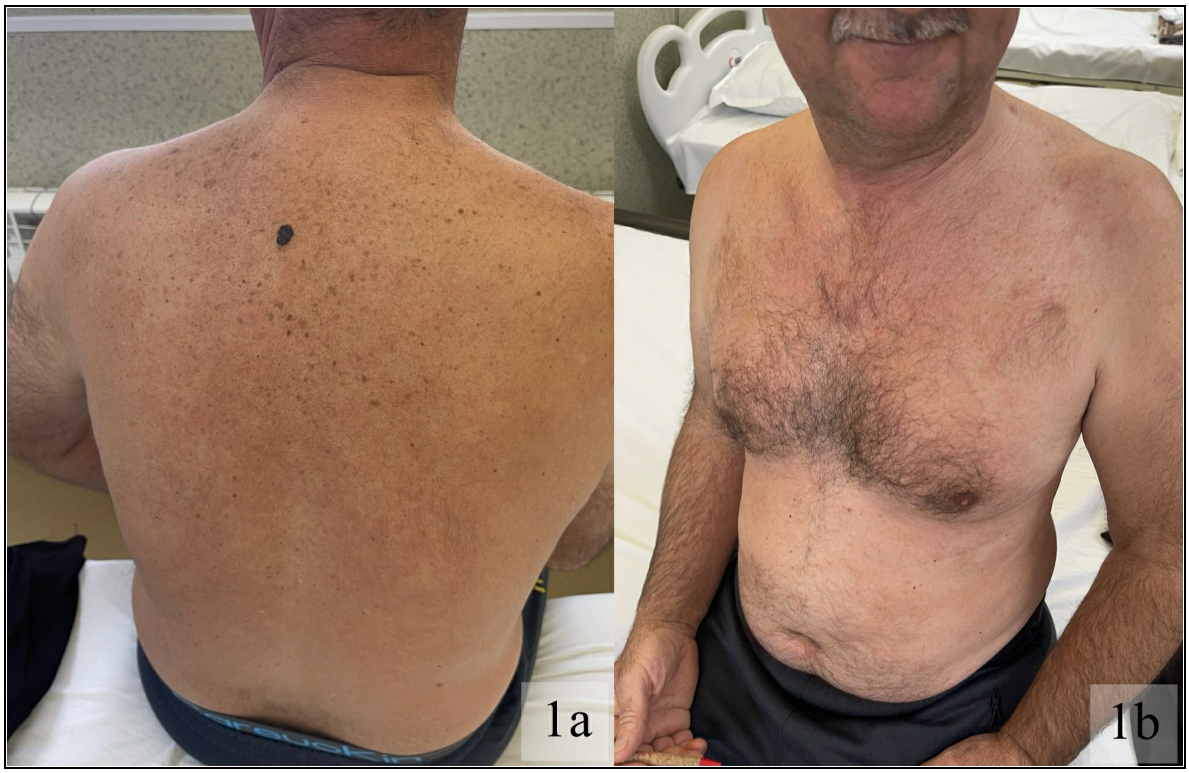

Fig.1a,b: A pigmented lesion located on the back, measuring 1 cm by 2 cm, with irregular borders (a). Additionally, a widespread erythem-infiltrative exanthem is observed on the trunkus – anterior (a) and posterior view (b).

Results

Treatment for the dermatitis was initiated with loratadin 5 mg, methylprednisolone 16 mg i.v. for 3 days, followed by 8 mg i.v., famotidine 80 mg and topical clobetasol propionate. A punch biopsy of the rash was performed., revealing drug-induced dermatitis/eczema.

For the pigmented lesion on the back, an elliptical excision was performed under local anesthesia with 2% lidocaine, with surgical margins of 0.3 mm. The skin edges were adapted with single skin sutures (Fig.2a-c). Postoperative complications were not observed (Fig.2d). The histological picture corresponded to melanoma in situ with a suspicious focus in the papillary dermis to a depth of 0.26 mm.

Re-excision was performed with margins of 0.7 mm. The materials were sent for histological verification, which showed no evidence of melanoma infiltration.

Due to the uncertainty of the CT scan, the following was recommended: 1) BRAF testing from primary/lesional tumor tissue, and 2) PET scan to clarify the dignity of the lesion in the lung. Regarding the drug-induced exanthema allergology consultation and testing for hypersensitivity to ACE inhibitors and ARBs were advised. Continued treatment with methylprednisolone 4 mg in a tapering schedule and loratadine 5 mg was recommended.

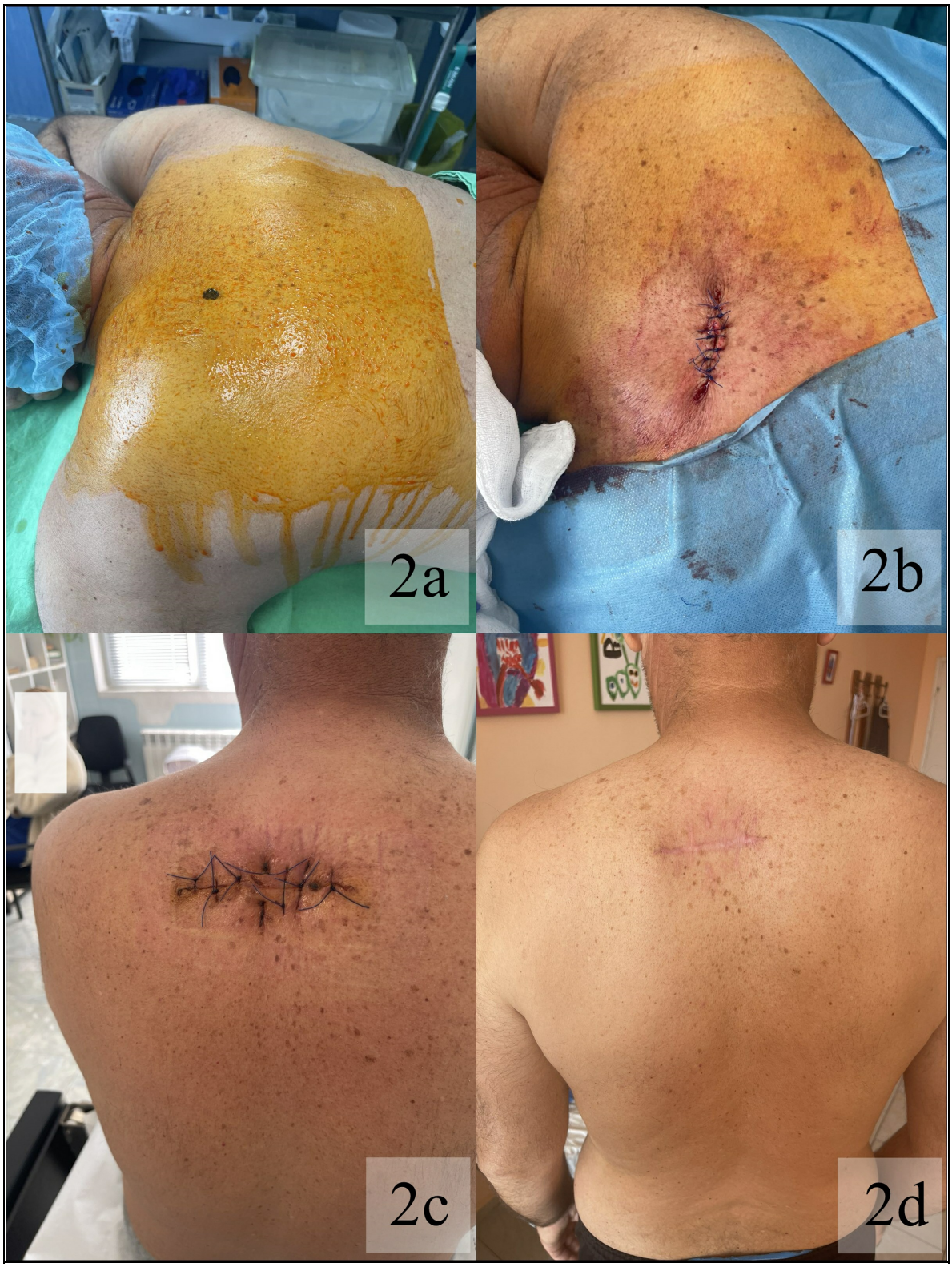

Fig.2a-d: The pigmented lesion on the back was preoperatively marked (a) and surgically removed with an elliptical excision, with surgical margins of 0.3 mm. The skin edges were adapted with single skin sutures (b). The postoperative suture removal was performed on day 7-th (c) and 14-th (d).

Conclusions

An analysis of the possible pathogenetic association is made, discussing recent literature concepts such as: drug-induced photo nitrosogenesis / carcinogenesis of cutaneous melanoma.

Abstract N°: ID-381

Topic: Cutaneous oncology

"The dangerous brassiere" and the nevus associated polypoid melanoma: possible role of the mechanical irritation as triggering factor

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

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Introduction

The development of cutaneous melanoma of the skin based on dysplastic nevus is not uncommon. The causes of the progression of nevi to melanomas are numerous and not well understood at present. Certain genetic and epigenetic factors have a major influence on this evolution.

Materials and Methods

We describe a 46-year-old female patient with multiple dermal melanocytic nevi who developed a polypoid melanoma in one of them. After a carefully performed anamnesis, the mole that developed into melanoma was found to be localized in the dorsal area adjacent to the brassiere and underwent permanent and daily mechanical irradiation during the last 6-7 years. Around this mole there were 5 other moles with similar clinical and dermatoscopic morphology, which did not transform into melanomas and were not subjected to mechanical irritation.
The patient had a dermatological examination 6 years ago and it was suggested that this lesion has to be surgically removed, which she declined.

Results

The patient was treated surgically and the lesion suspicious for cutaneous melanoma was removed in two stages according to the generally accepted AJCC/EJC recommendations. In parallel, 5 additional melanocytic nevi were removed (Fig.1a-f), which histologically had features of dysplastic dermal melanocytic nevi but no signs of progression to melanoma.

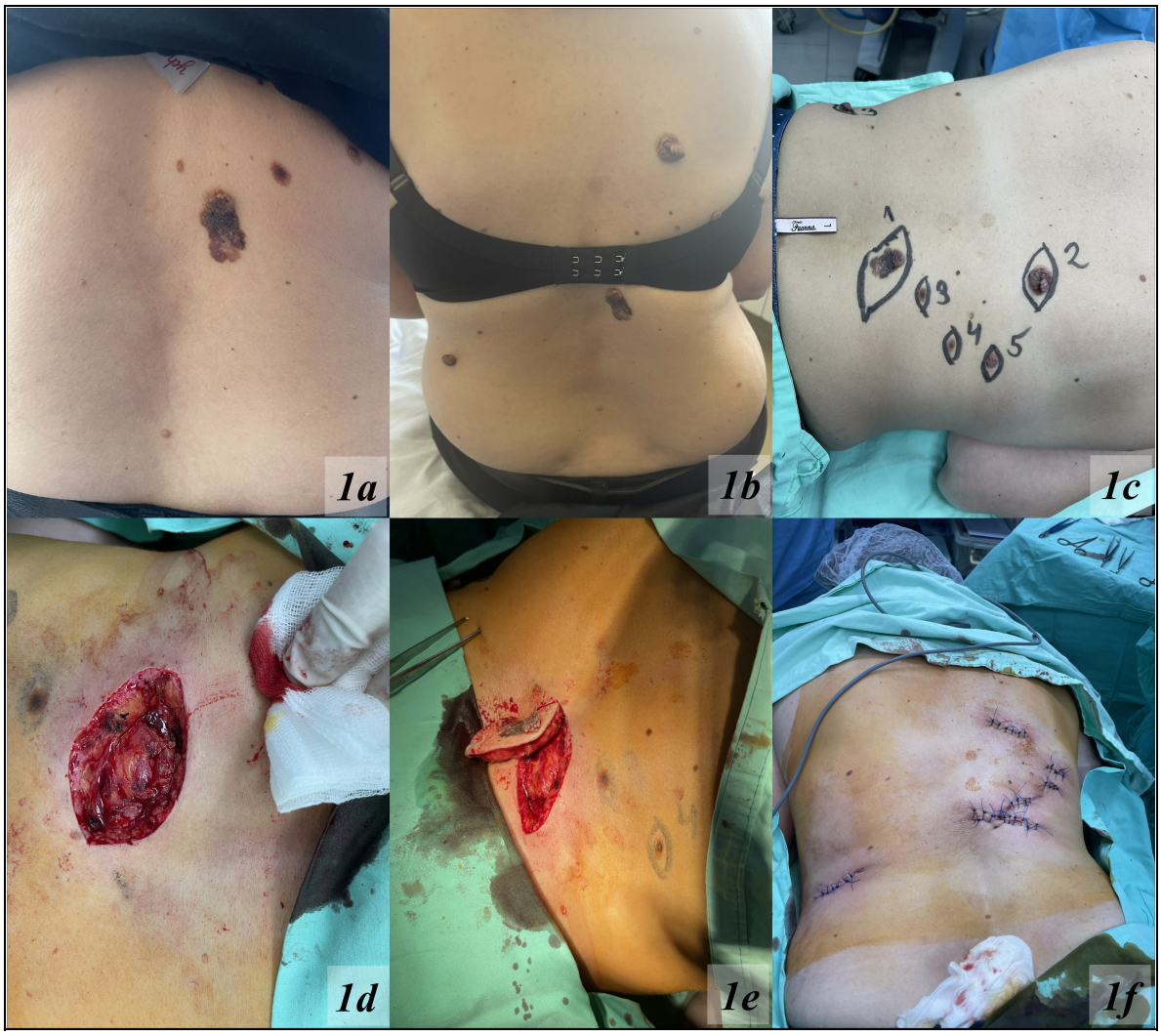

Figure 1a-e. 1a: Nevus-associated polypoid melanoma localized lateral to the posterior sweat trough. 1b: Nevus-associated polypoid melanoma localized adjacent to/under the brassiere. 1c: Preoperative resection field marking in a patient with nevus-associated polypoid melanoma and multiple dysplastic nevi in the back area. 1d,e: Deep surgical excision to the musculature in the form of an ellipse. 1f: Postoperative finding after surgical removal of 6 melanocytic lesions in the dorsal area.

Conclusions

This article discusses the causes of nevus -associated melanomas and emphasizes the thesis of potential malignant transformation through mechanical irritation - in this case that of the brassiere. The moles localized in this area, although clinically and dermatoscopically inapparent, should be treated surgically. This painless, short-term manipulation has a preventive effect on the future development of cutaneous melanomas.

Abstract N°: ID-382

Topic: Cutaneous oncology

A flavour of death: perindopril induced thick melanoma and bcc of the back: the special link to the drug mediated nitroso photo carcinogenicity

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Introduction

Contamination of certain drugs and foods with one of the most potent carcinogens/mutagens- nitrosamines, remains to be an issue and unresolved at present. This contaminants are phototoxic perf definition and therefore subsequently also photocarcinogenic prior their metabolisation in the liver , which seems to be very important , but forgotten fact. Exactly this contaminants could be seen as mediators for pohototoxicity and photocarcinogenicity, responssible for skin carcinogenicity . Both of them could be the reason for the appearance and progression of melanoma, but also for keratinocyte cancer. The introduction of permissive determinations of the presence of carcinogens in drugs only reinforces doubts about the powerlessness of regulatory authorities in the face of the influence of powerful pharmaceutical cartels. The FDA's encouraging promises of 2018 for strict control of carcinogens in sartans seems to have been permanently forgotten? Following alert checks confirming their post-existence in diabetes drugs, anti-smoking drugs, a number of antibiotics, ACE inhibitors, Sartans, thiazide diuretics, ranitidine, but probably a number of others, the decision has been taken to give the green light to their permissible availability. An availability that in all likelihood has the flavour of death. A "flavour" that has been confirmed in hundreds of international publications: directly or indirectly.

Materials and Methods

Starting from the mentioned facts and the data announced already in 2016/2017 of all-American data shared primary and originally in American scientific journals, using also their statistical estimates, we present the first case in the world literature of nodular melanoma and basal cell carcinoma occurring after taking perindopril (Fig.1a-c). This intake turns out to be confirmatory one with respect to the statistics presented by Beatrice Nardone dating back to 2017.

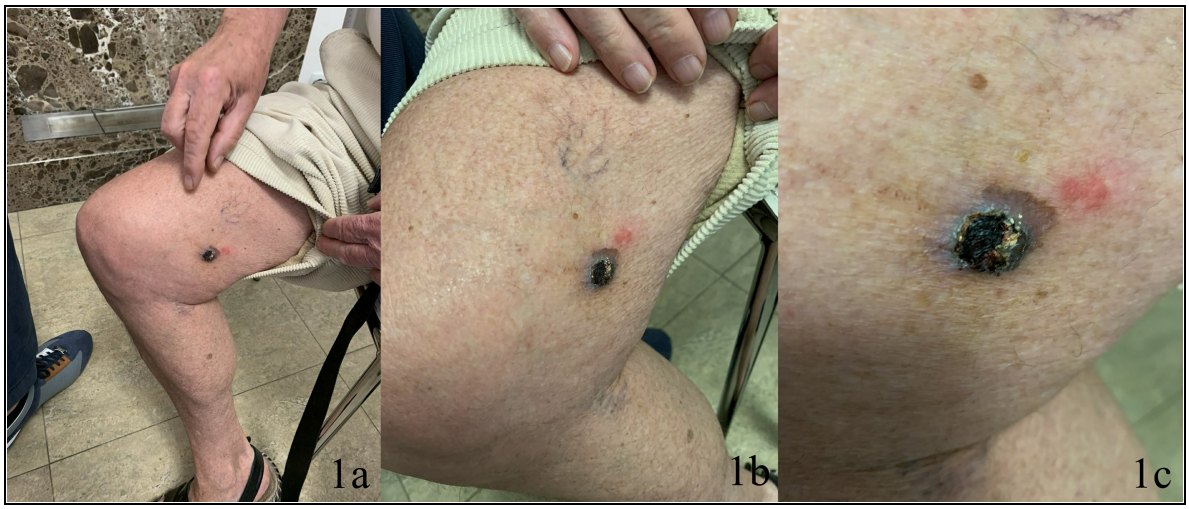

Figure 1a-c: Dark black-brown pigmented tumor formation with uneven texture and crusts located on the right inner thigh region.

Results

The lesion was surgically removed in 2021 in an oncosurgical department with an initial surgical safety margin of 2cm. The histological result showed a nodular malignant melanoma with a diameter of 15 mm, Breslow tumor thickness 4.2 mm, Clark level 4, with ulceration, mitoses 6 mm/sq, vertical growth, moderate amount of melanin pigment and scarce lymphocytic stromal reaction, BRAF negative, staged pT4bN0M0. Detection and removal of sentinel lymph node has not been performed. Postoperatively performed PET/CT scan showed a single hypermetabolic mesenteric lymph node located at L3 level, highly suspicious for melanoma metastasis. Pulmonary micronodules, inconclusive of malignancy, were found and were also subject for further follow-up. The patient was reevaluated at stage pT4b cN0 cM1a malignant melanoma. Initial ten courses of immunotherapy with pembrolizumab were started. In 02.12.2022 another PET/CT scan was performed which resulted in positively therapeutically affected mesenteric lymph node and lack of dynamics of the previously described pulmonary micronodules. Small lymph nodes with reactive nature in the right hilus were noticed. A newly appeared small metabolically active focus on the skin of the left lower leg was seen, which was referred for a follow-up and dermatological control. The immunotherapy was continued. A change in the antihypertensive therapy with perindopril was also recommended.

Conclusions

The potential pro-carcinogenic effects of both nitrosamines and the generic substance of perindopril are discussed. Special attention is drawn to the Nitroso Photocarcinogenicity, triggered via the permanent drug intake.

Abstract N°: ID-406

Topic: Cutaneous oncology

Investigating Novel Etiologies of Skin Cancer. The Correlation Between Nitrosamines in Pharmaceuticals and Photocarcinogenesis: The ROS-Nitric Oxide Interplay (During Polymedication Intake) as Skin Cancer Triggering Factor - case related explanation

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Introduction

The surrounding environment is a risk zone that could disrupt tissue homeostasis or tissue integrity, which could have frequent and fatal consequences for the affected organisms. Nitrosamines, as already known photocarcinogens in medicines, are among the substances that, in one form or another, enter the human body and could trigger a cascade of processes leading to probable mutations and skin cancer development and progression. The elimination of these cutaneous tumors is a serious challenge for dermatologic surgeons. We present a case of a primary defect in the right nasal ala, following basal cell carcinoma excision, successfully reconstructed both functionally and aesthetically using dermatologic surgery procedure (Fig.1).

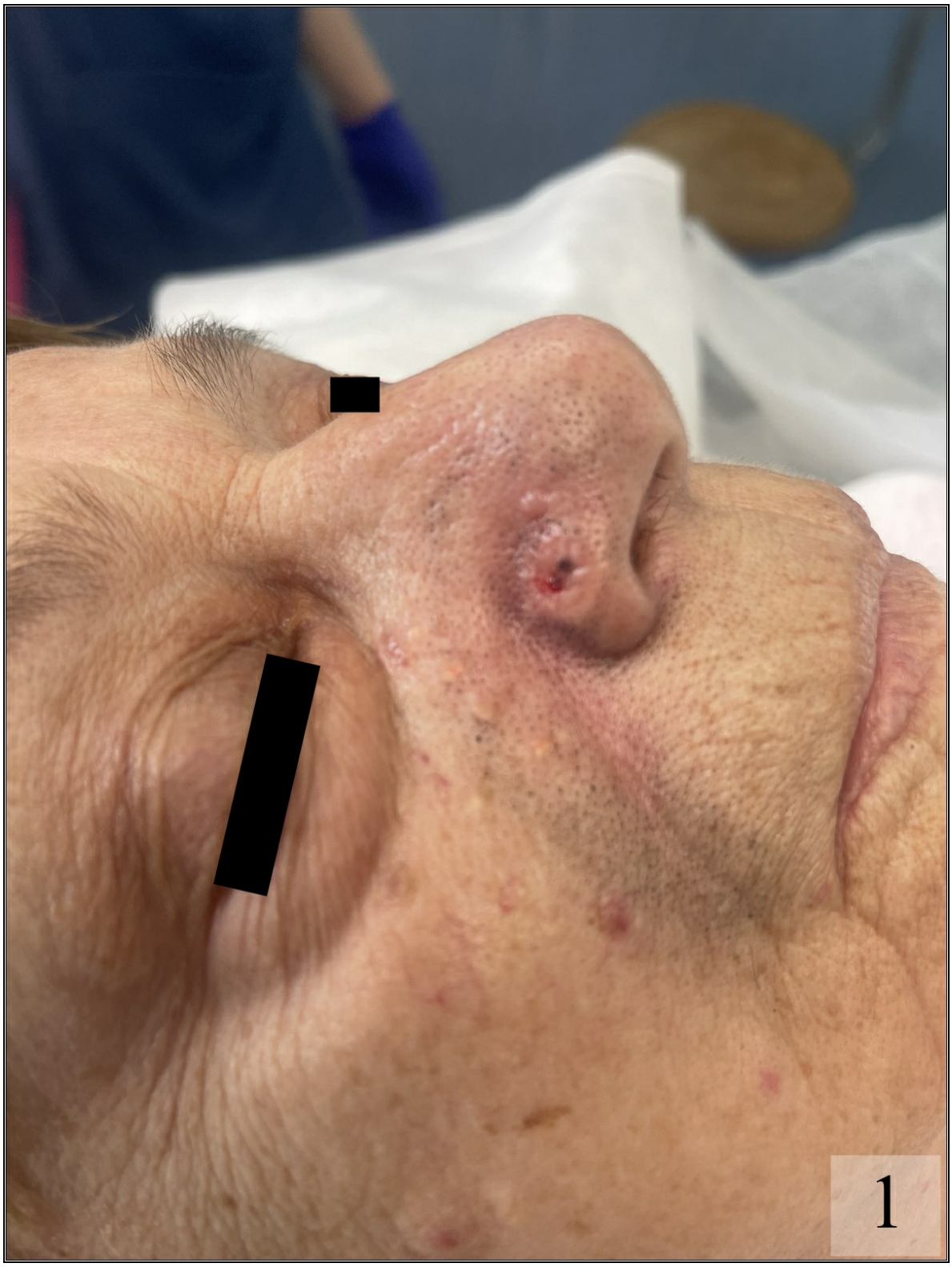

Figure 1: A Small Tumour Like Lesion in the Area of Ala Nasi Suspicious for Basal Cell Carcinoma

Materials and Methods

The article comments mainly on the possible pathogenetic role of the systemic medication taken by the patient to date, consisting of amlodipine, valsartan, bisoprolol, timolol, clopidogrel, pantoprazole, rosuvastatin, and latanoprost, in relation to the concepts of phototoxicity and photo carcinogenicity. Nitrosamines, as known contaminants in those drugs, are known to be photolabile and, under the influence of solar radiation, undergo photodecomposition and generate nitric oxide. The last one interacts with ROS and regarding the current scientific knowledge is/ could be associated with the subsequent generation of mutations responsible for skin cancer.

Results

Drug related Nitroso-Photo Carcinogenesis seems to be an important part of the skin cancers pathogenesis. For this reason,

the intake of polymedication, potentially contaminated with nitrosamines or prone to forming them in an acidic/gastric environment, could be considered as extremely problematic in terms of skin cancer generation.

Conclusions

At the same time, it should not be overlooked that many types of severe and risky dermatosurgical procedures performed in our patient (Fig.2), but not only, could be probably avoided entirely, given that the cause of skin cancer could be mediated precisely through the exposure of the human organism to known photo-carcinogens or so-called nitrosamines: pro carcinogenic substances also distributed through medicines.

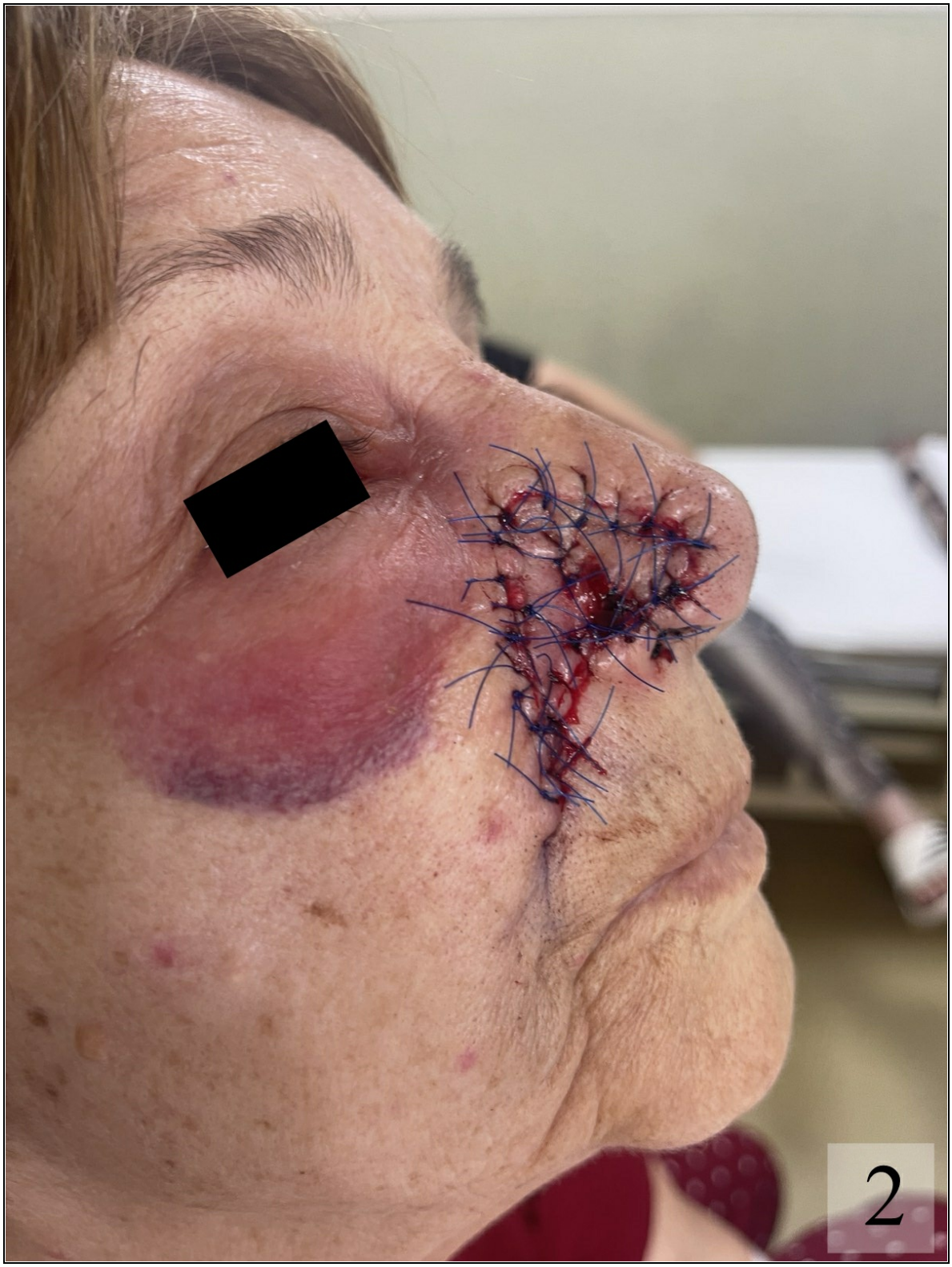

Figure 2: Severe Adverse Drug Events Due to the Possible Intake of Phototoxic Drugs. Immediate Postoperative Image after BCC Removal. Reconstruction of the Primary Defect using a Shark Flap

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Topic: Cutaneous oncology

Discover Oncology: The Interplay Between the Food/Drug Related Nitrosogenesis Based on ROS/Nitric Oxide (NO) Interaction: Two Powerful Factors possibly Responsible for the Photo Nitroso Carcinogenicity Concerning the Skin Cancers Pathogenesis

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Introduction

Nitrosamines are well known phototoxic/ photolabile substances from the distant past, some of them also having additional carcinogenic or mutagenic effects. The intake of nitrosamines with the drugs can be 1) in the framework of the so-called nitroso contamination or the intake of a ready carcinogen that has already occurred outside the body, such as NDEA, NMBA, NDMA, etc. or 2) they arise de novo in the organism when the following prerequisites are present: 2. 1) the presence of a secondary or tertiary amino group in the respective drugs, 2. 2) the presence of a gastric or acidic environment and 2. 3) the presence of nitrite-rich food.
Therefore, the simultaneous intake of some nitrite-rich foods such as Broccoli, Cabbage, Carrot, Cauliflower, Celery, Cucumber, Leek, Lettuce, Parsley, Pumpkin, Red beetroot, Spinach for example, together with some drugs could appear to be risky for the skin cancer generation.

On the other hand, the food itself could also be a direct donor of finished nitrosamines such as NDMA: cured meats, fish, and alcoholic beverages like beer and whiskey/ NDEA- in processed meats.

In practice, the exogenously defined, but this time predominantly nutritionally mediated, Nitrosogenesis concerning skin cancer mirrors the drug medicated one and could also be considered as 1) exogenous, based on direct intake of finished carcinogens with foods, or 2) mixed type : Namely, 1) intake of nitrite-rich foods, which in 2) under stomach conditions/acidic/ and 3) intake of secondary or tertiary amines with the medication.

Materials and Methods

The greater the number of drugs taken by a patient, the higher the risk of taking 1) drugs with pure phototoxicity/not nitrosamine related/ non nitroso contamination-based effects, but also 2) those whose final photocarcinogenicity could be defined on the basis of taking 2.1) finished , completed nitrosamines, as well as 2.2) those that are subsequently converted into such. In this context, we report a patient, who developed a high-risk tumor near the eye under systemic treatment with : (nitroso-) metoprolol, (nitroso-) torasemide, (nitroso-) rosuvastatin, (nitroso-) ezetinib, Nitroso acetylsalicylic acid (NO-ASA), (nitroso-) piroxicam , (nitroso-) dapaglifozin and (nitroso-) clopidogrel.
The photodecomposition of nitrosamines leads to the release of nitric oxide. The last one interacts with ROS, and this interaction could either promote or suppress carcinogenesis. Low concentrations of NO are thought to promote carcinogenesis. The interaction between NO and ROS influences and modulates the processes directly related to carcinogenesis: angiogenesis, programmed cell death, and cell signaling. Oxidative stress, caused by an imbalance in ROS levels, is a also key factor in the development and progression of skin cancer. Both UVB and UVA are considered generators of ROS in the context of photo carcinogenesis. Subsequent interactions with nitric oxide reinforce the concept of photo Nitrosogenesis/carcinogenesis of skin cancer or Nitroso photo carcinogenesis/Nitroso photo genesis of skin cancer based on drug (but also food) intake.

Results

The dermatological examination revealed a tumor-like lesion in the left periorbital area near the medial canthus, measuring approximately 1 cm, clinically suspected for basal cell carcinoma (Fig.1a). Surgical removal of the lesion was recommended (Fig.1b-e).

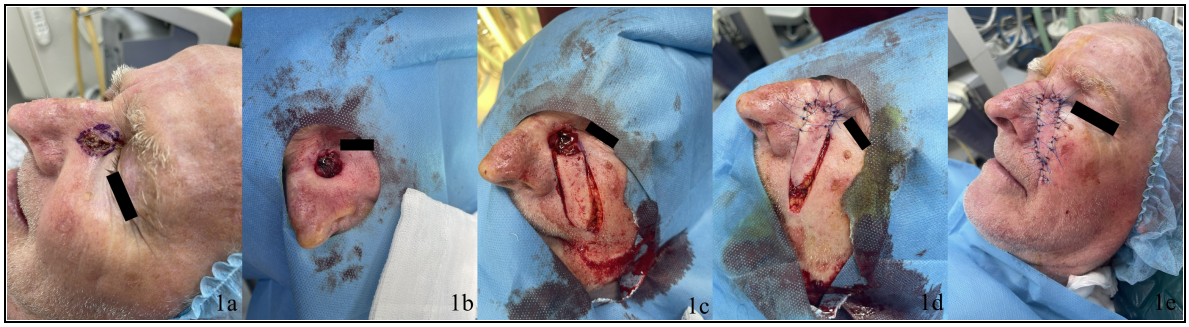

Figure 1a-e: 1a: A tumor-like lesion in the left periorbital area near the medial canthus, measuring approximately 1 cm. The lesion displays an erosive surface, pearly undermined borders, and a central hemorrhagic crust. 1b: Intraoperative view: The lesion in the left periorbital area near the medial canthus is removed with an oval excision 1c: The primary wound defect is then reconstructed with an island pedicle flap. 1d,e: secondary defect closure with single interrupted sutures

Conclusions

Photocarcinogenicity related to the onset and progression of keratinocyte cancer seems to be also nitroso-dependent, regardless of the mechanism by which it is generated: photodecomposition or phototoxicity: in fact the final result is the development of Nitroso Photo Carcinogenicity based on medicinal and/or dietary intake. Correction of this type of adverse drug reactions, namely skin cancer in high-risk areas, could be successfully treated using severe reconstructive surgical techniques such as island flap. Possible links of each and every drug in relation to Nitrosogenesis has been presented !

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Topic: Cutaneous oncology

Insights into the development of lentigo maligna and dysplastic nevi: spotlight on the possible relation with sartans, thiazides and nitrosamines

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Introduction

Since the alarming, yet prudent publication of the possible association of sartan use and development of various cancersin 2010, anti-hypertensive drugs (sartans and thiazide diuretics) have been closely monitored by various scientific and drugauthoritarian bodies around the world. Fast forward 12 years, the number of scientific publications showing an increased risk of developing various types of cancer, including skin cancers, after sartan and/ or hydrochlorothiazide use is on the rise.

Materials and Methods

A 77-year-old male with arterial hypertension under treatment for approximately 3 years (2018-2022) with three different preparations containing sartans in combination with hydrochlorothiazide was observed with a pigmented lesion present on the left cheek for 2 years with clinical and dermatoscopic suspicion of lentigo maligna (Fig.1a), confirmed by histopathology. Further three suspected dysplastic naevi were also identified on the back (Fig.1b), two of them confirmed by histopathology. Possible drug-induced melanocytic lesions were suspected and his drug regimen was changed. The prognosis was favorable with a good post-operative outcome.

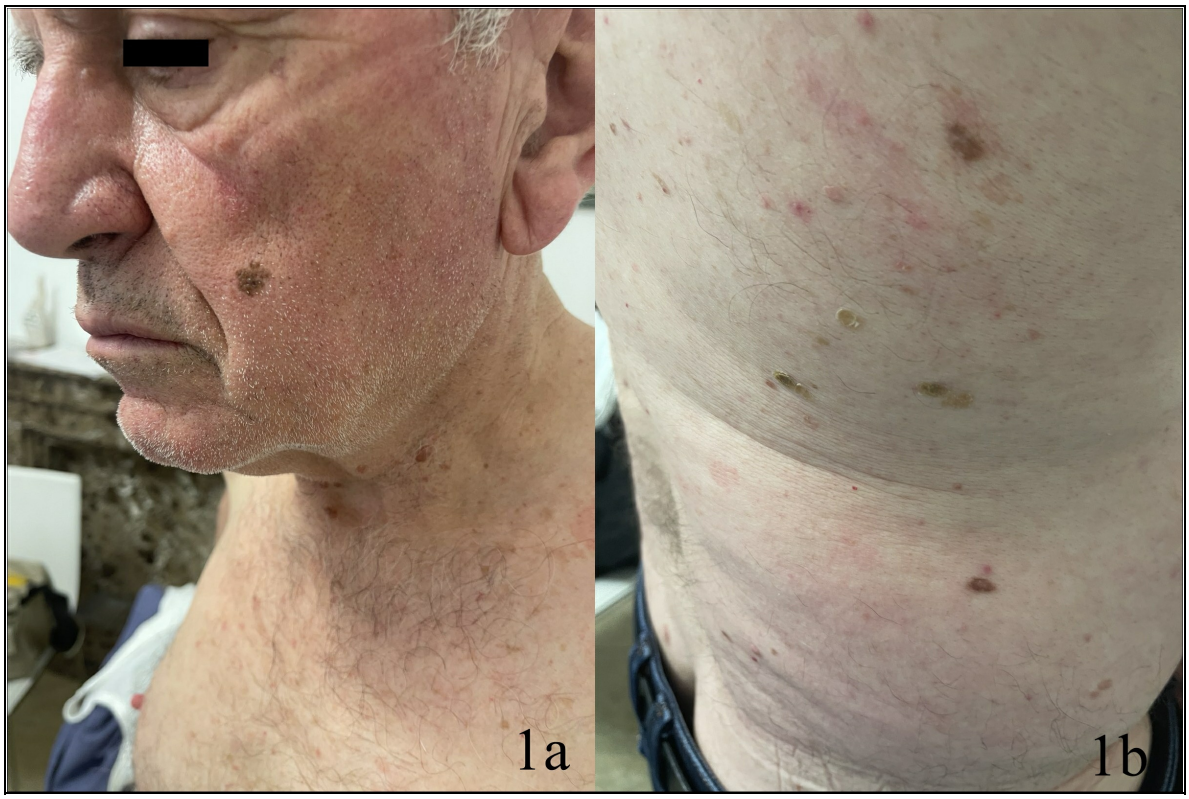

Figure 1a,b: A pigmented lesion present on the left cheek, clinically suspected for lentigo maligna (a). Three suspected dysplastic naevi on the back (b).

Results

The facial lesion was removed, under local anesthesia, in the form of an elliptical excision with a resection field of 0.1-0.3 cm (Fig.2a,b) and as histopathology confirmed as melanoma in situ, lentigo maligna type, a secondary excision for an additional surgical safety margin of 1 cm in all directions was performed with clean resection margins (Fig.2c-e). Histopathology of the three melanocytic naevi in the back confirmed dysplastic melanocytic naevi in two of them, with clean resection margins (Fig.2f). Post-operative outcome was positive with good signs of wound healing for all four lesions. A 4-week follow-up visit showed no signs of complication or other concerns.

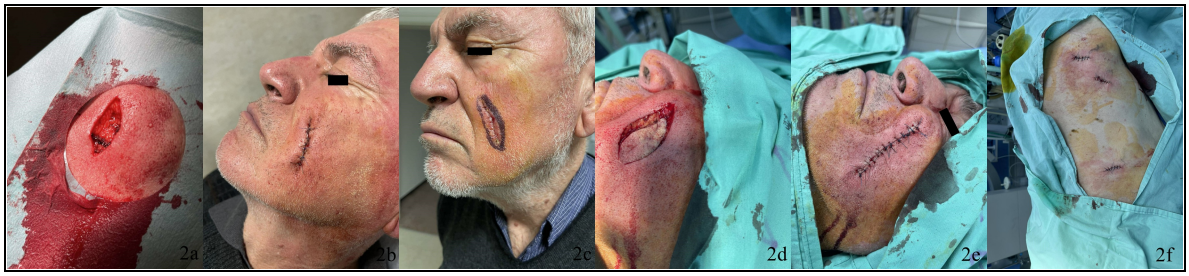

Figure 2a-f: First surgical session (a,b): resection field of 0.1-0.3 cm, histopathology confirmed as melanoma in situ, lentigo maligna type Second surgical session (c-e): excision for an additional surgical safety margin of 1 cm in all directions with clean resection margins. One melanocytic naevus and two Dysplastic melanocytic naevi, clean resection margins (f).

Conclusions

No signs of postoperative complications in the 4-week follow-up (Fig.3).

The amount of data linking the use of hydrochlorothiazide alone or in combination with sartans and the development of melanomas or their precursors, is worrying. Given the additional disclosure of pharmaceutical companies about the existingelevated concentrations of nitrosamines in these two classes of antihypertensive drugs, the establishment of a causal relationship between the intake of a particular carcinogen and the development of a tumor or tumor precursor

requires careful and detailed scrutiny. The extent to which sartan/hydrochlorothiazide used and the occurrence of the lentigo maligna, especially when shared data points in this direction, remains unclear. However, in clinical practice, it should be highly recognized.

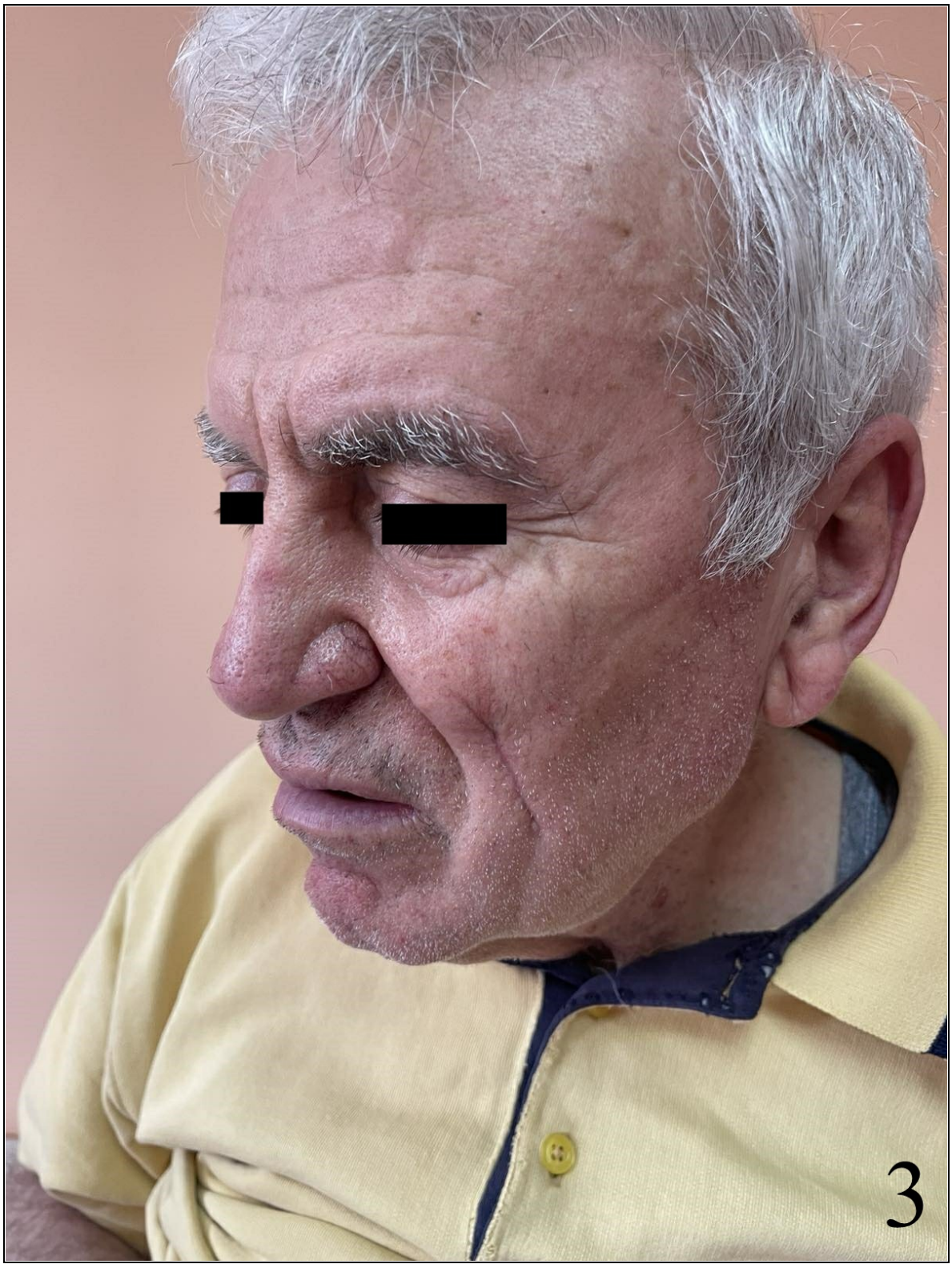

Figure 3: 4-week follow-up: no signs of complications

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Topic: Cutaneous oncology

A Wolf in sheep's clothing : Anaplastic large cell lymphoma masquerading as an axillary nodule

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Introduction

Anaplastic large cell lymphoma (ALCL) is a rare subtype of non-Hodgkin T-cell lymphoma that may present with primary cutaneous involvement or as part of a systemic disease. Cutaneous manifestations are often nonspecific and may mimic inflammatory or infectious conditions, leading to diagnostic delay. Dermoscopy is increasingly used in the evaluation of skin tumors, but its role in cutaneous lymphomas remains insufficiently characterized. We report a case of rapidly progressive ALCL in a young immunocompetent patient, initially presenting as a small axillary nodule in a misleading clinical context.

