Abstract N°: ID-51

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Labial Melanotic Macules: Clinical Features, Etiology, Histopathology and Association with Syndromes: A Systematic Review

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Introduction
Labial mucosal macules (LMM) are well-demarcated, hyperpigmented, and flat lesions. Although generally benign, accurate diagnosis of LMMs is essential because they have a broad differential diagnosis, may mimic malignant lesions such as mucosal melanoma, and can be associated with systemic syndromes.

Aim
This systematic review aimed to investigate the clinical characteristics, etiology, and histopathology of LMM and its association with systemic diseases.

Materials and Methods

A systematic literature search was conducted across PubMed, Google Scholar, and Web of Science databases to identify all reported cases of labial melanotic macules and their associated syndromic conditions, including Laugier–Hunziker syndrome, Peutz–Jeghers syndrome, and Addison’s disease. The search covered publications from June 1, 1981, to May 7, 2025.

Results

A total of 90 studies encompassing 130 patients with labial melanotic macules were included in this review. Among these, 70 patients were diagnosed with Laugier–Hunziker syndrome, 49 with Peutz–Jeghers syndrome, and 2 with Addison’s disease, while 9 patients had isolated labial melanotic macules without any associated systemic condition. LHS presented with melanonychia and hand pigmentation without malignancy; PJS with gastrointestinal tumors; and Addison’s disease with systemic features. Histopathology (31 studies) revealed basal layer hyperpigmentation, epidermal hyperplasia, pigment incontinence with melanophages, and normal to slightly increased melanocytes without atypia.

Conclusions

Our findings suggest that labial melanotic macules may serve as important clinical indicators of underlying systemic diseases or syndromic conditions. Therefore, a comprehensive evaluation to assess potential systemic involvement is essential to exclude clinically significant disorders, including genetic, endocrine, and gastrointestinal syndromes.

Abstract N°: ID-58

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Cutaneous Sarcoidosis Mimicking Lichen Planus: The Decisive Role of Dermoscopy in Early Systemic Diagnosis

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Introduction
Dermoscopy is an essential non-invasive diagnostic tool in daily dermatological practice, extending far beyond the evaluation of pigmented lesions. It plays a growing role in the assessment of inflammatory and granulomatous dermatoses. Cutaneous sarcoidosis is known as a great clinical imitator and frequently leads to delayed systemic diagnosis. We report a case in which dermoscopy was pivotal in establishing the correct diagnosis and initiating appropriate multidisciplinary management.

Materials and Methods
A 58-year-old woman presented with multiple small reddish-purple nodules localized on the upper back, persisting for several weeks. The patient had a history of unexplained shortness of breath. Prior to dermatological consultation, she had been treated for lichen planus by a therapist; secondary syphilis was excluded serologically. A complete dermatological examination was performed, followed by polarized dermoscopic evaluation of representative lesions. Based on dermoscopic findings, further investigations were initiated, including histopathological examination of a skin biopsy and chest computed tomography (CT).

Results
Clinically, the lesions appeared as firm, well-demarcated, livid-erythematous papules and nodules. Dermoscopy revealed a characteristic pattern consisting of multiple translucent orange-yellow areas, linear and arborizing vessels, and structureless zones, strongly suggestive of cutaneous sarcoidosis. A skin biopsy demonstrated non-caseating epithelioid granulomas, confirming the diagnosis. Chest CT revealed bilateral hilar lymphadenopathy consistent with systemic sarcoidosis. The patient was referred to a rheumatologist, and systemic therapy was initiated with significant clinical improvement of both cutaneous and respiratory manifestations.

Conclusions
This case highlights the critical role of dermoscopy as a rapid, non-invasive diagnostic tool in the evaluation of atypical inflammatory skin lesions. Dermoscopic recognition of sarcoidosis-specific patterns enabled early systemic investigation and definitive diagnosis, preventing further diagnostic delay and inappropriate treatment. Dermatologists play a key role in detecting systemic disease through careful dermoscopic assessment of the skin.

Abstract N°: ID-68

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Energy-Based Therapies are an Effective Treatment for Cutaneous Manifestations of Systemic Sclerosis: A Systematic Review of Health Outcomes

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Introduction
Systemic sclerosis (SSc) is a chronic autoimmune disease characterized by vasculopathy and fibrosis, with cutaneous manifestations including sclerosis, telangiectasias, microstomia, digital ulcers, and calcifications that can significantly impair quality of life. Systemic immunosuppressants are standard first-line therapy, but energy-based treatments provide targeted options with fewer systemic effects. This review evaluates the efficacy and safety of phototherapy, laser, and light-based interventions for cutaneous SSc.

Materials and Methods
A systematic review was conducted following PRISMA guidelines (PROSPERO CRD42024604860) using Medline, PubMed, and EMBASE. Studies reporting energy-based therapies in SSc were included. Sixty-three studies with 831 patients were analyzed. The mean age was 47.9 years (range 42–59), and 71% (n=589) were female. Cutaneous targets included telangiectasias (n=15), ulcers (n=10), microstomia (n=8), and sclerosis (n=20). Disease subtypes included diffuse and limited cutaneous SSc and one SSc-dermatomyositis overlap case. Risk of bias assessment revealed low risk in 10 studies (6.3%), moderate in 34 (53.1%), and high in 19 (30.1%).

Results
Phototherapy demonstrated benefit across sclerosis, vascular symptoms, and skin texture. UVA1 at 30 J/cm^2 three to four times per week across 11 studies achieved a 91.3% response rate (n=42/46), with 37% (n=17) complete response and 54.3% (n=