Materials and Methods

We describe a single clinical case with dermatological, dermoscopic, imaging, and histopathological correlation. Clinical examination and dermoscopy were performed at first presentation. Ultrasonography of the cutaneous lesion and lymph node areas was requested. A skin biopsy was subsequently performed due to rapid tumor progression.

Results

A 34-year-old man with no significant past medical history presented with a one-week history of a painful left axillary nodule. Two weeks prior, he had sustained a dog bite on the right hand, followed by the development of multiple lymphadenopathies, initially right-sided and subsequently bilateral.
Dermatological examination revealed a solitary erythematous nodule measuring 1.5 cm in greatest diameter, slightly tender, with a soft to cystic consistency, associated with unilateral lymphadenopathy. There was no discharge, bleeding, or systemic symptoms, and the patient was in good general condition.
Dermoscopy showed an erythemato-violaceous background surrounded by a crown of linear vessels.
Ultrasound of the lesion and lymph node areas was requested; however, the patient missed two scheduled appointments and was lost to follow-up. One month later, he re-presented with a rapidly enlarging axillary mass measuring approximately 12 cm in diameter, with an ulcerated surface and spontaneous bleeding.
An urgent skin biopsy was performed, revealing histopathological features consistent with anaplastic large cell lymphoma.

Conclusions

This case highlights the aggressive potential of anaplastic large cell lymphoma and the risk of diagnostic delay when initial presentation mimics benign or reactive conditions. The misleading context of a recent dog bite and reactive lymphadenopathy contributed to the initial diagnostic challenge. Dermoscopy revealed vascular features that may serve as early warning signs in atypical nodular lesions. Early biopsy should be considered in rapidly evolving nodules associated with lymphadenopathy, even in young immunocompetent patients.

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Topic: Cutaneous oncology

Drug related nitrosogenesis, photocarcinogenesis and oncopharmacogenesis of nodular melanoma: a case related analysis concerning the polycontamination of the polymedication with valsartan/hydrochlorothiazide and bisoprolol

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Introduction

Despite the fact that the pathogenesis of cutaneous melanoma is shrouded in mystery, factors that have been neglected or unnoticed until now have come to the attention in recent years, and in all likelihood, they could also be pivotal. These factors, known as nitrosamines or NDSRIs, are characterized by high carcinogenic and mutagenic potency, and some of them have demonstrated these properties to human DNA as well. Unfortunately, these ingredients also turn up as contaminants in about 300 of the most widely distributed drugs worldwide. According to the most recent literature, some of these ingredients are also identified as potent photocarcinogens, as well as human carcinogens. The intake of these carcinogens in the context of polycontamination of polymedication, has been associated for years with the occurrence of melanomas. The need for cataloguing of nitrosamines , as well as their accurate labelling on drug packaging, would help to classify them even more accurately as carcinogens affecting human DNA.

Materials and Methods

We present once again a patient , who developed nodular melanoma (Fig.1a) within the context of the intake of 3 potentially nitrosamine/ NDSRIs contaminated antihypertensive drugs (valsartan/ Hydrochlorothiazide/ bisoprolol).

Following thorough disinfection of the operative field under local anesthesia with lidocaine 1%, an elliptical excision was carried out with a safety margin of no more than 5 mm in all directions (Figure 1b). The wound edges were adapted with single interrupted sutures (Figure 1c), and a sterile dressing was applied.

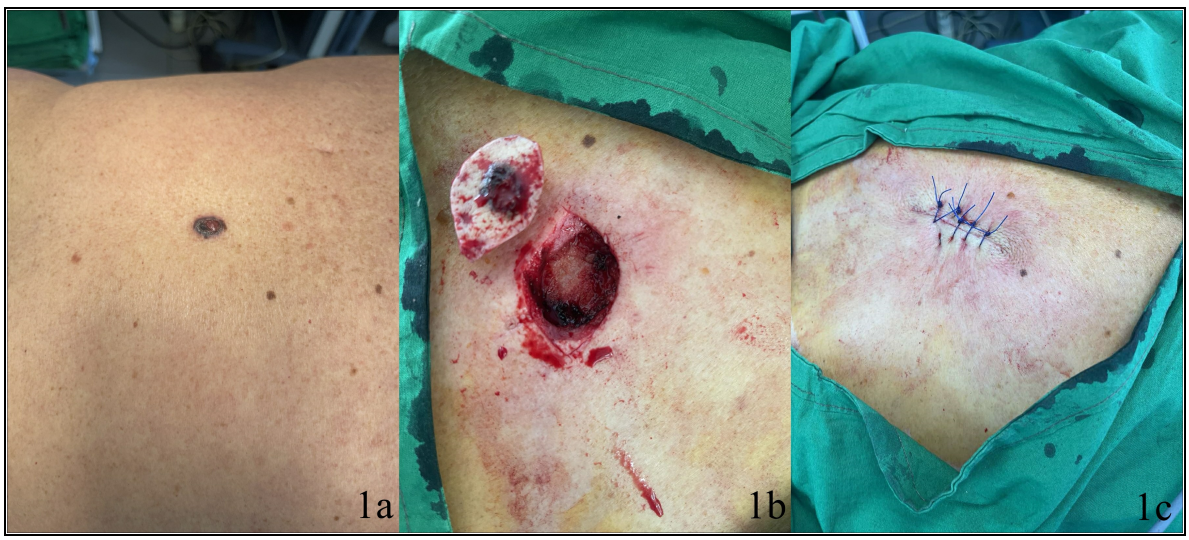

Figure 1a-c. Intraoperative view: surgical removal of the melanomalesion.1a: The lesion is preoperatively

marked.1b: Elliptical excision of the suspected melanoma lesion.1c: The wound edges were adapted with single interrupted sutures.

Results

The histopathology revealed an extensive, symmetrical,well-demarcated melanocytic lesion with epidermal necrosisand covered with parakeratotic crust. A compact proliferation of large, atypical melanocytes was observed, characterized by marked pleomorphism, centrally located nuclei with 1-2 nucleoi, and formation of atypical mitoses. Additionally, areas of desmoplastic degeneration and moderately expressed lymphocytic, well-vascularized, melanophage-rich stroma were identified. The resection margins were clear, and there was no evidence of perineural or lymphovascular invasion. A diagnosis of nodular melanoma with ulcerations, staged T3bN0M0, Clark level 3 and Breslow tumor thickness of 2.5 mm was established. The mitotic index was noted to be5-5/field.
The patient was referred for a reexcision with 1.5 cm in all directions, followed by detection and potential removal of asentinel lymph node.

Conclusions

Pathogenetic aspects concerning drug-induced nitrosogenesis, photocarcinogenesis and oncopharmacogenesis of skin cancer are discussed. Nitrosogenesis' of Cancer as concept in the medical literature has been known for decades, but in relation to other forms of human cancer. Exogenously mediated drug-mediated nitrosogenesis is a logically conditioned and newly defined concept whose significance with respect to the clinical manifestation of skin cancer is only beginning to grow.

Abstract N°: ID-459

Topic: Cutaneous oncology

The Nitrosamine contamination in Beta blockers , ACE inhibitors , thiazides diuretics , calcium channel blockers, sartans and the subsequent skin cancer development and progression: Apocalypse now

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Introduction

The problem of contamination of the most commonly used medicines with nitrosamines is worsening worldwide. According to recent literature data, this "contamination" is the cause not only of skin cancer (keratinocytic/melanoma) but also of gastrointestinal neoplasms, brain tumours, neuroblastoma, rectal carcinoma, acute lymphoblastic leukaemia, and many others. It is these clinical manifestations that are associated with/ or already directly linked to the nitrosamine content of drugs and food products used by patients in previous periods. And it is this permissive availability/contamination that could prove to be the most likely, powerful inducer of acquired mutations underlying the worldwide cancer pandemic. Of further concern is the evidence of contamination of newer classes of medications by nitrosamines- namely: beta blockers, calcium antagonists and selective serotonin reuptake inhibitors (SSRIs). In practice, mankind faces the problem of certainly over 1 billion patients taking nitrosamine-contaminated drugs: 280 million patients with depression (antidepressants), over 1 billion patients with arterial hypertension (antihypertensive drugs), over half a billion patients with type 2 diabetes mellitus (oral antidiabetic drugs/metformin/ sitagliptin), over 4 billion patients with gastritis (ranitidine), over 5 million with tuberculosis (rifampicin), and probably a number of others. The calculations are apocalyptic, since even if only 20-30% of the groups were affected, the number of patients taking these drugs would, by a rough calculation, currently amount to over 1 billion. And there are certainly other classes of drugs yet to be announced. It is for this reason that we should not be surprised that the data on the development of keratinocyte cancer after intake of nitrosamine-contaminated preparations is growing at a breakneck pace. This data indirectly but strongly confirms the importance of a newly introduced concept in the medical science : Nitrosogenesis of skin cancer. A concept, until recently unknown, incomprehensible, but at the same time frightening and gradually accepted, imposing itself and which with each passing day is gaining more and more scientific significance and "visibility", "scientific tangibility, receptivity, and acceptability."

Materials and Methods

The data presented, for the first time in the world literature, are focusing on 4 patients who developed single/multiple forms of keratinocytic cancer (partly in combination with melanoma precursors-dysplastic moles) (Fig.1a-e) after administration of two new classes of potentially nitrosamine-contaminated antihypertensive drugs: beta blockers (bisoprolol, metoprolol) and calcium antagonists (amlodipine, felodipine).

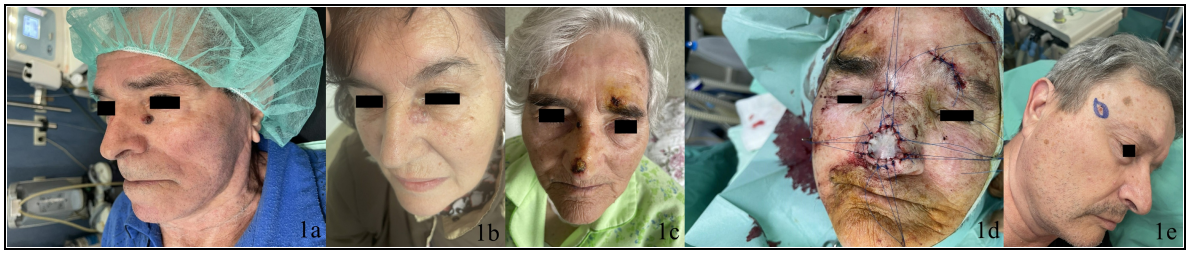

Figure.1a-e: 1a: 4 patients 1a: Drug-induced basal cell carcinoma (Bisoprolol/ Lisinopril) in the area under the left eyelid and immediately above the nasolabial fold. 1b: Drug-induced (Hydrochlorothiazide/ Felodipine) basal cell carcinoma in the medial orbital angle. Toxic antihypertensive drug combinations containing nitrosamines. 1c: Drug-induced (Amlodipine/ Bisoprolol) basal cell carcinoma of the nose and spinocellular carcinoma of the nose after amlodipine and bisoprolol administration. Nitrosamine contamination in Amlodipine and Bisoprolol as substantial skin cancer trigger. 1d: Postoperative findings after skin grafting in the form of full thickness mesh graft from the neck to the tip of the nose. There were 2 elliptical excisions of the tumors above the eyebrow and to the right of the dorsum of the nose. 1e: Drug-induced (Metoprolol/ Perindopril/ Candesartan) basal cell carcinoma localized in the right temporal region. Nitrosamine contamination in beta blockers seems to have the same procarcionogenic effect as Perindopril and Candesartan preparations.

Results

For the first time in the scientific literature, the contributory pro-carcinogenic role of another potentially nitrosamine-contaminated ACE inhibitor- lisinopril , as well as that of candesartan: in the development of keratinocytic cancer is also discussed. For the first time in the world literature, the conclusion regarding the pathogenetic relationship between the intake of potentially contaminated drugs (from different drug groups) and cancer development is based on the model of the equivalent clinical manifestation of skin tumors (rather than on controlled long-term prospective analyses). Nitrosamine contamination in these drug groups appears to be the sole and major unifying factor or causative agent for these manifestations.

Conclusions

The commonality in all the described classes of drugs could be only one: the presence of the same unifying component known as nitrosamine. The nitrosogenesis of skin cancer opens doors that lead to unraveling the puzzle of carcinogenesis worldwide. A carcinogenesis that is opening a business for billions and a carcinogenesis that is costing human lives or put another way: Apocalypse now.

Abstract N°: ID-536

Topic: Cutaneous oncology

A Twenty-Year Multicenter Cohort Study of Subcutaneous Panniculitis-Like T-Cell Lymphoma

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Introduction

Subcutaneous panniculitis-like T-cell lymphoma (SPTCL) is a peripheral T-cell lymphoma characterized by infiltration of subcutaneous adipose tissue by mature cytotoxic $CD8^+$ T cells. Patients are typically young and may have a history of autoimmune disease, particularly systemic lupus erythematosus (SLE), presenting clinically with non-ulcerated deep nodules mimicking panniculitis. Germline mutations in the HAVCR2 gene have been associated with hemophagocytic lymphohistiocytosis (HLH), a potentially fatal complication. However, large SPTCL cohorts remain scarce. Here, we report a 20-year multicenter cohort study describing the clinical characteristics, outcomes, and genetic features of SPTCL.

Materials and Methods

We retrospectively analyzed cases of SPTCL diagnosed between January 2000 and June 2025 across multiple centers, enrolling a total of 23 patients. All diagnoses were confirmed through multidisciplinary review by dermatologists, pathologists, and hematologists. Clinical data were obtained from electronic medical records, clinical photographs, and histopathologic slide reviews. Direct sequencing of HAVCR2 exon 2 was performed in 18 patients, covering previously reported variants (Y82C, I97M, T101I). Statistical analyses were conducted using R version 4.5.1.

Results

The cohort comprised 23 patients with a median age of 31 years (range, 10–56) and a female-to-male ratio of 1.3 (**Table**). One patient had SLE and one had autoimmune thyroiditis; no other autoimmune diseases or acquired immunodeficiencies were identified. At presentation, 50% had generalized tender deep nodules (T3), 27% had regional involvement with multiple lesions (T2), and 23% presented with a solitary lesion (T1). The trunk was the most frequently involved site (65.2%), followed by the upper extremities (56.5%), lower extremities (52.2%), and head and neck (26.1%).

Systemic manifestations included fever (52.2%), B symptoms (21.7%), and HLH (21.7%). Laboratory abnormalities included leukopenia (45.5%), anemia (63.6%), thrombocytopenia (31.8%), and elevated alanine aminotransferase levels (50%). Median lactate dehydrogenase was 376 U/L and β2-microglobulin was 2,527 ng/mL. Antinuclear antibody positivity was observed in 21.1%. Imaging study revealed splenomegaly in 27.3% and hepatomegaly in 9.1%. Hemophagocytosis was detected in 35% of bone marrow biopsies and 17.6% of skin biopsies.

Regarding treatment, 72.7% received chemotherapy as first-line therapy, and 18.2% underwent hematopoietic stem cell transplantation. The estimated 5-year overall survival rate was 84.8%, and the 5-year recurrence-free survival rate was 67.9%.

Among the 18 patients who underwent HAVCR2 exon 2 sequencing, 55% were wild type. One patient had a silent mutation, seven had missense mutations, and one harbored both missense and nonsense mutations. In addition to two cases with the previously reported Y82C variant, several novel HAVCR2 exon 2 variants were identified. Notably, some patients with these unreported variants developed fever, B symptoms, or HLH, while others did not, indicating heterogeneous clinical significance.

Characteristic	Total (23)	Missense (8)	Non-missense (10)
Age, median (range), y	31 (10-56)	28.5 (17-56)	38 (16-53)
Female-to-male ratio	1.3	1.67	0.67
Duration until diagnosis, median, m	2.28	2.96	2.22
Autoimmune	2/23 (8.7)	1/8 (12.5)	1/10 (10)
SLE	1/23 (4.3)	1/8 (12.5)	0/10 (0)
Disease extent (T1-3)			
T1	5/22 (22.7)	0/8 (0)	3/10 (30)
T2	6/22 (27.2)	4/8 (50)	2/10 (20)
T3	11/22 (50)	4/8 (50)	5/10 (50)
Anatomical involvement			
Head and neck	6/23 (26.1)	1/8 (12.5)	3/10 (30)
Trunk	15/23 (65.2)	5/8 (62.5)	8/10 (80)
Upper extremities	13/23 (56.5)	4/8 (50)	7/10 (70)
Lower extremities	12/23 (52.2)	5/8 (62.5)	6/10 (60)
Fever	12/23 (52.2)	4/8 (50)	7/10 (70)
B symptoms	5/23 (21.7)	0/8 (0)	5/10 (50)
HLH	5/23 (21.7)	3/8 (37.5)	2/10 (20)
Leukopenia	10/22(45.5)	5/8 (62.5)	4/10 (40)
Anemia	14/22 (63.6)	7/8 (87.5)	6/10 (60)
Thrombocytopenia	7/22 (31.8)	3/8 (37.5)	3/10 (30)
Elevated ALT	11/22 (50)	4/8 (50)	5/10 (50)
LDH, median (IQR), U/L	376 (194-847)	432.5(201.5-758.5)	368.5 (210.5-846.25)
β2-microglobulin, median (IQR), ng/mL	2527 (1398-5124)	3018 (2443-4793)	1963 (1290-5949)
Ferritin elevation	7/8 (87.5)	4/4 (100)	2/3 (66.7)
Ferritin, median (IQR), ng/mL	1187 (652-1234)	1126 (625-12739)	826 (425-8575)
ANA positivity	4/19 (21.1)	2/7 (28.6)	2/9 (22.2)
Splenomegaly	6/22 (27.3)	3/8 (37.5)	2/10 (20)
Hepatomegaly	2/22 (9.1)	1/8 (12.5)	0/10 (0)
Bone marrow-hemophagocytosis	7/20 (35)	3/8 (37.5)	4/10 (40)
Skin-hemophagocytosis	3/17 (17.6)	1/4 (25)	2/10 (20)
Chemotherapy	16/22 (72.7)	5/8 (62.5)	10/10 (100)
HSCT	4/22 (18.2)	1/8 (12.5)	2/10 (20)
5y-overall survival (95% CI)	84.8 (70.4-100)	87.5 (67.3-100)	78.8 (56.4-100)

*Abbreviations: SLE, systemic lupus erythematosus; HLH, hemophagocytic lymphohistiocytosis; HSCT, hematopoietic stem cell transplantation; IQR, interquartile range; 95% CI, 95% confidence interval

Table: Summary of the subcutaneous panniculitis-like T-cell lymphoma cohort

Conclusions

This 20-year multicenter cohort highlights the clinical features, treatment outcomes, and overall favorable prognosis of SPTCL. Importantly, we also identify previously unrecognized HAVCR2 exon 2 variants, underscoring the need for further studies to clarify their pathogenic role and prognostic implications.

Abstract N°: ID-556

Topic: Cutaneous oncology

Primary Cutaneous CD4⁺ Small/Medium-Sized T-Cell Lymphoproliferative Disorder with Folliculotropism: Clinicopathological Analysis of a Solitary Nasal Nodule

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Introduction
Primary cutaneous CD4⁺ small/medium-sized T-cell lymphoproliferative disorder (PCSM-TCLPD) is a rare, indolent lymphoid proliferation that typically presents as a solitary nodule on the head and neck. Although generally characterized by a dense dermal infiltrate of small to medium-sized CD4⁺ T cells with a polyclonal inflammatory background, folliculotropism is considered an uncommon finding and may lead to diagnostic overlap with folliculotropic mycosis fungoides. We describe a patient with solitary nasal involvement demonstrating notable folliculotropism, emphasizing its relevance in the differential diagnosis.

Materials and Methods
A 56-year-old male with a slowly enlarging erythematous nodule on the right nasal ala was evaluated clinically, dermoscopically, and histopathologically. Prior intralesional corticosteroid therapy had provided no improvement. A punch biopsy and immunohistochemical panel (CD3, CD4, CD8, CD20, Ki-67, keratin markers, neuroendocrine markers, light-chain analysis) were performed to determine the cellular composition, clonality, and diagnostic category. Clinical, histologic, and immunophenotypic features were integrated for final diagnosis.

Results
Histopathologic examination revealed a dense superficial and deep dermal infiltrate composed of small to medium-sized lymphocytes, plasma cells, eosinophils, and histiocytes with prominent folliculotropism. Light-chain studies showed balanced kappa and lambda staining, confirming a polytypic plasma cell population. Immunohistochemistry demonstrated a predominance of CD3⁺ T cells expressing both CD4⁺ and CD8⁺, admixed with CD20⁺ B-cell aggregates. The Ki-67 proliferation index was moderately elevated (35–40%), consistent with reported ranges for PCSM-TCLPD. Absence of cytologic atypia, epidermotropism, and monomorphic T-cell expansion, together with a mixed inflammatory background, supported a reactive lymphoid proliferation rather than overt cutaneous T-cell lymphoma. Complete surgical excision was recommended for definitive management.

Conclusions
This case highlights that folliculotropism—although uncommon—may occur in PCSM-TCLPD and can complicate the distinction from folliculotropic mycosis fungoides. Integration of clinical findings with histopathology, polytypic inflammatory features, and immunophenotypic heterogeneity is essential for accurate diagnosis. Recognition of these features prevents overtreatment and supports the indolent nature of PCSM-TCLPD, for which local excision is generally curative.

Abstract N°: ID-567

Topic: Cutaneous oncology

From Androgenetic Alopecia to Lymphoma: A Case Report of Anchoring Bias

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Introduction

Androgenetic alopecia (AGA) represents the most prevalent cause of hair loss in men and is commonly diagnosed based on characteristic clinical and dermoscopic patterns. However, overreliance on pattern recognition may result in anchoring bias, leading to delayed recognition of underlying conditions. We present a case that highlights the importance of comprehensive scalp examination and histopathological assessment in a male patient initially evaluated for androgenetic alopecia, in whom a primary cutaneous lymphoma was ultimately diagnosed.

Materials and Methods

A 37-year-old male patient presented for dermatological examination due to progressive hair loss, seeking assessment for potential platelet-rich plasma therapy. His past medical history was notable for papillary thyroid carcinoma treated surgically followed by radioactive iodine therapy three years ago. Clinical examination of the scalp revealed hair recession in frontoparietal region, consistent with AGA and classified as stage II according to Norwood–Hamilton scale. Dermoscopic assessment demonstrated anisotrichosis with more than 10% of velus hairs, supporting the diagnosis of AGA. During thorough scalp examination, a solitary, firm, asymptomatic, pale erythematous nodule measuring 15 mm in diameter was observed in the frontoparietal region. Dermoscopy of lesion revealed prominent, bright red reticular vessels over an erythematous background and white perifolicular scale. No other suspicious skin or visible mucosal lesions were noted on examination. Given the atypical presentation and the history of papillary thyroid carcinoma, a 4-mm punch incisional biopsy was performed for histopathological and immunohistochemical analysis, with initial consideration of possible cutaneous metastasis.

Results

Histopathological examination showed a dense dermal infiltrate of atypical lymphoid cells, predominantly medium-sized with few larger forms. Cells demonstrated scant eosinophilic cytoplasm and enlarged nuclei with focally prominent, peripherally located nucleoli. The infiltrate surrounded and infiltrated skin adnexal structures, including atrophic sweat glands and hair follicles, without evidence of epidermotropism. Immunohistochemical profiling of the atypical lymphoid cells demonstrated positivity for CD20, PAX5, BCL6, CD10 and CD23, with negativity for BCL2, Cyclin D1, MUM1, CD5, CD30 and T-cell markers. The proliferative index assessed by Ki-67 was approximately 70%. A background population of reactive T lymphocytes was identified (CD2+, CD3+, CD5+, CD7+, CD4+, CD8−/+). The combined morphological and immunophenotypic findings were consistent with a diagnosis of primary cutaneous follicle centre lymphoma.

Conclusions

This case underscores the critical importance of maintaining diagnostic vigilance and avoiding anchoring bias in

This case underscores the critical importance of maintaining diagnostic vigilance and avoiding anchoring bias in everyday dermatological practice, particularly when evaluating common conditions such as androgenetic alopecia. Focused consultations for hair loss may inadvertently delay the recognition of unrelated cutaneous diseases, particularly when clinical findings are subtle or nonspecific. Initially, the scalp lesion was suspected to represent a cutaneous metastasis due to the patient's history of papillary thyroid carcinoma. However, thorough clinical and dermoscopic examination of the entire scalp, combined with a low threshold for skin biopsy, enabled early detection of primary cutaneous follicle centre lymphoma. This case highlights the dermatologist's pivotal role in comprehensive scalp assessment, illustrating that even common-appearing conditions can conceal serious pathology and reinforcing the importance of systemic examination of the skin and visible mucous membranes in every patient.

Abstract N°: ID-568

Topic: Cutaneous oncology

When a Rash Isn't Just a Rash: Cutaneous T-Cell Lymphoma Mimicking Benign Dermatoses

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Introduction

Cutaneous T-cell lymphoma (CTCL), particularly early mycosis fungoides, can mimic eczema or contact dermatitis, contributing to misdiagnosis, transient corticosteroid responsiveness, and delayed definitive diagnosis. This review synthesises recurring diagnostic pitfalls and proposes a pragmatic escalation approach to support earlier recognition.

Materials and Methods

A narrative review was conducted in PubMed, PubMed Central and Scopus from inception to January 2026. Search terms included cutaneous T-cell lymphoma, mycosis fungoides, eczema/dermatitis, misdiagnosis, biopsy and histopathology. Titles/abstracts were screened for relevance; twelve papers addressing diagnostic delay, clinicopathologic pitfalls, or strategies to distinguish CTCL from benign inflammatory dermatoses were included and synthesised thematically.

Results

Across the twelve included papers, diagnostic difficulty consistently clustered into three failure points: (1) clinical under-recognition, with CTCL presenting as chronic pruritic "eczema," patch/plaque heterogeneity, and frequent involvement of sun-protected "bathing-trunk" sites; (2) reduced biopsy yield, particularly after topical corticosteroid exposure and when relying on a single, shallow biopsy often read as non specific/spongiotic change; and (3) delayed escalation when clinicopathologic correlation was discordant. Prior steroid exposure was repeatedly linked to non-diagnostic histopathology and prolonged diagnostic trajectories.
Quantitative data highlighted substantial delays: in a 157-patient mycosis fungoides series, the first biopsy was diagnostic in 25% and the median diagnostic delay was 2.3 years[1]; in a 256-patient CTCL cohort, median time to diagnosis was 365 days overall and 1095 days for mycosis fungoides, with longer delays associated with initial misdiagnosis[2]. The literature supported a pragmatic escalation pathway: steroid-aware sampling (≥2-week washout where feasible), multi-site biopsy (2–3 representative lesions), early immunophenotyping (CD2/CD3/CD5/CD7, CD4/CD8, CD30) with T-cell receptor clonality testing, and repeat biopsy when discordance persists.

Conclusions

CTCL should be actively considered in chronic, atypical, or treatment-refractory dermatitis, particularly when lesions recur after corticosteroids or localise to sun-protected sites. The reviewed literature supports steroid-aware multi-site biopsy with early immunophenotyping ± TCR clonality, and repeat biopsy when clinicopathologic findings are discordant, to enable timely stage-appropriate management.

Abstract N°: ID-628

Topic: Cutaneous oncology

Mind the Gap: Identifying Pre-Transplant Knowledge Deficits in Skin Cancer and Sun Protection among Solid Organ Transplant Candidates

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Introduction
Cumulative ultraviolet radiation exposure and chronic immunosuppression are major risk factors for keratinocyte cancers. Particularly squamous cell carcinoma, representing the overall most frequent malignancy after solid organ transplantation, arises with markedly increased incidence and aggressiveness in organ transplant recipients. While post-transplant dermatologic surveillance and education are well established, the pre-transplant period remains poorly characterised with respect to patients' skin cancer and sun protection knowledge. As disease-related knowledge is closely linked to preventive behaviour, early identification of knowledge deficits is essential to enable timely educational interventions. This study aimed to assess baseline skin cancer and sun protection knowledge in transplant candidates prior to immunosuppression.

Materials and Methods
In this monocentric cross-sectional study (August 2023 - August 2025), adult patients undergoing dermatological screening as part of their pre-transplant evaluation at a University Hospital dermatology outpatient clinic were consecutively enrolled. Skin cancer and sun protection knowledge was assessed using the validated Skin Cancer and Sun Knowledge (SCSK) scale, a 25 items questionnaire, supplemented by three specific questions regarding skin cancer, immunosuppression, and the self-perceived adequacy of knowledge. Immunosuppression-naive (IN) transplant candidates formed the primary study cohort, while a subgroup of immunosuppression-experienced (IE) transplant candidates served as a reference group. Additional demographic and clinical data were collected, and descriptive and non-parametric statistics were applied.

Results
A total of 154 transplant candidates were analysed (144 IN, 10 IE). IN-candidates (mean age: 52.15 years; 69.4% male; 16.7% current smokers; 2.1% reporting a personal and 11.1% a family history of skin cancer; 34.0% attending regular skin cancer screenings; 78.5% Fitzpatrick skin type II or III; 59.0% awaiting liver transplantation) demonstrated significantly lower mean total SCSK scores compared with IE-candidates (13.6 vs. 16.9; $p=0.018$). Knowledge deficits were most pronounced in tanning behaviour and skin cancer prevention, while symptom recognition of skin cancer was poor in both groups. Only 59.0% of IN-candidates correctly acknowledged immunosuppression as a major skin cancer risk factor, and less than one-third (29.2%) felt adequately informed. Higher knowledge levels were associated with personal ($p=0.031$) or family ($p<0.001$) history of skin cancer, regular skin cancer screenings at least every 2 years ($p<0.001$), and lighter Fitzpatrick skin types ($p=0.011$).

Conclusions
Transplant candidates awaiting solid organ transplantation exhibit substantial deficits in skin cancer and sun protection knowledge, particularly those without prior experience with immunosuppressive therapy. The pre-transplant phase represents a critical and underutilised opportunity for early dermatologic education. Integrating targeted, structured

preventive counselling into pre-transplant care may help promote sustained sun-protective behaviour before lifelong immunosuppression and rising skin cancer risk.

Abstract N°: ID-652

Topic: Cutaneous oncology

Malignant Melanoma and Gastrointestinal Involvement: A Narrative Review

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Introduction

Malignant melanoma (MM) is an epithelial cancer originating from melanocytes, predominantly affecting the skin. It accounts for 1–3% of global neoplasms and is considered the most aggressive form of skin cancer. MM has a high propensity for metastasis, particularly to the gastrointestinal tract (GIT), making it the most common carcinoma to involve this system. The small intestine is the primary metastatic site (51–71%), followed by the stomach (27%), colon (22%), and oesophagus (5%). Although rare, the 5-year survival rate of metastatic melanoma has increased from less than 5% in 2010 to approximately 30% in 2022. Given that the diagnosis of MM with gastrointestinal metastases is often challenging, studies have concluded that this improvement in survival is due to the integration of surgical treatment, systemic therapies, and multidisciplinary management. All of these are essential for early diagnosis and optimisation of patient outcomes.

Materials and Methods

A systematic literature review was conducted using the SCIELO and PubMed databases, as well as scientific journals, with the descriptors “metastatic melanoma,” “gastrointestinal melanoma,” and “gastrointestinal metastasis.” Articles published in English and Portuguese between 2005 and 2025 addressing melanoma with gastrointestinal involvement were included, while studies without such involvement were excluded.

Results

Studies have demonstrated that the pathophysiology of MM is explained by its marked tropism for the small intestine, mediated by the CCR9–CCL25 interaction, in which the ligand CCL25 is highly expressed in the intestinal epithelium. Clinically, this gastric tumour is predominantly asymptomatic; however, it may present with symptoms similar to other upper gastrointestinal lesions, such as abdominal pain, dyspepsia, weight loss, vomiting, acute gastrointestinal bleeding, and chronic iron-deficiency anaemia. Diagnosis is challenging and may require a combination of imaging techniques and endoscopic methods, with histopathological analysis being essential for definitive diagnosis. Computed tomography (CT) is the standard modality for staging and surveillance and is usually the first method to identify gastrointestinal lesions. In specific circumstances, PET-CT (positron emission tomography–computed tomography) may be used as an alternative to quantify disease extent and to select patients for surgical resection with curative intent. When combined with immunotherapy or targeted therapies, surgical intervention is responsible for prolonging survival and improving disease control.

Conclusions

Metastatic MM to the gastrointestinal tract is rare but highly aggressive and difficult to diagnose. The absence or nonspecific nature of symptoms delays identification and worsens prognosis. Therefore, knowledge of the different imaging modalities can accelerate diagnosis and facilitate elective treatment. The earlier the diagnosis—especially in patients with a history of melanoma and subtle gastrointestinal symptoms—the greater the chances of cure and improved survival.

Abstract N°: ID-664

Topic: Cutaneous oncology

Giant Melanoma of the Right Hemiface: An Impressive Case

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Introduction

Melanoma is an aggressive cutaneous tumor of melanocytic origin. Certain atypical forms may evolve slowly and remain unnoticed for several years. We report a rare case of giant melanoma of the hemiface, discovered at a locally advanced stage but without metastatic disease.

Materials and Methods

We report the case of an 82-year-old woman with no significant past medical history, who presented with a pigmented facial lesion evolving over six years, progressively enlarging and recently complicated by local pain and oozing. Clinical examination revealed a large, asymmetric, blackish pigmented plaque with heterogeneous coloration and irregular borders, measuring approximately 12 cm in its longest axis, involving the right hemiface in an X-shaped pattern. The lesion extended from the temporal region to the chin, involving the cheek, nasogenian region, border of the upper lip, and the labial commissure. It was surmounted by a 2-cm ulcerated and hemorrhagic nodule located on the upper lip.

Dermoscopy showed an atypical pigment network with obliteration of follicular openings, the presence of a blue-white veil, ink blotches, and chrysalis structures. Histopathological examination of the nodule after biopsy confirmed the diagnosis of ulcerated nodular melanoma. Staging investigations did not reveal secondary localizations. The patient was discussed in a multidisciplinary tumor board, and treatment with pembrolizumab was initiated, with good tolerance.

Results

Superficial spreading melanoma (SSM) is the most common histological subtype of cutaneous melanoma. It is initially characterized by a radial growth phase, often slow, which may last for several months or even years. In our case, the six-year evolution illustrates this prolonged phase, before progression to a vertical nodular growth phase, marking a worsening prognosis.

This clinical transformation toward an ulcerated nodular form is classic in the natural history of untreated SSM; however, it is rarely observed with such an impressive size. This giant presentation, in the absence of metastatic involvement on staging, is exceptional and may be explained by particular tumor biology or by a host immune response that may have limited dissemination.

The delayed diagnosis is probably related to initial trivialization of the lesion or delayed access to care, as is often observed in very elderly patients. This case highlights the importance of melanoma screening, including in elderly individuals, in whom evolving lesions should receive particular attention.

The decision to initiate immunotherapy with pembrolizumab was based on the locoregional extension of the lesion, the difficulty of achieving complete surgical excision, and the absence of major contraindications despite advanced age. Recent studies suggest that elderly patients may benefit from these treatments with a generally acceptable safety profile; however, multidisciplinary assessment remains essential.

Conclusions

A giant melanoma, even after several years of evolution, may remain localized. This case emphasizes the importance of individualized management, particularly with new therapeutic options such as immunotherapy.

Abstract N°: ID-666

Topic: Cutaneous oncology

Recurrent Breast Carcinoma Mimicking Morphea: A Diagnostic Pitfall

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Introduction

Breast carcinoma metastases may present with highly variable cutaneous manifestations. A large comparative European study of 70,834 women with breast cancer reported that 26.2% were diagnosed at stage IV, indicating metastatic disease at initial presentation, which underscores the clinical importance of recognizing atypical skin manifestations [*Kadys A et al.,* 2023]. We report a case of recurrent breast carcinoma that initially presented with clinical symptoms of breast-associated morphea (BAM). BAM may closely mimic mastitis, cellulitis, radiation dermatitis, lipodermatosclerosis, and malignant processes, such as inflammatory breast cancer or cutaneous metastases [*Papara C et al.,* 2023].

Materials and Methods

We report a case of recurrent breast carcinoma that was initially misdiagnosed and managed as BAM.

Results

A 48-year-old woman presented with progressive erythematous and indurated plaques on the right breast for over six months. She had a 4-year history of breast carcinoma, treated with neoadjuvant chemotherapy and surgery, and had been on tamoxifen since 2022. The patient had previously been diagnosed with BAM based on a 3.5 mm skin punch biopsy, which demonstrated epidermal atrophy and prominent dermal collagen deposition. Topical glucocorticoids were administered without clinical improvement.

As the BAM-like symptoms progressed, the clinical diagnosis was revised. Physical examination revealed widespread, non-tender erythematous infiltration involving most of the affected breast, with localized edema potentially related to prior axillary lymphadenectomy. Laboratory tests (CRP, ESR) were unremarkable, ANA was negative. Breast and axillary ultrasound showed only postoperative changes, with no evidence of suspicious focal masses or additional pathological abnormalities.

Therefore, an excisional biopsy of the skin lesion was performed. The histology revealed tumor cells within vascular structures in the dermis, arranged in solid nests. Immunohistochemically, the cells were GATA3-positive, negative for estrogen and progesterone receptors, and exhibited weak HER2 expression. Based on immunohistologic evaluation of excisional biopsy, the recurrent breast carcinoma with dermal involvement and lymphatic spread was confirmed. The patient has initiated first-line chemotherapy with carboplatin and paclitaxel.

Conclusions

Recurrent breast carcinoma may mimic inflammatory or fibrosing dermatoses, including morphea. A high index of suspicion and histopathological re-evaluation are essential in patients with atypical clinical progression and oncologic history.

Abstract N°: ID-679

Topic: Cutaneous oncology

Use of a CE Class III Artificial Intelligence as a Medical Device in community-based diagnostic hubs to increase the conversion rate of urgent suspected skin cancer referrals - a prospective, multi-centre clinical evaluation

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Introduction

Dermatology receives the highest volume of Urgent Suspected Cancer (USC) referrals of all specialties in the UK National Health Service (NHS). Demand continues to rise with the volume of USC referrals for suspected high-risk skin cancer tripling over the last decade [1, 2]. Whilst the number of referrals has risen substantially, the proportion that result in a diagnosis of high-risk skin cancer ("conversion rate") has fallen. In 2009/10, the USC conversion rate for suspected high-risk skin cancer was 8.3% compared to 6.2% in 2022/23 [3].

Rising USC referrals and falling conversion rates mean more benign lesions are being referred to USC pathways, increasing diagnostic workload and waiting times. This has a knock-on effect on the routine dermatology caseload as clinical capacity is redirected to meet USC waiting time targets. For patients with benign lesions, a USC referral creates anxiety and unnecessary appointments.

A potential solution involves using Artificial Intelligence as a Medical Device (AIaMD) in primary care to (1) identify benign lesions that do not require referral, (2) direct low risk lesions to non-urgent pathways and (3) improve the quality of referrals to the USC pathway.

In standard care, USC referrals are made by a primary care practitioner. This study aimed to determine whether the use of an AIaMD in lieu of standard primary care assessment and triage increases the conversion rate for high-risk skin cancers.

Materials and Methods

A prospective, post-deployment, multi-centre clinical performance review of a CE Class III AIaMD was performed. The AIaMD is intended for use in the screening, triage and assessment of lesions suspicious for skin cancer.

Across three Integrated Care Boards (ICBs) between December 2023 and April 2025, eligible patients contacting primary care with up to three suspicious skin lesions were directly routed to community-based imaging clinics for AIaMD assessment without the need for primary care review.

The conversion rate of the AIaMD pathway during the evaluation period was compared with standard care using local datasets where available. Where local datasets covered only part of a region, or provided insufficient data, pre-deployment ICB-level Cancer Waiting Time (CWT) data [3] was used as the benchmark. High risk cancer diagnoses were confirmed by histology or CWT-coded outcomes. Conversion rates are presented with 95% confidence intervals (Wilson method). Statistical comparisons are made using two-tailed Two-Proportion Z Tests (significance threshold $p < 0.05$).

Results

In the AIaMD pathway, 11,721 cases were assessed. All Fitzpatrick skin types were represented, and patients ranged in age from 18 to 102 years. The AIaMD referred 4,426 cases to the USC pathway, among which 405 high-risk malignancies

(melanoma, SCC and rare skin cancers) were confirmed.

The conversion rate was significantly higher than standard care in all three AIaMD pathways (Table 1). Overall, standard care pathways had a conversion rate of 6.9% (6.7-7.1) which significantly increased to 9.2% (8.3-10.0) in AIaMD pathways ($p < 0.0001$).

	Standard care pathway	AIaMD pathway	p value
ICB 1	4.4% [4.2-4.7]	5.8% [4.5-7.5]	0.0404*
ICB 2	9.0% [8.4-9.6]	11.3% [9.7-13.3]	0.0085*
ICB 3	7.5% [7.0-7.9]	9.4% [8.3-10.6]	0.0017*
Combined	**6.2% [6.0-6.4]**	**9.2% [8.3-10.0]**	**< 0.00001***
*Point estimates are presented with 95% confidence intervals. * Statistically significant*			

Table 1: High risk skin cancer conversion rates in standard care and AIaMD pathways.

Conclusions

Conversion rates for high-risk skin cancers were significantly higher in AI-enabled community diagnostic pathways compared with standard care. AIaMD use in the community can improve the quality of referrals to the USC pathway.

AIaMD-enabled community diagnostic pathways represent a scalable solution to improve the efficiency of urgent skin cancer pathways, supporting earlier cancer diagnosis, protecting dermatology specialist time and returning clinical capacity to primary care.

[1] https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
[2] https://www.edgehealth.co.uk/news-insights/ai-in-dermatology-white-paper/
[3] https://nhsd-ndrs.shinyapps.io/cwt_referral_conversion_detection/

Abstract N°: ID-695

Topic: Cutaneous oncology

The 31-GEP provides personalized prognostic information beyond AJCC staging in patients with cutaneous melanoma

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Introduction
Multiple studies have demonstrated that cutaneous melanoma (CM) tumors within the same American Joint Committee on Cancer (AJCC) stage behave differently, indicating intra-stage heterogeneity. This heterogeneity could be explained by molecular risk not captured by current staging. The 31-gene expression profile (31-GEP) analyzes the molecular risk of a tumor and has been validated to stratify patients with stage I-III CM as low (Class 1A), intermediate (Class 1B/2A), or high (Class 2B) risk of tumor recurrence, metastasis, and death. Using a novel, prospectively tested cohort, we demonstrate that the 31-GEP independently stratifies risk of recurrence in patients with CM and increases the accuracy of AJCC staging when used together.

Materials and Methods
This analysis included patients with stage I–III CM (n=1,817) who were clinically tested with the 31-GEP (2013-2017). Kaplan-Meier analysis was used to estimate 5-year recurrence-free survival (RFS), and log-rank test was used to compare survival outcomes between groups. Multivariable Cox regression identified significant predictors of recurrence. Interaction terms determined whether the 31-GEP adds independent prognostic value, and analysis of deviance was used to identify whether the prognostic information provided by the 31-GEP significantly improved risk prediction independent of AJCC staging.

Results
Class 1A patients had higher 5-year RFS than patients with Class 1B/2A or Class 2B (95.2% vs. 80.4% vs. 67.7%; log-rank, $p<0.001$). Notably, stage I-IIA patients with Class 2B results had a similar 5-year RFS to all patients with stage IIB-IIIA disease (80.8% vs. 75.2%, respectively, $p=0.6$). Multivariable Cox regression identified significant predictors of recurrence as 31-GEP Class 2B (Hazard Ratio [HR]=2.69, $p<0.001$), Class 1B/2A (HR=2.33, $p<0.001$), ulceration status (HR=1.71, $p=0.002$), Breslow thickness (HR=1.12, $p=0.005$), mitotic rate (HR=1.03, $p=0.03$), age (HR=1.02, $p<0.001$), and a positive SLN (HR=3.75, $p<0.001$). There were no significant interactions between 31-GEP Class 1B/2A or Class 2B and a positive SLNB ($p=0.54$, $p=0.81$, respectively), demonstrating that 31-GEP adds prognostic information that is independent of SLN status. When 31-GEP Class was combined with AJCC staging, risk of recurrence prediction significantly improved compared to AJCC staging alone (ANOVA: $\chi^2=29.5$, $p<0.001$).

Conclusions
Consistent with prior studies, the 31-GEP significantly stratifies patients with stage I-III CM, adding prognostic value for identifying patients at increased risk of recurrence. Importantly, patients identified as low stage I-IIA but high risk by 31-GEP had similar event rates as patients with stage IIB-IIIA thus identifying a population of patients who should receive similar surveillance and referral to multidisciplinary care teams for additional management considerations. Overall, the 31-GEP can significantly improve care for all patients with CM, enabling more informed and risk-aligned disease

management decisions.

Abstract N°: ID-704

Topic: Cutaneous oncology

Clinicopathologic Features and Clinical Outcomes of Non-Melanoma Cutaneous Metastases: A Single-Center Study

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Introduction
Cutaneous metastases are uncommon but clinically significant manifestations of internal malignancy and may represent the first sign of cancer or indicate advanced disease. While previous studies have described the epidemiology of cutaneous metastases, many series combine melanoma and non-melanoma cases despite their distinct biology and clinical behavior. Data focusing exclusively on non-melanoma cutaneous metastases remain limited, particularly from certain geographic regions. We aimed to describe the clinicopathologic characteristics and outcomes of non-melanoma cutaneous metastases and to evaluate factors associated with patient outcomes.

Materials and Methods
A retrospective review was conducted at a tertiary referral center of patients diagnosed histopathologically with cutaneous involvement of internal malignancies between January 2008 and October 2025. Cases of primary cutaneous malignancies and melanoma-related metastases were excluded. Cutaneous involvement was categorized as true cutaneous metastasis or direct local invasion, with the former constituting the primary study cohort. Demographic data, primary tumor characteristics, clinical presentation, anatomic distribution, timing of cutaneous metastasis, treatments, and survival outcomes were collected. Continuous variables were summarized descriptively and categorical variables as counts/percentages; group comparisons used appropriate parametric or non-parametric tests. Overall survival was assessed using Kaplan–Meier methods and compared with log-rank testing; a two-sided p value <0.05 was considered significant.

Results
A total of 57 patients were included, of whom 48 (84.2%) had true cutaneous metastases and 9 (15.8%) had direct local invasion. The mean age at diagnosis of cutaneous metastasis was 62.3 years, with a slight male predominance. The most common primary tumors were breast and lung carcinomas (each 26.1%), followed by gastrointestinal malignancies (19.6%). Adenocarcinoma was the most frequent histologic subtype (37.5%). Cutaneous metastases most commonly involved the chest and head and neck regions (each 34%), with chest involvement predominating in breast carcinoma and head and neck involvement most frequently associated with lung carcinoma. Nodular lesions were the predominant clinical presentation (57.4%). Cutaneous metastasis was the first manifestation of internal malignancy in 22.9% of patients. Overall prognosis was poor, with a mean survival of 11.8 months after cutaneous metastasis diagnosis, and 85.4% of patients died during follow-up. Female patients demonstrated significantly longer survival compared with males. Nodular morphology was associated with longer survival, whereas ulcerated lesions were linked to poorer outcomes. Patients with direct local invasion demonstrated significantly longer survival compared with those with true cutaneous metastases.

Conclusions
This long-term, single-center study provides updated clinicopathologic and prognostic data on non-melanoma cutaneous metastases from a region with limited contemporary reporting. The distribution of primary tumors, favored anatomic sites, and overall survival patterns were largely consistent with previously published series, confirming breast

and lung carcinomas as the leading sources of cutaneous metastases and the chest and head and neck as the most commonly involved sites. The relatively high proportion of cases in which cutaneous metastasis represented the first sign of malignancy underscores the importance of early dermatologic recognition. Additionally, the association between clinical morphology and survival suggests that gross presentation may carry prognostic relevance. These findings reinforce the role of the skin as a clinically meaningful site of metastatic disease and highlight the need for continued region-specific data to refine prognostic assessment and clinical awareness.

Abstract N°: ID-705

Topic: Cutaneous oncology

Basal Cell Carcinoma of the scalp Presenting as Alopecic plaque: Importance of Dermoscopy

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Introduction
Basal cell carcinoma (BCC) is the most common cutaneous malignancy, with a steadily increasing incidence. Although it typically presents with irregular, ulcerative lesions and rolled borders, BCC may occasionally mimic other conditions, leading to delayed diagnosis. We report a rare case of BCC presenting as an alopecic plaque on the scalp.

Materials and Methods
A 33-year-old woman presented with an asymptomatic, skin-colored plaque associated with localized hair loss on the scalp for approximately one year. The lesion had previously been diagnosed as alopecia areata at another clinic and was treated with topical corticosteroids without clinical response. Dermoscopic examination revealed multiple telangiectatic vessels and structureless hypopigmented areas. Histopathologic examination of a punch biopsy specimen demonstrated nests and cords of atypical basaloid cells infiltrating the dermis, with peripheral palisading and retraction clefts, consistent with BCC. The patient underwent complete surgical excision with reconstruction using skin grafting and has remained recurrence-free on follow-up.

Results
Histopathology confirmed BCC in a clinically alopecic plaque initially misdiagnosed as alopecia areata. The tumor was completely excised with skin graft reconstruction, and no recurrence has been observed.

Conclusions
BCC of the scalp may present as an alopecic plaque and be misdiagnosed as alopecia areata or discoid lupus erythematosus. A long-standing indurated alopecic plaque with prominent telangiectasia and structureless hypopigmented areas on dermoscopy should prompt consideration of BCC and early biopsy. Recognition of this atypical presentation may help avoid diagnostic delay and facilitate appropriate management.

Abstract N°: ID-710

Topic: Cutaneous oncology

Estimating melanoma depth from dermoscopic images using vision transformers

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Introduction
Accurate detection of melanoma and precise estimation of lesion depth are essential for clinical decision-making and prognostic assessment. Histopathologic examination remains the gold standard for both diagnosis and measurement of Breslow depth; however, advances in dermoscopic imaging and artificial intelligence enable non-invasive prediction of lesion depth. Accordingly, this study aimed to develop and validate a deep learning model utilizing Vision Transformer (ViT)–derived feature representations for melanoma detection and depth estimation from dermoscopic images.

Materials and Methods
Dermoscopic images from publicly available datasets (ISIC and HAM10000) were combined with institutional image data collected at Hanyang University Hospital and Seoul St. Mary's Hospital. A ViT model was trained using the public datasets to perform multi-class skin lesion classification. Feature representations derived from the trained model were subsequently extracted and incorporated into separate deep learning models developed for melanoma detection and lesion depth estimation. The performance of the proposed models was evaluated against three reference models, including a conventional ViT model trained end-to-end without external feature representations, a ResNet-based convolutional neural network (CNN), and a simple CNN baseline.

Results
The proposed model demonstrated a melanoma detection accuracy of 0.988 with an F1 score of 0.890. For lesion depth estimation, the model achieved a root mean square error (RMSE) of 0.0633 mm and outperformed the reference models. Predicted lesion depth showed a strong correlation with histopathologically confirmed Breslow depth (Pearson correlation coefficient r = 0.82).

Conclusions
Deep learning models incorporating ViT–derived feature representations enable accurate melanoma detection and precise lesion depth estimation from dermoscopic images. This artificial intelligence–based, non-invasive approach may assist clinical risk stratification and management by providing quantitative diagnostic and prognostic information. Further studies incorporating patient-specific clinical variables and prospective validation in real-world settings are needed to establish clinical applicability.

Abstract N°: ID-721

Topic: Cutaneous oncology

Genomic landscape and therapeutic relevance of NRAS, KRAS, and HRAS alterations in skin cancer: Insights from cBioPortal

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Introduction

Alterations in *RAS* family genes represent key oncogenic drivers in several skin malignancies. Although targeted inhibition of the MAPK pathway has substantially improved outcomes in *BRAF*-mutant melanoma, effective targeted treatment options for *RAS*-mutant skin cancers remain limited, with immune checkpoint blockade constituting the main therapeutic approach. Cetuximab is also used off label for patients with advanced cutaneous squamous cell carcinoma.

Materials and Methods

We performed a comprehensive analysis of *NRAS, KRAS,* and *HRAS* genomic alterations using publicly available datasets within cBioPortal across cutaneous melanoma (CM), cutaneous squamous cell carcinoma (cSCC), and basal cell carcinoma (BCC). Mutations affecting 24 predefined codons with potential oncogenic relevance were evaluated based on OncoKB annotations.

Results

Overall, *RAS* alterations were detected in 24% of cases for *NRAS*, and in 3% each for *KRAS* and *HRAS*. CM exhibited the highest frequency of *RAS* mutations (*NRAS* 27%, *KRAS* 3%, *HRAS* 2%). In contrast, cSCC was characterized by a predominance of *HRAS* alterations (14%), while *NRAS* and *KRAS* mutations were infrequent (2% each). BCC demonstrated a low prevalence of *RAS* alterations, most commonly involving *HRAS* (3%), followed by *KRAS* (2%) and *NRAS* (1%). Within melanoma subtypes, *NRAS* and *KRAS* mutations were observed in 12% and 6% of acral melanomas, respectively, whereas desmoplastic melanoma showed only sporadic *RAS* alterations.

Across the 24 evaluated codons, mutations were detected in 12 *NRAS*, 14 *KRAS*, and 8 *HRAS* codons. *NRAS* alterations predominantly involved Q61 (n=456), followed by G12 (n=24) and G13 (n=17), with rare substitutions at Q22, P34, T50, T58, A59, E62, A83, A146, and E153. *KRAS* mutations clustered at G12 (n=14), G13 (n=6), and Q61 (n=5)), with infrequent substitutions in V14, A18, Q22, T50, G60, E62, E63K, K117, D119, A146, and F156. *HRAS* mutations were most common at G13 (n=19) and Q61 (n=17), followed by G12, T58, A59, R68, K117, and A146. In cSCC, *HRAS* was the most commonly mutated *RAS* gene, predominantly involving G13 substitutions (n=7), with G13D being the most frequent, followed by Q61 (n=6). No *NRAS* G12, G13, or Q61 mutations were detected in cSCC, with E153A being the only *NRAS* potentially oncogenic alteration observed. *RAS* mutations in BCC were rare and primarily involved *HRAS* (G13R , G13V).

G12C mutations were uncommon, including one case each in *KRAS*-mutant cSCC, BCC, and melanoma, as well as three patients in *NRAS*-mutant melanoma. G12D mutations were identified in all three *RAS* genes.

RAS-altered tumors were more frequently identified in metastatic compared with primary samples and were associated with advanced patient age, without a significant impact on overall survival. *RAS*-altered tumors demonstrated significant co-occurrence with alterations in *TERT, CDKN1A/B/C, CDKN2A/B, CCND1, MDM4, RB1*, *ARID2/4B, PPP6C, RAC1,* and *STK19.* Conversely, alterations in *BRAF, KIT, MAP2K1, PTEN* alterations were enriched in *RAS*-wild-type tumors.

Conclusions

In the context of emerging RAS-targeted and combinatorial therapeutic strategies, including allele-specific, pan-RAS inhibitors, farnesyltransferase inhibitors for *HRAS*-mutant cancers, and the possibility of targeting coccurrent genomic alterations comprehensive molecular testing is important to identify actionable alterations and guide personalised treatment strategies in skin cancer.

Abstract N°: ID-724

Topic: Cutaneous oncology

Genetic biomarkers and their correlation with clinico-pathological features of Cutaneous Squamous Cell Carcinoma

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Introduction

Cutaneous squamous cell carcinoma (cSCC) is the second most common skin cancer among the Caucasian population. The majority of tumors are successfully treated surgically, but a small subset of patients (3–7%) develop locally advanced or metastatic disease associated with significant morbidity and mortality. Next-generation sequencing (NGS) technologies have substantially improved the understanding of the molecular pathogenesis of cSCC and have revealed new perspectives for risk stratification and targeted therapy development. Our study aims to characterize the genetic profile of cSCC in a Bulgarian patient cohort and to investigate correlations between genetic alterations and clinical, histopathological, and immunohistochemical features of the disease.

Materials and Methods

We conducted a prospective study of 70 patients diagnosed with invasive cSCC. Tumors were divided into low-risk (n = 35) and high-risk (n = 35) groups based on tumor diameter, depth of invasion, recurrence and metastasis rates, and local advancement. Histopathological examination and immunohistochemical analysis of PD-1, PD-L1, CD4/CD8 ratio and Ki-67 were performed. Tumor DNA was extracted and analyzed using sequencing-by-synthesis technology with a kit targeting 60 genes associated with solid tumors, including key genes involved in cSCC (TP53, NOTCH1/2, CDKN2A, PIK3CA, PTEN, EGFR, HRAS). Statistical analysis was performed using IBM SPSS to assess associations between molecular findings and clinicopathological parameters.

Results

Statistically significant differences were found between both groups of cSCC. Frequent pathogenic mutations, often multiple, were detected in high-risk cSCC tumors. In contrast, low-risk tumors exhibited fewer genetic alterations, predominantly single mutations. TP53 mutations were more frequent in high-risk tumors, while CDKN2A mutations were almost exclusive to this group. Combined TP53 and CDKN2A mutations were associated with significantly greater tumor thickness, an increased tumor proliferation index, and elevated PD-L1 expression, indicating aggressive tumor behavior.

Conclusions

This research provides the first comprehensive clinico-genetic correlation analysis of cSCC in a Bulgarian population. High-risk cSCC is characterized by a higher mutational burden and distinct genetic alterations. The results suggest a link between genetic instability and immune evasion. These findings highlight the potential value of molecular profiling for improved risk stratification and may support the integration of genetic and immunohistochemical markers into personalized management strategies for patients with cSCC.

Abstract N°: ID-740

Topic: Cutaneous oncology

Erythrodermic Mycosis Fungoides with Palmoplantar Keratoderma and Nail Dystrophy: A Case Report

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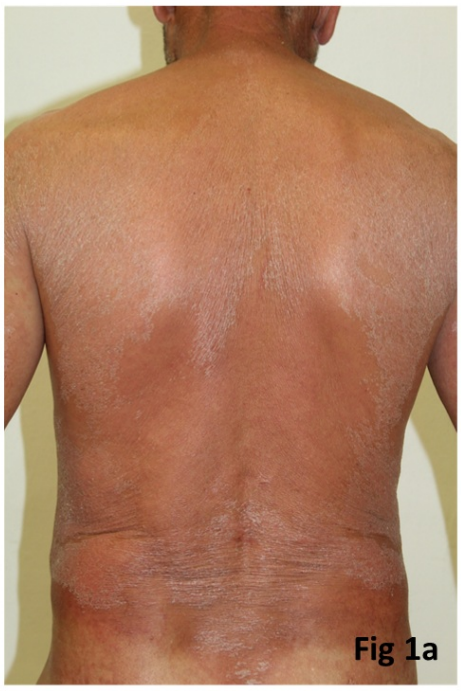
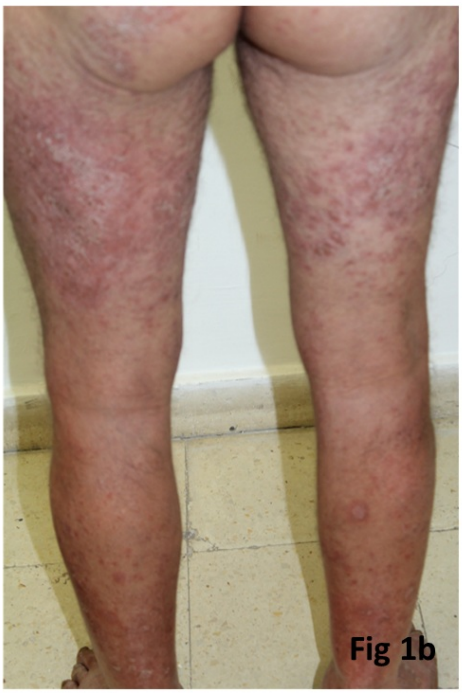
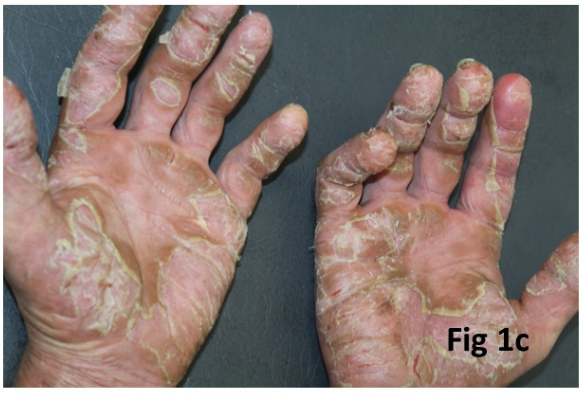
Introduction

Mycosis fungoides (MF), the most common primary cutaneous T-cell lymphoma, is often considered a dermatological masquerader due to its wide range of clinical presentations. Erythrodermic MF is an uncommon and advanced form, occasionally associated with atypical acral manifestations. We report a case of erythrodermic MF with palmoplantar keratoderma and nail dystrophy.







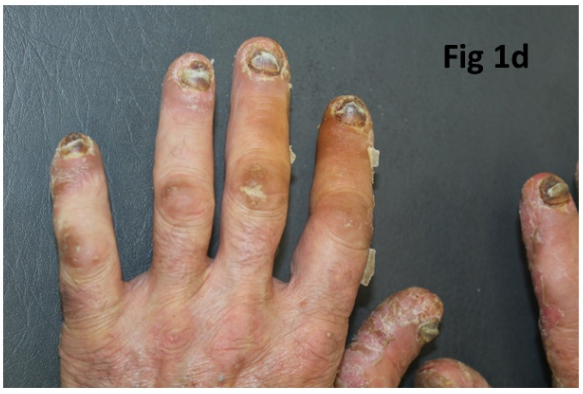


Figure1:

Fig 1a+b: dry erythroderma

Fig 1c: palmar kera-toderma

Fig 1d: Nail involvment

Results

A 55-year-old man with no significant medical history presented with a three-month history of dry erythroderma associated with intense pruritus and unquantified weight loss, without preceding drug exposure. Physical examination revealed a diffuse erythemato-squamous eruption involving the trunk, limbs, face, skin folds, and palmoplantar areas, with thick fissured palmoplantar keratoderma and lamellar desquamation. Crusted cheilitis was noted. Nail examination showed pachyonychia, distal onycholysis, and subungual hyperkeratosis affecting both fingernails and toenails.

Laboratory investigations, including renal and hepatic function tests and lactate dehydrogenase levels, were normal.

Viral serologies (HIV, hepatitis B and C) were negative. Peripheral blood smear revealed rare Sézary-like cells. Skin biopsies confirmed MF, including a biopsy from the feet showing keratinocyte necrosis. Mycological examinations were negative. Initial immunophenotyping showed a CD4/CD8 ratio of 2.03 without criteria for Sézary syndrome; a later analysis demonstrated an increased CD4/CD8 ratio of 5.3 with partial CD7 loss, still insufficient for diagnosis of Sezary syndrome. Imaging revealed right inguinal and axillary lymphadenopathy, with reactive findings on biopsy.

Treatment with methotrexate (15 mg/week) and topical corticosteroids led to complete resolution of erythroderma within one month, with partial improvement of palmoplantar keratoderma and nail changes. Eight months after self-discontinuation of treatment, the patient relapsed with persistent palmoplantar keratoderma, nail dystrophy, residual plaques, a CD4/CD8 ratio of 5, and 3% Sézary cells in peripheral blood.

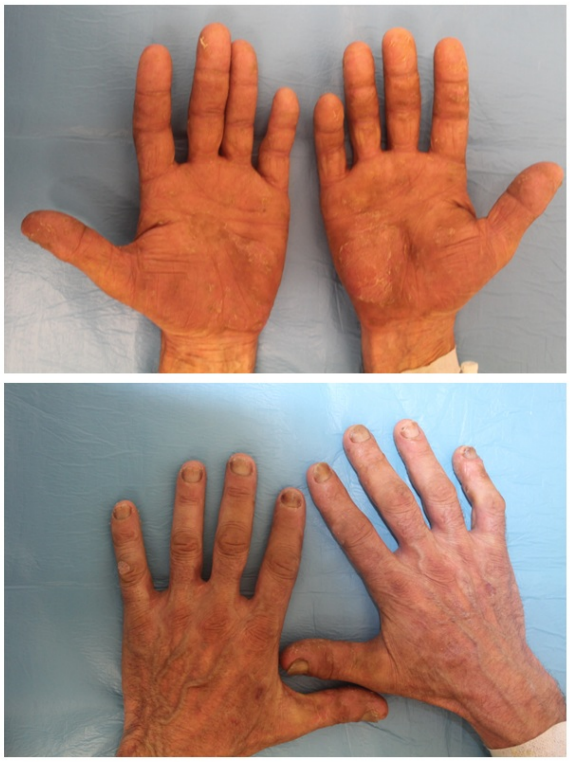


Figure 2:

Improvement of palmoplantar keratoderma and nail dystrophy after methotrexate treatment

Conclusions

This case highlights a rare presentation of erythrodermic MF associated with palmoplantar keratoderma and nail dystrophy. Palmoplantar involvement in MF is uncommon and is mainly described in erythrodermic MF or Sézary syndrome. Nail involvement is even rarer and frequently mimics benign nail disorders. Its pathogenesis is attributed to infiltration of malignant T lymphocytes into the nail apparatus, leading to structural nail abnormalities. Although nail changes are unusual in early-stage MF, their presence may indicate more advanced or aggressive disease. Palmoplantar involvement does not systematically extend to the nails. Indeed, series of MF patients with extensive hand and foot involvement but without nail abnormalities have been reported, underscoring the heterogeneous tropism of malignant

T-cell clones.

Methotrexate proved effective for erythroderma, but the persistence of acral lesions highlights their relative resistance to systemic therapy. Previous reports suggest variable efficacy of radiotherapy, phototherapy, CO_2 laser, and methotrexate, whereas topical corticosteroids, acitretin, and bexarotene appear less effective for palmoplantar MF. No standardized treatment guidelines exist for MF-related nail disease, therapeutic options are limited to topical corticosteroids, retinoids, or nitrogen mustard, with inconsistent outcomes.

Palmoplantar and nail involvement, though rare, should raise suspicion for MF, particularly in erythrodermic patients even in the absence of Sézary syndrome criteria. Optimal management may require a multimodal approach combining systemic therapy with targeted treatments for resistant acral sites, along with long-term maintenance to prevent relapse

Abstract N°: ID-753

Topic: Cutaneous oncology

When Colorectal Cancer Reaches the Skin: A Rare Case of Cutaneous Metastasis

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Introduction

Colorectal cancer is one of the most common malignancies worldwide. The most frequently metastases are liver, lungs, peritoneum, and lymph nodes, whereas cutaneous involvement remains an exceptionally rare occurrence. Skin lesions typically develop during the advanced stages of the disease, however, their presentation at the time of initial diagnosis, known as synchronous metastasis, is even less frequent. Skin manifestations often appear in association with other distant metastases. This case report highlights the diagnostic and therapeutic challenges associated with this uncommon presentation, contributing to the limited evidence currently available in the literature.

Materials and Methods

A 74-year-old male presented to the dermatology department with a two-week history of disseminated erythematous infiltrative lesions. Physical examination revealed numerous firm, palpable infiltrates arranged in a linear distribution, extending from the right axilla through the lower abdomen to the scrotum, inguinal region, and right thigh. Notably, the lesions in the lower abdominal region involved the postoperative surgical scar.
The patient had a documented history of clinical stage IV colorectal cancer. Histopathological examination of the primary tumor revealed a poorly differentiated adenocarcinoma involving the cecum, ileocecal valve, and appendix. The disease was staged as pT4aN2bM1, with microscopically positive resection margins (R1). Molecular analysis showed no mutations in the KRAS, NRAS, and BRAF genes. At the time of dermatological presentation, the patient had undergone surgical treatment and had been receiving palliative chemotherapy with 5-fluorouracil (5-FU) for two months.
Histopathological examination of skin biopsy specimens revealed metastatic colorectal adenocarcinoma infiltrating the dermis, confirming the diagnosis of cutaneous metastases. Despite the continuation of palliative chemotherapy, the patient's clinical condition deteriorated, and he died within two months of the diagnosis of cutaneous metastases.

Results

The cutaneous lesions were located predominantly on the abdominal skin near the surgical scar, consistent with the commonly reported sites of skin metastases in colorectal adenocarcinoma. The presence of cutaneous metastases was associated with disseminated disease. Based on the clinical presentation, lymphatic spread was considered the most likely mechanism of metastasis, although intravascular dissemination, direct tumor extension, and surgical implantation may also play a role. The diagnosis of cutaneous metastasis correlated with short overall survival in this patient.

Conclusions

Cutaneous metastases from colorectal cancer are rare and typically indicate advanced, disseminated disease with a poor prognosis. Surgical scars on the abdominal wall represent a common site of involvement. Diagnosis is challenging,

as the differential diagnosis often includes chemotherapy-related drug reactions, paraneoplastic syndromes, and direct tumor infiltration. Therefore, histopathological examination supported by immunohistochemical analysis is essential, while molecular profiling (e.g., BRAF, KRAS) may aid therapeutic decision-making. Clinicians should maintain a high index of suspicion for new skin lesions in oncological patients, as early recognition of cutaneous metastases can significantly influence treatment and prognosis.

Abstract N°: ID-756

Topic: Cutaneous oncology

Vulvar Bowen's disease as a sentinel marker for massive synchronous pelvic malignancy: The critical concept of HPV induced anogenital field cancerization.

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Introduction

Vulvar Bowen's disease (vBD), or High-Grade Squamous Intraepithelial Lesion (HSIL), is frequently managed as a localized cutaneous condition. However, it should be regarded as a marker for a broader "field cancerization" where the entire anogenital tract is at risk due to shared oncogenic factors (HPV). We report a demonstrative case where vBD was the sentinel sign of a **distinct, synchronous, and deep anogenital malignancy**.

Materials and Methods

We report the case of a 90-year-old female patient presenting with a progressive vulvar lesion. Clinical examination revealed a 5-cm, heterochromic, and vegetative plaque involving the labia. To ensure accurate staging, a deep fusiform biopsy was performed on the most clinically infiltrated area. Histopathology confirmed **Squamous Cell Carcinoma in situ (Bowen's disease)** without dermal invasion. Given the extensive and infiltrated clinical presentation, a comprehensive assessment was performed to screen for synchronous deep associations. **A thorough gynecological and proctological digital examination** revealed a palpable infiltration of the anal and vaginal canals. This alarming clinical finding prompted a **pelvic MRI**.

Results

While the cutaneous lesion was superficial, the MRI identified a **massive, distinct tumor process (65 x 60 mm)** in the deep pelvis, invading the urethra, the bladder neck, and the anal canal (Stage T3). Radiologically, this mass was **distinct** from the superficial vulvar lesion (separated by healthy tissue). The final diagnosis was established as a **synchronous association** of two independent malignancies: a superficial vulvar Bowen's disease and a deep invasive pelvic tumor. This confirmed that the vBD was merely the visible marker of a severe multicentric HPV-driven process.

Conclusions

This case highlights a critical diagnostic pitfall. The trap was not that the biopsy "missed" the invasion, but that the Bowen's disease was hiding a **separate, synchronous enemy**. Diagnosing an **infiltrated** Vulvar Bowen's disease in an elderly patient must trigger a "Red Flag" alert. The dermatologist must not limit the exam to the skin but perform a complete **pelvic digital examination**. Imaging (MRI) is essential in these cases to detect **synchronous deep associations**.

"Screen the tract before treating the lesion" is the key message to avoid futile superficial management in complex oncologic fields.

Abstract N°: ID-765

Topic: Cutaneous oncology

Cutaneous Adverse Events of Modern Oncologic Therapies: A Real-World Clinical Experience

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Introduction

The rapid development of targeted oncologic therapies and immune checkpoint inhibitors has significantly improved cancer outcomes but has also led to an increasing incidence of cutaneous adverse events. Given the expanding use of targeted therapies and immunotherapy in clinical practice, a better understanding of their dermatologic safety profile is essential to optimize multidisciplinary patient management.

Materials and Methods

This work is based on the clinical experience accumulated over approximately three years in a tertiary dermatology center, involving patients who developed cutaneous adverse events during treatment with targeted oncologic therapies or immunotherapy and required specialized dermatologic evaluation. Cutaneous manifestations were assessed clinically, and their timing, severity, and impact on treatment continuation were analyzed in relation to the therapeutic class.

Results

Across the observed cohort, cutaneous adverse events were documented in association with all major classes of modern oncologic therapies, including epidermal growth factor receptor inhibitors, angiogenesis inhibitors, intracellular signaling pathway inhibitors, and immune checkpoint inhibitors. Papulopustular eruption emerged as the most frequent dermatologic toxicity overall and represented the leading cause of treatment interruption across therapeutic classes. Beyond frequency, this reaction consistently proved to be one of the most clinically impactful toxicities, often prompting dermatologic referral due to symptom burden and inflammation severity.

Immune checkpoint inhibitor–associated cutaneous adverse events most commonly manifested as maculopapular rash, xerosis, pruritus, eczematous, psoriasiform, and lichenoid eruptions. These reactions showed a delayed and highly variable onset and were generally manageable with dermatologic treatment, allowing continuation of oncologic therapy in most cases. Notably, several of these immune-mediated manifestations followed a chronic or fluctuating course, requiring prolonged dermatologic follow-up rather than acute intervention.

In contrast, targeted therapies—particularly angiogenesis inhibitors—were associated with an earlier onset of cutaneous toxicity and a higher immediate clinical impact. Severe papulopustular eruption, palmar–plantar erythrodysesthesia, rash, and psoriasiform lesions were the adverse events most frequently prompting treatment modification or temporary interruption. In this setting, dermatologic toxicity often emerged as a limiting factor for treatment tolerability, emphasizing its relevance in therapeutic decision-making.

Overall, cutaneous adverse events differed not only in clinical morphology but also in timing, severity, and therapeutic consequences depending on the oncologic treatment class, outlining distinct toxicity profiles with variable impact on treatment continuation and clinical management.

Conclusions

Cutaneous adverse events are frequent during modern oncologic therapies and show distinct patterns depending on the therapeutic class. In this cohort, papulopustular eruption was the most common dermatologic toxicity and the leading cause of treatment interruption. Immune checkpoint inhibitor–related skin reactions generally had a later onset and a lower impact on treatment continuation, underscoring the importance of early dermatologic recognition and management to support optimal oncologic outcomes.

Abstract N°: ID-824

Topic: Cutaneous oncology

Mediterranean Kaposi sarcoma: a case-based discussion

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Introduction
Classic Kaposi sarcoma is a low-grade vascular neoplasm associated with human herpesvirus 8 infection, typically affecting elderly, immunocompetent patients and characterized by a slow, indolent evolution. Atypical clinical presentations may occur and can mimic acute vascular or infectious disorders, leading to delayed diagnosis. We report a case of classic Kaposi sarcoma with an unusual painful and inflammatory presentation, emphasizing the diagnostic difficulties encountered in daily clinical practice.

Materials and Methods
An 83-year-old HIV-negative patient, without chronic immunosuppressive therapy and with significant cardiovascular comorbidities, initially presented to several outpatient medical services, where he was misdiagnosed with acute lower limb ischemia, deep vein thrombosis or cellulitis. These diagnoses were subsequently ruled out by clinical and paraclinical investigations. The evolution at home was unfavourable, and the patient presented to the emergency department, being admitted to the Infectious Diseases unit and later referred to Dermatology.
Clinical examination revealed multiple hyperpigmented macules and well-demarcated nodular lesions, some brown-violaceous and others erythemato-violaceous, measuring 0.5–1.5 cm, infiltrated with a tendency to coalesce into plaques, localized on the left lower limb. These findings were associated with significant edema and severe pain.There was performed a skin biopsy with histopathological examination which showed a proliferation of spindle-shaped cells arranged in fascicles, with irregular vascular clefts, hemosiderin deposits and a peritumoral lymphoplasmacytic inflammatory infiltrate, confirming the diagnosis of classic Kaposi sarcoma, plaque stage. Further investigations identified a suspicious gastric mass; however, biopsy excluded malignancy, directing therapeutic management toward a cutaneous-limited form. Under supportive and symptomatic treatment, partial clinical improvement was observed, with reduction of pain and inflammatory markers

Conclusions
This case highlights an atypical presentation of classic Kaposi sarcoma, characterized by marked pain and inflammatory features, which posed significant diagnostic challenges. The report underscores the importance of considering Kaposi sarcoma in the differential diagnosis of unilateral lower limb edema with violaceous lesions in elderly patients. Histopathological confirmation remains essential for accurate diagnosis. In patients with advanced age and multiple comorbidities, management should be individualized and focused on symptom relief and preservation of quality of life through a multidisciplinary approach.

Abstract N°: ID-834

Topic: Cutaneous oncology

Efficacy of bath-water PUVA in patients with early-stage mycosis fungoides

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Introduction
Oral PUVA therapy is one of the main methods of treatment early-stage mycosis fungoides. Bath-water PUVA can be used as an alternative treatment in patients with early-stage mycosis fungoides if they have contraindications to the oral administration of the photosensitizer, such as cataract, liver or gastrointestinal diseases.

Materials and Methods
15 patients with early-stage mycosis fungoides, 4 males and 11 females, were treated with bath-water PUVA four times weekly (the initial UV dose ranged from 0.25 to 1.0 J/cm2, the full course consisted of 20 treatments). As a control, we chose a retrospective group composed of 15 patients with early-stage mycosis fungoides, 7 males and 8 females, which had been earlier treated with oral PUVA four times weekly (the initial UV dose ranged from 0.25 to 1.0 J/cm2, the full course consisted of 20 treatments). Disease severity was evaluated by modified Severity-Weighted Assessment Tool (mSWAT) and Body Surface Area (BSA) before therapy and after completion of the full course. Both groups of patients were comparable in relation to disease severity before therapy (mean mSWAT in groups of patients treated with bath-water PUVA and oral PUVA – 41.55±29.48 and 43.15±29.1 respectively, p=1,0; mean BSA in groups of patients treated with bath-water PUVA and oral PUVA – 28,57±17,33 and 27,62±18,44 respectively, p=0,87). For evaluation of the effectiveness of treatment, we used disease response score proposed by the International Society for Cutaneous Lymphomas (ISCL), the United States Cutaneous LymphomaConsortium (USCLC), and the Cutaneous Lymphoma Task Force of the European Organization for the Research and Treatment of Cancer (EORTC).

Results
MSWAT value decreasing in patients treated with bath-water PUVA after completion of the full course reached 83.36%±17.61% and BSA – 74.95%±28.33%. MSWAT value decreasing in patients treated with oral PUVA, after completion of the full course reached 48.83%±22.17% and BSA – 43.21%±24.48%. Therefore mSWAT and BSA values in group of patients treated with bath-water PUVA, were significantly lower than in control group (p-value 0.0004 and 0.0054 respectively). Evaluation with disease response score proposed by ISCL, USCLC and EORTC demonsrated that treatment with bath-water PUVA leaded to complete response in 27% of patients, partial response in 53% of patients and stabilization of the disease in 20% of patients, cases of disease progression were not registrated. In group treated with oral PUVA partial response was achieved in 40% of patients and stabilization of the disease – in 60% of patients, cases of complete response or disease progression were not registrated.

Conclusions
Our investigation shows that bath-water PUVA has high efficacy in patients with early-stage mycosis fungoides and can be a potential alternative to oral PUVA.

Abstract N°: ID-851

Topic: Cutaneous oncology

A case of combination of mammary and extramammary Paget's disease

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Introduction

Paget's disease accounts for 0.5 to 5% of breast cancer cases and is a relatively rare disease, occurring primarily in the perimenopausal period. The most common association between perianal location of secondary extramammary Paget's disease and gastric, colorectal, and breast cancers is noted. The aim of this study was to describe and analyze a case of concurrent mammary and extramammary Paget's disease.

Materials and Methods

We observed a 43-year-old woman who presented with complaints of a rash on her left labia majora. At the clinic, she underwent histological and immunohistochemical analysis of a biopsy specimen from the lesion. A PCR test for the most common STIs was performed on a genitourinary tract mucosal scraping, along with other routine tests.

Results

The patient first married at age 40. She had been sexually active since her marriage. She has no children and has never become pregnant. Three years ago, she first noticed intermittent itching and burning in the labia majora, intensifying during menstruation. She received topical antifungal treatment, which was temporary. Over the past four to five months, she has noted the development of an erosive lesion in the genital area. She consulted an oncologist and was referred to us to rule out benign dystrophic vulvar disease. Subjectively, she complains of itching, burning, tenderness, and discomfort when urinating. Internally, she complains of general weakness and difficulty gaining weight.

The skin pathology localized on the left labia majora, it presents as a raised, tumor-like, painful, erosive lesion of irregular oval shape with uneven, blurred borders gradually blending into healthy skin. The surface is bumpy, with prominent sebaceous gland openings and covered with a serous-purulent discharge with a pungent, foul odor. A soft infiltrate is present at the base of the erosion. The primary lesion is located against an area of dystrophy and maceration of the vulva, located in the upper third, which, according to the patient, has been present for several years. A complete retraction of the nipple on the right side is also noted, causing no subjective discomfort. The left nipple is unchanged.

Histological findings: epidermis with acanthosis. Large atypical cells with abundant vacuolated cytoplasm and eccentrically located hyperchromatic nuclei, occurring singly and in small groups, are found within the epidermis, primarily in the basal and suprabasal layers. A pagetoid dissemination of atypical cells is noted within the epidermis. Lymphocytic infiltrates, disorganization and fibrosis of collagen fibers, vascular proliferation and congestion are observed in the dermis; skin appendages are not visible. Immunohistochemical analysis revealed 50% Ki-67 tumor marker nuclear staining. PCR for urogenital infections revealed Ureaplasma parvum, Gardnerella vaginalis and HPV type 6.

After a course of anti-inflammatory therapy, significant improvement in the pathological process was noted, including decreased pain, burning sensation, tumor size and density, decreased hyperemia and swelling, resolution of serous

exudate and odor, and cessation of vaginal discharge and urinary frequency. The patient was referred to the Republican Center for Oncology and Radiology for further observation and treatment.

Conclusions

This descriptive case demonstrates such possible triggers of neoplasia as late onset of sexual activity (40 years) and its short duration (3 years); dystrophic condition of the vulva 3 years before the onset of the main oncological process; the presence of ureaplasma and papillomavirus infection, which could have been acquired from the spouse and become a cofactor of dystrophy and subsequent neoplasia, taking into account the onset of the disease immediately after the onset of sexual activity. It is also necessary to pay attention to such symptoms as pain, itching, foul odor, unilateral nature of genital lesions, asthenia and underweight, the condition of the nipples of the mammary glands.

Abstract N°: ID-861

Topic: Cutaneous oncology

Mycosis fungoides in skin of colour: diagnostic lessons from a refractory case

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Introduction

Mycosis fungoides (MF) is the most common subtype of cutaneous T-cell lymphoma and is well recognised as a clinicopathological mimic of chronic inflammatory dermatoses. Its often indolent course, variable morphology, and overlapping histological features can lead to diagnostic delay, particularly in patients with skin of colour. We report a case of hyperpigmented MF initially misdiagnosed as cutaneous lupus erythematosus, highlighting important diagnostic considerations.

Materials and Methods

A single case report, with retrospective chart review and key learning points identified.

Results

A 55-year-old man of Pakistani origin, currently residing in Ireland, presented with a ten-year history of a progressive scaly rash. The eruption began bilaterally on the hands and gradually extended over five years to involve the arms, face, and trunk. There was no history of inflammatory dermatoses, photosensitivity, fevers, night sweats, or unintentional weight loss.

Clinical examination demonstrated widespread hyperpigmented, scaly patches, some with associated atrophic change, and plaques involving approximately 53% of the total body surface area.

Over a five-year period, three skin biopsies taken from different active sites showed histological features suggestive of cutaneous lupus erythematosus. During this time, the patient was treated sequentially with hydroxychloroquine, methotrexate, and mycophenolate mofetil, without clinical improvement.

The combination of treatment refractoriness and ongoing clinicopathological discordance prompted reassessment of the diagnosis. Two deep 5-mm punch biopsies were subsequently obtained from representative lesions and submitted for haematoxylin and eosin staining and T-cell receptor gene rearrangement studies. Histopathology revealed a dermal lymphoid infiltrate with epidermotropism and lymphoid nuclear atypia. Molecular analysis confirmed T-cell clonality with a CD8-positive phenotype, establishing a diagnosis of mycosis fungoides.

Conclusions

This case highlights several diagnostic pearls; the importance of maintaining a high index of suspicion in refractory disease, the need for repeated, adequately deep, multisite biopsies and the value of clonality studies in strengthening the diagnosis. Cessation of topical corticosteroids for at least two weeks prior to biopsy is also recommended to optimise histological yield.

The hyperpigmented phenotype observed aligns with a recognised MF variant more commonly reported in patients with skin of colour and is frequently associated with a CD8-positive immunophenotype, strengthening clinicopathological correlation.

This case also underscores the importance of diagnostic persistence, optimised biopsy strategies, and careful clinicopathological integration to avoid delayed diagnosis.

Abstract N°: ID-891

Topic: Cutaneous oncology

Invasive Melanoma Treated with Topical Imiquimod in a Non-surgical Elderly Patient: A Case Report

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Introduction

Background: Topical imiquimod, a Toll-like receptor 7 agonist, has been used as an off-label treatment for lentigo maligna, particularly in patients who are not suitable candidates for surgical excision. In contrast, surgical management remains the standard of care for invasive melanoma, and evidence supporting the use of topical imiquimod in this setting is limited to isolated case reports.

Objective: To describe a case of invasive melanoma managed with topical imiquimod in a patient who denied surgical treatment.

Materials and Methods

Methods / Case Presentation: A 93-year-old patient was diagnosed with histologically confirmed locally advanced invasive melanoma. The measured Breslow thickness in the partial biopsy was 2.7mm, with ulceration present. Total body imaging (brain MRI, CT thorax and abdomen,ultrasound of inguinal area) did not reveal pathologic findings. Surgical excision was suggested but not pursued due to patient refusal. Systemic immunotherapy was discussed as an option but also excluded by patient's denial. After careful clinical consideration, topical imiquimod 5% was administered as an off-label, non-surgical therapeutic approach. Clinical evolution was documented with serial examinations and macroscopic and dermatoscopic photographic records. Follow-up included clinical assessment and cross-sectional imaging.

Results

Complete clinical regression of the melanoma was observed following completion of topical treatment. Since surgical excision was not performed, the presence of histopathologic residual tumor cannot be excluded. However, at two years of follow-up, the patient remains free of clinico-dermatoscopic recurrence and radiological evaluation with CT and MRI revealed no evidence of local regional recurrence or distant metastatic disease. The patient remains under regular surveillance.

Conclusions

This case indicates that imiquimod might be effective in other than LM melanoma types. Although it cannot be considered as an alternative to surgery, imiquimod could represent an option for exceptional cases of patients that deny the standard treatment. Further studies are required to clarify its role, efficacy, and limitations in invasive melanoma.

Abstract N°: ID-905

Topic: Cutaneous oncology

Integrated Flow Cytometry and TCR-Cβ1 Analysis for the Identification of Malignant T Cells in Cutaneous T-Cell Lymphoma

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Introduction
Cutaneous T-cell lymphomas are characterised by substantial clinical and immunophenotypic heterogeneity, leading to persistent diagnostic challenges. Flow cytometry is widely used for identifying malignant T-cell populations; however, commonly applied markers such as CD7 and CD26 demonstrate limited specificity because similar patterns may occur in reactive T-cell subsets. Assessment of T-cell receptor beta constant region 1 (TCR-Cβ1) expression has emerged as a reliable method for evaluating clonality. This study compares automated clustering with conventional manual gating and evaluates the added diagnostic value of TCR-Cβ1.

Materials and Methods
A retrospective analysis was conducted on 68 peripheral blood samples obtained from 46 adult subjects, including controls (n=17) and patients with primary cutaneous lymphomas (n=29), including Mycosis Fungoides and Sézary Syndrome. Multiparametric flow cytometry was performed using a standardised antibody panel including CD2, CD3, CD4, CD7, CD8, CD26, CD45, and TCR-Cβ1. Data were analysed using both manual gating and automated clustering with FlowSOM. After quality control and preprocessing, approximately 4.24×10^6 events were included. FlowSOM was applied using a 10×10 self-organising map with eight metaclusters.

Results
Automated clustering identified 100 clusters consolidated into eight metaclusters. A malignant population with a $CD4^+CD7^-CD26^-$ phenotype (metacluster #7) was detected and showed progressive enrichment from controls to mycosis fungoides and Sézary syndrome, consistent with increasing blood involvement. This population demonstrated marked loss of TCR-Cβ1 expression (<1%), supporting clonal restriction, whereas major non-malignant $CD4^+$ and $CD8^+$ populations retained high expression levels. Automated analysis improved sensitivity for detecting low-frequency malignant populations compared with conventional gating. Dimensionality reduction confirmed spatial separation between malignant and reactive clusters.

Conclusions
The integration of automated clustering and TCR-Cβ1 analysis enables robust identification of malignant T-cell populations in cutaneous T-cell lymphoma. The combined $CD4^+CD7^-CD26^-TRBC1^-$ immunophenotypic signature provides reliable clonality assessment without immediate molecular sequencing and enhances diagnostic accuracy and reproducibility, supporting its use for diagnosis and disease monitoring in clinical practice.

Abstract N°: ID-916

Topic: Cutaneous oncology

Facial Cutaneous Lesions Unmasking a Centrofollicular B-Cell Lymphoma

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Introduction
Centrofollicular B-cell lymphoma, also known as follicular lymphoma, is an indolent non-Hodgkin lymphoma derived from germinal center B lymphocytes. It represents one of the most common subtypes of indolent lymphomas and may present with superficial or deep lymphadenopathy, sometimes associated with cutaneous or visceral involvement.

Materials and Methods
We report the case of a 49-year-old woman with no significant medical history, who presented with a progressive onset of facial skin lesions evolving over four months. Clinical examination revealed erythematous, infiltrated, slightly pruritic papulo-nodular facial lesions, some of which were confluent into plaques, involving the forehead, cheeks, and chin. The remainder of the physical examination was unremarkable.
Skin biopsy showed a malignant lymphomatous tumor proliferation with a diffuse architecture and focally follicular pattern, composed of centrocytes and centroblasts. Immunohistochemical analysis revealed positivity for CD3, CD20, CD23, and BCL6, and negativity for CD10 and BCL2, with a Ki-67 proliferation index of 30%, confirming the diagnosis of primary cutaneous centrofollicular B-cell lymphoma.
Staging investigations revealed pathological hypermetabolic lymphadenopathy above and below the diaphragm, allowing the disease to be classified as 2
After multidisciplinary team discussion, the patient was started on rituximab therapy.

Results
Centrofollicular B-cell lymphoma is an indolent lymphoma accounting for approximately 11% of cutaneous lymphomas, characterized by a generally slow course, with a risk of transformation into aggressive lymphoma in 5–10% of cases. Distinguishing primary cutaneous centrofollicular B-cell lymphoma from secondary cutaneous involvement of a systemic lymphoma is crucial, as prognosis differs significantly.
Cutaneous involvement typically presents as papules, nodules, tumors, or infiltrated plaques, often with an arcuate appearance and a red-violaceous color, most commonly affecting the head, neck, and upper trunk, and more rarely the legs. Diagnosis is based on histological and immunohistochemical examination. Prognosis is favorable, with a 5-year survival rate exceeding 95%. Management depends on disease stage, tumor burden, and clinical impact. Targeted therapies have improved outcomes, although the disease most often remains chronic.

Conclusions
This case highlights the importance of histological confirmation and comprehensive staging to guide therapeutic strategy. Long-term follow-up is essential due to the risk of relapse and transformation.

Abstract N°: ID-919

Topic: Cutaneous oncology

From pityriasis lichenoides chronica to systemic CD30⁺ anaplastic large-cell lymphoma : a 10-year evolution

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Introduction

Pityriasis lichenoides chronica (PLC) is a rare, generally self-limited, inflammatory skin disorder that affects children and young adults. In rare instances, progression to cutaneous T-cell lymphomas has been reported in both pediatric and adult patients.

In contrast, the association between lymphomatoid papulosis (LyP) and PLC is much less well understood. LyP is a chronic, recurrent CD30⁺ lymphoproliferative disorder that typically follows an indolent course, occasionally progressing to systemic malignancies such as anaplastic large cell lymphoma. Some publications describe PLC and LyP as occurring sequentially or note challenges in distinguishing them clinically and histologically. Still, cases of LyP arising after a long-standing diagnosis of PLC remain scarce.

We present the unique case of a 13-year-old patient initially diagnosed with PLC, who developed LyP eight years later, followed by transformation into systemic anaplastic large cell lymphoma (ALCL). This represents an exceptional and rarely reported sequence of disease evolution.

Materials and Methods

The patient first consulted in 2014, at the age of 13, for a papulovesicular eruption on the limbs and trunk. A skin biopsy at the time confirmed the diagnosis of PLC, which was treated with topical corticosteroids, leading to a complete response.

He presented again in 2022 at the age of 20 with a one-month history of new asymptomatic necrotic papules on the arms and the trunk. Histopathology examination showed CD30-positive lymphoproliferative disorder such as seen in type A LyP. Given the histologic overlap between PLC and LyP, the patient's initial biopsy was reviewed and was consistent with PLC. A CT scan of the chest, abdomen, and pelvis showed no abnormalities. The patient was successfully treated with methotrexate 10 mg per week.

In February 2024, the patient was evaluated for persistent fever, profuse night sweats, and an unintentional weight loss. Skin examination at that time was unremarkable. A contrast-enhanced thoraco-abdominopelvic CT scan demonstrated large retroperitoneal lymphadenopathies and splenomegaly. An image-guided biopsy of one of the lymph nodes confirmed the diagnosis of ALCL (Figure 1).

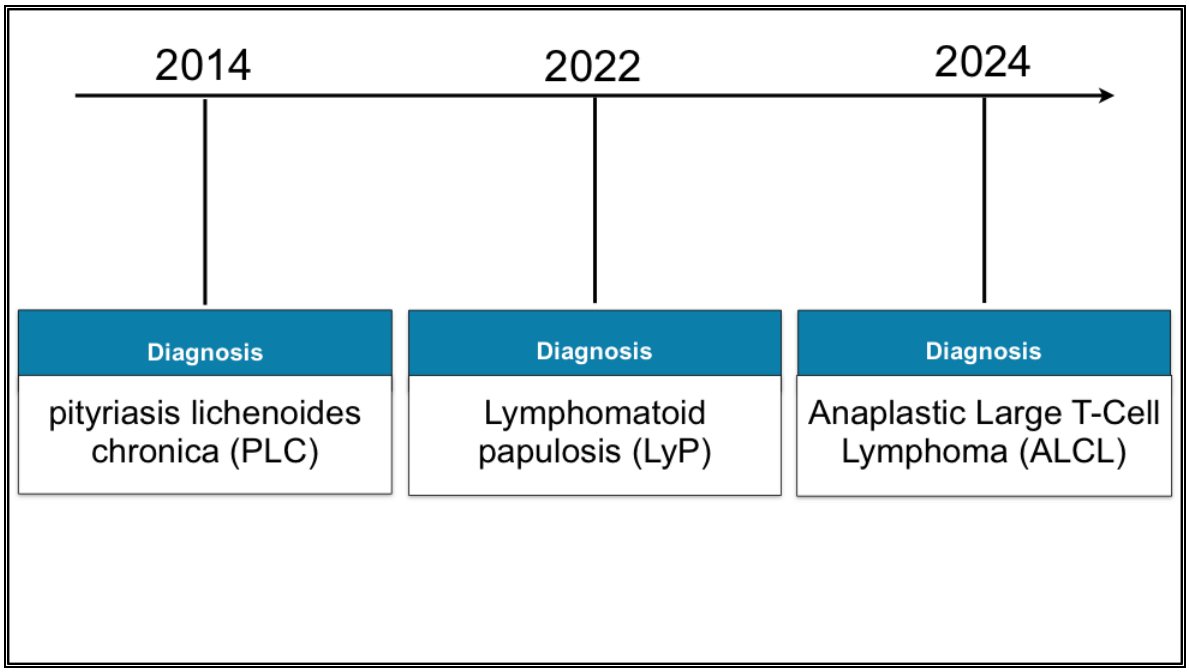

Figure 1. From pityriasis lichenoides chronica to systemic CD30⁺ anaplastic large-cell lymphoma : a 10-year evolution

Results

PLC is traditionally considered a benign inflammatory reaction, often post-viral in origin. Nevertheless, a growing number of reports suggest that PLC may be associated with lymphoproliferative disorders such as mycosis fungoides or even LyP, particularly when CD30+ cell proliferation is observed. Although transition from PLC to LyP remains exceptional, this sequence has been reported in the literature. In our case, PLC preceded LyP by 8 years, which adds to the hypothesis that both diseases may lie on a shared spectrum of cutaneous T-cell lymphoproliferative disorders rather than being entirely separate entities. Importantly, the initial diagnosis of PLC was confirmed both clinically and histologically, with features clearly distinct from LyP, including an excellent response to topical corticosteroids and the absence of a waxing and waning course. These clues further supports that this was a true PLC and not a misclassified early LyP. LyP is a clonal lymphoproliferative disorder marked by CD30+ atypical T cell infiltrates in the skin. Patients with LyP have a lifelong increased risk of developing hematologic malignancies, most commonly mycosis fungoides and ALCL.

Conclusions

Although the relationship between PLC and LyP remains debated, increasing clinical and histopathological evidence supports the hypothesis that these entities lie on a shared spectrum of cutaneous T-cell lymphoproliferative disorders. Their coexistence in the same patient may reflect distinct immune responses to a common antigenic trigger. This raises the question: could such patients carry a heightened risk of malignant transformation? In our case, the progression from PLC to ALCL via LyP over a ten-year interval is exceptionally rare. This rare sequence highlights the need for prolonged clinical surveillance.

Abstract N°: ID-939

Topic: Cutaneous oncology

A Case of Giant Basal Cell Carcinoma with Adnexal Differentiation

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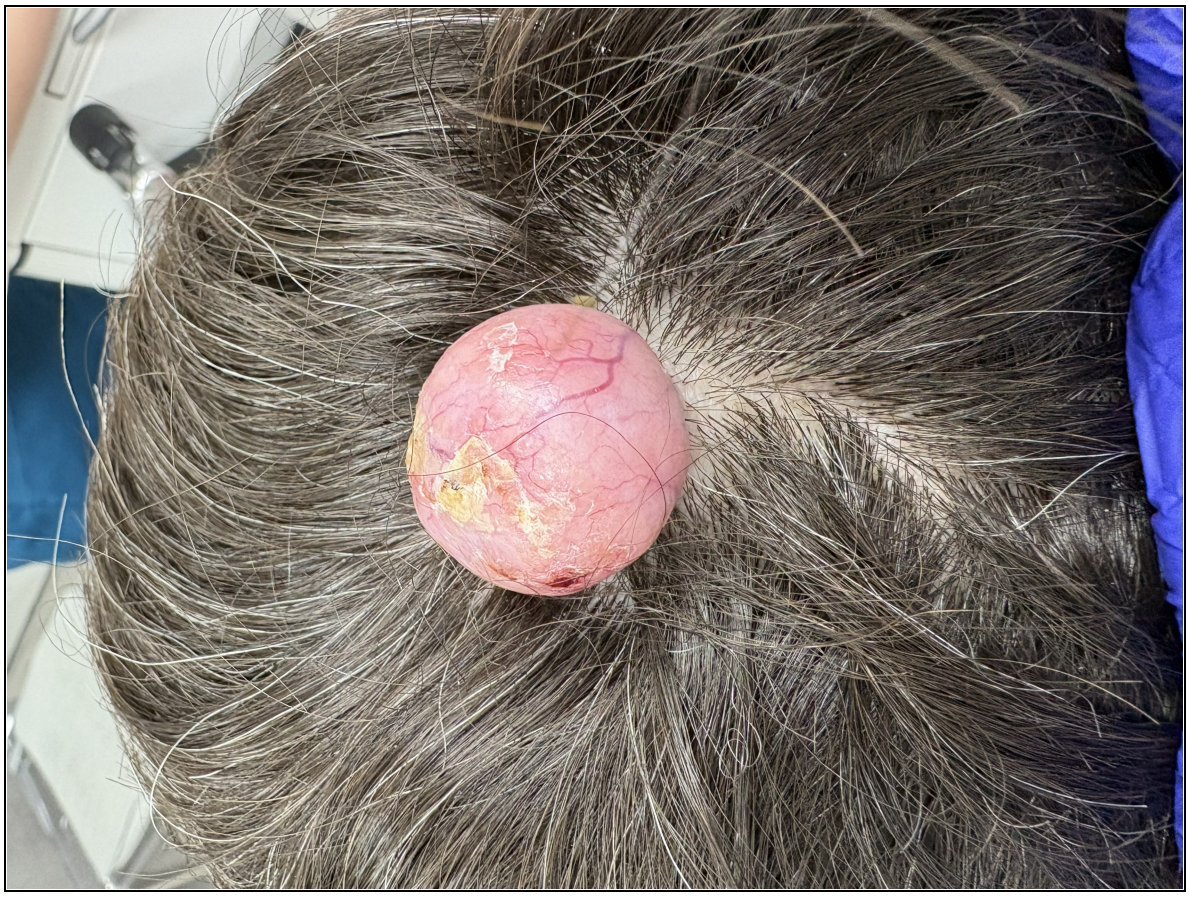
Introduction

Basal cell carcinoma (BCC) is the most common malignant skin tumor, accounting for approximately 70–80% of all non-melanoma skin cancers. Several histopathological subtypes of BCC have been described, including nodular, superficial, infiltrative, micronodular, and morpheaform variants. Among these, basal cell carcinoma with adnexal differentiation represents a rare histopathological subtype characterized by morphological features resembling normal skin adnexal structures.

Materials and Methods

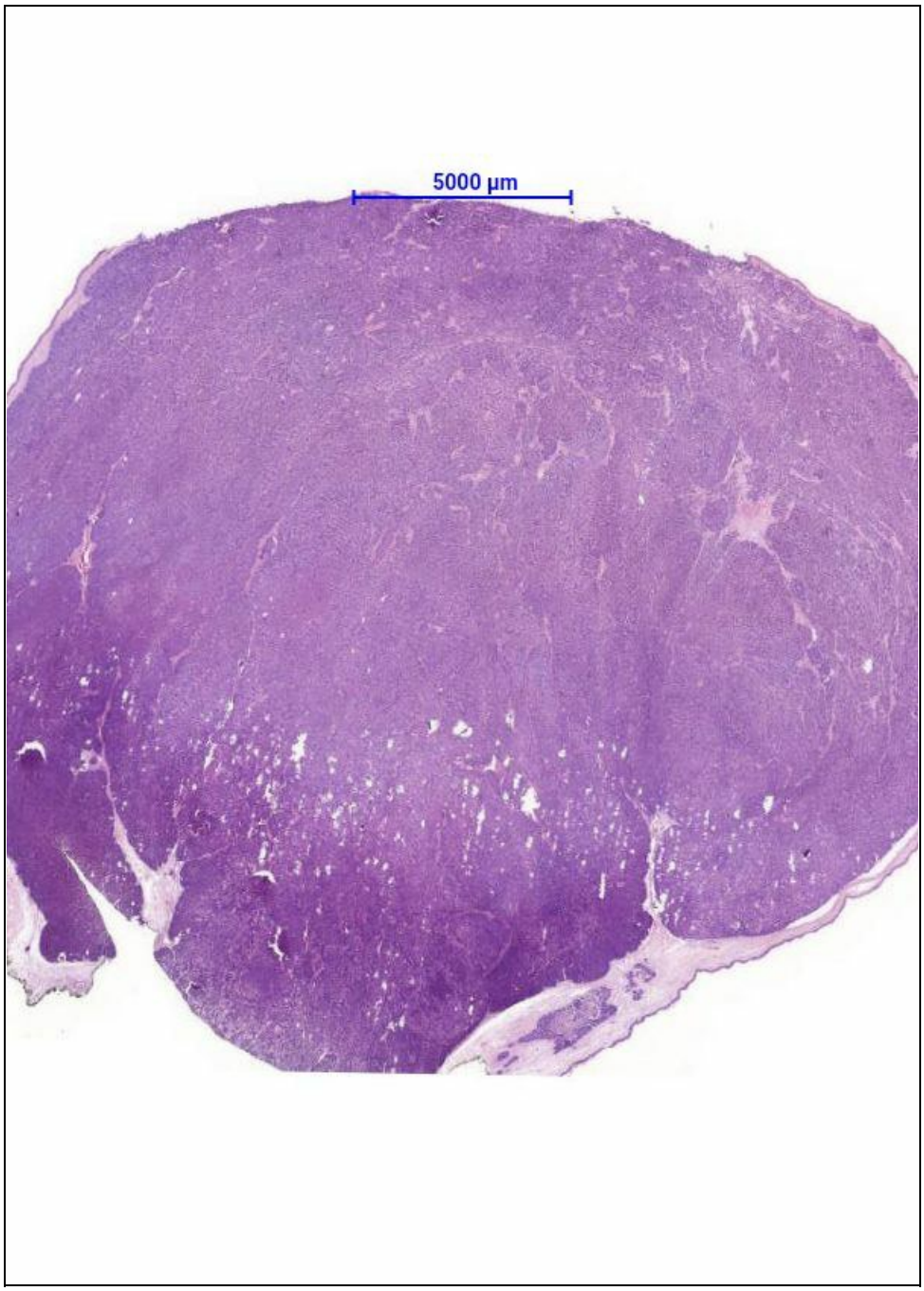
A 63-year-old woman presented with a lesion on the scalp. The lesion had been present for approximately five years, with a noticeable increase in size over the past two years. Physical examination revealed a well-demarcated, spherical lesion located in the vertex region, measuring approximately 24 mm in diameter The surface was pale pink in color with visible arborizing vessels. A central ulceration covered by a yellowish crust was also observed.

A shave biopsy was performed. Following removal of the main tumor mass, an additional nodular lesion spontaneously separated from the deeper layers of the skin. Both specimens were submitted for histopathological examination.



Results

Results of histopathological examination : №1)Nodular formation, partially covered with hair, measuring 2.9×2.8×2.3 cm. On section, it is homogeneous, gray in color.There is a residue.
№2) Nodular formation, partially covered with hair, measuring 1.5×1.3x1 cm. On section, it is homogeneous, gray in color. There is no residue
Histilogy diagnosis : №1-2.: Basal cell carcinoma of the skin with adnexal differentiation (LVIO Pn0 R1) (ICD-0 code8090/3)
Tumor excision was performed with micrographic control of the resection margins according to Mohs
Results of histopathological examination: Maximum tumor size: 10 mm;
Clarke grade of invasion: IV (tumor extends into the reticular layer of the dermis);
Lymphovascular invasion: none
Perineural invasion: none



Conclusions

Basal cell carcinoma with adnexal differentiation is a rare histological variant that may clinically mimic benign or slowly progressive lesions.This case emphasizes the importance of dermatoscopic evaluation, histopathological confirmation, and complete surgical excision using Mohs micrographic surgery to achieve optimal oncologic control and minimize recurrence risk.

Abstract N°: ID-955

Topic: Cutaneous oncology

A case of Stewart-Treves syndrome (STS) occurring secondary to idiopathic chronic lymphedema of the lower extremities.

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Introduction

Stewart-Treves syndrome (STS) is a rare and severe form of cutaneous angiosarcoma that typically arises as a complication of chronic lymphedema, most commonly following postmastectomy treatment. However, it is only rarely reported in cases of idiopathic chronic lymphedema affecting the lower limbs. We report here a case of STS occurring secondary to idiopathic chronic lymphedema of the lower extremities

Materials and Methods

A 51-year-old woman was referred to the dermatology department for evaluation of chronic lymphedema of the left leg that had become painful with change of skin colour, texture and contour over the preceding 03 months.Her past medical history was remarkable for idiopathic chronic lymphedema of the lower extremities for over 20 years , obesity and right hip replacement surgery.Physical examination revealed signs of chronic lymphedema that affected the left lower leg with violaceous angiomatous plaque surmonted by poorly circumscribed yellow patch with scattered and coalescing purpuric areas .the skin was thickened and fibrotic limiting dorsiflexion of the foot.The remainder of the physical examination was unremarkable .multiple punch biopsies revealed diffuse dermal infiltration by atypical sinusoidal vessels dissecting collagen bundles, with numerous mitotic figures, areas of necrosis and ulceration. Immunohistochemistry was positive for CD31 ,ERG,MYC and negative for HHV-8.These findings were consistent with the diagnosis of Stewart-Treves syndrome. A CT scan of the chest, abdomen and pelvis showed no metastasis.she was referred urgently to the oncology departement .8 months after initiation of paclitaxel treatment, there was worsening of the edema ,involving the entire limb, with extension of lesions toward the ipsilateral thigh, reaching the pubic region, along with the appearance of blackish nodules.The patient was placed on morphine.MRI of the right lower leg demonstrated extensive lymphedema and a poorly demarcated cutaneous tumor infiltrating the subcutis .A metastatic workup returned without abnormalities. Given the worsening clinical picture, the appearance of blisters, and after obtaining the patient's consent, a hip disarticulation was performed.Two months later, the patient died after develloping bone and liver metastases.

Results

The occurrence of STS in the context of idiopathic chronic lymphedema of the lower extremities is extremely rare.The initial presentation of STS is insidious,with subtle contusiform, poorly circumscribed lesions.Over time, purpuric macules and nodules progressively coalesce, ultimately resulting in diffuse cutaneous infiltration a pattern observed in our case over an 11-month period. Metastatic disease is frequent.Histologically, STS is characterized by proliferating vascular channels that split apart dermal collagen.Some areas may show undifferentiated, pleomorphic epithelioid, or spindle-shaped cells. Most angiosarcomas have positive stain results for vascularmarkers.Owing to its low incidence, there are no standardized management guidelines for this tumor.Surgery was performed at a late stage in our patient ,following clinical deterioration and failure of paclitaxel treatment.None of the available treatments have yet been found to substantially modify the aggressive course of this disease.

Conclusions

Although rare, it is important that clinicians are aware of this type of angiosaroma as diagnosis is often delayed and prognosis is poor.

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ATHENS 7 - 9 MAY

Abstract N°: ID-1003

Topic: Cutaneous oncology

Erysipeloid Cutaneous Lymphangitic Carcinomatosis: A Misleading Form of Breast Cancer Cutaneous Metastasis

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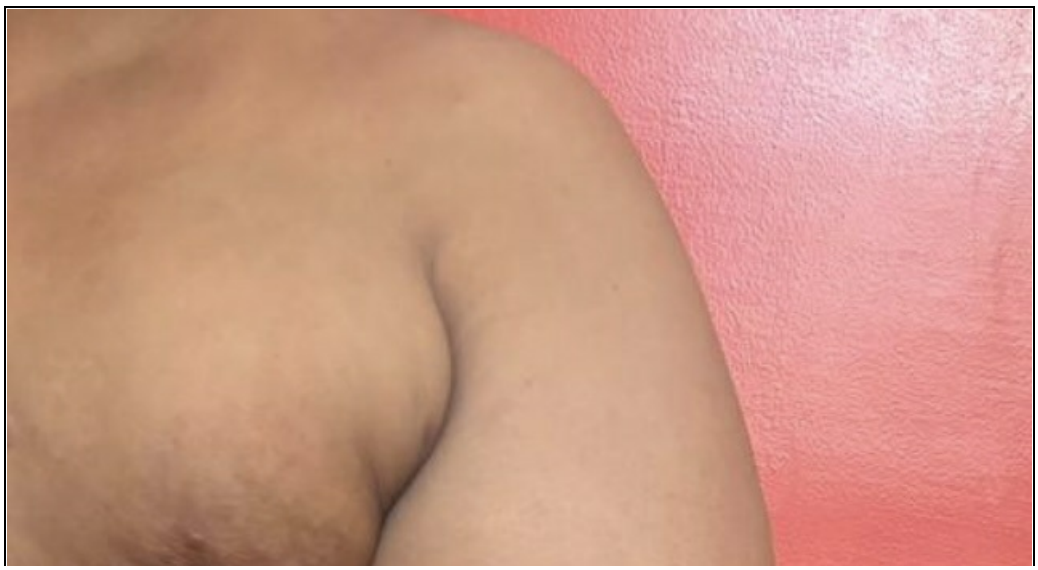
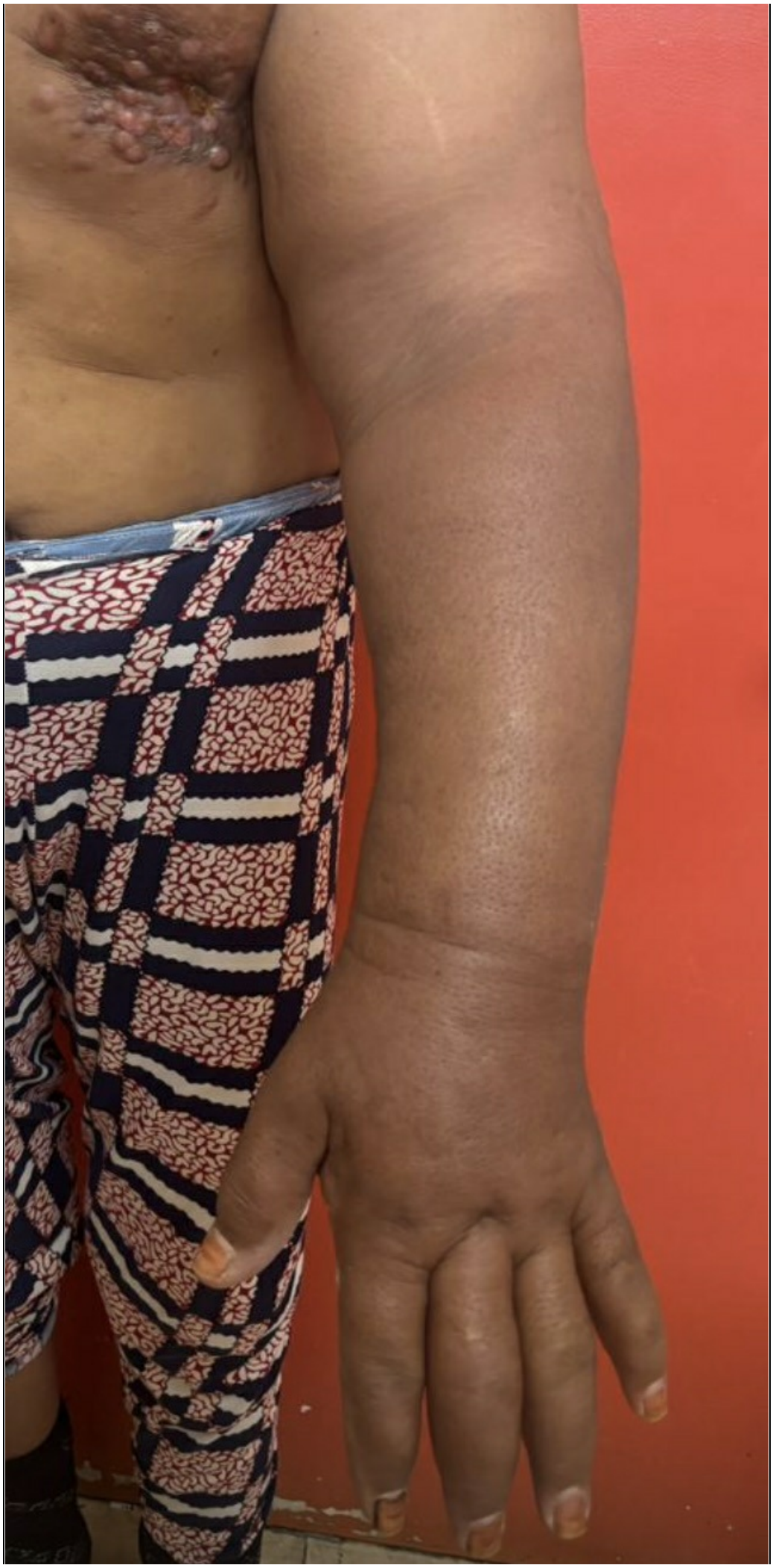
Introduction

Cutaneous lymphangitic carcinomatosis is a rare manifestation of cutaneous metastases characterized by invasion of dermal lymphatic vessels by tumor emboli. It most frequently occurs in advanced breast carcinomas and may clinically mimic infectious dermohypodermitis such as erysipelas, leading to diagnostic delay. Its identification is essential as it reflects neoplastic progression with poor prognosis.

Materials and Methods

We report the case of a 56-year-old woman followed for ten years for hormone receptor–positive, HER2-negative invasive ductal carcinoma of the left breast, previously treated with radiochemotherapy and maintained on hormonal therapy.
Clinical examination revealed an extensive inflammatory plaque of the left upper limb extending from the fingers to the shoulder, associated with marked painful infiltrated edema and peau d'orange appearance. The course was marked by absence of improvement under well-conducted empirical antibiotic therapy. Additionally, the patient presented suppurative nodular lesions on a cicatricial background of the left breast, evolving for several months. Biological investigations showed a major inflammatory syndrome with elevated CRP and VS rate exceeding 140 mm, contrasted with low procalcitonin levels, supporting a noninfectious process. Doppler ultrasound of the left upper limb demonstrated a conglomerate of pathological axillary lymph nodes with irregular contours and heterogeneous echostructure. Skin biopsy revealed massive dermal infiltration by an infiltrating carcinomatous proliferation organized into glandular structures, tubes, cords, and trabeculae. Tumor cells exhibited numerous atypical mitoses within a fibro-inflammatory stroma, consistent with secondary cutaneous localization of poorly differentiated breast carcinoma.





Results

Cutaneous lymphangitic carcinomatosis, also known as carcinoma erysipeloides, corresponds to tumor dissemination through dermal lymphatics, leading to lymphatic drainage obstruction responsible for a pseudo-infectious inflammatory presentation. Although rare, this entity is particularly important in clinical practice because it is highly misleading and often constitutes a marker of metastatic activity. Clinically, the erysipeloid form presents as an erythematous, warm, infiltrated inflammatory plaque, sometimes painful, with edema and peau d'orange, mimicking erysipelas or cellulitis. Diagnostic confusion is common, particularly in the presence of chronic post-therapeutic lymphedema, where true infections are themselves frequent. Several studies emphasize the polymorphism of metastatic cutaneous manifestations and their ability to mimic common dermatoses. In a series of seven cases of cutaneous lymphangitic carcinomatosis secondary to breast cancer, erysipeloid presentation was observed in four cases, with associated edema, erythema, maculopapular lesions, ulcerations, or papulonodules, illustrating this clinical pitfall. A frequent diagnostic trap is the presence of a marked inflammatory syndrome that may falsely reinforce the infectious hypothesis. The most useful argument is the discrepancy between elevated CRP and ESR with low procalcitonin levels, absence of microbiological documentation, and the context of tumor progression, including deterioration of general condition and elevation of tumor markers. Histological examination confirm dermal tumor infiltration and/or lymphatic invasion. Histological descriptions in published cases are highly consistent, showing dermal carcinomatous proliferation, atypia, mitoses, and lymphatic emboli depending on sampling.

Conclusions

Cutaneous lymphangitic carcinomatosis is a major dermatological warning sign and should be considered in any persistent or atypical erysipeloid dermatitis occurring in a patient with a history of breast carcinoma. This entity generally reflects advanced neoplastic progression and requires prompt oncological reassessment.

Abstract N°: ID-1017

Topic: Cutaneous oncology

Cutaneous Adenoid Cystic Carcinoma located on the Breast and arising on Radiotherapy Field for Lymph Node Hodgkin's Lymphoma

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Introduction

Primary cutaneous adenoid cystic carcinoma (pcACC) is a rare skin cancer and raises the issue of differential diagnosis with a cutaneous metastasis of adenoid cystic carcinoma (ACC) from another origin. We hereby report a case of cutaneous ACC arising on the thoracic irradiation field of a Hodgkin lymphoma.

Materials and Methods

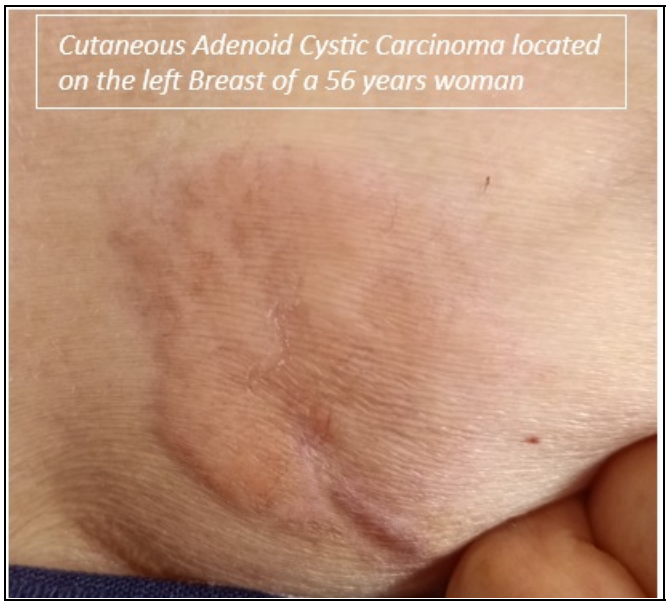
A 56-year-old woman was referred by her radiotherapist for a cutaneous left breast lesion appeared one year earlier and had progressed slowly and extensively. The patient had regular radiotherapy and haematology check-ups after remission of Hogdkin lymphoma of the lymph nodes treated with polychemotherapy and radiotherapy of the lymph node fields 10 years earlier.

Dermatological examination revealed a painless, non-itchy, erythematous orange-pink plaque, 5 cm in diameter, located on the inferomedial quadrant of the left breast, very firm at palpation, forming a disc infiltrating the skin but very mobile and not adherent to the subcutaneous layer. Radiotherapy tattoos were noted on the inferomedial part of both breasts.

Biopsy of the lesion revealed a malignant epithelial proliferation in the dermis and hypodermis with a dual architecture consisting of cystic-like cribriform masses and tubular structures.

Immunohistochemical staining showed intense and diffuse positivity for CK7, CD117 and P40, weak positivity for Ki67 and negativity for GATA3 and RO. The diagnosis of adenoid cystic carcinoma (ACC) was arrested.

Mammography, breast ultrasound and full-body CT scans showed no loco-regional infiltration of the tumour, particularly in the breasts, and no distant othorhinolaryngological, pulmonary or other locations. This led us to assume the primary skin location of the adenoid cystic carcinoma (pcACC) and to recommend surgical excision.



Results

ACCs most often develop in the salivary glands or other glandular structures, particularly the mammary gland, and may give rise to skin metastasis.
pcACC is exceptional, often occurring after the age of 50 and preferentially in the cephalic areas (more than 50% of cases). It may be associated with a risk of lympho-haematological malignancies (Rütten A. et al) as described for our patient who suffered from a Hodgkin lymphoma ten years ago.
Clinical, histological and molecular biology tests (MYB gene rearrangements in 60% of cases) cannot differentiate pcACC from the cutaneous metastatic form. The search for a primary extra-cutaneous location and local or distant extension is fundamental in order to assess whether the tumour is of primary cutaneous origin or not, as it was the case with our patient. Wide resection is recommended as a first-line treatment.
The risk of developing cutaneous carcinomas on irradiation fields after a long period of chronic radiodermatitis is well known but they are rarely described of adnexal type, with one reported case of pcACC arising on radiodermatitis of the scalp (Forrestier et al). Our patient had no radiodermatitis prior to the adnexal tumour.

Conclusions

Our reported case presenting with a pcACC developed on a breast, included itself in a field of radiotherapy for Hodgkin's lymphoma without prior radiodermatitis, is exceptional and has not been reported so far in the literature to our knowledge. It highlights the importance of the clinical and pathological confrontation as well as the diagnostic difficulty of pcACC

Abstract N°: ID-1034

Topic: Cutaneous oncology

Monitoring paediatric longitudinal melanonychia with sequential digital dermatoscopic imaging: lessons from a 10-year delayed melanoma diagnosis

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Introduction
Longitudinal melanonychia in children is uncommon and most often benign, creating significant diagnostic uncertainty when concerning features are present. Sequential digital dermatoscopic imaging (SDDI) is increasingly used to monitor equivocal nail unit lesions in an effort to avoid invasive nail matrix biopsy. However, evidence supporting the safety of prolonged monitoring is limited, and melanomas may not demonstrate early or obvious change. This study presents a paediatric case of nail unit melanoma diagnosed following extended surveillance and integrates a focused review of literature examining risks associated with monitoring strategies.

Materials and Methods
We report a paediatric case of longitudinal melanonychia managed with serial clinical and dermoscopic imaging for over a decade prior to diagnostic biopsy confirming melanoma. A focused review of published SDDI studies was performed, examining time to diagnosis, Breslow thickness at excision, detection methods, and patient compliance, with emphasis on delayed recognition of invasive disease.

Results
A four-year-old child initially presented with a pigmented nail streak considered low risk and was managed conservatively with serial SDDI. Despite longitudinal monitoring over 10 years, progressive change ultimately prompted biopsy, confirming melanoma in situ of the nail unit. Review of SDDI literature demonstrates that melanomas may remain morphologically subtle during early surveillance and that reliance on interval change can shift diagnosis to later time points. Several cohorts report invasive melanomas detected after prolonged monitoring, including lesions exceeding 1 mm in thickness. No controlled studies demonstrate that SDDI reduces melanoma metastasis or mortality. Patient non-attendance further compromises monitoring strategies, with loss to follow-up reported in high-risk populations.

Conclusions
This case highlights limitations of prolonged monitoring for paediatric longitudinal melanonychia and underscores the risk of delayed melanoma diagnosis when escalation relies primarily on photographic change. While SDDI may reduce unnecessary biopsies, clinicians must recognise that lesion stability does not exclude malignancy, particularly in anatomically complex sites such as the nail unit. Early biopsy should be strongly considered when clinical concern persists, supported by shared decision-making with families. Clear thresholds for escalation and cautious use of extended surveillance are essential to minimise diagnostic delay in paediatric nail pigmentation.

Abstract N°: ID-1062

Topic: Cutaneous oncology

When Skin Tells the Story

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Introduction
Mantle cell lymphoma (MCL) is an aggressive B-cell non-Hodgkin lymphoma with a generally poor prognosis. Cutaneous involvement occurs in only 1% of cases and frequently signals disease progression with aggressive histologic features. We present a case highlighting the crucial role of dermatological evaluation in detecting MCL relapse.

A 68-year-old male with multiple comorbidities (chronic kidney disease stage IV with solitary kidney, insulin-dependent diabetes mellitus type II, Fahr's disease) presented with Ann Arbor stage IV B mantle cell lymphoma with bone marrow involvement and leukemic phase. Initial staging revealed extensive, splenomegaly, severe anemia, thrombocytopenia, and high-risk MIPI score. Flow cytometry demonstrated CD5+, lambda light chain-restricted B-cells without CD23 expression, consistent with MCL. Due to significant comorbidities, palliative rituximab monotherapy was initiated.

Materials and Methods
Treatment was complicated by grade IV thrombocytopenia with epistaxis requiring nasal packing, grade III anemia and neutropenia, and lower gastrointestinal bleeding under anticoagulation. After four months of therapy, the patient developed progressive facial swelling, particularly periorbital edema bilaterally, with palpable subcutaneous nodules in the preauricular and temporal regions. External MRI revealed contrast-enhancing subcutaneous and intraorbital lesions bilaterally. Skin punch biopsy from the right preauricular region proved diagnostic, demonstrating infiltrates of malignant lymphoma consistent with MCL relapse.

Results
Cutaneous MCL involvement is exceedingly rare but clinically significant, often presenting with blastoid or pleomorphic morphology and correlating with relapsed or progressive disease. In this case, skin manifestations were the first clinical indicator of treatment failure under rituximab monotherapy. The dermatological examination and subsequent biopsy were pivotal in detecting progression that might otherwise have been missed until more advanced systemic manifestations developed. This case underscores the importance of thorough dermatological surveillance in MCL patients, as cutaneous lesions may represent the earliest detectable sign of relapse, particularly in patients receiving less intensive therapy regimens.

Conclusions
Dermatological vigilance is essential in MCL management. Skin biopsies can provide critical diagnostic information for detecting disease progression, enabling timely therapeutic intervention. Clinicians should maintain a high index of suspicion for cutaneous involvement in MCL patients presenting with new skin lesions, as this may represent an early opportunity to modify treatment strategies.

Abstract N°: ID-1065

Topic: Cutaneous oncology

Unusual Presentation of Congenital Melanocytic Nevus: A Case Report and Literature Review

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Introduction

Dysplastic nevi are melanocytic lesions with clinical and histopathological features intermediate between common nevi and melanoma (1). Congenital variants may present at birth and exhibit heterogeneous clinical and genetic characteristics(2). Rare presentations with hypopigmentation and alopecia are poorly described and may mimic atypical nevi, scar-like lesions, or regressive processes, raising diagnostic and prognostic challenges (3,4). This study reports a rare pediatric case of dysplastic nevus with hypopigmentation and hairlessness (DNHH) and reviews the relevant literature.

Materials and Methods

A pediatric case of congenital dysplastic nevus with hypopigmentation and alopecia was evaluated at a tertiary dermatology center. Clinical, dermoscopic, ultrasound, histopathological, and immunohistochemical findings were analyzed. A narrative literature review was performed using PubMed, Scopus, and Google Scholar databases, focusing on hypopigmented and desmoplastic melanocytic nevi.

Results

A 9-year-old girl presented with a congenital occipital scalp lesion showing progressive hypopigmentation and alopecia. Clinical examination revealed a hardened, alopecic, hypopigmented plaque measuring approximately 10 cm in diameter. Dermatologic ultrasound showed well-defined hypoechoic nodules without Doppler vascularization. Incisional biopsy demonstrated a desmoplastic stroma with reduced nevus cell density, absence of hair follicles, and mild dermal fibrosis. Immunohistochemistry revealed diffuse Fontana–Masson and Melan-A positivity, preserved p16 expression, weak or absent HMB-45 staining, and a Ki-67 index below 1%. These findings confirmed the diagnosis of congenital hypopigmented desmoplastic dysplastic nevus with alopecia. The patient remains under clinical follow-up without progression or malignant transformation after 12 months.

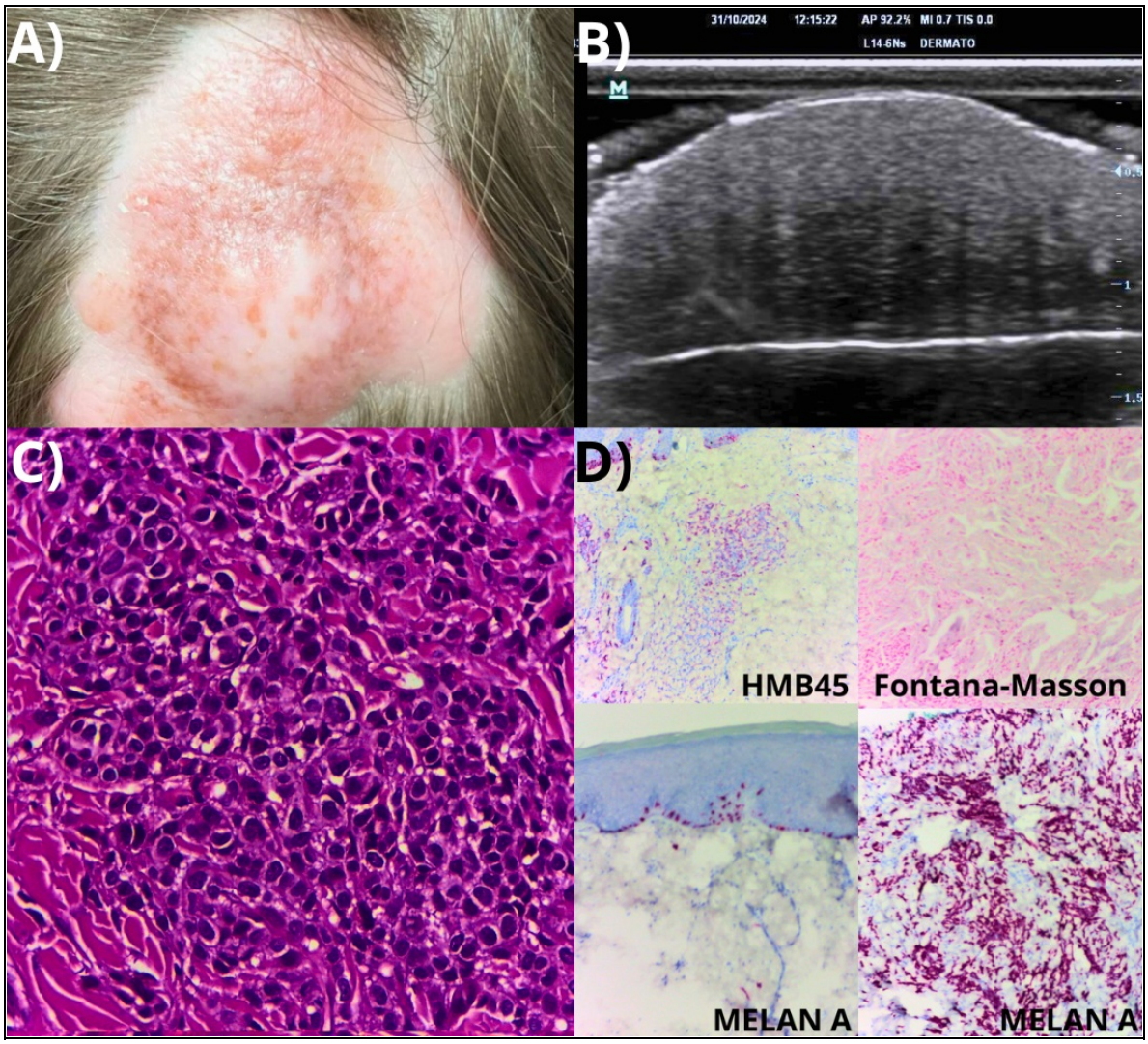

Figure. (A) Congenital hypopigmented melanocytic nevus with alopecia. (B) Ultrasound showing a hypoechoic dermal nodule. (C) Histopathology (H&E, ×400) revealing nests of ovoid melanocytic cells. (D) Immunohistochemistry showing positivity for Melan-A and HMB-45, with Fontana–Masson staining highlighting melanin deposition.

Conclusions

DNHH is a rare melanocytic entity that requires careful clinicopathological and immunohistochemical correlation to differentiate it from desmoplastic melanoma and other fibrous or regressive lesions(4,5). The benign immunohistochemical profile supports conservative management with clinical surveillance in stable cases(6-8). Reporting such rare variants contributes to a better understanding of melanocytic nevus heterogeneity and helps prevent unnecessary aggressive treatments.

EA SYMPOSIUM DV 2026 ATHENS 7 - 9 MAY

Abstract N°: ID-1079

Topic: Cutaneous oncology

Adamantinoid Trichoblastoma of the Skin: A Narrative Review and Two Case Reports

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Introduction

Adamantinoid trichoblastoma, also referred to as cutaneous lymphadenoma, is a rare benign cutaneous adnexal neoplasm that may clinically and histopathologically mimic malignant skin tumors, particularly basal cell carcinoma (1,2). Accurate diagnosis is essential due to its potential for recurrence and rare reports of regional metastasis(3,4).

Materials and Methods

A narrative review was conducted using PubMed, Scopus, Web of Science, Embase, and Google Scholar databases with the search terms “adamantinoid trichoblastoma,” “cutaneous lymphadenoma,” “trichoblastoma-like lymphoepithelial tumor,” and “lymphadenoma,” combined with Boolean operators (Table 1). Additionally, two cases diagnosed at a tertiary dermatology center were retrospectively analyzed, including clinical, dermoscopic, histopathological, and immunohistochemical findings.

Caso	Sexo	Idade	Localização	Duração da Lesão	Caracteristicas Clinicas	Diagnóstico Inicial	Comorbidades	Tratamento Cirúrgico	Autor Principal
1	Masculino	54	Região retroauricular	6 anos	Nódulo firme, com superficie lisa é sem ulceracão	Neoplasia anexial benigna	HAS, dislipidemia	Sim	Monteagudo C
2	Feminino	58	Região frontal.	5 anos	Lesão nodular, bem delimitada, bordas	CBC	DM tipo 2	Sim	Monteagudo C
3	Feminino	59	Região temporal	4 anos	Lesão nodular, , bordas regulares, e pigmentada	CBC, triquilemoma	CBC, nevo sebăceo	Sim	Dong J
4	Feminino	50	Bochecha	8 anos	Lesão papulonodular, êndurecida, sem inflamação	CBC, nevo sebăceo	Cisto, epidermoide	Sim	Dong J
5	Masculino	45	Região parotidea	10 anos	Nódulo firme, assin-tomático	Cisto epidermoide	Cisto epidermoide, CBC	Sim	Dong J
6	Masculino	62	Região nasal	10 anos	Nódulo firme, asi-ntomătico sem ulce-	CBC, epidemoide, CBC	Nenhuma relatada	Sim	Santa Cruz DJ
7	Masculino	49	Mandibula	15 anos	Nódulo pegeneto, crescimento lento	CBC, carcinoma anexial	HAS	Sim	Santa Cruz DJ
8	Masculino	60	Região occipital	12 anos	Lesão endurecida, tamano crescente	CBC, carcinoma anexial	HAS	Sim	Santa Cruz DJ
9	Masculino	53	Região parotidea	12 anos	Nódulo pequeno, crescimento,	CBC, cisto triquilemal	Nenhuma relatada	Sim	Kazakov DV
10	Masculino	68	Mandibula esquerda	1 ano	Papula de 0.5 x 0.4 cm,com brilho perlac, peăntomicrăt. 2.com	CBC, adenoma sebăceo	Hipertensão arterial	Sim	Dados não publicados
11	Masculino	78	Perna direita	Indeterminado	Nódulo romoçrórmica, endurecida, p lăcerita 8.rifh.sado, meaudincio geraqpie-be bresaeentale, na perfleita,	Tricoepitelioma	Excisão convencional	Excisão convencional	Dados não publicados

Table 1. Cases literature review

Results

The literature review highlights that adamantinoid trichoblastoma typically presents as well-circumscribed nodules, most commonly located on the head and neck (1-4). Histopathological features include epithelial lobules surrounded by dense stroma, peripheral palisading basaloid cells, intraepithelial lymphocytes, and Reed–Sternberg–like cells(1,3). Recent studies report diffuse androgen receptor expression and somatic EGFR mutations in a subset of cases(1,8). Case 1 involved a 78-year-old man with a long-standing nodular lesion on the right leg. Histopathology and immunohistochemistry confirmed adamantinoid trichoblastoma, and complete surgical excision achieved clear margins (Figure 2). Case 2 involved a 68-year-old man with a pearly papule on the left mandible; histopathology and immunohistochemistry were consistent with adamantinoid trichoblastoma, and surgical margins were expanded due to the tumor's uncertain biological behavior (Figure 2).

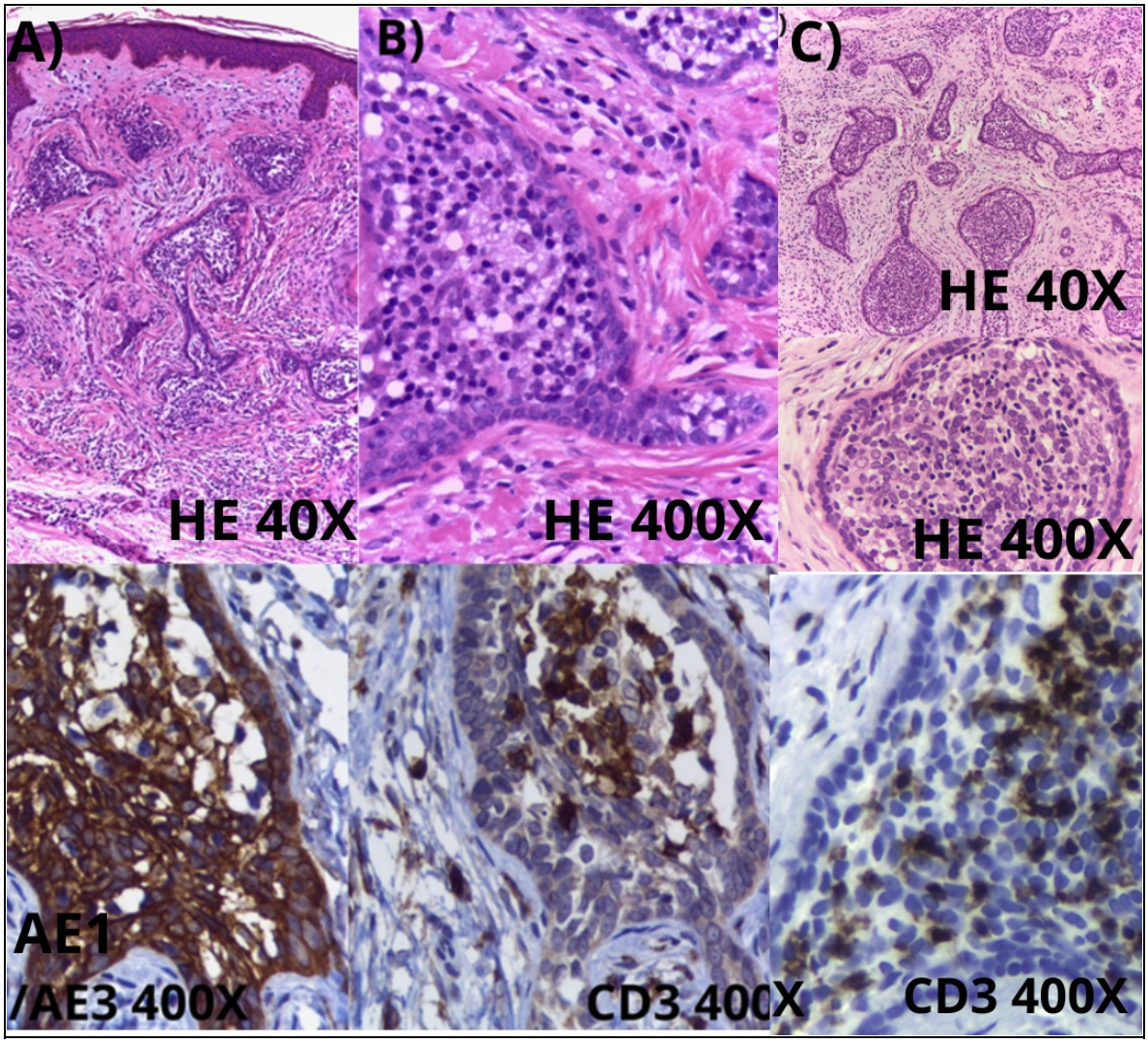
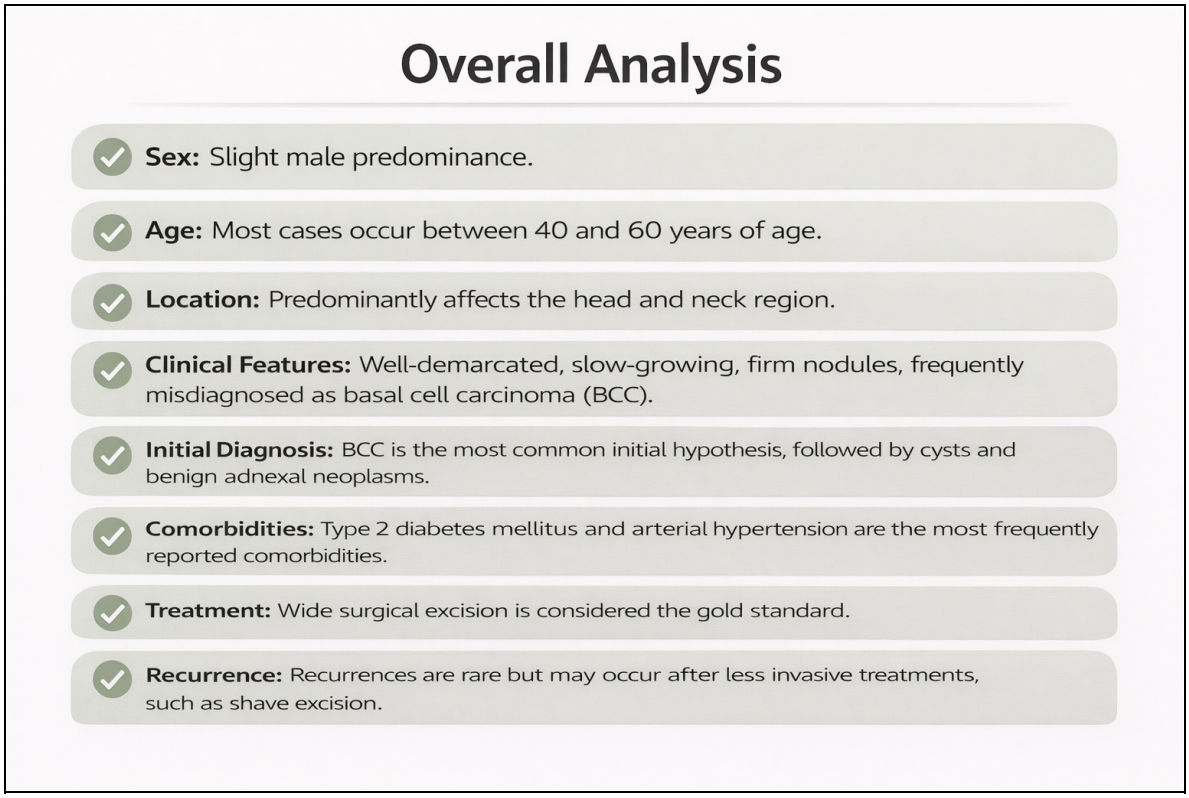


Figure 2. Histopathological and immunohistochemical findings. Upper panels show hematoxylin and eosin (H&E) stained sections, and lower panels show immunohistochemistry (IHC). Panels A and B correspond to histopathology and IHC of Case 1, demonstrating dermal nests and cords of basaloid cells within a fibrous stroma. Panel C shows histopathology and IHC of Case 2, revealing similar adnexal epithelial tumor architecture with lymphoid-rich stroma. IHC staining includes AE1/AE3, CD3, and CD30 (original magnification ×400).

Conclusions

Adamantinoid trichoblastoma is a rare adnexal tumor that requires careful histopathological and immunohistochemical evaluation to differentiate it from basal cell carcinoma and other malignant neoplasms (Figure 3) (4-8). Complete surgical excision remains the gold standard treatment, and long-term follow-up is recommended due to rare reports of

recurrence and metastasis(4). Further studies are needed to clarify its molecular pathogenesis and biological behavior.



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Abstract N°: ID-1087

Topic: Cutaneous oncology

Cutaneous Metastasis From Salivary Duct Carcinoma Mimicking Maculopapular Drug Eruption

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Introduction

Salivary duct carcinoma (SDC) is a rare and highly aggressive malignancy that most frequently arises in the parotid gland, followed by the submandibular gland, and rarely the minor salivary glands. It predominantly affects older male patients and is characterized by high rates of local recurrence, distant metastasis, and mortality. Although regional and distant lymph node involvement is common, cutaneous metastases are exceedingly rare and may present with atypical clinical features, leading to diagnostic delay. Early recognition of skin involvement is crucial, as it has significant implications for disease staging, prognosis, and treatment strategy. Herein, we present a case of cutaneous metastasis from parotid gland SDC that initially mimicked a maculopapular drug eruption.

Materials and Methods

A 73-year-old male with a 13-month history of parotid gland SDC and known metastases to cervical, supraclavicular, axillary, and mediastinal lymph nodes presented with a rapidly progressive, diffuse erythematous maculopapular eruption involving the upper arms, chest, and back. The eruption developed over five days while the patient was receiving carboplatin and paclitaxel chemotherapy, initiated three months earlier. Based on clinical suspicion of a drug-induced exanthematous eruption, chemotherapy was discontinued, and symptomatic treatment with oral antihistamines and topical corticosteroids was initiated by medical oncology. Two weeks later, the patient was consulted to our inpatient clinic from the intensive care unit due to the spread and enlarging of the lesions. Physical examination revealed that the lesions were diffuse, nodular and indurated, with some areas taking on a yellowish hue (Figure 1).

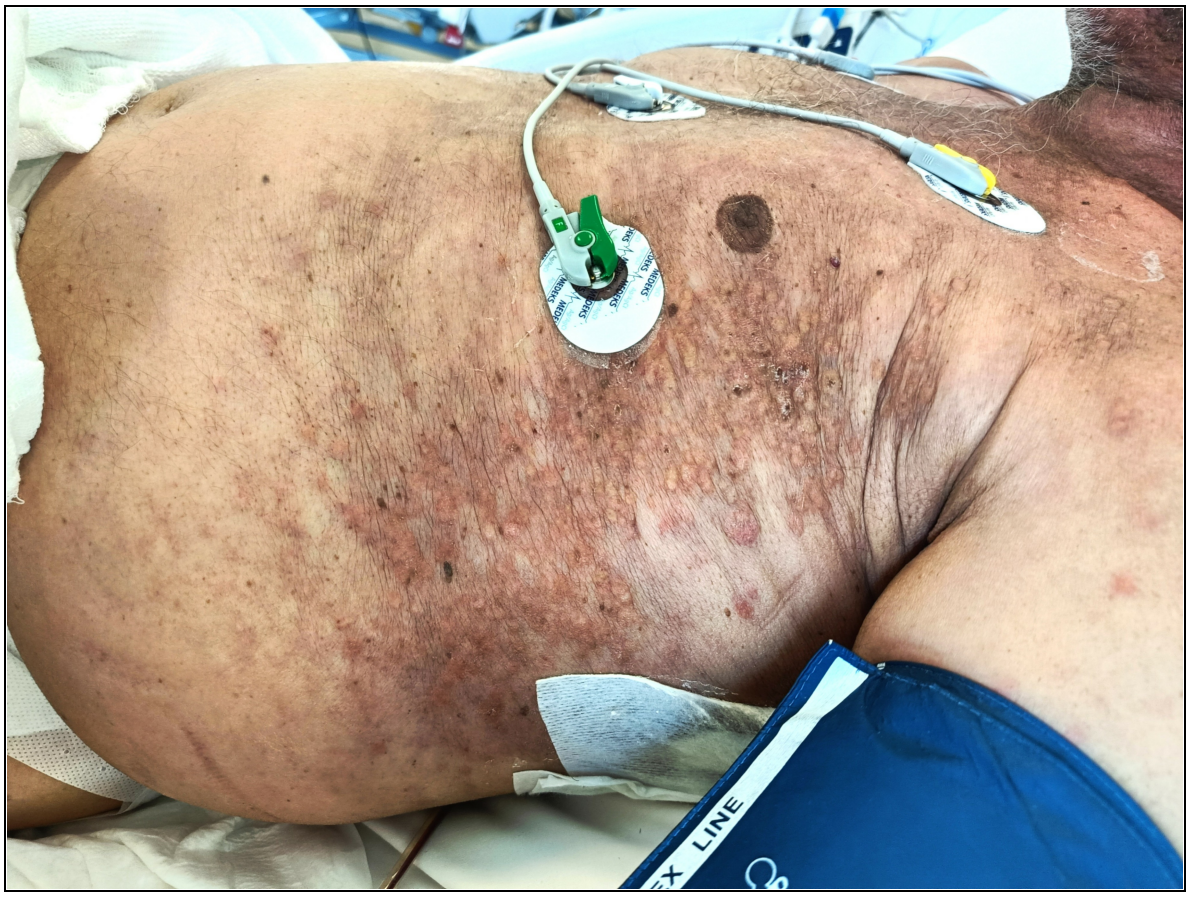

Figure 1: Clinical presentation showing diffuse, nodular, yellowish cutaneous lesions with overlying crusts and focal erythematous areas.

Results

An 8-mm punch biopsy was obtained with preliminary diagnosis of cutaneous metastasis of salivary gland carcinoma. The biopsy results showed a highly cellular dermal proliferation, without epidermal involvement, composed of pleomorphic spindled to epithelioid cells with scattered enlarged, atypical nuclei and mitotic figures. Peripheral collagen trapping and inflammatory infiltrate were noted. Staining for cytokeratin 7, androgen receptor and GATA 3 were diffusely positive. Histochemical study of mucicarmine and PAS was positive for intracytoplasmic inclusions. Comparing with tru-cut biopsy of parotid gland showed poorly differentiated adenocarcinoma extends into the underlying subcutaneous tissue, composed of single detached tumor cells showing cytologic atypia with striking nuclear pleomorphism, accompanied by variable desmoplasia (Figure 2). These findings were consistent with cutaneous metastasis of poorly differentiated salivary duct carcinoma and were concordant with previous parotid gland biopsy specimens. The patient was subsequently transitioned to a cisplatin and vinorelbine chemotherapy regimen.

In our case, the cutaneous metastasis from salivary duct carcinoma mimics a maculopapular drug eruption, showing a symmetric and bilateral distribution. Due to a high proliferation index and mitosis, a rapid spread was observed and the lesions took on an infiltrative character in a short period.

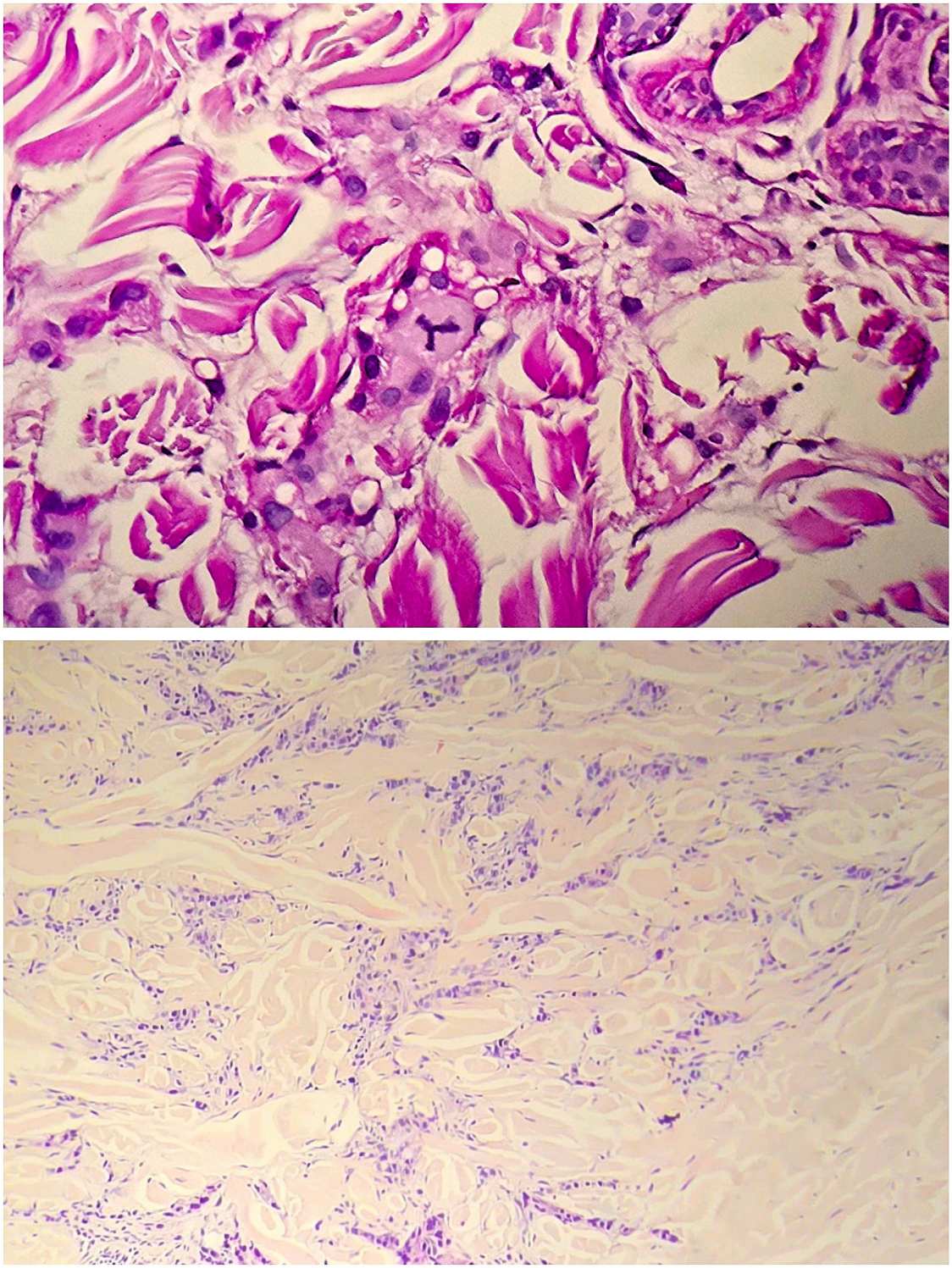

Figure 2: Histopathological analysis shows highly cellular dermal proliferation with pleomorphic spindled to epithelioid cells containing scattered enlarged, atypical nuclei and mitotic figures.

Conclusions

Although distant skin metastases of salivary duct carcinomas are rare, they indicate a high mortality rate that should not be overlooked by dermatologists, as they can significantly affect the prognosis and treatment regimen. In tumors with a high proliferation index, skin metastases may develop acutely and, as in this case, mimic drug reactions in the early stages. Prompt diagnosis through the clinician's experience and careful physical examination can have a substantial impact on the patient's treatment and follow-up.

Abstract N°: ID-1092

Topic: Cutaneous oncology

Superficial Spreading Melanoma Arising Centrally Within a Small Congenital Melanocytic Nevus in Adulthood: Dermoscopic Features (Polychromasia, Pseudopods, Chrysalis Structures, Regression) Leading to Early Detection of Breslow 1 mm Melanoma

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Introduction

Congenital melanocytic nevi (CMN) carry a risk of malignant transformation, though melanoma arising in small CMN (<1.5 cm) during adulthood after decades of stability is uncommon. Dermoscopy significantly enhances early recognition through characteristic features including marked asymmetry, polychromasia, irregular/broken pigment network, peripheral pseudopods, regression zones, and shiny white structures (chrysalis) indicating stromal fibrosis. We present a rare case of central melanoma transformation within a long-stable small CMN, detected through abrupt clinical changes and distinctive dermoscopic signs, confirmed on histopathology as thin invasive melanoma.

Materials and Methods

A 35-year-old fair-skinned male with no family history of melanoma presented with a pigmented lesion on the left arm, present since birth as a congenital melanocytic nevus and stable for decades. Six months prior, he observed sudden darkening, irregular borders, color variegation, shape change, growth, and itchiness. Clinical examination revealed an asymmetric, irregularly bordered macule measuring approximately 5–6 mm with variegated pigmentation. Polarized dermoscopy was performed (Fig. 1). Incisional biopsy was obtained, followed by complete surgical excision.

Fig. 1 - Dermoscopy of a small congenital melanocytic nevus showing asymmetry, polychromasia, irregular pigment network, peripheral pseudopods, regression areas, and multiple chrysalis structures

Results

Polarized dermoscopy demonstrated marked asymmetry in structure and pigment distribution across two axes. Polychromasia was evident with at least four shades: light brown, warm brown, dark brown, and near-black. The pigment network showed irregularity with thickening, breaks, and zonal disappearance, frequently replaced by amorphous areas. A focal zone of intense black-brown hyperpigmentation at the inferior pole exhibited radial streaming and pseudopods oriented peripherally. Central and peripheral amorphous whitish areas indicated regression, accompanied by multiple chrysalis structures (linear shiny white streaks visible under polarized light), consistent with fibro-sclerotic stromal remodeling. Mosaic-like unstructured brown zones alternated with lighter areas,

contributing to a chaotic appearance.
Incisional biopsy revealed atypical melanocytic proliferation suspicious for melanoma. Complete surgical excision with histopathology confirmed invasive superficial spreading melanoma arising within the congenital nevus (low chronic sun damage type), Breslow depth 1 mm, Clark level III, pT1a, L0 V0 Pn0, no lymphovascular or perineural invasion, moderate lymphohistiocytic infiltrate, clear margins.

Conclusions

This case highlights rare central malignant transformation in a small, long-stable CMN in adulthood, triggered by abrupt clinical and dermoscopic changes. The combination of polychromasia, disrupted pigment network, peripheral pseudopods, regression features, and especially chrysalis structures was crucial in raising high suspicion for melanoma, enabling timely excision and diagnosis of a thin (Breslow 1 mm) invasive melanoma.
Regular dermoscopic surveillance of even CMN in adults is essential, as these dermoscopic patterns can facilitate early detection and contribute to favorable outcomes.

Abstract N°: ID-1096

Topic: Cutaneous oncology

When necrotizing cutaneous vasculitis uncovers an underlying B-cell lymphoma

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Introduction
Cutaneous vasculitis may occur as an isolated dermatological condition or reflect an underlying systemic disorder. Although uncommon, paraneoplastic vasculitis can precede the diagnosis of hematological malignancies, particularly B-cell lymphomas. Atypical or refractory presentations should prompt thorough investigation to avoid diagnostic delay.

Materials and Methods
N/A

Results
Case report :

An 83-year-old woman with multiple cardiovascular and metabolic comorbidities presented with a six-month history of diffuse pruritus and recurrent maculopapular eruptions that were unresponsive to symptomatic treatment. The clinical course worsened with the sudden appearance of purpuric lesions on the lower limbs, distal digital necrosis, and a necrotic ulcer of the lateral malleolus.

She subsequently developed dyspnea and a dry cough, without fever, arthralgia, hemoptysis, or ear–nose–throat symptoms. Physical examination revealed excoriated maculopapular lesions on the trunk and limbs, palpable purpura of the lower extremities, and painful necrotic skin lesions. Peripheral pulses were diminished, and no palpable lymphadenopathy was initially detected.

Laboratory investigations showed a marked inflammatory response, significant eosinophilia, and elevated total immunoglobulin E levels. Histopathological analysis of a skin biopsy with direct immunofluorescence confirmed leukocytoclastic vasculitis. Given the necrotizing and atypical presentation, together with the absence of features suggestive of classical ANCA-associated vasculitis or polyarteritis nodosa, additional investigations were undertaken. Lymph node biopsy ultimately revealed a non-Hodgkin B-cell lymphoma.

Discussion :

Paraneoplastic vasculitis is believed to result from immune-mediated mechanisms, including immune complex deposition, antigenic cross-reactivity, and cytokine dysregulation. Among hematological malignancies, B-cell lymphomas are the most frequently associated. Necrotizing cutaneous involvement, resistance to conventional therapies, and misleading inflammatory or eosinophilic profiles may delay recognition of the underlying disease. In elderly patients, such presentations should raise suspicion for a paraneoplastic process, even in the absence of obvious lymphadenopathy.

Initial management consisted of symptomatic cutaneous treatment, including local wound care, antihistamines, antiplatelet therapy, and colchicine, while awaiting disease-specific oncological management.

Conclusions

This case highlights the importance of considering a paraneoplastic etiology in elderly patients presenting with atypical, necrotizing cutaneous vasculitis. Early skin biopsy combined with comprehensive systemic evaluation, including targeted lymph node assessment, is essential for the timely diagnosis of an underlying hematological malignancy and may significantly influence patient management and prognosis.

Abstract N°: ID-1099

Topic: Cutaneous oncology

A deceptive acral nodular lesion revealing an extraosseous giant cell tumor

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Introduction

Acral nodular lesions in elderly patients represent a diagnostic challenge, as they may mimic benign, inflammatory, or malignant conditions. Giant cell tumors of soft tissues are rare entities, particularly when presenting as superficial, ulcerated, and bleeding lesions in acral locations. Early recognition is essential to guide appropriate surgical management.

Materials and Methods

A single-patient observational case was analyzed. Clinical evaluation was followed by skin biopsy with histopathological examination. Magnetic resonance imaging of the foot was performed to assess soft tissue extension and bone involvement. Multidisciplinary discussion guided therapeutic decision-making.

Results

An 83-year-old woman presented with a three-month history of a progressively enlarging nodular lesion located in the interdigital space between the first and second toes. The lesion was initially painful, later becoming painless and non-pruritic, with recurrent bleeding on contact. Clinical examination revealed a smooth-surfaced, erythematous, polypoid nodule.

Histopathological analysis of the excised lesion showed a dermal proliferation composed of numerous osteoclast-like multinucleated giant cells admixed with mononuclear cells lacking cytological atypia. Reactive osteogenesis with immature bone trabeculae, hemorrhagic remodeling, hemosiderin deposits, and pseudovascular spaces were observed. The lesion was ulcerated and covered by granulation tissue, with inflammatory infiltrates. No histological signs of malignancy were identified. The deep margin was close to the lesion. These findings were consistent with a giant cell–rich proliferation, raising the diagnosis of an extraosseous giant cell tumor.

Magnetic resonance imaging revealed a well-circumscribed soft tissue mass measuring approximately 22 mm in greatest diameter, located adjacent to the medial cortex of the proximal phalanx of the second toe. The lesion displayed heterogeneous signal intensity with enhancement after contrast administration, associated with focal cortical thinning without frank bone invasion. Tendinous structures were preserved, and no joint effusion was detected.

Based on clinicopathological and radiological correlation, wide local excision was recommended.

Conclusions

This case highlights an unusual presentation of an extraosseous giant cell tumor manifesting as a superficial, bleeding acral nodule in an elderly patient. Such lesions may mimic malignant or inflammatory conditions, leading to diagnostic delay. Careful clinico-radiological-pathological correlation is crucial to establish the diagnosis and to guide optimal surgical management. Acral nodular lesions with atypical features should prompt consideration of rare soft tissue tumors.

Abstract N°: ID-1133

Topic: Cutaneous oncology

Melanomas with mutations in chromatin regulators are associated with higher mutational burden and improved response to checkpoint immunotherapy

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Introduction

Melanoma is characterized by a high mutational load driven largely by ultraviolet-induced DNA damage. Tumor mutational burden (TMB) has emerged as a predictive biomarker for response to immune checkpoint inhibitors (ICIs), yet the genomic determinants of TMB variability remain incompletely defined. Beyond canonical DNA repair defects such as mismatch repair (MMR) or POLE/POLD1 mutations, alterations in chromatin regulators (CRs) may reshape chromatin architecture and influence genome stability. We hypothesized that mutations in CR genes are associated with increased TMB and improved response to ICI therapy in melanoma.

Materials and Methods

We analyzed melanoma cohorts from three independent datasets accessed through cBioPortal TCGA (n=448, whole-exome sequencing), MSK-Met (n=1,142; MSK-IMPACT panel), and MSK-ICI (n=320 ICI-treated patients; MSK-IMPACT panel). TMB was compared between CR-mutant, CR–wild-type, and overall cohorts using Kruskal–Wallis tests with multiple comparisons. Gene-level analyses evaluated individual CRs and compared their TMB distributions with tumors harboring mutations in MMR or POLE/POLD1 genes. Co-occurrence patterns were assessed by oncoprint analysis, linear regression and Pearson correlation between number of CR mutations and TMB. Overall survival (OS) in ICI-treated patients was evaluated using Kaplan–Meier curves and Cox proportional hazards models, with TCGA serving as a non–ICI-treated comparator.

Results

Across all three datasets, melanomas harboring mutations in CR genes demonstrated significantly higher TMB compared with CR–wild-type tumors ($p<0.0001$). At the gene level, several CRs including *ARID1A, DNMT3A, EP300, CREBBP, TET2*, and *NSD2* were associated with elevated median TMB, in some instances comparable to tumors with MMR or POLE/POLD1 mutations. Tumors carrying multiple CR alterations showed a strong positive linear relationship between number of CR mutations and TMB ($r=0.91$, $p<0.0001$), exceeding correlations observed for co-mutated MMR or canonical oncogenes.

In the MSK-ICI cohort, higher TMB was associated with improved survival following checkpoint blockade. CR-mutant tumors demonstrated significantly prolonged OS compared with CR–wild-type cases (HR 0.657, 95% CI 0.461–0.936, $p=0.0166$). This association was not observed in the TCGA cohort, suggesting treatment specificity. Although TMB ≥10 mutations/Mb showed the strongest survival signal, CR-mutant subsets exhibited a consistent survival advantage within ICI-treated patients. Enrichment analyses further demonstrated that high-TMB CR genes were overrepresented among long-term survivors in the MSK-ICI dataset but not in non–ICI-treated cohorts.

Conclusions

Mutations in chromatin regulator genes define a subset of melanomas with elevated tumor mutational burden and improved outcomes following immune checkpoint inhibition. The relationship between CR mutations and TMB appears partially independent of canonical DNA repair defects, suggesting distinct mutagenic mechanisms linked to chromatin dysregulation. While the magnitude of survival benefit is modest relative to established hypermutator phenotypes, CR status may refine patient stratification when integrated with TMB thresholds. Prospective validation is warranted to determine whether composite CR mutation signatures enhance prediction of immunotherapy response in melanoma.

Abstract N°: ID-1139

Topic: Cutaneous oncology

Atypical presentation of paediatric plexiform fibrohistiocytic tumor: diagnostic challenges and therapeutic management

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Introduction
Plexiform fibrohistiocytic tumor (PFHT) is a rare mesenchymal neoplasm of intermediate malignancy that usually presents as a slow-growing, painless mass in the upper extremities of children and young adults. Our objective is to present a case of PFHT in a pediatric patient with an atypical location, as well as to review its diagnostic and therapeutic management.

Materials and Methods
We present the case of a 3-year-old boy who consulted for a long-standing prepatellar skin tumour.

Results
A 3-year-old male patient consulted for a left prepatellar lesion that had been present for 3 years, with progressive growth and pain upon trauma. Examination revealed a 6 x 4 mm papule of normal colour, with no specific signs on dermatoscopy. Doppler ultrasound revealed a poorly defined, non-specific mass with hypoechoic areas and no vascularization in the subcutaneous tissue. Surgical excision was performed, with the pathological result showing plexiform proliferation composed of nests of spindle cells, histiocyte-like cells and CD 68-positive multinucleated giant cells with affected margins. The diagnosis of TFHP was confirmed, and surgical enlargement was performed to achieve clear margins. The extension study with chest CT and abdominal ultrasound was negative.

Conclusions
It is essential to consider TFHP in the differential diagnosis of soft tissue tumours in children, despite its rarity. Treatment involves surgical excision with wide margins, as it presents infiltrative growth that leads to a high rate of local recurrence. Therefore, accurate and early diagnosis will allow us to reduce the morbidity associated with surgery. Finally, although metastasis is very rare, it is considered necessary to perform an initial staging study and maintain prolonged clinical follow-up to detect possible local recurrence.

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Abstract N°: ID-1145

Topic: Cutaneous oncology

Radiation Therapy and Survival Outcomes in Metastatic Merkel Cell Carcinoma in the Immune Checkpoint Inhibitor Era

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Introduction
The role of radiotherapy (RT) in metastatic Merkel cell carcinoma (MCC) has evolved with the adoption of immune checkpoint inhibitors (ICIs) as first-line systemic therapy. However, population-based evidence defining the contemporary role of RT in the ICI era remains limited.

Materials and Methods
We conducted a population-based analysis using data from the Surveillance, Epidemiology, and End Results (SEER) program and the National Cancer Database (NCDB). Temporal trends in treatment utilization were evaluated, including RT use. In SEER, disease-specific survival (DSS) was evaluated in the post-2017 era according to RT receipt. In NCDB, 2-year overall survival (OS) was examined according to RT receipt, stratified by immunotherapy use, using Kaplan–Meier methods and multivariable Cox proportional hazards models. A 60-day landmark analysis was performed to address potential immortal time bias.

Results
In SEER, receipt of RT in the contemporary treatment era was associated with higher DSS among patients with metastatic MCC. In NCDB, the association between RT and survival differed by immunotherapy receipt. Among patients who did not receive immunotherapy, RT was associated with higher 2-year OS after multivariable adjustment. In contrast, among patients who received immunotherapy, RT was not associated with a statistically significant difference in 2-year OS. Results were consistent in landmark sensitivity analyses.

Conclusions
In population-based analyses, RT remains commonly utilized in metastatic MCC and is associated with favorable survival outcomes in selected clinical contexts. The absence of an additional survival association with RT among immunotherapy-treated patients is consistent with prospective trial data suggesting limited systemic synergy between RT and ICIs. Together, these findings support a continued role for RT primarily as a local treatment modality for disease control and palliation in the ICI era, while highlighting the need for prospective studies with detailed treatment characterization to better define optimal integration of RT into modern multidisciplinary care.

Abstract N°: ID-1175

Topic: Cutaneous oncology

Understanding Sentinel Node Patterns in Melanoma: Breslow, Multiple Drainage, and Surgical Risks.

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Introduction
Currently, sentinel lymph node biopsy is considered an essential step in the staging of melanoma, as staging determines the indication for adjuvant treatment. The lymphatic system shows marked interindividual variability; therefore, preoperative imaging is required to accurately identify the sentinel lymph node(s), which may be located in one or multiple anatomical regions. Histopathological assessment requires a surgical procedure, which entails morbidity, particularly when multiple drainage areas are involved.

Recent literature has demonstrated improved survival outcomes with neoadjuvant treatment strategies. The aim of this study is to describe our institutional experience and to assess the risks and benefits to which our patients are exposed.

Materials and Methods
Data were collected from all patients who underwent the sentinel lymph node biopsy technique during the period from 2015 to 2025. A total of 124 patients were identified. For these patients, data were collected on demographic characteristics, melanoma-related variables, type of lymphatic drainage, adjuvant therapies, and the presence of concomitant tumors at other anatomical sites. The data were analyzed using SPSS software.

Results
A total of 124 patients were included, 46% male and 54% female, with a mean age at diagnosis of 62.25 years. The mean Breslow thickness was 5.77 mm, and nodular melanoma was the most frequent histological subtype.

Lymphatic mapping using technetium-99m lymphoscintigraphy was performed in all cases. Multiple drainage basins were identified in 37 patients, with up to four basins involved. Sentinel lymph node positivity was observed in one case among melanomas <0.8 mm (n=16), eight cases in melanomas 0.8–2.0 mm (n=54), and 19 cases in thicker melanomas (n=54). Completion lymphadenectomy was performed in 10 patients with positive sentinel nodes and in three due to nodal recurrence.

Adjuvant chemotherapy or radiotherapy was administered to 30 patients. During follow-up, 11 of 121 patients died, seven due to disease progression. Concomitant malignancies were identified in 17 patients, most commonly prostate adenocarcinoma. Among patients with multiple drainage basins (n=40), seven had positive sentinel nodes, five undergoing lymphadenectomy. The most frequent complications were mild regional dysesthesia and seroma formation (n=12). All sentinel node–negative patients were alive at last follow-up.

Conclusions
he collected data are consistent with previous literature, confirming the marked interpersonal variability in lymphatic

drainage patterns. Overall, the findings support the prognostic relevance of Breslow thickness for staging, as lower Breslow values are associated with lower rates of sentinel lymph node positivity. However, sentinel node involvement may also occur in thin melanomas when adverse histological features are present, indicating that omission of sentinel lymph node biopsy may lead to disease understaging and subsequent undertreatment.

Multiple lymphatic drainage was relatively frequent (33%), highlighting the importance of preoperative lymphoscintigraphy for accurate surgical planning. Although multiple drainage increases surgical complexity, operative time, and morbidity, associated complications—most commonly mild sensory dysesthesia—are generally limited. Patients with multiple drainage showed similar demographic characteristics, prognosis, and rates of concomitant malignancies compared with those with single drainage patterns.

Abstract N°: ID-1176

Topic: Cutaneous oncology

Molluscum pendulum mimicking a keloid: importance of clinicopathological correlation

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Introduction

Molluscum pendulum, also known as acrochordon or fibroepithelial polyp, is a common benign cutaneous tumor characterized by soft, pedunculated lesions usually arising in intertriginous areas. The diagnosis is generally clinical due to its characteristic morphology. However, atypical clinical presentations may occur and mimic other fibroproliferative or tumoral lesions, leading to diagnostic uncertainty. The aim of this study is to report an unusual presentation of molluscum pendulum clinically simulating a keloid and to highlight the importance of histopathological confirmation.

Results

A 34-year-old woman with no significant medical history presented with a recurrent nodular lesion located in the intergluteal region. The patient had previously developed, in 2013, an 8 cm nodular lesion at the same site. Surgical excision was performed in 2015, and histopathological examination confirmed the diagnosis of molluscum pendulum.

Three years prior to the current consultation, the patient noticed the progressive development of a new lesion at the same location, associated with localized pruritus. Dermatological examination revealed a 5 cm perianal exophytic mass that was pedunculated, polylobulated, well-circumscribed, flesh-colored, and displayed a smooth, slightly folded surface. The lesion was firm on palpation and showed no inflammatory or ulcerative changes.

Based on its clinical presentation and recurrence pattern, a keloid was initially suspected. Complete surgical excision was performed. Histopathological analysis revealed a polypoid fibrovascular lesion covered by unremarkable epidermis, consistent with molluscum pendulum, confirming recurrence of the initial lesion.

Conclusions

This case highlights the essential role of histopathological examination in the evaluation of atypical or recurrent cutaneous lesions. Although molluscum pendulum is usually a clinically recognizable benign lesion, it may rarely mimic keloidal or other fibroproliferative processes. Awareness of such atypical presentations is important to avoid misdiagnosis and ensure appropriate management. Histological confirmation remains the gold standard, particularly in recurrent or clinically misleading lesions.

Abstract N°: ID-1181

Topic: Cutaneous oncology

Squamous Cell Carcinoma Arising in Long-Standing Hidradenitis Suppurativa: A Case Report

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Introduction

Hidradenitis suppurativa (HS), also known as Verneuil's disease, is a chronic inflammatory disorder of the folliculopilosebaceous unit characterized by recurrent nodules, abscesses, sinus tract formation, and scarring, mainly affecting intertriginous areas. Malignant transformation into squamous cell carcinoma (SCC) is a rare but severe complication, typically occurring in long-standing and severe disease. SCC arising in HS is often aggressive and associated with delayed diagnosis and poor prognosis. We report a case of SCC developing in chronic gluteal hidradenitis suppurativa.

Results

A 60-year-old man presented with an ulcerative and proliferative lesion of the right buttock evolving for three years in the context of hidradenitis suppurativa diagnosed seven years earlier. His medical history included heavy smoking (47 pack-years), chronic cannabis uses for 43 years, alcohol dependence with abstinence for seven years, and treated pulmonary tuberculosis five years prior. The clinical presentation was associated with weight loss without fever.

Physical examination revealed a conscious and hemodynamically stable patient with Fitzpatrick skin phototype III–IV. Dermatological examination of the right gluteal region showed multiple ulcerative exophytic nodular lesions covered with fibrinous deposits, including one fistulized lesion with purulent discharge. The lesions had irregular elevated borders resting on an indurated base, with focal pigmentation and peripheral erythema, and were locally warm and painful on palpation, involving most of the right buttock. A polylobulated erythematous-violaceous dermoepidermal nodule overlying an indurated subcutaneous plaque measuring approximately 5 cm was also noted, presence of open and closed comedones on the face, trunk, and retroauricular area.

Multiple bilateral inguinal lymphadenopathies of variable sizes were detected. Skin biopsy revealed histological features consistent with squamous cell carcinoma. Ultrasound showed necrotic right inguinal lymph node conglomerates. Magnetic resonance imaging demonstrated an ulcerative tumoral process involving the right gluteal soft tissues with ipsilateral inguinal lymphadenopathies. Proctological examination was normal. Thoraco-abdomino-pelvic computed tomography revealed locoregional tumor extension with necrotic ipsilateral inguinal lymphadenopathies and additional subcentimetric iliac lymph nodes. Bilateral pulmonary micronodules were considered likely sequellar.

Following multidisciplinary tumor board discussion, neoadjuvant chemotherapy based on 5-fluorouracil and cisplatin was initiated, with surgical management planned subsequently.

Conclusions

Malignant transformation of hidradenitis suppurativa into squamous cell carcinoma is uncommon but represents a life-threatening complication, particularly in long-standing gluteal disease. Chronic inflammation and delayed diagnosis

contribute to aggressive tumor behavior and regional metastatic spread. This case highlights the importance of close clinical monitoring of chronic HS lesions and early histopathological assessment of suspicious or non-healing lesions to ensure timely diagnosis and appropriate multidisciplinary management.

Abstract N°: ID-1182

Topic: Cutaneous oncology

Subungual Glomus Tumor – A Rare Diagnosis in Everyday Clinical Practice

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Introduction

Glomus tumor (GT) is a benign vascular neoplasm originating from the nail bed or nail matrix. Solitary glomus tumors are rare, whereas multiple glomus tumors are usually hereditary. From an etiopathogenetic perspective, they arise from modified smooth muscle cells of the Suquet–Hoyer bodies (glomera cutanea), which regulate blood flow through arteriovenous anastomoses. Histologically, glomus tumors consist of three components: glomus cells, myoid spindle cells, and endothelium-lined blood vessels.

Materials and Methods

We present a patient with a subungual glomus tumor, evaluated through clinical examination, dermoscopy, surgical excision, and histopathological analysis.

Results

A 38-year-old male patient presented for an urgent dermatological examination due to pain in the right thumb. Dermatological examination revealed an oval, bluish-violet structure in the proximal portion of the nail plate, with longitudinal erythronychia extending along the nail plate, accompanied by discrete distal onycholysis and mild subungual hyperkeratosis.

The patient reported that the nail lesion had appeared two years earlier and had progressively worsened. He also described pain on palpation and upon exposure to cold. Based on the medical history, clinical presentation, and dermoscopic findings, a diagnosis of suspected glomus tumor of the nail unit was made. The patient was referred to a plastic surgeon for an excisional biopsy. Histopathological examination demonstrated a solitary tumor composed of nests of round pericytes surrounding vascular lumina within the dermis. Immunohistochemical analysis showed that the pericytes were positive for smooth muscle actin (SMA), calponin, and caldesmon, and negative for S100 protein and cytokeratin AE1/AE3. Following excision of the tumor, an excellent clinical outcome was achieved, with complete resolution of pain and high patient satisfaction.

Conclusions

The differential diagnosis of onychalgia is broad and primarily includes tumorous lesions. Thorough knowledge of nail unit anatomy, clinical presentation, and dermoscopy is essential for the accurate diagnosis of rare benign tumors of the nail unit.

Abstract N°: ID-1206

Topic: Cutaneous oncology

A Rare Presentation of Neurilemmoma in the Nasal Vestibule

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Introduction

Neurilemmoma, also known as schwannoma, is a benign tumor arising from Schwann cells of the peripheral nerve sheath. These tumors commonly occur in the head and neck region; however, involvement of the nasal cavity and paranasal sinuses is rare, accounting for less than 4% of cases. Neurilemmoma of the nasal vestibule is extremely uncommon, with only a few cases reported in the literature. Due to its rarity and nonspecific clinical presentation, diagnosis is often delayed or overlooked.

Materials and Methods

A case-based descriptive study was conducted involving a 27-year-old female who presented with a solitary, asymptomatic lesion in the left nasal vestibule of four years' duration. Detailed clinical examination was performed, followed by excisional biopsy of the lesion. Histopathological examination and immunohistochemical analysis were carried out to establish the diagnosis and to differentiate it from other benign spindle cell neoplasms of neural origin.

Results

Clinical examination revealed a solitary, skin-colored, pedunculated mass measuring approximately 0.5 × 0.5 cm in the left nasal vestibule, firm on palpation. Histopathological evaluation showed a dermal tumor composed of randomly arranged bundles and fascicles of spindle-shaped cells embedded in a myxoid matrix with intervening collagen bundles. The tumor cells exhibited indistinct cell borders and elongated nuclei. Immunohistochemistry demonstrated positivity for S100 protein and smooth muscle actin, CD34 positivity in an interstitial pattern, and negativity for desmin. These findings confirmed the diagnosis of neurilemmoma. Complete excision was achieved, and no recurrence was noted.

Conclusions

Neurilemmoma of the nasal vestibule is an exceptionally rare entity and can be easily missed due to its benign appearance and slow growth. This case highlights the importance of considering neurilemmoma in the differential diagnosis of long-standing nasal vestibular masses. Histopathological examination supported by immunohistochemistry is essential for accurate diagnosis. Early recognition and complete surgical excision offer excellent prognosis.

Abstract N°: ID-1220

Topic: Cutaneous oncology

Transcriptomic analysis identifies eIF3j as a potential mediator of Vemurafenib resistance in melanoma cell

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Introduction
Melanoma is the most aggressive form of skin cancer and is frequently driven by the BRAFV600E mutation, which promotes uncontrolled cell proliferation and dysregulated translational signaling. Although BRAF inhibitors such as vemurafenib have significantly improved patient outcomes, the emergence of drug resistance remains a major clinical challenge. Increasing evidence suggests that alterations in translational control, including dysregulation of eukaryotic initiation factors (eIFs), contribute to melanoma progression and therapeutic resistance.

Materials and Methods
Vemurafenib-resistant (VR) melanoma cell lines were generated from A375 and SK-MEL-5 parental cells following long-term drug exposure. Transcriptomic profiling was performed by RNA sequencing to identify differentially expressed genes associated with acquired resistance, with a particular focus on translation initiation factors. Based on RNA-seq results, melanoma cell lines representing different disease stages were engineered to stably overexpress eIF3j. Cell proliferation was assessed using crystal violet staining assays, while cell migratory capacity was evaluated by scratch wound-healing assays. Changes in translational machinery were examined by quantitative real-time PCR analysis of eIF3 complex subunits, and protein expression levels were assessed by immunoblotting.

Results
RNA-seq analysis revealed extensive dysregulation of eukaryotic initiation factors in VR melanoma cell lines, with eIF3j being significantly downregulated in both A375 and SK-MEL-5 resistant cells. Stable overexpression of eIF3j resulted in reduced proliferation across multiple melanoma cell lines, with more pronounced effects observed in aggressive and metastatic models. In addition, eIF3j overexpression markedly impaired cell migration, as demonstrated by delayed wound closure in scratch assays. Transcript-level analysis further revealed consistent downregulation of eIF3h and additional eIF3 complex subunits upon eIF3j overexpression, suggesting disruption of translational complex homeostasis. Collectively, these findings indicate that altered eIF3j expression impacts melanoma cell growth and motility through modulation of translational control pathways.

Conclusions
Our findings identify eIF3j as an important regulator of melanoma cell proliferation, migration, and resistance to vemurafenib. Dysregulation of eIF3j-mediated translational control appears to contribute to the resistant phenotype, highlighting eIF3j as a potential molecular target for overcoming therapeutic resistance in melanoma. Further studies are warranted to elucidate the precise mechanisms linking eIF3j function to drug response and disease progression.

Abstract N°: ID-1223

Topic: Cutaneous oncology

A Rare Case of Vitiligo Associated with Ocular Melanoma on nevus of Ota:A Warning for Close Monitoring

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Introduction

Although Ota's nevus is a benign dermal melanocytosis, it carries a risk for the patient to develop glaucoma or choroidal melanoma. We
report the case of a 53-year-old patient, highlighting the importance of regular ophthalmological follow-up in cases of oculodermal
melanocytosis, as well as the need for periodic multidisciplinary monitoring, including dermatological and neurological assessments.

Materials and Methods

Mr. H.M, a 53-year-old man with no significant medical history, presented for a consultation due to a recently developed ocular lesion.

The patient first noticed a barely visible episcleral hyperpigmentation at the medial canthus of the left eye at the age of 8.
Around the age of 53, he observed an increase in the size of the pigmented lesion, which led him to seek consultation in ophthalmology. Moreover, the patient also reports the appearance of hypopigmented spots 5 years before the increase in
size of the ocular lesion.

Physical examination revealed a conjunctival pigmentation at the medial angle of the eye (fig. 1). The clinical examination
also showed hypochromic patches with blurred borders on the trunk (Fig 2a) and penis, with islands of repigmentation under Wood's light (Fig 2b) .

The patient underwent excision of a lesion measuring 4.5 × 5 cm, composed of a melanocytic epithelioid proliferation with
moderate to high cellular density, consisting of elongated polygonal cells with hyperchromatic, heavily pigmented nuclei, dissociated by an inflammatory infiltrate with a tumor-infiltrating lymphocytes (TILs) estimate of 5%. The mitotic index was
estimated at 4 mitoses/field. This proliferation infiltrated the palpebral conjunctiva and adjacent orbital conjunctivo-muscular tissue without vascular embolism, with perineural sheath involvement. The S-100 and HMB-45 markers were positive. This histological appearance was consistent with melanoma. As for the hypopigmented lesions, the
histological appearance was suggestive of vitiligo.

CT and PET scans revealed two dense pulmonary nodules with irregular contours, suggesting a secondary origin.

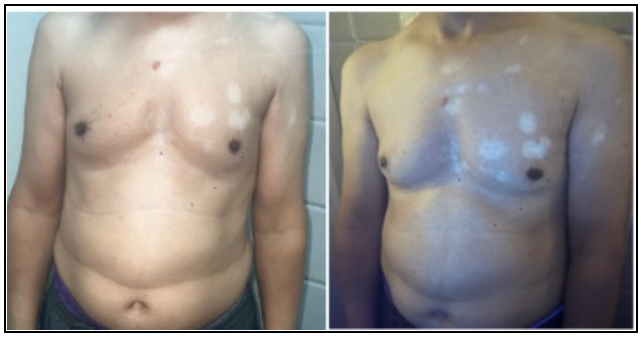
The patient was referred to oncology for further management.

Results

Ocular melanocytosis, also known as dermal melanocytosis (ODM), is a congenital condition marked by excessive pigmentation in the periocular area, episclera, sclera, and choroid. It was first described by Halbe in1869, before Ota's definitive description in1939 (1). Though typically congenital, this disorder may first appear at puberty and is more common in women. It is caused by an overabundance of melanocytes in the skin surrounding the eyes, the sclera, the uvea, the orbit, the meninges, the palate, or the tympanic membrane. This is a result of irregular migration of melanoblastic cells from the primitive neural tube, primarily through the first and second branches of the trigeminal nerve during early development.

Malignant degeneration within Ota's nevus is not uncommon and can involve the choroid, brain, orbit, and skin (2).

Spontaneous vitiligo occurs much more frequently in individuals with melanoma compared to the general population (3, 4). Histologically, melanoma-associated vitiligo and vitiligo appear indistinguishable (5). A prospective study involving 2,954 melanoma patients of all stages found a vitiligo prevalence of 2.8%, while the prevalence in the general population ranged from 0.4% to 2.0% (6). Three-quarters of melanoma-associated vitiligo (MAV) developed spontaneously without any treatment. In 20.5% of patients, vitiligo preceded the melanoma diagnosis by a span of 2 to 45 years and was identified as an
independent, favorable predictor of overall survival for patients in stages III and IV.



Clinical examination showing hypochromic patches with blurred borders on the trunk, with islands of repigmentation under Wood's light

Conclusions

The appearance of vitiligo in an individual at risk of developing melanoma, such as a patient with a history of melanoma or having
a nevus of Ota, should prompt close monitoring to detect any appearance of a suspicious lesion.

Abstract N°: ID-1227

Topic: Cutaneous oncology

Telangiectasia macularis eruptiva perstans in adults: a skin marker of clonal mast cell disease

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Introduction
Telangiectasia macularis eruptiva perstans (TMEP) is a rare variant of cutaneous mastocytosis that predominantly occurs in adults and may represent an early cutaneous marker of underlying clonal mast cell disease. Due to its non-specific clinical presentation and often subtle histopathological findings, recognition is frequently delayed, potentially postponing appropriate hematologic evaluation.

Materials and Methods
We conducted a retrospective review of our institutional database from January 2010 to December 2024 to identify histologically confirmed cases of TMEP in adult patients. Clinical characteristics, dermoscopic features, histopathological findings, serum tryptase levels, molecular testing for KIT mutations, and bone marrow involvement were collected and analyzed.

Results
Five adult patients (three women and two men; age range 46–80 years) were identified. All patients presented with persistent pink-to-red macules, predominantly involving the upper trunk and proximal extremities. Three patients reported episodic flushing and paroxysmal pruritus, while Darier's sign was negative in all cases. Dermoscopic examination demonstrated a uniform vascular pattern characterized by reticulated telangiectatic vessels and short linear vessels on a pale-brown background. Histopathological findings were subtle, consisting mainly of mild perivascular infiltrates in the superficial dermis composed of spindle-shaped mast cells. All patients had elevated baseline serum tryptase levels (>20 ng/mL). Activating KIT mutations were detected in three patients, all of whom fulfilled World Health Organization criteria for systemic mastocytosis based on bone marrow biopsy findings. The remaining two patients showed isolated cutaneous involvement.

Conclusions
This case series supports TMEP in adults as a clinically relevant skin marker of clonal mast cell disease. Recognition of its characteristic clinicodermoscopic features may facilitate earlier identification of patients requiring comprehensive hematologic evaluation, thereby improving diagnostic pathways for systemic mastocytosis.

Abstract N°: ID-1229

Topic: Cutaneous oncology

Verrucous Carcinoma of the Temporal Region in a Woman: An Uncommon Cutaneous Localization with Dermoscopic Clues

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Introduction
Verrucous carcinoma (VC) is a rare, slow-growing, well-differentiated variant of squamous cell carcinoma with locally destructive behavior and low metastatic potential. It typically affects the oral cavity, anogenital region, or plantar surface; facial involvement is uncommon. We report a rare temporal localization in a female patient and highlight clinical, dermoscopic and histopathologic features supporting early suspicion and adequate management.

Materials and Methods
A 60-year-old woman presented with a 9-month history of a solitary lesion on the left temple. She had no immunosuppression, no prior radiotherapy, and no history of warts. Clinical examination showed a ~1 cm pigmented, exophytic, verrucous lesion, painless but bleeding on contact. There were no symptoms suggestive of deep local invasion (no paresthesia or neurologic complaints). Dermoscopy revealed diffuse hyperkeratosis, a central hemorrhagic ulcer/crust, and dotted vessels.

The lesion was surgically excised, and histopathology confirmed verrucous carcinoma with dermal invasion and histologically free margins. Microscopy showed a papillomatous endo- and exophytic squamous tumor proliferation with mitotic activity and cytologic atypia. There was no lymphovascular invasion and no perineural involvement. Lymph node ultrasound and chest X-ray were normal. At 6-month follow-up, there was no local recurrence.

Results
At unusual sites such as the temple, VC may mimic benign lesions (viral wart, seborrheic keratosis) or other keratinizing tumors. Dermoscopy is not specific; however, the combination of marked hyperkeratosis, hemorrhagic/ulcerated areas, and vascular structures in a chronic, bleeding, exophytic lesion should prompt suspicion of a malignant keratinizing neoplasm and lead to complete excision or an adequately deep biopsy. Histologic diagnosis can be challenging if sampling is superficial, as VC can appear deceptively bland and requires evaluation of the architecture and invasion pattern. Surgical excision remains the treatment of choice, and follow-up is recommended due to the risk of local recurrence.

Conclusions
This case emphasizes that verrucous carcinoma, although rare in the temporal region and in women, should be included in the differential diagnosis of chronic verrucous or ulcerated facial lesions. Early recognition and excision with free margins are essential to optimize outcomes.

Abstract N°: ID-1235

Topic: Cutaneous oncology

Treatment of stage IIA Mycosis Fungoides with bexarotene and UVA_1: A Case Report

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Introduction

Mycosis fungoides is a rare form of T-cell lymphoma. The therapy we use includes bexarotene, a third-generation retinoid, for example. In some cases, especially when patches and plaques persist, PUVA therapy is added to the treatment. However, PUVA therapy cannot currently be used due to the unavailability of psoralens. In this case, we opted for a combination of bexarotene and UVA_1 therapy (wavelength 340–400 nm).

Materials and Methods

We present the case of a 49-year-old patient who was diagnosed with stage IIA MF. Previous treatment with methotrexate (15–17.5 mg/week) resulted in limited improvement and caused side effects, including abdominal pain. Since January 2025, the patient has been receiving bexarotene at a dose of five to seven capsules per day, depending on laboratory results (mainly triglyceride levels). Despite improvement in mSWAT, minor patches and plaques persisted despite local steroid therapy (preUVA_1 – mSWAT – 21%). The patient was therefore started on UVA1 radiation therapy. Twenty-five irradiations were performed with a gradual increase in dosage up to a maximum of 60 J/cm^2 (postUVA_1 – mSWAT- 2%).

Results

After the UVA_1 series was completed, local improvement was observed, with the patches and plaques resolving and the mSWAT score decreasing. Only post-inflammatory hyperpigmentation remained.

Conclusions

Combining bexarotene with UVA_1 therapy could be an effective treatment option for patients with MF who continue to have plaques despite a partial response to systemic treatment, particularly when PUVA therapy is not available. Although the combination of bexarotene and PUVA has been reported, there are currently no published studies on the use of bexarotene with UVA_1. The combination of bexarotene and UVA_1 therapy has been documented for the first time in this study. Further observation and consensus on the indications, dosage regimens and safety of such treatment are required.

Abstract N°: ID-1249

Topic: Cutaneous oncology

Line-field confocal optical coherence tomography (LC-OCT) monitoring of cryosurgery in non-melanoma skin cancer: a retrospective study

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Introduction
Line-field confocal optical coherence tomography (LC-OCT) is a non-invasive imaging technique providing real-time, high-resolution, *in vivo* visualization of skin architecture and has shown promising results in the diagnosis of non-melanoma skin cancer (NMSC). While cryosurgery is commonly used for superficial and nodular basal cell carcinoma (BCC) and for actinic keratosis/Bowen's disease [collectively referred to as in situ squamous cell carcinoma (isSCC)], data on LC-OCT monitoring of cryosurgical treatment outcomes remain scarce.The aim of this study was to evaluate the role of LC-OCT in the follow-up of NMSC treated with cryosurgery.

Materials and Methods
We retrospectively evaluated NMSC lesions (superficial BCC [sBCC], nodular BCC [nBCC], and isSCC) that underwent LC-OCT examination followed by cryosurgery in our department between June 2022 and September 2025. LC-OCT imaging was performed immediately before cryosurgery, at 30 minutes post-treatment, and at 3-month follow-up.

Results
A total of 155 lesions were included: 96 (61.9%) sBCC, 16 (10.3%) nBCC, and 43 (27.7%) isSCC. LC-OCT images/videos were available at baseline in all lesions; follow-up imaging was available in 94 (60.6%) lesions at 30 minutes and in 96 (61.9%) lesions at 3 months; 66 lesions (42.5%) underwent LC-OCT at both follow-up time points.

Among the 96 lesions evaluated at 3 months, absence of residual tumoural features on LC-OCT was observed in 80 (83.3%) lesions, while 16 (16.7%) showed persistent LC-OCT features suggestive of residual disease. LC-OCT-based clearance rates were 93.3% for sBCC, 76.9% for nBCC, and 60.9% for isSCC.

Among the 66 lesions assessed at both time points [47 (71.2%) sBCC, 9 (13.6%) nBCC, 10 (15.2%) isSCC], the presence and severity of immediate LC-OCT features (*i.e.* dermal oedema, altered dermal–epidermal junction, and disruption of tumour architecture) were associated with cryosurgery outcome at 3 months.

Conclusions
LC-OCT appears to be a promising non-invasive imaging tool for monitoring cryosurgical treatment of NMSC. Early post-treatment LC-OCT features may help anticipate imaging-based treatment response. Prospective studies incorporating clinical and histopathological correlation and longer follow-up are warranted.

Abstract N°: ID-1268

Topic: Cutaneous oncology

Second Cutaneous Neoplasms in Patients with a Personal History of Melanoma: A Single-Center Retrospective Observational Study

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Introduction

Introduction
Patients with cutaneous melanoma have an increased risk of developing second primary cutaneous neoplasms, including both non-melanoma skin cancer (NMSC) and new melanomas. However, few studies have investigated whether this risk varies according to the histological subtype of the primary melanoma.

Materials and Methods

Objective
To evaluate differences in the development of additional cutaneous neoplasms according to the histological subtype of melanoma.

Materials and Methods
A retrospective observational study was conducted in a cohort of 402 patients diagnosed with cutaneous melanoma at Miguel Servet University Hospital (Zaragoza, Spain). Demographic, clinical, and histological variables were collected, and the presence of other cutaneous neoplasms was assessed, including basal cell carcinoma, squamous cell carcinoma, second primary cutaneous melanomas, and Merkel cell carcinoma. Statistical significance was established at $p < 0.05$.

Results

A total of 402 patients were included, of whom 231 (57.5%) were women. The mean age at diagnosis was 59.7 years (SD 17.2). Age at diagnosis differed between sexes, with women being diagnosed at a younger age than men ($p = 0.037$). Men more frequently presented melanomas on the head and neck, whereas women more commonly had melanomas on the lower extremities ($p = 0.002$). The most frequent histological subtype was superficial spreading melanoma (62.9%), followed by lentigo maligna melanoma (17.2%), nodular melanoma (8.7%), and acral lentiginous melanoma (5.0%). Second primary cutaneous neoplasms were highly prevalent in this series: 104 patients developed basal cell carcinoma (25.9%), 29 squamous cell carcinoma (7.2%), and 25 developed second primary melanomas (6.2%). Basal cell carcinoma was the most frequent secondary cutaneous neoplasm across all histological subtypes, except in nodular melanoma, in which squamous cell carcinoma was more common. Lentigo maligna melanoma, superficial spreading melanoma, and nodular melanoma showed a significant association with squamous cell carcinoma ($p = 0.003$).

Conclusions

Our study shows that patients diagnosed with melanoma have a high incidence of secondary cutaneous neoplasms. These findings highlight the importance of close and long-term follow-up, especially in patients with additional risk

factors.

Abstract N°: ID-1269

Topic: Cutaneous oncology

A rare location of the most common skin cancer: basal cell carcinoma of the nipple–areola complex – case report

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Introduction
Basal cell carcinoma (BCC) is the most common skin cancer worldwide and occurs predominantly in sun-exposed areas. Most lesions are located on the face, followed by the trunk, lower and upper extremities, neck, and scalp. Fewer than one hundred cases of BCC arising in the nipple–areola complex (NAC) have been reported in the literature. This location is more common in men, mainly in Caucasians, and the most frequent histological subtype is the nodular type. Some reports suggest a higher risk of metastasis due to the anatomy of this region, including a rich network of blood and lymphatic vessels associated with the lactiferous ducts. Moreover, the literature describes a dermoscopic feature observed in NAC BCC — the “large black web,” in which the pigment network appears thicker than the typical areolar pigment network.

Materials and Methods
Presentation of the clinical and dermoscopic features of a case of basal cell carcinoma in a rare location — the nipple–areola complex.

Results
A 56-year-old female patient with a medical history of alopecia areata presented to the Department of Dermatology, Venereology and Allergology due to a pigmented nodule on the right nipple. The lesion had been present for many years. Dermoscopic examination revealed: arborizing vessels, small erosions, gray, blue, brown dots/globules, as well as gray and brown structureless areas. A biopsy was performed. Based on the histopathological examination, nodular basal cell carcinoma was diagnosed. The patient was treated with surgical excision of the lesion.

Conclusions
The nipple–areola complex is an extremely rare site for basal cell carcinoma, likely due to the relative absence of pilosebaceous units and limited sun exposure. A unilateral lesion in this area should be considered in the differential diagnosis of malignancy, including melanoma, Paget disease, Bowen disease, and basal cell carcinoma.

Abstract N°: ID-1275

Topic: Cutaneous oncology

Oncogenic HPV realated squamous cell carcinoma *in situ* of the eyelid.

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Introduction

A 74-year-old Caucasian (white) woman presented with an extensive scaling plaque on the left upper eyelied, extenidng from the eyelash margin on the mid eyelid to the lateral canthus and also spreading onto the lateral left lower eyelid, at the eyelash line. She repoted having a lesion at this site for more than 10 years, previously treated with cryotherapy.

Materials and Methods

The patient underwent two skin biopsies and her previous biopsies from 2016 and 2013 were reviewed. She was seen jointly in the dermatology and oculoplastic service where the biopsy sites were agreed to determine the highest yield.

Results

The previous biopsy in 2016 demonstrated a cutaneous horn, arsing from actinic keratosis, reportedly completely excised. However, an earlier biopsy in 2013 had shown papillomatous changes with hypergranulosis, consitent with a viral wart. In 2024, the large plaque on the left upper eyelid was biopsied in two areas, one showing features of a viral wart and the other showing features of an evolving acintic keratosis and Bowen's disease. No invasive malignancy was seen. HPV type 18 was identifed. Therefore, the two biopsies from 2024 demostrated a combination of the findings seen in the earlier histology. An area on the contralateral zygomatic cheek was also biopsied, demonstrating actinic keratosis, but without the viral features. All areas were treated with imiquimod 5% cream for 8 weeks. The left upper eyelid, lateral canthus and left lower eyelid cleared completely with topcial therapy, which was well tolerated without eye irriation. This remission was sustained on review 6 months later. Interestingly, the area on the contralateral cheek, which did not have viral features, only had a partial response to topcial therapy, suggesting that the role of HPV in the pathogenesis may explain the good response to imiquimod.

Conclusions

This is a rare example of an oncogenic HPV leading to verrucous, in situ carcinoma in an extragenital location. The upper eyelid would be a highly unusual location for such an HPV infection. Typically, cutaneous in situ carcinoma is the result of sun exposure, but other carcinogens can less commonly lead to skin cancer. In this case, imiquimod appeared to be the ideal treatment option, licenced for both HPV treatmenn and the treatment of actinic keratosis. The treatment was highly successful and led to a sustained resoluitiion, which she had not experienced in more than 10 years.

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Abstract N°: ID-1279

Topic: Cutaneous oncology

Mycosis fungoides, lichenoid variant: a rare variant and a clinico-pathological diagnostic challenge

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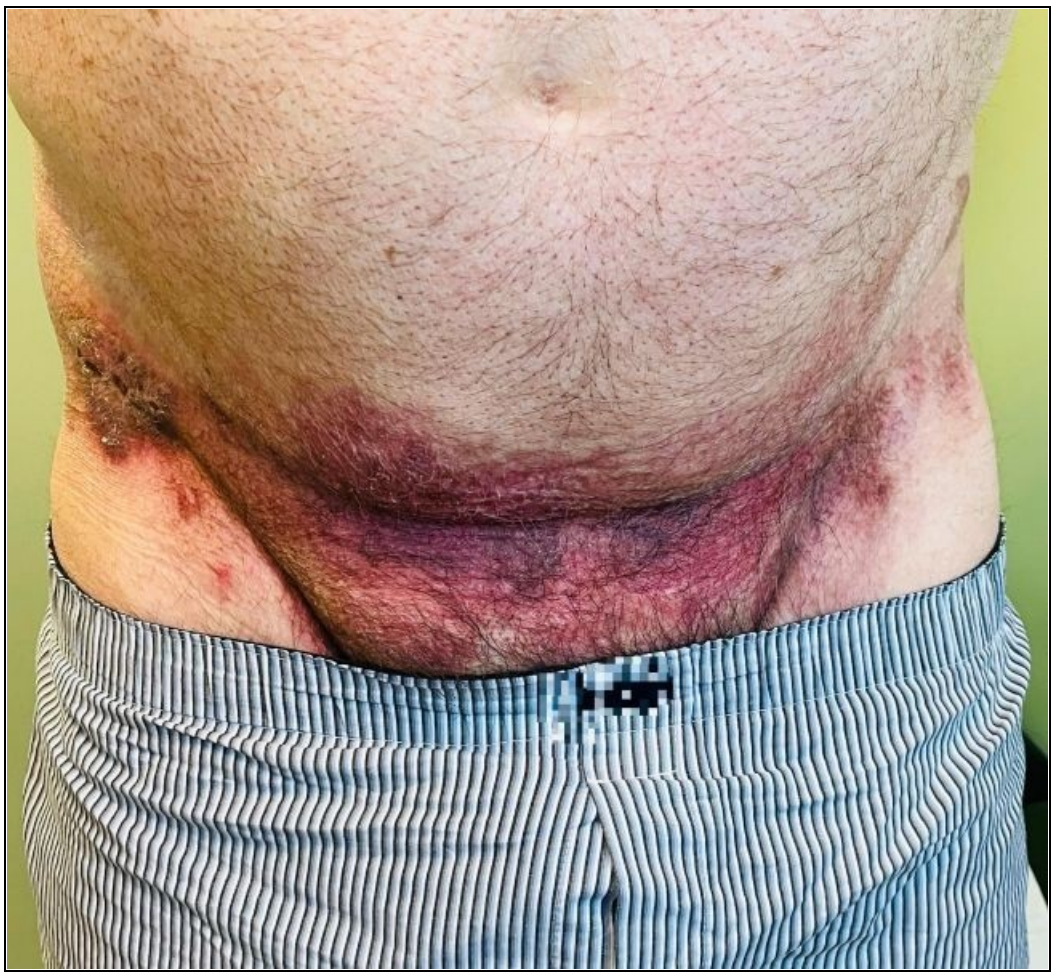
Introduction

Mycosis fungoides (MF) is the most common cutaneous T-cell lymphoma and, as a “great imitator,” may present with multiple clinical variants and histopathological patterns.

Materials and Methods

We report the case of a 70-year-old asymptomatic male patient, referred for evaluation of a dermatosis with decades of evolution and slow progression. On current assessment, the patient presented with a dermatosis consisting of shiny erythematous-violaceous patches and plaques involving both axillae, bilateral inguinal regions, and the sacral area. In the right inguinal region, a larger infiltrated violaceous plaque with focal superficial erosions was noted, clinically suggestive of hypertrophic lichen planus.



Clinical presentation of lichenoid mycosis fungoides

Results

Skin biopsies were performed from the right inguinal lesion and from a thin plaque at another anatomically distinct site, for histological examination, immunophenotyping, and clonality studies. Histopathology revealed a predominantly lichenoid inflammatory infiltrate, more pronounced in the lesion with a tumoral component. Immunohistochemistry was positive for CD3 and pan-T-cell markers, with a predominance of CD4-positive over CD8-positive T lymphocytes; CD20 and CD30 were negative. Immunophenotyping performed on the skin specimen did not identify aberrant findings. Although the histological pattern was not initially strongly suggestive of MF, clinico-pathological correlation supported the diagnosis of lichenoid variant mycosis fungoides.

Conclusions

The lichenoid variant of MF is characterized by a band-like infiltrate at the dermoepidermal junction, resembling lichen planus, and represents a relevant diagnostic challenge. Only a limited number of cases have been described in the literature, restricted to a single series of 12 cases and isolated case reports, and in some instances multiple biopsies and several years of disease evolution are required to establish a definitive diagnosis. This case highlights the diagnostic complexity of MF, whose histopathological features may mimic benign dermatoses, underscoring the importance of clinico-pathological integration.

Abstract N°: ID-1281

Topic: Cutaneous oncology

When Tumors Meet: A Rare Simultaneous Association of Mycosis Fungoides, Basal Cell Carcinoma, and Squamous Cell Carcinoma.

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Introduction

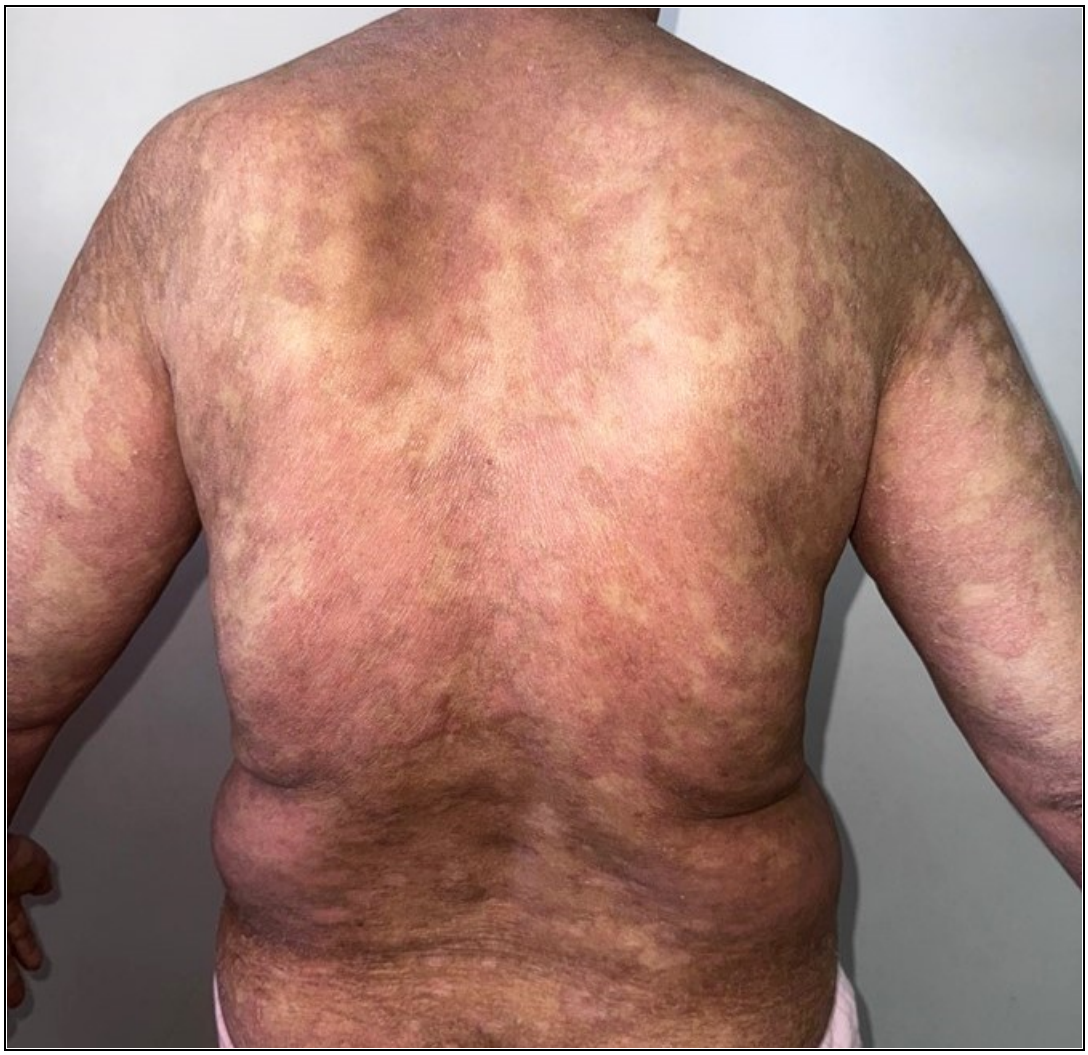
Mycosis fungoides (MF) is the most common primary cutaneous T-cell lymphoma, characterized by chronic skin lesions. Basal cell carcinoma (BCC) and squamous cell carcinoma (SCC), associated with ultraviolet exposure, are the most frequent non-melanoma skin cancers. Although MF is occasionally associated with secondary malignancies, the simultaneous occurrence of MF, BCC, and SCC remains rare. This case raises the question of shared pathogenic mechanisms and highlights the importance of long-term dermatological surveillance.

Materials and Methods

A 61-year-old woman with no significant past medical history presented with generalized erythroderma evolving over a 16-year period. Clinical examination revealed finely scaly erythematous plaques, confluent over the trunk and limbs, with sparing of the face and neck. In addition, an ulcerated nodular lesion on the dorsum of the left hand (1-year duration) and a pearly lesion in the right supralabial region (present for 5 years) were noted. No palpable lymphadenopathy was detected.

Four skin biopsies were performed: two from erythrodermic lesions (abdomen and right leg), and two excisional biopsies of the nodular and supralabial lesions. Histopathological examination of the erythrodermic biopsies demonstrated features consistent with mycosis fungoides. Immunophenotypic analysis ($CD3^+$, $CD4^+$, $CD5^+$, $CD8^-$, $CD20^-$) confirmed the diagnosis. Histological examination of the hand lesion revealed a follicular-type basal cell carcinoma with clear surgical margins. The supralabial lesion corresponded to a well-differentiated squamous cell carcinoma, also completely excised.

Staging investigations identified axillary lymph node involvement. Treatment consisting of a compounded topical corticosteroid preparation combined with subcutaneous methotrexate at a dose of 15 mg/week was initiated. The erythroderma showed a favorable clinical response under this therapeutic regimen.



Results

The coexistence of distinct cutaneous neoplasms is uncommon but has been described in the context of chronic dermatoses or immune dysregulation. Mycosis fungoides is associated with an increased risk of secondary malignancies, particularly cutaneous cancers. However, the simultaneous association of MF, BCC, and SCC is exceptional.

Proposed pathogenic mechanisms include chronic cutaneous inflammation, local immune dysregulation, immunosuppressive therapies (absent in the present case), as well as shared risk factors such as cumulative ultraviolet exposure, advanced age, and genetic susceptibility.

In this case, the long-standing history of MF, the absence of systemic immunosuppression, and the distinct anatomical locations of the carcinomas support the hypothesis of three independent primary tumors. This case underscores the necessity for enhanced cutaneous screening in patients with mycosis fungoides.

Conclusions

This exceptional case of simultaneous mycosis fungoides, basal cell carcinoma, and squamous cell carcinoma in an untreated patient highlights the potential role of MF-associated immune dysregulation in the development of secondary cutaneous malignancies. It emphasizes the importance of regular long-term dermatological follow-up in these patients, even in the absence of systemic therapy, and underscores the need for further studies to elucidate the underlying shared mechanisms.

Abstract N°: ID-1283

Topic: Cutaneous oncology

A 4-Point Checklist for Skin Cancer Screening in Primary Care

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Introduction

Skin cancer is the most diagnosed malignancy in Ireland, with rising melanoma incidence and substantial morbidity and healthcare costs from non-melanoma skin cancers (NMSC). Existing public campaigns and tools such as ABCDE and the MacKie weighed 7-point checklist focus mainly on pigmented melanoma and have limited validation.

We set out to prospectively evaluate the diagnostic performance of a new simple skin cancer screening tool called the “Buckley 4-point checklist” giving a score of one for each of the following items identified by the patient in the presenting skin lesion: **N**ew, **C**hanging, **D**ifferent, **S**ore (Table 1). Each lesion was then given a score of a minimum of 0 up to a maximum of 4. The score was used to help the patient and GP detect all suspicious skin lesions including all skin cancers (melanomas, amelanotic melanomas and NMSCs) and precancers and to explore its potential to reduce unnecessary biopsy and referral.

These are the warning signs that a mark on the skin (a growth, a sore or a mole) that is present or changing for more than six weeks be turning cancerous in adults (>18 years old): -

''**N**ew **C**ancers **D**o **S**how''

- **N**ew - A **n**ew growth, sore, or mole that is present for more than 6 weeks.
- **C**hanging - A growth, sore or mole that is **c**hanging in size, shape, or color over the past 6 weeks to 1 year.
- **D**ifferent - A growth, sore or mole that looks, feels, or behaves **d**ifferently from any other growth, sore or mole on the body (the ''ugly duckling'').
- **S**ore - A growth, sore or mole that is **s**ore, tender to touch, has specks of blood, is itchy or will not heal after 6-12 weeks.

Table 1. The Buckley 4-point checklist

Table 1. The 4 point check list for detection of skin cancer, pre-cancer and suspicious skin lesions

Materials and Methods

This is a prospective diagnostic validation study of patient-selected skin lesions in a specialist-led primary care dermatology clinic in Ireland. Adults aged ≥18 years nominated up to three concerning skin lesions that had been present for more than six weeks, completed the four-point checklist questionnaire, and underwent a clinical and dermoscopic examination by a primary care physician with extra training in lesion recognition and dermoscopy. Histology was the reference standard where biopsy was performed (Table 2); non-biopsied lesions were classified by clinical and dermoscopic assessment, with adjustment for verification bias using inverse probability weighting and

logistic regression. Sensitivity, specificity, predictive values and odds ratios were calculated for the different 4-point checklist thresholds.

Table 2: Categorisation of 190 Cutaneous Lesions According to Clinical, Dermoscopic, and Histopathological Diagnosis

Malignant and pre-malignant lesions that were biopsied		Benign lesions that were biopsied		Lesions diagnosed clinically and with dermoscopy only	
Squamous Cell Carcinoma (SCC)	6	Dermatofibroma	1	Actinic keratosis	31
Basal Cell Carcinoma (BCC)	14	Seborrhoeic Keratosis	10	Seborrhoeic Keratosis	38
Melanoma	2	Intradermal nevus	4	Stable mole	19
Merkel Cell tumour	1	Neurofibroma	1	Intradermal nevus	10
Lentigo Maligna	2	Sebaceous Cyst	2	Solar lentigo	6
Bowens disease	7	Lichenoid Keratosis	1	Dermatofibroma	4
Melanoma in situ	1	Chondrodermatitis Nodularis Helicis	1	Fibroepithelial polyp	2
Actinic keratosis	3	Atypical Melanocytic hyperplasia	1	Sebaceous gland hyperplasia	3
Total	**36**	pilomatrixoma	1	Halo naevus	2
		Haemangioma	1	Cherry angioma	2
		Warts	2	Sebaceous Cyst	2
		Benign mole	1	Spider Naevus	1
		Inflammatory features	1	Open Comedone	1
		Pyogenic granuloma	1	Linear epidermal naevus	1
		Total	**28**	Psoriasis	1
				Keratoacanthoma*	1
				Skin tag	2
				Total	**126**

* One keratoacanthoma was diagnosed clinically and dermoscopy but resolved spontaneously before a biopsy could be organized.

Table 2: Categorisation of 190 Cutaneous Lesions According to Clinical, Dermoscopic, and Histopathological Diagnosis

Results

A total of 199 lesions from 149 patients were recruited, of which 190 lesions from 141 patients met inclusion criteria.

Disease prevalence for malignant, suspicious, or premalignant lesions was 44.2% unadjusted and 26.4% after adjustment for verification bias. For unadjusted data, a score ≥1 yielded sensitivity 97.6%, while ≥3 gave specificity 84.9%. A cutoff of ≥2 showed the optimal balance, with sensitivity of 77.4%, specificity of 52.8%, PPV of 56.5%, and NPV of 74.7% (Table 3). Increasing scores were associated with progressively higher odds of malignant/pre-malignant/suspicious lesions, with adjusted odds ratios up to 9.6 for a score of 4 versus 0. There was excellent discrimination, with an area under the curve (AUC) of 0.863. 95% CI:0.810-0.915, SE = 0.027) when including confounding variables.

Table 3: Diagnostic Accuracy of Cumulative Scores from the Buckley 4-Point Checklist for Malignant/Suspicious/Premalignant Lesions Outcomes.

Malignant invasive/suspicious/premalignant lesions[d]										
Buckley 4 PCL[G] Total Lesions	Sensitivity		Specificity		Test of Assoc[a]	Effect Size[b]	PPV[c]		NPV[c]	
	Unadj	Adjus[e]	Unadj	Adjus[e]	Adjusted	Adjusted	Unadj	Adjus[e]	Unadj	Adjus[e]
≥1[f]	97.6% (82/84)	90.1% 95% CI [85.6-93.6]	14.2% (15/106)	25.1% 95% CI [21.8-28.6]	<.001	.165 ***Modest***	47.4% (82/173)	30.3% 95% CI [29.0-31.6]	88.2% (15/17)	87.6% 95% CI [82.4-91.4]
≥2[f]	77.4% (65/84)	61.4% 95% CI [54.8-67.7]	52.8% (56/106)	71.4% 95% CI [67.7-74.8]	<.001	.299 ***Moderate***	56.5% (65/115)	43.6% 95% CI [39.7-47.5]	74.7% (56/75)	83.7% 95% CI [81.2-85.9]
≥3[f]	48.8% (41/84)	31.9% 95% CI [26.0-38.3]	84.9% (90/106)	93.0% 95% CI [90.8-94.9]	<.001	.321 ***Moderate***	71.9% (41/57)	62.2% 95% CI [54.0-69.8]	67.7% (90/133)	79.2% 95% CI [77.7-80.6]

[a] P-values are from the χ^2 test of association between an item test result and disease status adjusted for verification bias

[b] Effect Size is measured using the Phi coefficient (φ)

[c] PPV (Positive Predictive Value) and NPV (Negative Predictive Value).

[d] Disease prevalence = 26.5% [95% CI 23.6% to 29.6%) - Adjusted for ***Verification Bias***

[e] Adjusted for ***Verification Bias***

[f] Cutoff ≥1 [+LR = 1.20 & -LR = 0.39] – Cutoff ≥2 [+LR = 2.14 & -LR = 0.54] – Cutoff ≥3 [+LR = 4.58 & -LR = 0.73] - Adjusted for ***VB***

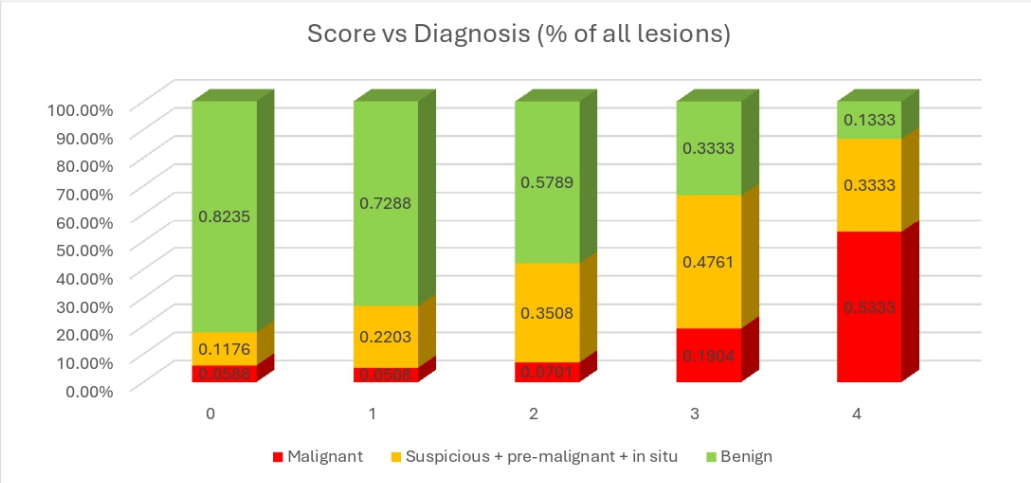
[G] 4 PCL = 4 Point Checklist

Table 3: Diagnostic Accuracy of Cumulative Scores from the Buckley 4-Point Checklist for Malignant/Suspicious/Premalignant Lesions Outcomes.

Conclusions

The Buckley 4-point checklist demonstrates promising diagnostic performance for helping patients and GPs identify suspicious skin lesions including malignant and premalignant skin lesions in a primary care, particularly at a threshold of ≥2 with high sensitivity and specificity. Used alongside targeted GP education, dermoscopy when available, tele-dermatology and possibly AI, the 4-point checklist could support earlier detection of skin cancer while helping to rationalise biopsy and referral decisions in resource-constrained services (Table 4).

TABLE 4 – Diagnostic proportions across test scores (N=190 lesions)*



*Raw distribution shown. Adjusted logistic regression (verification bias-corrected) showed monotonically increasing odds of malignant/suspicious + pre-malignant + in situ outcome: OR = 0.95 (score 1 vs 0), 2.60 (2 vs 0), 8.66 (3 vs 0), 9.56 (4 vs 0)

TABLE 4 – Diagnostic proportions across test scores (N=190 lesions) *

Abstract N°: ID-1294

Topic: Cutaneous oncology

Differential survival association of adjuvant immunotherapy in resected stage III acral lentiginous versus non-acral cutaneous melanoma

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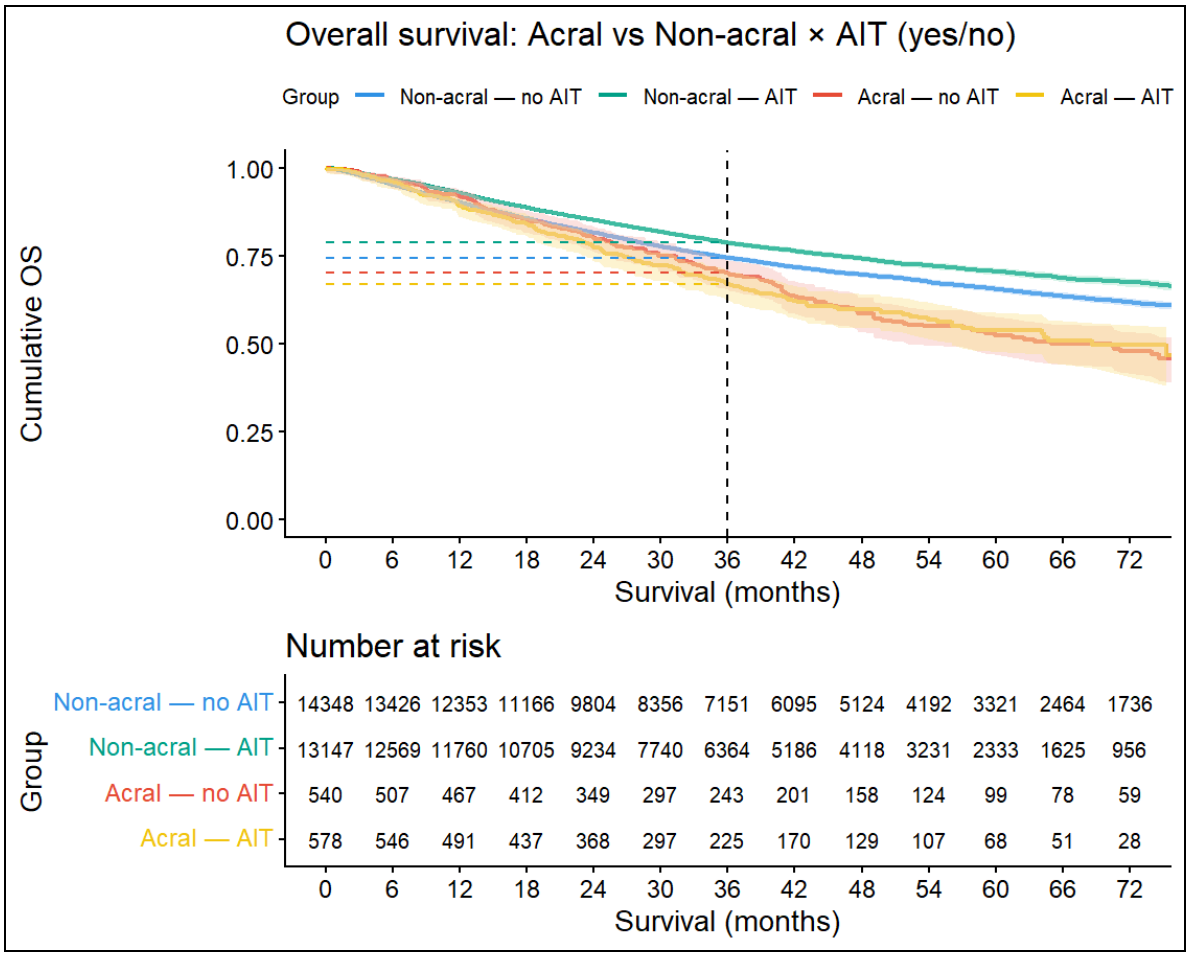
Introduction
Acral lentiginous melanoma (ALM) is a rare and biologically distinct melanoma subtype that has been associated with less favorable survival outcomes compared with non-acral cutaneous melanoma (CM). Since 2017, immune checkpoint inhibitors (ICIs) have been approved by the United States Food and Drug Administration for adjuvant treatment of resected stage III melanoma; however, emerging evidence suggests that the benefit from these therapies may be attenuated in ALM, with studies showing mixed effects in both recurrence-free survival and overall survival.

Materials and Methods
We conducted a retrospective cohort study of adults with resected stage III cutaneous melanoma diagnosed between 2017 and 2022 using data from the United States National Cancer Database (NCDB), a nationwide hospital-based cancer registry. Melanoma subtype was classified as acral lentiginous or non-acral cutaneous based on histology codes. To mitigate immortal time bias, a landmark analysis at 84 days after definitive surgery was performed. Overall survival was defined from the landmark to death from any cause or last follow-up and administratively censored at 36 months. Multivariable Cox proportional hazards models were used to evaluate the association between adjuvant immunotherapy and overall survival, adjusting for demographic, clinicopathologic, and treatment-related covariates. Effect modification by melanoma subtype was assessed using a multiplicative interaction term, with additional substage-specific analyses.

Results

Among 28,613 patients with resected stage III melanoma, 1,118 (3.9%) had acral lentiginous melanoma and 27,495 (96.1%) had non-acral cutaneous melanoma. In Kaplan–Meier analyses, receipt of adjuvant immunotherapy was associated with improved overall survival among patients with non-acral cutaneous melanoma, whereas no statistically significant association was observed in acral lentiginous melanoma. In multivariable analyses, adjuvant immunotherapy remained independently associated with improved overall survival in non-acral cutaneous melanoma (adjusted hazard ratio [aHR] 0.81; 95% confidence interval [CI] 0.77–0.85). In contrast, no significant association between adjuvant immunotherapy and overall survival was observed in acral lentiginous melanoma (aHR 1.12; 95% CI 0.81–1.14). A statistically significant interaction was identified between melanoma subtype and adjuvant immunotherapy use (p for interaction = 0.005). In exploratory substage-specific analyses, the association between adjuvant immunotherapy and overall survival appeared more pronounced in patients with stage IIIB–IIID non-acral cutaneous melanoma, whereas no consistent or statistically significant association was observed across substages in acral lentiginous melanoma.



Kaplan-Meier overall survival curves for resected stage III melanoma, stratified by melanoma subtype (acral lentiginous vs non-acral cutaneous melanoma) and receipt of adjuvant immunotherapy. Overall survival was calculated from the 84-day post-surgery landmark

Conclusions

In this large national cohort, adjuvant immunotherapy was associated with improved overall survival among patients with resected stage III non-acral cutaneous melanoma, whereas no statistically significant association was observed in acral lentiginous melanoma. These findings indicate potential heterogeneity in survival associations by melanoma subtype and underscore the need for further investigation to optimize risk stratification and treatment strategies for patients with acral lentiginous melanoma.

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Abstract N°: ID-1313

Topic: Cutaneous oncology

Giant basal cell carcinoma mimicking cicatricial alopecia in a 93-year-old woman: A diagnostic and therapeutic challenge

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Introduction

A 93-year-old woman was referred for the evaluation of crusted lesions on her scalp. She reported earlier loss of density in the area, attributed to aging. She suffered from high blood pressure and essential thrombocytosis, without previous radiation therapy or surgery on her scalp.

Materials and Methods

Examination revealed a large well-defined patch of alopecia in the parietal area, with superficial crusted ulcerations and telangiectasias. Dermoscopy showed loss of follicular openings, branching vessels and white structureless zones. Differential diagnosis included basal cell carcinoma (BCC), erosive pustular dermatosis of the scalp and discoid lupus erythematosus.

Results

Two 4-mm skin biopsies confirmed the diagnosis of morphoeic BCC. Given the patient's good overall condition, together with the pain and recurrent superinfections secondary to the skin erosions, treatment sonidegib was initiated. After 4 weeks of treatment the drug has been well tolerated and although the BCC remains with the same extension, the erosions have healed, and the patient is now asymptomatic.

Conclusions

Scarring alopecia requires proper evaluation, even in elderly patients, as it may be due to secondary causes, including malignancies, or primary inflammatory diseases. Morphoeic BCC is an uncommon high risk histological BCC subtype, which requires high index of clinical suspicion to prevent late diagnosis.

Sonidegib has demonstrated good safety and efficacy in locally advanced BCC. However, experience with very elderly patients is scarcer. A recent study suggested that even in >85-year-old patients, sonidegib was well tolerated, with even milder adverse effects than in younger patients.

Sonidegib can be a treatment option in very elderly patients with irresectable BCC, especially in patients with symptomatic lesions, which may improve after just a few weeks of treatment.

Abstract N°: ID-1324

Topic: Cutaneous oncology

Assessing the Concordance of Clinical and Pathological Diagnoses in Basal Cell Carcinoma Among the Iranian Population: A Cross-Sectional Analysis of 229 Cases

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Introduction
Basal cell carcinoma (BCC) is the most common nonmelanoma skin cancer, particularly affecting sun-exposed skin areas in older adults. Accurate diagnosis is critical to ensuring appropriate treatment and preventing complications. This study evaluates the concordance between clinical and pathological diagnoses of BCC in the Iranian population, focusing on gender, age, lesion location, and diagnostic accuracy.

Materials and Methods
This cross-sectional study reviewed clinical and pathological records of 229 patients diagnosed with BCC between 2020 and 2024. The patients' demographic data, lesion locations, and the clinical and pathological diagnoses were analyzed. The diagnostic agreement between the clinical diagnoses made by healthcare providers and the final pathological findings was assessed using descriptive statistics and the chi-square test.

Results
The study found a high concordance between clinical and pathological diagnoses of BCC, with 94.6% of clinically diagnosed cases matching the pathological results. Among the 229 patients, the majority (84.3%) were male, with a mean age of 67.72 years. The scalp, face, and nose were the most common lesion locations. The clinical diagnosis was missing for 42% of cases, particularly those referred by nondermatologists, highlighting the importance of improved education for non-specialists. The study also found no significant differences in diagnostic accuracy among various BCC subtypes.

Conclusions
There is a high level of agreement between clinical and pathological diagnoses of BCC. However, a significant number of cases lacked prior clinical suspicion, particularly in nondermatology referrals. The study emphasizes the need for improved training in early BCC detection for non-specialist healthcare providers. Dermatologists play a crucial role in accurate diagnosis and treatment, and collaboration is key to improving patient outcomes.

Abstract N°: ID-1337

Topic: Cutaneous oncology

Efficacy and safety of PD-1/PD-L1 blockade in patients with Merkel cell carcinoma

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Introduction
Merkel cell carcinoma (MCC) is a rare and aggressive neuroendocrine tumor arising from the basal layer of the epidermis. Due to its aggressiveness and resemblance to benign lesions, diagnosis often occurs at an advanced stage, with metastases. Treatment has traditionally involved lymphadenectomy and/or adjuvant radiotherapy and, more recently, immunotherapy with anti–PD-1/PD-L1 antibodies. This newer therapeutic approach has emerged as a promising strategy, demonstrating improved progression-free and overall survival. To analyze the efficacy and safety of PD-1/PD-L1 blockade in the treatment of MCC.

Materials and Methods
This is a systematic review in the PubMed database following the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines. The descriptors were used: “Merkel Cell Carcinoma”, “PD-L1 Inhibitors”, “PD-1 Inhibitors”, “Immune Checkpoint Inhibitors” and their variations, combined by OR and AND. Clinical and observational studies were included, which addressed patients with advanced MCC treated with immunotherapy and presented data on responses, survival and adverse events. After screening by two reviewers, 13 studies were selected.

Results
The 13 studies encompassed 540 patients with advanced or metastatic MCC, including elderly, immunocompromised, and previous-line refractory patient populations. The therapies used were: Avelumab (62.78%), Pembrolizumab (14.97%), IPI/NIVO (ipilimumab plus nivolumab) (9.26%), Nivolumab (7.22%), IPI/NIVO combined with stereotactic body radiotherapy (4.44%), Atezolizumab with Bevacizumab (4.07%) and Avelumab with subhot IPI/NIVO therapy (4.07%). The analysis showed high antitumor activity of PD-1/PD-L1 inhibitors, with objective response rates between 33% and 64%, alternating depending on the agent used. Progression-free survival ranged from 5.1 to 9 months, while overall survival had a median of 12.6 to 23.5 months in studies with pembrolizumab and avelumab. Most adverse events (AEs) were mild to moderate in degree, but serious reactions occurred in 10–28% of patients, with Ipilimumab + Nivolumab treatment in refractory immune-mediated AEs in 57.1% with 21.4% of patients discontinued early. The most common effects include: fatigue, skin reactions, colitis, pneumonitis, hypothyroidism and proteinuria.

Conclusions
The studies indicate that PD-1/PD-L1 inhibitors demonstrate high efficacy and durable responses and currently represent the main systemic treatment strategy for MCC. With consistent evidence and an acceptable safety profile, including in immunosuppressed patients, these therapies show clinically relevant response rates and generally manageable toxicity. However, further clinical trials are needed to confirm the efficacy and safety of these approaches.

Abstract N°: ID-1339

Topic: Cutaneous oncology

From Inflammation to Carcinogenesis : The Dark Side of Hidradenitis Suppurativa « case report »

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Introduction

Verneuil's disease (hidradenitis suppurativa) is a chronic inflammatory, suppurating, fistulizing and scar-producing disease of apocrine gland-bearing skin. The degeneration of Verneuil disease into squamous cell carcinoma (SCC) is a rare and unusual complication in two respects. It occurs only in the perineal and gluteal regions, and almost exclusively in men.

The aim of this paper is to present a clinical case of degeneration to epidermoid carcinoma in a man and to highlight the clinical features, risk factors, diagnostic difficulties, and management strategies of SCC occurring in the context of hidradenitis suppurativa (HS).

Materials and Methods

This 79-year-old patient, a known chronic smoker with a history of acne in adolescence, presented with an abscessed placard on the buttock that had been evolving for 20 years. Clinical examination revealed a patient in good general health. Cutaneous findings included a slightly pigmented, abscessed placard, fistulated to the skin with pus discharge, occupying the buttock region bilaterally, surmounted by nodular lesions and two budding lesions located on either side of the lower third of the intergluteal sulcus, one measuring 0.5 cm in large diameter and the other 1 cm in large diameter, which had been evolving for over a year. There was an axillary retractile scar, and no inguinal, axillary, perineal or gluteal fold lesions. The rest of the clinical examination was unremarkable. Skin biopsy of the plaque revealed chronic inflammatory remodeling, while biopsy of the vegetative lesions revealed a well-differentiated squamous cell carcinoma with no invasive component. MRI of the soft tissues of the buttocks showed multiple interrelated masses. Bacteriologic and parasitologic studies excluded tuberculosis or deep mycosis. The extension work-up was negative.

The decision of the multidisciplinary consultation was to perform a wide excision of the budding and nodular lesions with a 2 cm margin. The patient underwent surgery and wound healing. The histopathologic result of the margins was negative. The evolution after three months was favorable.

Conclusions

Verneuil's disease is a chronic inflammatory pathology whose degeneration into squamous cell carcinoma is rare but formidable. The disease is more common in women, but the risk of degeneration is almost exclusively observed in men. Although the pathophysiology of the disease and its malignant transformation is not yet understood, several factors have been implicated, including chronic inflammation, diabetes, and smoking. An average delay of about 20 years between the onset of Verneuil's disease and degeneration has been described. The perineo-gluteal region is most commonly affected. The diagnosis should be suspected in cases of non-healing vegetative, verrucous, recurrent or atypical lesions. Histology usually reveals well-differentiated squamous cell carcinoma. An extended workup should be performed to check for locoregional and lymph node involvement. Treatment consists of wide surgical excision with

minimum margins of 2 cm. The risk of mortality is very high, estimated at 50% of cases within two years of surgery.

Abstract N°: ID-1357

Topic: Cutaneous oncology

Clinicopathologic Features and Pre-diagnostic Spectrum of Nail Unit Squamous Cell Carcinoma: A 10-Patient Case Series

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Introduction

Nail unit squamous cell carcinoma (nSCC), including nSCC in situ (Bowen disease), is the most common malignant tumor of the nail unit and presents with a broad and often misleading clinical spectrum. Because these lesions frequently mimic infections or benign subungual solitary and pigmentary conditions, diagnosis is commonly delayed for years (1–4). Early recognition requires a high index of suspicion, awareness of warning clinical features, and timely nail unit biopsy using an appropriate technique followed by careful dermatopathological evaluation. The aim of this study was to evaluate the clinical and epidemiological characteristics of patients with subungual squamous cell carcinoma, focusing on clinical presentation, diagnostic challenges, diagnostic work-up, and treatment outcomes.

Materials and Methods

A retrospective evaluation was conducted on 10 patients with histopathologically confirmed nSCC or nSCC in situ diagnosed between 2022 and 2025. Epidemiologic characteristics and risk factors, clinical features, clinical pre-diagnoses, final dermatopathological diagnosis (in situ or invasive), HPV status (when molecular testing was available), and planned treatment modalities were analyzed.

Results

A total of 10 patients were included (6 males, 4 females), with a mean age of 59.5 ± 14.7 years (24–79 years). Lesions were located on the hand in 60% (6/10) and on the foot in 40% (4/10), with predominant involvement of the first digit/thumb in 70% (7/10). The most common presenting findings were subungual hyperkeratosis (50%, 5/10) and discharge (50%, 5/10), followed by ulceration (30%, 3/10), nail color changes (30%, 3/10), nail dystrophy (30%, 3/10), and subungual mass formation (30%, 3/10) (Table 1). Verrucous lesions were observed in 20% (2/10). A history of trauma was present in one patient. The mean interval between lesion onset and definitive diagnosis was 30.5 months (4–96 months). Six patients had previously received treatment for presumed onychomycosis, and three had undergone prior nail avulsion. Histopathologically, 20% of cases were classified as nSCC in situ and 80% as invasive nSCC. High-risk HPV was detected in 33.3% (2/6) of tested patients. Therapeutic wide local excision was performed in 60%, while bone invasion–associated amputation was performed in 30%.

Table 1: Clinicopathologic Characteristics, Clinical Pre-diagnoses, and HPV Status of Patients with Nail Unit Squamous Cell Carcinoma

Case	Age (years)	Sex	Clinical Pre-diagnoses	Clinical Characteristics	Final Histopathological Diagnosis	Degree of Differentiation	HPV Status
1	60	M	Squamous cell carcinoma	Periungual mass	Invasive squamous cell carcinoma	Poorly differentiated	Not assessed
2	69	F	Squamous cell carcinoma, Bowen disease, verruca	Onycholysis, subungual hyperkeratosis, subungual mass, verrucous lesion	Squamous cell carcinoma *in situ*(Bowen disease)	-	High- and low-risk HPV positive
3	63	M	Amelanotic melanoma, pyogenic granuloma	Nail discharge and nail dystrophy	Invasive squamous cell carcinoma	Moderately differentiated	Not assessed
4	70	M	Squamous cell carcinoma	Nail dystrophy, nail color change, nail discharge, ulceration	Invasive squamous cell carcinoma	Not specified	Not assessed
5	24	M	Squamous cell carcinoma, verruca	Verrucous lesion, subungual hyperkeratosis	Invasive squamous cell carcinoma (verrucous morphology)	Well differentiated	High-risk HPV positive
6	51	F	Bowen disease, squamous cell carcinoma	Ulceration, nail discharge	Squamous cell carcinoma *in situ*(Bowen disease)	-	High- and low-risk HPV negative
7	61	F	Glomus tumor, amelanotic melanoma, squamous cell carcinoma	Subungual mass, nail color change, subungual hyperkeratosis	Invasive squamous cell carcinoma	Poorly differentiated	High- and low-risk HPV negative
8	58	F	Onychomatricoma, squamous cell carcinoma, Bowen disease	Subungual hyperkeratosis, nail color change, nail discharge	Invasive squamous cell carcinoma	Moderately differentiated	High- and low-risk HPV negative
9	79	M	Glomus tumor	Onycholysis, ulceration	Invasive squamous cell carcinoma	Moderately differentiated	Not assessed
10	58	M	Amelanotic melanoma, squamous cell carcinoma, verrucous carcinoma	Nail discharge, subungual mass, nail dystrophy, subungual hyperkeratosis	Invasive squamous cell carcinoma	Well differentiated	High- and low-risk HPV negative

SCC: Squamous cell carcinoma
M: Male, F:Female
High-risk HPV positivity was defined based on PCR detection of HPV 16/18 and additional high-risk genotypes (31, 33, 45, 52, 58) included in the institutional assay.

Table 1: Clinicopathologic Characteristics, Clinical Pre-diagnoses, and HPV Status of Patients with Nail Unit Squamous Cell Carcinoma

Conclusions

nSCC predominantly affects individuals over 50 years of age, shows male predominance, and most frequently involves the first digit (1,2). Consistent with the literature, the mean age in our cohort was 59.5 years, 60% of patients were male, and first-digit involvement was observed in 70%. All cases presented with single-nail involvement, and the most common findings were subungual hyperkeratosis (%50), discharge (%50), and nail dystrophy (%30), reflecting the nonspecific clinical presentation of nSCC (1,3). Nonspecific features contribute to diagnostic delays of up to 5–7 years in previous reports (1,3); in our cohort, the mean delay was 30.5 months. While amputation rates of approximately 20% have been reported (2), amputation was required in 30% of our patients, emphasizing the importance of early diagnosis to prevent advanced disease and limb-sacrificing surgery. Although high-risk HPV has been reported in 60–80% of cases (4), positivity was detected in only 30% of our series, indicating that nSCC is not exclusively HPV-related. The primary therapeutic goal is complete tumor excision with histologically clear margins; accordingly, wide local excision with margins exceeding 4–6 mm was performed in 60% of patients, in line with current recommendations (2,5).

Abstract N°: ID-1365

Topic: Cutaneous oncology

Pembrolizumab-Associated Dermatomyositis in a Patient with Triple-Negative Breast Cancer

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Introduction

Immune checkpoint inhibitors have revolutionized cancer therapy; however, they are increasingly associated with immune-related adverse events affecting the skin and musculoskeletal system. Dermatomyositis is a rare but potentially severe autoimmune condition that has been infrequently reported in association with pembrolizumab.

Materials and Methods

A detailed clinical evaluation was performed in a patient with triple-negative breast cancer receiving pembrolizumab therapy. Dermatological examination, laboratory investigations including serum creatine kinase levels and autoimmune serology, and relevant imaging studies were used to establish the diagnosis of dermatomyositis. Alternative causes, including paraneoplastic dermatomyositis and disease progression, were excluded through multidisciplinary assessment. Clinical and laboratory responses to immunosuppressive treatment were monitored during follow-up.

Results

We report the case of a middle-aged female patient with triple-negative breast cancer who developed dermatomyositis following treatment with pembrolizumab. The patient presented with progressive proximal muscle weakness and characteristic cutaneous manifestations, including heliotrope rash and Gottron papules, several weeks after initiation of immunotherapy.Laboratory evaluation revealed markedly elevated creatine kinase levels. Autoimmune work-up supported the diagnosis of dermatomyositis. Imaging and electromyography findings were consistent with inflammatory myopathy. No evidence of disease progression or paraneoplastic dermatomyositis was identified. Pembrolizumab was discontinued, and systemic corticosteroid therapy was initiated. The patient demonstrated significant clinical and biochemical improvement following immunosuppressive treatment, with gradual resolution of muscle weakness and cutaneous symptoms.

Conclusions

This case highlights dermatomyositis as a rare immune-related adverse event associated with pembrolizumab therapy. Early recognition of dermatologic and neuromuscular symptoms is essential to ensure prompt management and favorable outcomes. Increased awareness among dermatologists and oncologists is crucial for the multidisciplinary care of patients receiving immune checkpoint inhibitors.

Abstract N°: ID-1400

Topic: Cutaneous oncology

Lethal Outcomes due to blastic transformation of Mycosis Fungoides: A Retrospective Case Series from a Tertiary Center

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Introduction

In advanced-stage mycosis fungoides (MF), most deaths result from infectious complications or cardiopulmonary failure. Large-cell transformation (LCT) is a rare adverse prognostic event associated with rapid progression and reduced survival, yet the terminal clinical course of transformed MF remains insufficiently characterized.

Materials and Methods

From a single-center, retrospective case series of patients with MF and LCT who experienced disease-related death, demographics, clinical trajectories, histopathology and immunophenotyping, staging (TNMB), treatments, and palliative-care involvement were retrieved from electronic medical records.

Results

Five patients (3 men, 2 women; mean age at death 64.6 years, range 52–79) received multiple prior skin-directed and systemic therapies. In the final months, all developed rapidly progressive erythroderma with >50% body surface area involvement, marked scaling/xerosis, and increasing numbers of painful, ulcerated lesions with therapeutic refractoriness. Recent nodal involvement occurred in three patients; MF-related blood involvement (B1–B2) was observed in two. The last available biopsies showed >50% large pleomorphic/anaplastic/immunoblastic cells in three patients, with CD30 expression in >50% of atypical large cells in two. Severe pain, especially during wound care, was universal; palliative-care engagement typically occurred late (1–13 days before death).

Conclusions

Fatal outcomes in LCT-MF were characterized by extensive erythroderma, widespread ulceration, rapid clinical deterioration, treatment resistance, and high proportions of large cells (often CD30-positive) on histology. Extensive ulceration and refractoriness may be strong predictors of mortality even without overt visceral disease. Early restaging, LCT-adapted management, structured wound care, and timely palliative-care integration are warranted.

Abstract N°: ID-1402

Topic: Cutaneous oncology

Clinicopathologic Predictors of Invasive Disease and Recurrence in Extramammary Paget Disease: A Retrospective Cohort Study in an Asian Population

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Introduction
Extramammary Paget disease (EMPD) is a rare cutaneous adenocarcinoma characterized by high local recurrence and variable risk of invasive transformation. Prognostic factors remain inconsistently defined, particularly in Asian populations. We aimed to identify clinicopathologic variables associated with invasive disease, recurrence, and overall survival (OS) in an Asian EMPD cohort.

Materials and Methods
This retrospective cohort study included patients with histologically confirmed EMPD treated at a tertiary center in Taipei, Taiwan between January 2010 and January 2022. Demographic, clinical, pathological, and treatment variables were reviewed. Invasive disease was defined as dermal invasion beyond the epidermal basement membrane. Recurrence-free survival (RFS) and OS were estimated using Kaplan–Meier analysis. Cox proportional hazards regression was performed to identify prognostic factors. Statistical significance was defined as $p<0.05$.

Results
Among the 25 patients recruited, 20 patients (80%) were male, with a mean age of 72 years. Invasive disease was identified in 8 patients (32%), all demonstrating deep dermal invasion >1 mm. During a median follow-up of 3.62 years (IQR 1.30–6.29), recurrence occurred in 4 patients (16%) and 10 patients (40%) died. The estimated 3-year and 5-year RFS rates were 85% and 78.7% respectively. The 3-year and 5-year OS rates were 70% and 57.9% respectively. On univariate Cox analysis, deep dermal invasion was significantly associated with reduced RFS (HR 10.65; 95% CI, 1.10–103.0; p=0.041). For OS, any dermal invasion (HR 5.51; 95% CI, 1.13–26.80; p=0.035), deep dermal invasion (HR 4.39; 95% CI, 1.09–17.68; p=0.037), and lymphovascular invasion (HR 4.10; 95% CI, 1.09–15.40; p=0.036) were significantly associated with increased mortality. In multivariable analysis adjusting for age ≥75 years, lesion size ≥5 cm, deep dermal invasion, lymphovascular invasion, and metastatic status, deep dermal invasion showed a trend toward worse OS (HR 6.61; 95% CI, 0.80–54.40; p=0.079).

Conclusions
Overall, deep dermal invasion emerged as the dominant determinant of recurrence and mortality. Patients with invasive disease demonstrated markedly worse survival outcomes, highlighting the central role of tumor biology over margin status or immunophenotypic profile in prognostic stratification. These findings emphasize the importance of early diagnosis, meticulous pathological assessment of invasion depth, and risk-adapted surveillance strategies. Improved identification of high-risk patients may inform individualized management approaches and optimize long-term outcomes in EMPD.

Abstract N°: ID-1407

Topic: Cutaneous oncology

A Visible Warning: Cutaneous Metastasis as the Initial Presentation of Occult Breast Carcinoma-A case report

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Introduction

The skin is an uncommon site for distant metastasis. Breast cancer is the most common cause of cutaneous metastases in women. Cutaneous metastases of breast cancer may present with a broad spectrum of clinical manifestations. They can be mistaken for benign cutaneous conditions such as cysts or dermatofibroma, primary skin malignancies including melanoma and non-melanoma skin cancers, or inflammatory and infectious disorders such as erysipelas, furunculosis, or folliculitis. In addition, cutaneous metastases of breast cancer may appear in well-recognized forms including carcinoma erysipeloides, Paget's disease of the nipple, telangiectatic carcinoma, and neoplastic alopecia. In up to one-third of cases, cutaneous metastasis is identified before the primary tumor; therefore, its identification may be essential for early diagnosis and starting treatment. In this report we present a case of breast carcinoma diagnosed through cutaneous metastasis. This case highlights that recognition of breast cancer through cutaneous findings may accelerate the diagnostic process and allow earlier initiation of appropriate management.

Materials and Methods

A 46-year-old female patient presented with a 2-month history of erythematous lesions on the upper trunk. She did not report pain or pruritus associated with the lesions. A superficial ultrasonography performed at an external center was reported as compatible with folliculitis. Dermatological examination revealed two erythematous indurated plaques on the right breast, one indurated plaque beneath the left breast and in the left axillary region, three indurated plaques on the back, the largest measuring 2 × 1 cm in diameter. No cervical, axillary, or inguinal lymphadenopathy was detected.

Based on clinical examination and findings, differential diagnoses included cutaneous T-cell lymphoma, cutaneous B-cell lymphoma, pseudolymphoma, cutaneous metastasis, and folliculitis. A punch biopsy of the skin lesion was performed. Histopathological examination of the skin biopsy demonstrated an infiltration of small cells with scant cytoplasm arranged in a single-file pattern within the dermis. Immunohistochemical staining showed positivity for cytokeratin 7 (CK7), GATA3, GCDFP-15, estrogen receptor, and p120 (cytoplasmic staining). These findings were reported as consistent with infiltration of lobular breast carcinoma.

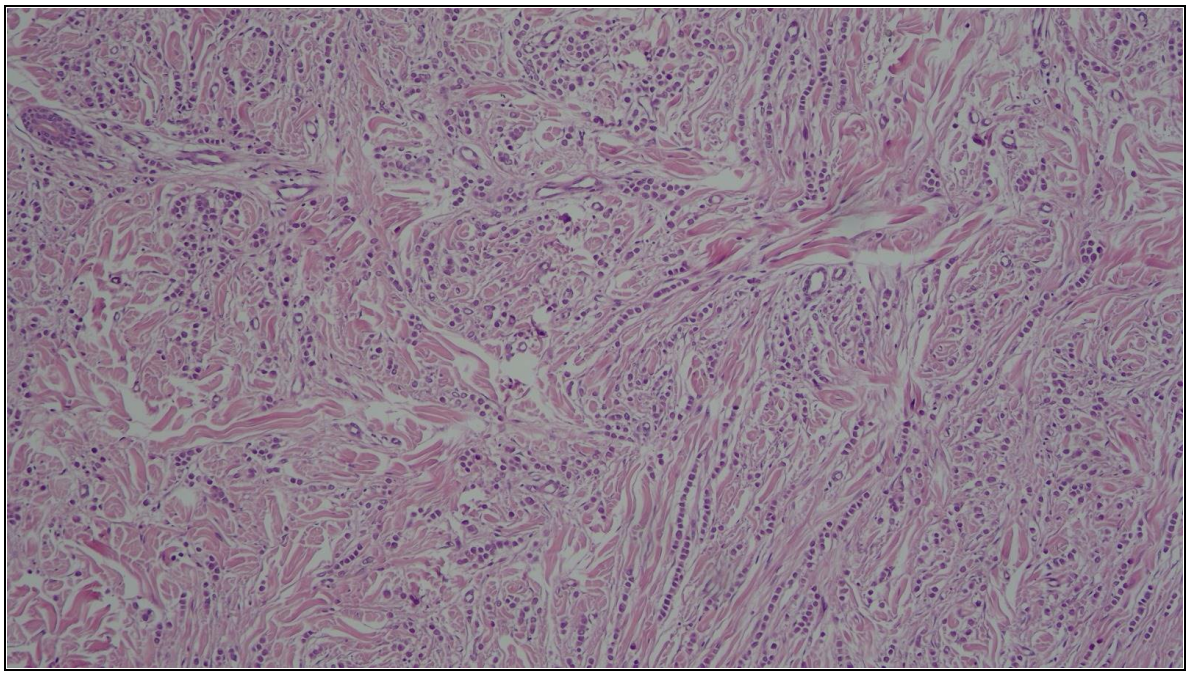

Image.1: Infiltration of small cells with scant cytoplasm arranged in a single-file pattern within the dermis.

Results

Following the histopathological diagnosis, the patient was urgently referred to the Department of General Surgery to identify the primary tumor origin. Multimodal imaging assessments comprising mammography, breast ultrasonography, and magnetic resonance imaging (MRI) were conducted. These investigations revealed a mass in the left breast classified as BI-RADS 5, which necessitated a biopsy. Additionally, a suspicious periareolar appearance was observed in the right breast, requiring further detailed evaluation. Consequently, these radiological findings identified the breast as the primary site of the malignancy, correlating with the histopathological diagnosis of the cutaneous lesions.

Conclusions

Cutaneous metastasis of breast cancer may sometimes be the only sign of unrecognized or recurrent malignancy. It is usually associated with an unfavorable prognosis. Cutaneous breast metastases show diverse clinical presentations and may show multiple distinct morphologies. This variability often leads to confusion with other dermatoses and referral to dermatologists. Therefore dermatologists should be able to recognize suspicious skin lesions and obtain appropriate biopsy specimens. Identification of cutaneous metastasis in breast cancer should alert oncologists to possible involvement of other organs such as the brain, lungs, and bones. With this case, we aim to highlight the clinical presentations of cutaneous metastasis in breast cancer. Recognition of breast cancer through skin findings may accelerate the diagnostic process and emphasizes the important role of dermatologists.

Abstract N°: ID-1426

Topic: Cutaneous oncology

Sister Mary Joseph Nodule unveiling carcinoma stomach in a young female

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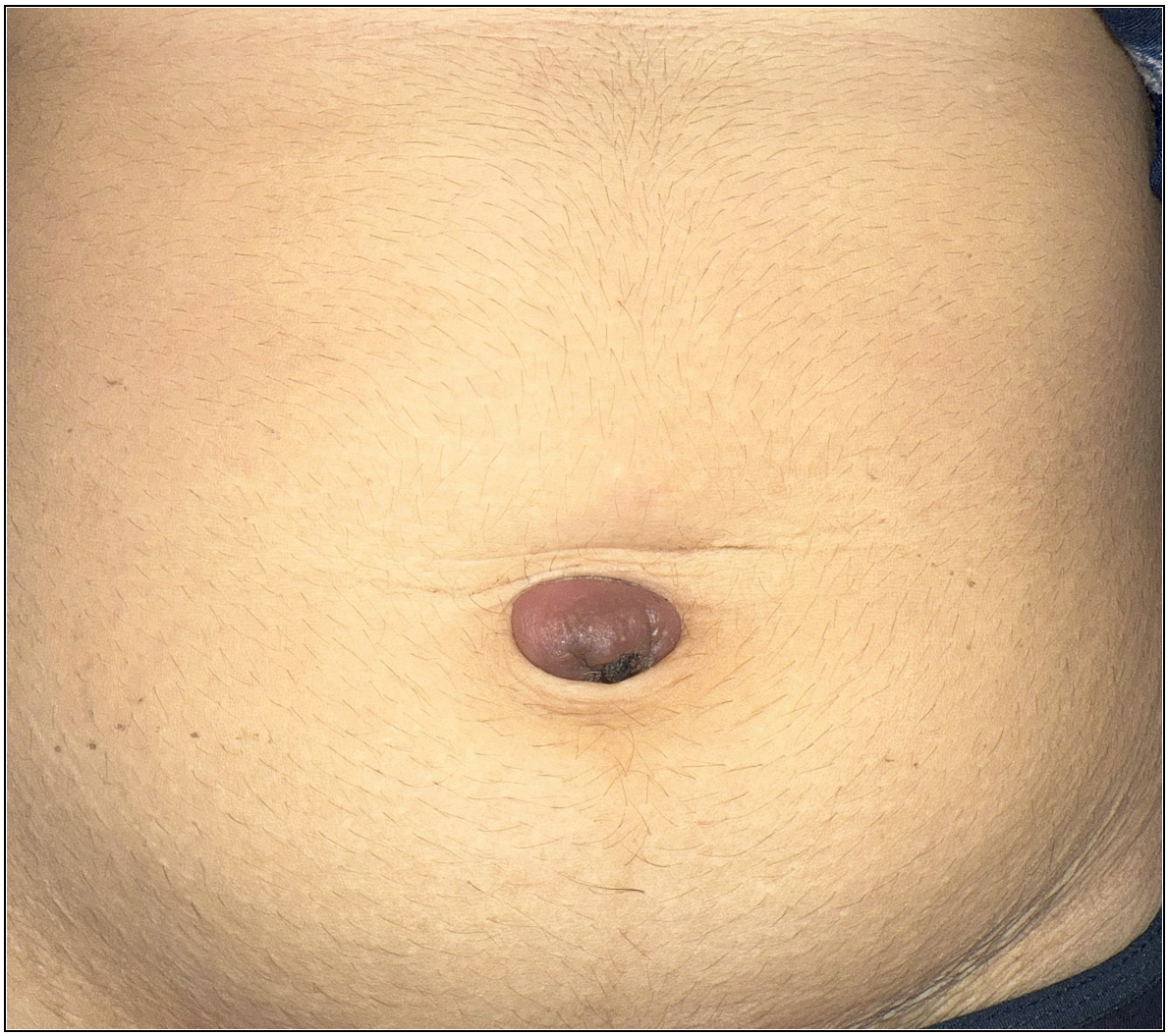
Introduction
Sister Mary Joseph nodule (SMJN) represents a rare cutaneous metastasis to the umbilicus, typically originating from intra-abdominal malignancies, most commonly of gastrointestinal or gynaecological origin. It is often associated with advanced disease and poor prognosis.

Materials and Methods
A 29-year-old woman presented with a one-month history of a gradually progressive, firm, pink erythematous nodule measuring 3×2 cm over the umbilicus. The lesion was asymptomatic and unrelated to menstrual cycles. She reported early satiety, nausea, and mild back pain but no weight loss. Histopathological examination revealed atypical epithelial cells in the deep dermis and subcutis with signet ring morphology. Immunohistochemistry was positive for CK20, EMA, and CDX2, confirming a gastrointestinal origin. Whole-body PET-CT showed FDG-avid circumferential mural thickening in the proximal stomach along the lesser curvature, confirming carcinoma stomach. FDG uptake was also seen in the umbilical nodule. The patient was started on FLOT chemotherapy (fluorouracil, leucovorin, oxaliplatin, and docetaxel) and remains under follow-up.



Results

SMJN most frequently arises from gastrointestinal (52.3%) or gynaecological (28%) malignancies. Eighty % of cases are adenocarcinomas. In 15-30% patients, the primary may remain unknown even after evaluation. The presence of SMJN is considered a poor prognostic sign, with a mean survival time of 7.9 months, though prognosis is better when it is the first clinical presentation rather than a subsequent development in a patient with a known malignancy.

Conclusions

This case emphasizes that SMJN, though uncommon, should be considered in the differential diagnosis of umbilical nodules. Early recognition allows timely detection of an underlying malignancy, thereby improving diagnostic accuracy and management outcomes.

Abstract N°: ID-1428

Topic: Cutaneous oncology

Addressing the field, not just the lesion: A translational study of skin quality and actinic keratoses improvement

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Introduction

Actinic keratoses (AKs) are visible markers of chronic ultraviolet (UV) induced photodamage and accelerated cutaneous aging, with an estimated annual progression risk of 0.025-16% to invasive squamous cell carcinoma (1,2,3). AKs may extend into deeper epidermal layers and remain clinically unapparent, contributing to recurrence and incomplete clearance. Two-thirds of cutaneous malignancies are thought to arise from pre-existing AKs, underscoring the importance of early, field directed intervention (4). While standard treatments such as cryotherapy and 5-fluorouracil are effective, they are limited by side effects, adherence challenges, and recurrence (5). Preventive strategies that enhance cellular repair, reverse photodamage, and support long-term field control are therefore increasingly sought (6-20).

Materials and Methods

In this study, we evaluated an adaptogenic, multi-active topical cosmeceutical incorporating Genoplex Microdelivery Activator (GMA) technology, containing niacinamide, bakuchiol, green tea and coffee extract, hydroxytyrosol, oleuropein, and ceramides. In vitro assays assessed effects on UV induced oxidative stress, inflammatory cytokines, extracellular matrix integrity, hypoxia-related signaling, and cellular senescence. In vivo antioxidant capacity was evaluated using PAOT analysis. A prospective cohort of thirteen patients with recurrent facial AKs applied the formulation twice daily for ≥12 weeks, either as monotherapy or with adjunctive topical 1% simvastatin. Outcomes were assessed using the Actinic Keratosis Area and Severity Index (AKASI) and evaluation of standardized high-resolution photography. A separate real-world longitudinal analysis evaluated AK burden across consecutive visits in 48 patients from an independent dermatology clinic. Multicentre questionnaire data were analyzed to characterize patient-reported tolerability, satisfaction, and perceived effectiveness.

Results

The formulation demonstrated activity across biological pathways implicated in cutaneous aging and carcinogenesis. In vivo PAOT analysis showed up to a 95.5% reduction in reactive oxygen species. In vitro testing demonstrated attenuation of UV-induced inflammatory cytokines, restoration of extracellular matrix and hypoxia-related markers, and reduced expression of senescence-associated signals. Clinically, all patients

in the prospective cohort improved, with a mean AKASI reduction of 2.10 ($p<0.0001$), visible improvement in surrounding photodamaged skin, and no treatment-related adverse events; four patients achieved near-complete lesion clearance, with the largest improvements observed in those receiving treatment containing adjunctive simvastatin. AK counts also demonstrated consistent reductions across consecutive visits, supporting durable benefit. Multicentre questionnaire data showed patients reports of 87% global satisfaction, 83% perceived effectiveness, and 96% with little to no side effects.

Conclusions

This adaptogenic cosmeceutical targets key biological drivers of aging skin, including oxidative stress, chronic inflammation, extracellular matrix degradation, and cellular senescence. The reductions in AK burden, combined with visible improvement in surrounding photodamaged tissue, support this cosmeceutical as a promising adjunct for aesthetic and anti-aging practice Its favorable clinical, real-world, and patient-reported outcomes support its role as a field-directed, prevention-focused adjunct in aesthetic and anti-aging dermatology.

Abstract N°: ID-1432

Topic: Cutaneous oncology

The long-term effect of the COVID-19 pandemic on the diagnosis of Actinic Keratosis: real world data from a rural hospital in Athens, Greece

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Introduction

Actinic keratosis (AK) is one of the most common dermatological conditions in outpatient clinics. The global prevalence rate of AK has been reported in the general population at 14%. The effect of the COVID-19 pandemic on the epidemiology of AK has not been independently investigated but has been addressed in studies with cSCC. Our objective was to assess and compare the prevalence of diagnosis of AK in everyday dermatological practice in two years time period before and after the COVID-19 pandemic.

Materials and Methods

We compared the demographic characteristics of the patients and the disease associated parameters of the diagnosis of the Aks in the dermatological outpatients clinics in a rural hospital in southern Greece in two time periods each involving data from two years: the first in the years 2016-2017 and the second in the years 2023-2024. Assessment of the severity of the actinic damage using the Actinic Keratosis Area and Severity Index (AKASI) system score was performed only for patients who received field treatments. The AKASI score system was introduced in 2017 and patients from the initial time period were retrospectively assessed using the detailed photographic archive that was available for all.

Results

In 9042 dermatology patient visits in the years 2016- 2017, we identified 745 (8,23%) visits for Aks which corresponded to 411 patients, and in 17395 total dermatology visits in the years 2023-2024, we recorded 1271 (7,30%) visits for Aks which were attributed to 633 patients. Of these outpatient consultations, only 311 consultations (3,43%) in the years 2016-7 and 471 (2,70%) in the years 2023-4 were solely for Aks, and the rest were for Aks and other dermatological conditions. There were no statistically significant differences between age, gender and number of visits for patients with Aks. Furthermore, of the total patients treated for Aks, a small and strikingly similar proportion was identified with medium to severe actinic damage calculated with AKASI score system: of the 411 patients treated for Aks in the years 2016-7 only 19 (4,62%) and of the 633 treated in the years 2023-4 only 31 (4,89%). In all of these patients in both time periods, actinic damage was located in the same anatomic regions and the AKASI score range was also similar: AKASI 5,2-10,4 and 4,8-9,6 respectively.

Conclusions

In a recent meta-analysis the prevalence of AK in the general population has been reported globally at 14%. Our study did not investigate the incidence of new AK cases but the prevalence of dermatology visits in outpatient clinics in the

settings of a public hospital. Actinic damage is a phenomenon slowly evolving within decades and the underlying prevalence of AK in the population is likely to remain stable or increase due to aging. Our findings suggest that the incidence and/or the severity in the long-term was not influenced by the COVID-19 pandemic. Further studies from diverse medical settings and larger numbers of patients are warranted to support our initial conclusions.

Abstract N°: ID-1435

Topic: Cutaneous oncology

Advancing early skin cancer detection: non-invasive diagnostic tools and structured diagnostic reasoning

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Introduction
Early detection of skin cancer is a major public health challenge, as prognosis is closely linked to tumor thickness at diagnosis. Clinical examination alone is limited by interobserver variability and overlapping features between benign and malignant lesions. In recent years, non-invasive diagnostic tools have substantially improved diagnostic accuracy and early detection.
The objective of this review is to examine their role, strengths, and limitations, and to propose a structured diagnostic reasoning framework to support clinical decision-making

Materials and Methods
A mini-systematic narrative review was conducted using PubMed databases. Articles published between January 2010 and December 2024 were included. Search terms combined non-invasive imaging, dermoscopy, reflectance confocal microscopy, total body photography, sequential digital dermoscopy, melanoma, and non-melanoma skin cancer. Eligible publications included diagnostic accuracy studies, meta-analyses, prospective cohorts, and clinical guidelines. Data extraction focused on sensitivity, specificity, diagnostic yield, impact on biopsy rates, and clinical outcomes. Findings were synthesized qualitatively.

Results
The literature consistently demonstrates that dermoscopy significantly improves diagnostic accuracy for melanoma and non-melanoma skin cancers compared with naked-eye examination, particularly when used by trained clinicians. Reflectance confocal microscopy provides near-histological resolution and has been shown to reduce unnecessary biopsies in equivocal lesions while maintaining high sensitivity for malignancy. Total body photography and sequential digital dermoscopy imaging enable early detection of new or changing lesions in high-risk patients, supporting proactive surveillance strategies. Importantly, the combined use of these modalities yields superior diagnostic performance compared with isolated application. This review highlights that non-invasive diagnostic tools should not be viewed as competing technologies but as complementary components of a unified diagnostic strategy. Dermoscopy remains the cornerstone of initial lesion assessment due to its accessibility and high diagnostic yield. Reflectance confocal microscopy is particularly valuable for resolving diagnostic uncertainty and optimizing biopsy decisions, while total body photography supports longitudinal monitoring in patients with multiple nevi or elevated melanoma risk. A structured reasoning framework integrating lesion morphology, patient risk profile, and tool-specific indications allows rational selection of diagnostic modalities. Such an approach enhances early detection, minimizes unnecessary procedures, and optimizes resource utilization. Training and experience are critical determinants of diagnostic performance, underscoring the need for continued education in non-invasive imaging.

Conclusions
Non-invasive diagnostic tools significantly enhance early detection of skin cancer when integrated into a structured, reasoning-based diagnostic framework. Dermatologists should adopt an integrated diagnostic strategy combining dermoscopy, reflectance confocal microscopy, and digital monitoring to improve early skin cancer detection while reducing unnecessary biopsies.

Abstract N°: ID-1439

Topic: Cutaneous oncology

Iatrogenic Kaposi sarcoma due to corticosteroids in a case of Lepromatous Leprosy

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Introduction

Kaposi sarcoma(KS) is a low grade vascular neoplasm derived from the lymphatic endothelial cells. The iatrogenic subtype is rare and has been reported due to immunosuppressive therapy especially corticosteroids. Herein, we report a case of iatrogenic Kaposi Sarcoma due to corticosteroids in a case of lepromatous leprosy with erythema nodosum leprosum.

Materials and Methods

A 29-year-old heterosexual male, was diagnosed as lepromatous leprosy 8 months back and prescribed multibacillary multi drug therapy (Rifampicin monthly with daily clofazimine & dapsone). After being on treatment for 6 months he started developing multiple episodes of recurrent type 2 reaction presenting with erythema nodosum leprosum & ulnar nerve neuritis. He had been initiated on oral prednisolone 1mg/kg body weight & thalidomide 100mg thrice daily for management of reaction. The lesions of erythema nodosum leprosum resolved with improvement in neuritis as well. While on prednisolone & thalidomide for 2 months he developed asymptomatic purple red lesions over lower limbs. On examination there were multiple non tender well-defined reddish-purple plaques and macules distributed asymmetrically over bilateral lower limbs. There was no significant lymphadenopathy or peripheral edema. Mucosal and systemic examination revealed no abnormality. Dermoscopy of the plaques revealed red purple background colour with central area showing rainbow pattern, multiple white lines & four dot clods. His blood work up including complete blood count, liver & kidney function test and serology for syphilis, hepatitis B, C and HIV were negative. X ray chest & ultrasound abdomen including pelvis were within normal limits. A punch biopsy was performed which revealed extensive haemorrhage in the upper dermis with spindled cells forming poorly formed vascular channels. Nuclei were oval with inconspicuous nucleoli ,scanty cytoplasm & few mitoses. Immunohistochemistry was positive for CD31. The histological findings were consistent with Kaposi sarcoma. Hence a final diagnosis of iatrogenic Kaposi sarcoma due to immunosuppression induced by high dose corticosteroids was made. Patient's corticosteroids were tapered and within 2 months the lesions showed significant improvement.

Results

KS is a low grade vascular neoplasm derived from lymphatic endothelial cells. Majority of these lesions are associated with HHV-8. There are five subtypes described classical, endemic, HIV associated, iatrogenic and KS in men having sex with men.[1] Iatrogenic subtype is usually seen in patients on immunosuppressive medication especially organ transplant recipients. Iatrogenic variant comprises 5-20% of total cases.[2] It presents as single or multiple red to purple coloured macules, plaques or nodules with or without ulceration. The commonest site is the lower limbs. Extra cutaneous involvement has been reported in lymph nodes, gastrointestinal tract & lungs. Dermoscopic signs described for KS include white lines, clods, polychromatic colour change & curved vessels.[3] Common drugs associated with iatrogenic form include corticosteroids, ciclosporin, TNFα inhibitors, mycophenolate mofetil, rituximab etc.[4,5] Glucocorticoids are implicated in the pathogenesis of KS by inhibiting action of transforming growth factor β that leads to increased cellular

proliferation.[6] There has only been a single case report of KS in lepromatous leprosy with erythema nodosum leprosum treated with corticosteroids.[7] The mainstay of treatment of the iatrogenic subtype is tapering or withdrawal of the offending drug or a change in the immunosuppressive agent.[8]

Conclusions

Iatrogenic Kaposi sarcoma has been frequently reported due to high dose systemic corticosteroids but rarely in the setting of leprosy. The diagnosis can be further delayed due to its resemblance to erythema nodosum leprosum. Thus, it is imperative for dermatologists to keep a high index of suspicion for Kaposi sarcoma in patients of leprosy who are on systemic steroids for early diagnosis & management.

Abstract N°: ID-1449

Topic: Cutaneous oncology

Impact of time to definitive surgical treatment on overall survival in acral lentiginous melanoma

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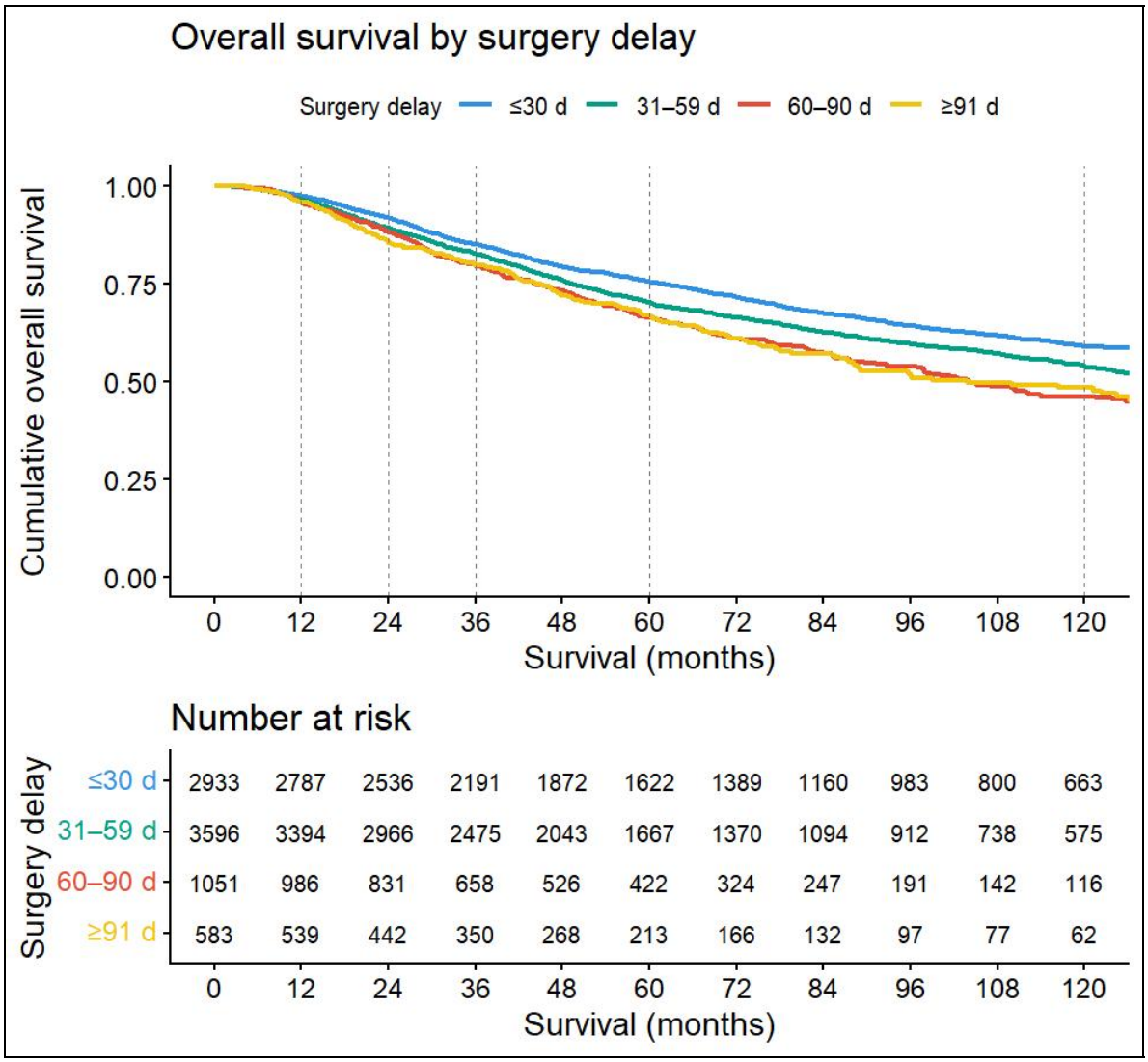
Introduction
Acral lentiginous melanoma (ALM) is a biologically distinct melanoma subtype with worse outcomes than non-acral melanoma. While delays in surgical treatment have been associated with inferior survival in cutaneous melanoma overall, evidence specific to ALM remains limited. We evaluated the association between time to definitive surgical treatment and overall survival in patients with ALM.

Materials and Methods
We conducted a retrospective cohort study using data from the National Cancer Database, a large U.S. hospital-based oncology registry. Adults diagnosed with stage I-III acral lentiginous melanoma between 2004 and 2022 were included. Time to treatment initiation (TTI) was defined as the interval from diagnostic biopsy to definitive surgical excision and categorized as ≤30, 31-59, 60-90, or ≥91 days. Overall survival was assessed using Kaplan-Meier analysis and multivariable Cox proportional hazards regression, adjusting for demographic, clinicopathologic, and treatment-related factors. Sensitivity analyses were performed to assess robustness.

Results
A total of 8,163 patients with stage I-III ALM were included. Longer TTI was associated with older age, non-White race, Hispanic ethnicity, higher comorbidity burden, and more advanced tumor characteristics. Kaplan-Meier analysis demonstrated progressively worse overall survival with increasing treatment delay. In multivariable models, TTI of 31-59 days (adjusted hazard ratio [aHR] 1.10; 95% CI 1.01-1.19), 60-90 days (aHR 1.25; 95% CI 1.11-1.41), and ≥91 days (aHR 1.23; 95% CI 1.06-1.43) were independently associated with higher mortality compared with treatment within ≤30 days. In sensitivity analyses, delays of 60-90 days and ≥91 days remained significantly associated with worse survival.



Kaplan-Meier curves depicting overall survival stratified by time to treatment initiation (≤30 days, 31-59 days, 60-90 days, and ≥91 days), with numbers at risk shown below the plot.

Conclusions

In this large real-world cohort, longer time to definitive surgical treatment was independently associated with worse overall survival in patients with acral lentiginous melanoma, with adverse effects observed at delays beyond 30 days. These findings suggest that ALM may be particularly sensitive to surgical timing and support efforts to minimize delays to definitive excision in this high-risk melanoma subtype.

Abstract N°: ID-1469

Topic: Cutaneous oncology

Basal Cell Carcinoma of the Perianal Region: A Diagnostic Challenge in a Non–Sun-Exposed Area

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Introduction
Basal cell carcinoma (BCC) is the most common cutaneous malignancy, usually arising in sun-exposed areas such as the head and neck. Rarely, BCC can develop in non–sun-exposed regions, where atypical presentation may delay diagnosis. Perianal BCC is uncommon and may mimic other malignant or inflammatory conditions, representing a diagnostic challenge.

Materials and Methods
An 82-year-old man presented with a perianal lesion for several years, which had gradually increased in size. The patient occasionally reported minor bleeding and mild discomfort. Examination revealed a fleshy, exophytic, slightly friable perianal mass. Initial differential diagnosis included melanoma and squamous cell carcinoma. Biopsy confirmed nodular basal cell carcinoma. The lesion was excised with conventional surgery and direct closure, achieving clear surgical margins. Postoperative recovery was uneventful, with no recurrence on follow-up.

Results
Perianal BCC is rare and often diagnosed late due to low clinical suspicion. Unlike typical BCC, ultraviolet exposure is unlikely to be a significant factor. Contributing factors may include advanced age, chronic irritation, inflammation, trauma, and immunosenescence. Clinically, lesions may resemble other malignancies or benign conditions, underscoring the need for biopsy. In our experience, persistent perianal lesions, even if apparently benign, should always be evaluated histologically to avoid missed diagnoses.

Conclusions
This case emphasizes the importance of considering BCC in the differential diagnosis of atypical perianal lesions, especially in elderly patients. Dermatologists should remain aware that basal cell carcinoma may arise in non–sun-exposed areas and include it in the differential diagnosis of atypical perianal lesions to avoid diagnostic delay. Early recognition and appropriate surgical management are essential for optimal outcomes.

Abstract N°: ID-1492

Topic: Cutaneous oncology

Delivering a melanoma diagnosis: evidence review and structured clinical approach

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Introduction
Communicating a melanoma diagnosis is a pivotal moment in a patient's care, with significant psychological, emotional, and clinical implications. The manner of disclosure can directly affect patient understanding, emotional adjustment, trust in clinicians, treatment adherence, and engagement in follow-up. Despite its importance, communication practices remain inconsistently structured.
The objective of this review is to evaluate evidence-based strategies for melanoma diagnosis disclosure and to propose a structured clinical reasoning framework to guide effective and patient-centered communication.

Materials and Methods
A mini-systematic narrative review was conducted using PubMed databases. Articles published between January 2005 and December 2024 were included. Search terms combined melanoma, diagnostic communication, breaking bad news, patient-centered care, shared decision-making, and dermatology. Eligible publications included qualitative studies, observational cohorts, randomized communication interventions, clinical guidelines, and systematic reviews addressing diagnostic disclosure and psychosocial outcomes. Data extraction focused on communication structure, clinician behaviors, patient emotional responses, comprehension, and adherence to management plans. Findings were synthesized qualitatively to identify recurrent principles and clinically applicable strategies.

Results
The literature consistently demonstrates that structured, patient-centered communication is associated with superior outcomes compared to unstructured disclosure. Effective communication strategies include assessing the patient's baseline knowledge and expectations, delivering the diagnosis using clear and non-alarmist language, explicitly naming the diagnosis while avoiding euphemisms, and allowing pauses to facilitate emotional processing. Providing staged information regarding prognosis, treatment options, and follow-up reduces cognitive overload and improves retention. Studies report that patients receiving empathetic, structured disclosure experience lower anxiety levels, greater satisfaction with care, improved adherence to treatment and surveillance protocols, and enhanced trust in the medical team.
This review emphasizes that communication should be regarded as a core clinical competency in melanoma management rather than an ancillary skill. Diagnostic disclosure requires deliberate preparation, emotional awareness, and adaptability to individual patient needs. A reasoning-based communication framework allows clinicians to tailor the depth and timing of information while maintaining clarity and consistency. Common pitfalls include excessive technical detail, premature discussion of worst-case scenarios, and failure to assess patient emotional readiness. Dermatologists occupy a central role in initiating melanoma communication, often being the first specialists to convey the diagnosis and outline the initial management plan. Structured communication also facilitates multidisciplinary coordination and continuity of care. Incorporating communication frameworks into routine practice may improve both psychosocial outcomes and long-term clinical adherence.

Conclusions

Evidence supports that structured, empathetic, and patient-centered communication significantly improves psychological adjustment, comprehension, and clinical outcomes following a melanoma diagnosis. Dermatologists should adopt advanced, evidence-based communication frameworks when delivering a melanoma diagnosis, integrating medical information with emotional support and shared decision-making to optimize patient-centered care.

Abstract N°: ID-1500

Topic: Cutaneous oncology

Localized Facial Sweet Syndrome During Relapse of Acute Myeloid Leukemia

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Introduction

Sweet syndrome is an acute febrile neutrophilic dermatosis frequently associated with malignancies, particularly acute myeloid leukemia (AML). Cutaneous presentations in this setting may be atypical and localized, leading to diagnostic challenges. We report a case of localized facial Sweet syndrome occurring during AML relapse.

Materials and Methods

A 26-year-old man with relapsed acute myeloid leukemia undergoing chemotherapy presented with fever and a rapidly evolving facial lesion. Dermatological examination revealed a well-demarcated, erythematous and infiltrated plaque on the right cheek, associated with smaller surrounding inflammatory papules. The lesion was tender and edematous.

Laboratory investigations showed elevated inflammatory markers with leukocytosis and neutrophilia (neutrophils 9.5×10^{9}/L, CRP 120 mg/L). Skin biopsy confirmed a dense neutrophilic dermal infiltrate without vasculitis, consistent with Sweet syndrome.

The patient was treated with systemic corticosteroids, leading to rapid clinical improvement and complete regression of the lesion.

Results

Sweet syndrome is a neutrophilic dermatosis that can be idiopathic, drug-induced or malignancy-associated. Approximately 15–20% of cases are linked to underlying malignancies, most commonly acute myeloid leukemia. In this setting, Sweet syndrome may occur at diagnosis, during treatment or as a manifestation of relapse.

Malignancy-associated Sweet syndrome often presents with atypical clinical features, including localized or limited lesions, which may delay recognition. Facial involvement has been reported but remains uncommon and can mimic infectious or inflammatory conditions, particularly in immunocompromised patients undergoing chemotherapy. Histopathological confirmation is therefore essential for diagnosis.

Early recognition of Sweet syndrome in patients with hematologic malignancies is important, as systemic corticosteroids usually lead to rapid and dramatic improvement. Moreover, the occurrence of Sweet syndrome may reflect underlying disease activity and should prompt careful hematologic evaluation.This case highlights localized facial Sweet syndrome as a potential cutaneous manifestation of AML relapse and emphasizes the importance of prompt recognition and treatment.

Conclusions

This case highlights localized facial Sweet syndrome as a potential cutaneous manifestation of AML relapse and emphasizes the importance of prompt recognition and treatment.

Abstract N°: ID-1505

Topic: Cutaneous oncology

Mycosis fungoides in female patients: A 6-Year Retrospective analysis

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Introduction
Mycosis fungoides (MF) is the most common primary cutaneous T-cell lymphoma. The clinical course of the disease is typically characterized by progression from a nonspecific phase of erythematous patches to the appearance of plaques and, ultimately, tumors in some patients. The basic histopathological feature is an epidermotropic infiltrate of small to medium atypical CD4+ T-lymphocytes. This study aimed to analyze the demographic and clinical characteristics, therapeutic modalities, and treatment outcomes of female patients with *MF* hospitalized at the First Female Department of the Clinic of Dermatology and Venereology, at the University Clinical Center of Serbia, over 6 years.

Materials and Methods
This descriptive retrospective study analyzed data from medical records of 15 incident cases hospitalized at the First Female Department of the Clinic for Dermatovenerology, University Clinical Center of Serbia, with a confirmed diagnosis of Mycosis fungoides during the period from January 2019 to December 2024.

Results
The average age of the studied population was 58 years. The average duration of skin changes before diagnosis was 28 months. The majority of patients (86.7%) had the classic variant of MF, while one patient presented with folliculotropic, and one with the ichthyosiform variant. Sezary cells were present in 38.5% of the patients. Most patients were in the early stage of the disease (stage IB). Immunohistochemical analysis revealed marked CD4 positivity (92.9%), while CD8 positivity was present in 35.7% of samples. The average Ki-67 index was 17.5%, and CD30 expression was recorded in 46.7% of patients. The most commonly used therapies were acitretin, methotrexate, and PUVA therapy, with most patients achieving a partial therapeutic response without disease progression.

Conclusions
Female patients in this study predominantly presented with an early-stage disease, classic MF, and pronounced CD4+ phenotypic expression. The observation of a favorable therapeutic response without significant disease progression highlights the efficacy of established treatment modalities in managing these patients over six years.

Abstract N°: ID-1514

Topic: Cutaneous oncology

Pigmented Mycosis Fungoides with a Reticular Pattern: An Atypical Presentation Mimicking Purpuric Capillaritis in a Setting of Venous Insufficiency

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Introduction

Mycosis fungoides (MF) is the most prevalent primary cutaneous T-cell lymphoma, classically defined by a monoclonal proliferation of CD4+ T-lymphocytes. While typical presentations are well-documented, rare variants can be deceptively subtle. This is particularly true for pigmented, reticulated forms, which mimic benign chronic dermatoses like purpuric capillaritis or post-inflammatory hyperpigmentation. We report a case of atypical MF presenting as a diagnostic challenge in an elderly patient with vascular compromise, highlighting the risk of misdiagnosis in such clinical settings.

Materials and Methods

An 80-year-old female with no hematological history presented with a one-month history of a non-infiltrated eruption on the lower limbs. The lesions appeared as asymptomatic brownish macules organized in a reticular pattern. Given the patient's background of chronic venous insufficiency, the initial clinical impression favored a vascular etiology, specifically capillaritis or senile purpura. However, the lack of response to symptomatic treatment prompted a skin biopsy.

Histological examination revealed a slightly spongiotic, occasionally thinned epidermis, focal parakeratotic hyperkeratosis, and a band-like lymphoid infiltrate in the dermis. This infiltrate consisted of small, minimally atypical lymphocytes exhibiting focal epidermotropism and basal layer vacuolization. Immunohistochemistry confirmed a predominantly CD4+ and CD3+ T-cell population, with weak CD8 expression. Negative results for anti-CD20 and CD30 antibodies ruled out B-cell origin or large-cell lymphoma, confirming the diagnosis of mycosis fungoides.

Laboratory findings showed moderate anemia and the presence of scattered Sézary cells. Flow cytometry is currently underway to assess the CD4/CD8 ratio. Further analyses—including LDH, beta-2 microglobulin, and liver, renal, and infectious screenings—are in progress. A lymph node ultrasound and a chest-abdomen-pelvis CT scan have been scheduled for staging.

Results

This clinical case illustrates the diagnostic complexity of certain MF variants. The reticular pigmentation, absence of palpable infiltration, and lower-limb topography initially led to a misdiagnosis of purpuric capillaritis. However, the diagnosis was rectified by the absence of erythrocyte extravasation or hemosiderin deposits and the identification of a characteristic monoclonal T-cell infiltrate. While pigmented MF is more frequently reported in darker phototypes or associated with a CD8+ phenotype, this case demonstrates that it can occur within a CD4+ context, likely facilitated by chronic basal layer damage and a vascular environment predisposing the patient to secondary pigmentation.

Conclusions

Mycosis fungoides may present in misleading clinical forms, particularly in its early stages. A chronic pigmented reticular eruption on the lower limbs should not be reflexively attributed to capillaritis or venous stasis. This case underscores the necessity of early skin biopsy, comprehensive immunohistochemistry, and rigorous staging to ensure an accurate diagnosis and prevent therapeutic delays.

Abstract N°: ID-1526

Topic: Cutaneous oncology

Vulvar Paget's Disease: A Case Report and Literature Review

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Introduction

Vulvar Paget's disease (VPD) is a rare malignant tumor of the vulva, predominantly affecting postmenopausal women. Owing to the lack of specific clinical manifestations, it is frequently misdiagnosed as chronic inflammatory dermatoses, particularly eczematous lesions, leading to delayed diagnosis. Surgical excision remains the standard treatment; however, it is often mutilating and associated with high recurrence rates. In recent years, alternative therapeutic approaches have been proposed, including topical imiquimod, topical photodynamic therapy (PDT) and CO_2 laser therapy.

Materials and Methods

We report the case of a 65-year-old woman who presented with vulvar pruritus for six months, fifteen years after menopause. Dermatological examination revealed a well-defined erythematous plaque with peripheral hyperpigmentation, extending from the labia majora to the right inguinal fold, with a whitish coating at the base of the right inguinal fold. Mycological examination was performed and revealed C. albicans. Antifungal treatment with econazole was prescribed, resulting in partial improvement. Histological analysis of the vulvar biopsy confirmed the diagnosis of Paget's disease, with an immunohistochemical profile (CK7+, CK20−, CDX2−, TRPS1+) consistent with primary Paget's disease. A staging workup was requested and was unremarkable. She was treated with imiquimod for four weeks, resulting in a favorable outcome with near-complete disappearance of the plaque.

Results

Extramammary Paget's disease (EMPD) is a rare intraepithelial adenocarcinoma, accounting for approximately 6.5% of all Paget's disease cases. EMPD primarily develops in areas rich in apocrine glands, with the vulva being the most commonly affected site. Vulvar Paget's disease (VPD) mainly affects postmenopausal women. Clinically, VPD presents as well-demarcated erythematous or brown vulvar plaques, often associated with pruritus, localized pain, or a burning sensation. Its nonspecific clinical manifestations can lead to misdiagnosis, with differential diagnoses including eczema, malignant melanoma, vulvar intraepithelial neoplasia, squamous cell carcinoma of the vulva, chronic simple lichen, and atrophic lichen sclerosus. Vulvar skin biopsy remains the gold standard for diagnosis. Treatment selection for Paget's disease depends on lesion size, symptom severity, and the patient's general condition. For small lesions, surgery is considered first-line treatment, whereas for more extensive lesions, non-surgical alternatives may be used, including topical imiquimod (an immune response modifier), CO_2 laser, and photodynamic therapy.

Conclusions

Although rare, vulvar Paget's disease (VPD) primarily affects postmenopausal women and presents with atypical symptoms, often resembling eczematous skin lesions. This can lead to delayed diagnosis and disease progression. In cases of suspected VPD, clinicians should carefully review the patient's history and clinical signs and promptly perform a biopsy for accurate diagnosis. Individualized treatment should then be planned based on histopathological findings.

Abstract N°: ID-1560

Topic: Cutaneous oncology

Cervical Dermatofibrosarcoma Protuberans: Atypical presentation

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Introduction

Dermatofibrosarcoma protuberans (DFSP) is an uncommon locally aggressive cutaneous soft tissue sarcoma of the dermis layer of the skin, with an incidence of 0.8 - 4.5 cases per million per year. Approximately 85 to 90% of DFSPs are low grade. While it predominantly arises on the trunk and proximal extremities, cervical involvement is exceedingly rare.

We report the case of a young male presenting with a cervical Dermatofibrosarcoma that was treated surgically.

Results

We report the case of a 44-year-old male who presented with a slowly enlarging cervical mass evolving over six years. The patient denied any recent weight loss, fever, night sweats or chills. On physical examination the patient presented with a nodular, erythematous-violaceous lesion with irregular borders, exophytic appearance, and central ulceration. It was firm and infiltrated, with vascularization marked by telangiectasias, measuring approximately 6 cm in diameter, located in the left supraclavicular fossa, with no palpable cervical lymphadenopathies. Histopathological examination confirmed DFSP, demonstrating a characteristic storiform pattern of spindle cells with CD34 immunoreactivity. Cervical MRI showed a hyper vascular lower cervical mass not infiltrating the muscle tissues. TAP-CT scans showed the presence of multiple pulmonary nodules. The pet scan then showed no suspicious hypermetabolic lesions other than the cervical mass. The patient then underwent a challenging wide excision of the tumor with a 3cm margin all around, and a skin graft a month later. Radiotherapy was not indicated in this case. The patient currently has no signs of local recurrence after surgery, and is under regular follow-up with sonography exam.

Conclusions

This case underscores the importance of early recognition of cervical DFSP and highlights the challenges in achieving complete surgical resection in anatomically complex regions.

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Topic: Cutaneous oncology

Transformed Mycosis Fungoides : Diagnostic, Prognostic and Therapeutic Challenges

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Introduction

Mycosis fungoides is the most common primary cutaneous T-cell lymphoma and usually follows an indolent clinical course. Large-cell transformation represents a rare but severe complication, associated with aggressive disease behavior and poor prognosis. Diagnosis relies on a close clinicopathological correlation supported by immunohistochemical findings.

Materials and Methods

We report a case of transformed mycosis fungoides highlighting the diagnostic and therapeutic challenges of this advanced stage.

Results

A 69-year-old woman with a 20-year history of type 2 diabetes treated with insulin, presented with chronic diffuse erythematous, scaly, and infiltrated nodular skin lesions. Clinical examination revealed multiple erythematous-violaceous infiltrated nodules and tumoral masses, some confluent or ulcerated, involving the trunk, back and limbs, associated with diffuse erythematous-scaly plaques and palmoplantar keratosis. Firm, painless axillary and inguinal lymphadenopathy was noted, with no mucosal or phanerian involvement.
Skin biopsy showed an epidermotropic lymphomatous proliferation composed of atypical medium- to large-sized lymphoid cells with increased mitotic activity, consistent with tumoral transformation. Immunohistochemical analysis demonstrated diffuse CD3 expression, a CD4-positive/CD8-negative phenotype, heterogeneous CD30 expression in approximately 30% of large tumor cells, and a high proliferative index (Ki-67 ≈ 70%), confirming the diagnosis of transformed mycosis fungoides. A complete staging work-up was performed, and the case was discussed at a multidisciplinary tumor board, leading to the initiation of systemic polychemotherapy based on the CHOP regimen.

Conclusions

Transformed mycosis fungoides represents a critical stage in the disease course and is associated with aggressive clinical behavior and poor prognosis. Accurate diagnosis requires close clinicopathological correlation supported by immunohistochemical findings, including CD30 expression and a high proliferative index. Early recognition of transformation is essential to allow prompt staging and initiation of appropriate systemic therapy. This case highlights the importance of vigilant follow-up and multidisciplinary management in patients with advanced mycosis fungoides.

Abstract N°: ID-1573

Topic: Cutaneous oncology

Acquired Ichthyosis as a Paraneoplastic Manifestation of Bladder Cancer: A Case Report

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Introduction

Acquired ichthyosis (AI) is a rare skin disorder characterized by generalized dry, scaly skin resembling fish scales. Unlike hereditary forms, AI typically occurs in adulthood and may be associated with systemic conditions, including malignancies. Several reports highlight its occurrence as a paraneoplastic phenomenon, particularly in lymphoproliferative disorders and solid tumors. Recognition of AI is crucial, as it can be an early cutaneous marker of an underlying neoplasm, prompting timely investigations. We report the case of a 64-year-old man presenting with acquired ichthyosis of the lower limbs, leading to the diagnosis of bladder cancer.

Materials and Methods

A 64-year-old man with no significant past medical history presented with progressive, adult-onset fish-scale-like hyperkeratosis, predominantly affecting the lower limbs. He had no prior dermatologic conditions.

Given the atypical presentation, further evaluation was performed. Uro-CT scan revealed a bladder mass with irregular tissue formations, and intravenous urography (UIV) confirmed a tumoral lesion associated with moderate right-sided hydronephrosis. Laboratory tests were within normal limits.The skin findings were interpreted as paraneoplastic acquired ichthyosis secondary to the bladder malignancy. While acquired ichthyosis is most commonly associated with hematologic malignancies such as Hodgkin's and non-Hodgkin's lymphoma, it has also been reported in association with solid tumors including breast, lung, and renal transitional cell carcinoma. Its occurrence with bladder cancer is rare but plausible.

The patient was referred to urology for definitive oncologic management, and dermatologic supportive care for skin scaling was initiated concurrently.

Results

Acquired ichthyosis is an uncommon dermatologic manifestation in adults and can serve as a paraneoplastic sign. The literature indicates that AI is most frequently associated with lymphomas, but associations with solid tumors such as bladder, lung, and gastric cancers have been reported.

The pathophysiology of paraneoplastic AI is not fully understood but may involve tumor-derived cytokines affecting epidermal differentiation, leading to hyperkeratosis. Typically, the presentation involves the lower limbs, with diffuse scaling resembling ichthyosis vulgaris.

Recognition of AI in adults should prompt systematic screening for underlying malignancies, especially when the presentation is sudden or extensive.In this patient, cutaneous signs preceded the discovery of a bladder tumor, highlighting the importance of multidisciplinary evaluation (dermatology, urology, oncology).

Conclusions

Adult-onset acquired ichthyosis can serve as a paraneoplastic marker of internal malignancy, including bladder cancer. Sudden or extensive ichthyosis, particularly on the lower limbs, should prompt comprehensive investigation for an underlying tumor, enabling earlier diagnosis, timely management, and supportive dermatologic care.

Abstract N°: ID-1575

Topic: Cutaneous oncology

The environmental burden of melanoma in the UK: a stage-specific carbon footprint analysis

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Introduction

Healthcare delivery contributes substantially to climate change, accounting for approximately 4–5% of global greenhouse gas emissions. Melanoma is a fatal cancer with rising incidence in the UK, where advanced stage disease is associated with significant morbidity, mortality, and escalating healthcare costs. While the clinical and economic burden of melanoma increases markedly with advancing stage at diagnosis, its environmental impact remains unquantified. Where NHS has committed to achieve net zero emissions by 2040, estimating the stage-specific carbon footprint of melanoma care provides critical evidence to show that prevention and early detection can reduce clinical harm, healthcare costs, and environmental burden of cancer care, supporting the delivery of sustainable healthcare systems. We aim to estimate the stage-specific carbon footprint of melanoma care.

Materials and Methods

Using published 2023 UK data on stage-specific melanoma costs and NHS reference costs, average healthcare costs for each stage of melanoma treatment were calculated. These costs were converted to estimated carbon emissions for each stage by applying a standard UK healthcare carbon intensity factor derived from environmentally extended input–output analysis.

Results

In 2023, average treatment costs for stage I–IV melanoma were £9,512, £77,813, £179,274, and £213,801 respectively. Estimated carbon emissions rose sharply with advancing stage, from ~1,482 $kgCO_2e$ for stage I to ~33,310 $kgCO_2e$ for stage IV, representing difference of approximately 31,828 $kgCO_2e$ and 22.5-fold increase.

Conclusions

This study provides the first UK stage-specific estimates of the carbon footprint of melanoma care, demonstrating exponential increases in emissions with advancing stage and the disproportionate environmental burden of late-stage disease. These findings underscore the urgent value of prevention, early detection, and timely intervention to maximise clinical benefit while reducing healthcare costs and carbon emissions. We emphasise the importance of incorporating environmental impact alongside economic and clinical outcomes to guide more sustainable cancer care in line with the NHS net-zero commitment.

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Topic: Cutaneous oncology

When the skin becomes armor: carcinoma en cuirasse revealing breast cancer progression

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Introduction

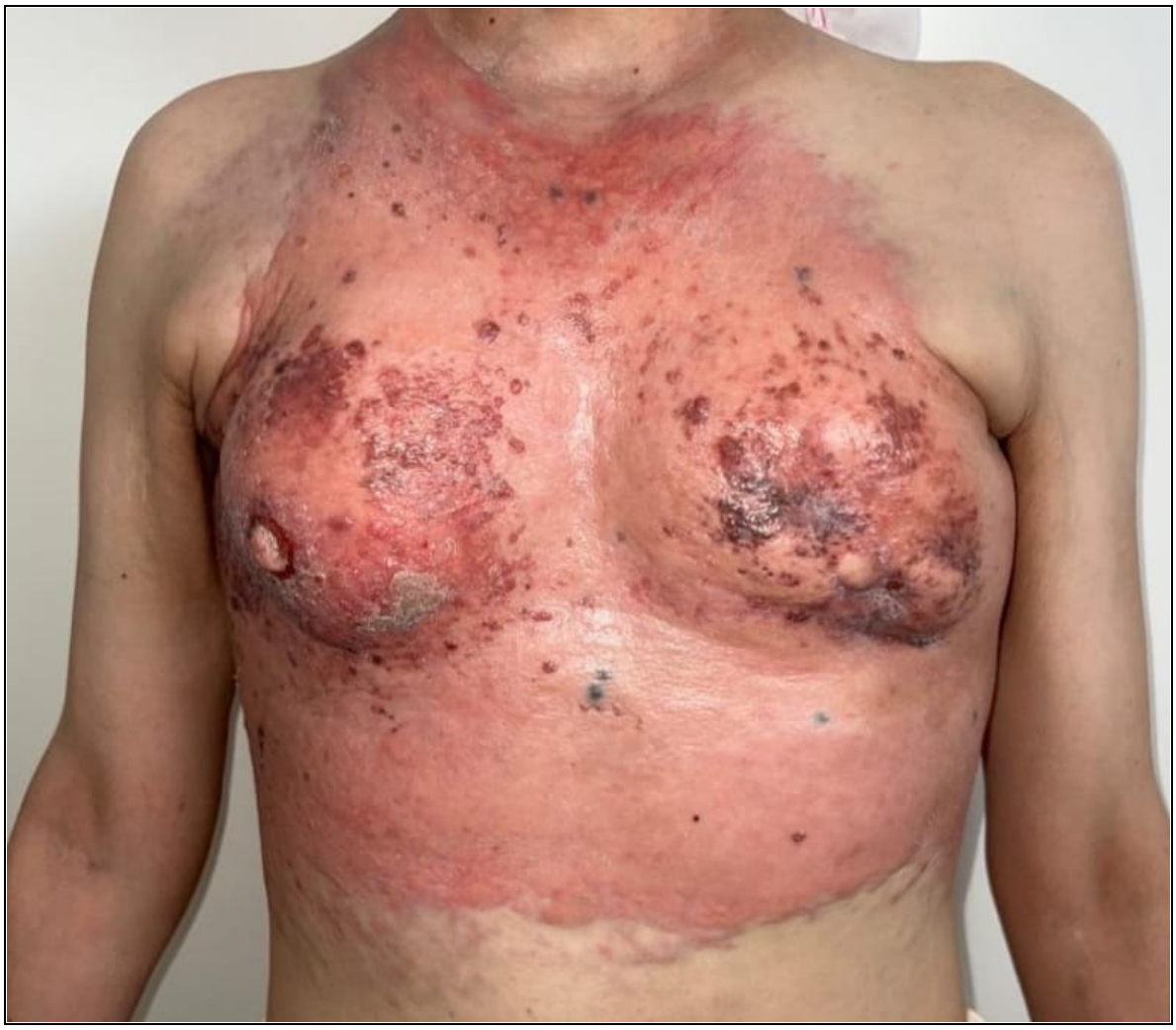
Carcinoma en cuirasse (CeC) is a rare and aggressive form of cutaneous metastasis most commonly associated with breast carcinoma. It is characterized by diffuse, indurated, sclerodermiform plaques infiltrating the skin and subcutaneous tissues, giving an armor-like appearance. CeC usually occurs after initial treatment of the primary tumor and reflects advanced disease.

Materials and Methods

We report the case of a 50-year-old woman followed since 2015 for left-sided invasive ductal breast carcinoma. She had previously undergone surgery, chemotherapy, radiotherapy, and was receiving hormone therapy. Disease progression was marked seven years later by the occurrence of pulmonary metastasis, followed by the appearance of an erythematous, indurated infiltrated plaque on the anterior chest wall, associated with multiple non-painful infiltrated papules and a peau d'orange aspect. Bilateral axillary lymphadenopathy was noted, in a context of general health deterioration.

Histopathological examination revealed a normal epidermis overlying a dermis and hypodermis infiltrated by a malignant epithelial proliferation arranged in cords and trabeculae. Tumor cells showed marked nuclear atypia with occasional mitotic figures. Immunohistochemical study (LEICA BOND-MAX platform) demonstrated strong expression of GATA3, E-cadherin, and estrogen receptors (intense staining in approximately 90% of tumor cells). These findings confirmed cutaneous invasion by a grade II invasive ductal carcinoma according to the Elston and Ellis classification.

The patient was referred to an oncology center for further multidisciplinary management.



Results

Carcinoma en cuirasse represents approximately 3–6% of cutaneous metastases in patients with breast cancer. It typically develops after initial treatment and progresses through two clinical phases: an early inflammatory phase with erythema and edema, often misdiagnosed as benign dermatoses, followed by a late phase characterized by diffuse sclerodermiform induration due to extensive stromal fibrosis. Histologically, tumor cells are often sparsely distributed within dense fibrotic stroma, sometimes arranged in “Indian file” patterns, which contributes to therapeutic resistance.

The clinical presentation may mimic post-radiation morphea, inflammatory breast cancer, radiodermatitis, or other cutaneous metastases, making histopathological confirmation essential. Prognosis remains poor, and no standardized treatment exists. Management is mainly palliative, relying on systemic therapies aimed at symptom control and quality-of-life improvement.

Conclusions

Carcinoma en cuirasse is a rare but distinctive manifestation of advanced breast cancer. Dermatologists play a crucial role in its early recognition and diagnosis through skin biopsy. This case highlights the importance of considering cutaneous metastasis in patients with a history of breast carcinoma presenting with indurated chest wall lesions.

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Topic: Cutaneous oncology

Non surgical treatment of a periocular basal cell carcinoma with imiquimod : a case report

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Introduction

Basal cell carcinoma (BCC) is the most common malignant skin tumor, predominantly affecting the head and neck, with about 20% occurring in the periocular region. Despite its slow growth and rare metastasis, periocular BCC poses a therapeutic challenge due to the high risk of aesthetic sequelae. Surgery, particularly Mohs micrographic surgery, remains the treatment of choice. When surgical intervention is not possible or refused, topical imiquimod represents an effective alternative, stimulating immune responses and inducing tumor cell apoptosis. We report a case of periocular BCC successfully treated with imiquimod, achieving excellent aesthetic results.

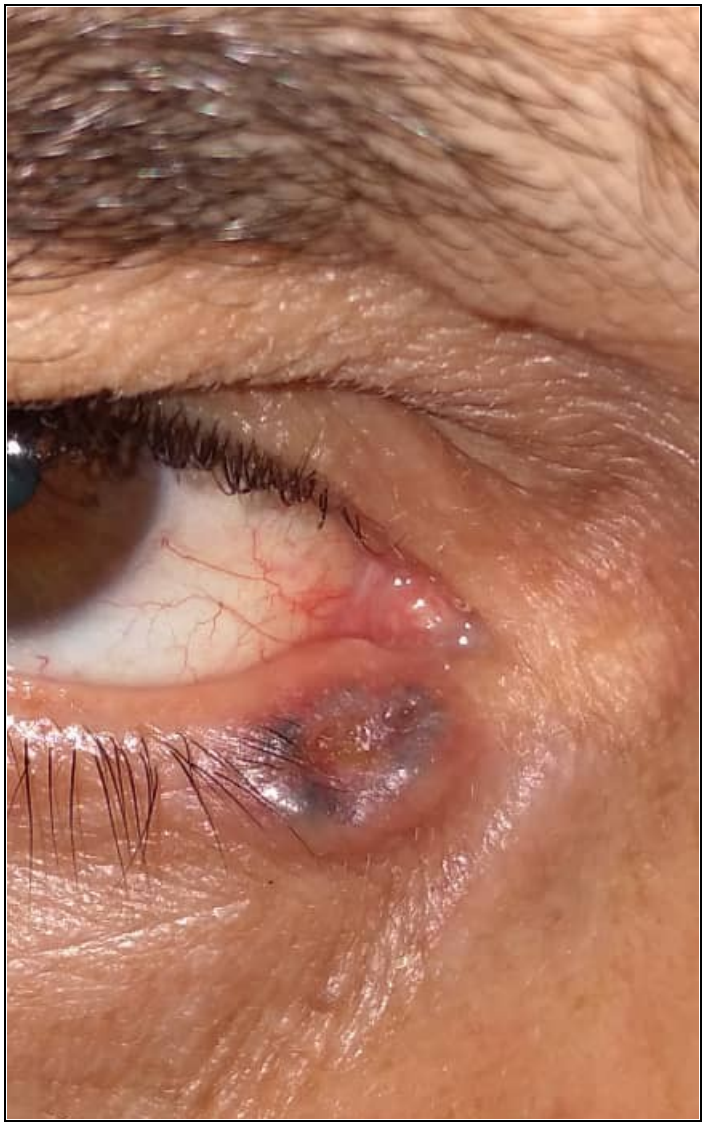

Figure 1: Periocular basal cell carcinoma before treatment with imiquimod

Results

A 48-year-old patient, phototype III, presented with a 6 mm pigmented papulonodular lesion on the lateral third of the right lower eyelid, evolving over 12 months. Clinical and dermoscopic examination suggested basal cell carcinoma (blue-gray dots and globules, fine telangiectasias), confirmed by biopsy as **nodular BCC**. Given the patient's refusal of surgery and the small size of the lesion, topical imiquimod was prescribed: three times per week for three months, then twice per week for three months, and once per week for the final three months. Only a local inflammatory reaction was observed. The lesion regressed completely, with no recurrence at 9 months, and the aesthetic outcome was excellent, without scarring or ocular functional impairment.

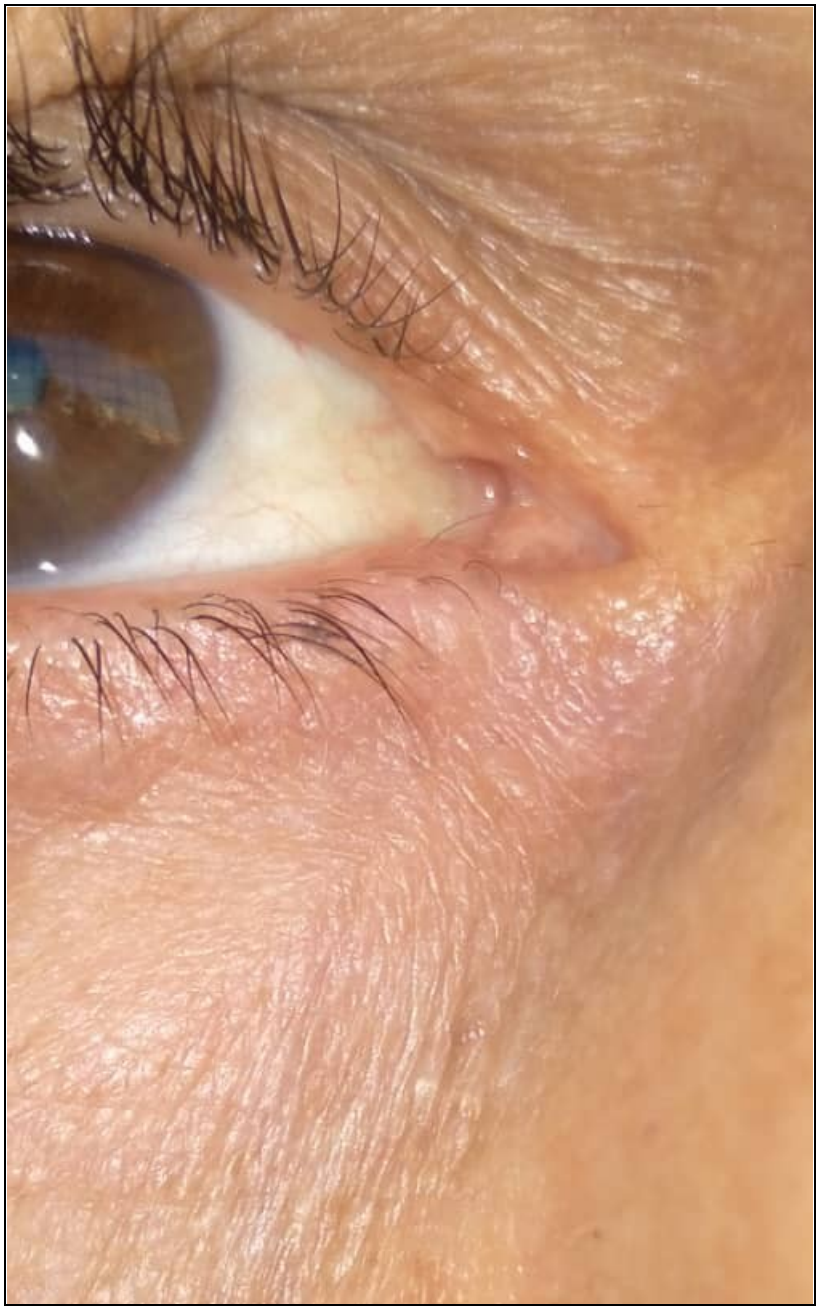

Figure 2: Complete resolution of the lesion after treatment with imiquimod

Conclusions

Topical 5% imiquimod is an effective non-surgical alternative for superficial and nodular periocular basal cell carcinoma, especially when surgery is risky or refused. Its mechanism involves stimulation of innate and adaptive immune responses, with generally good local tolerance and transient side effects. Gradual application schedules, such as three times per week, help minimize inflammation while maintaining efficacy. Aesthetic outcomes are excellent, with preservation of eyelid function. Regular follow-up is essential to detect potential recurrences.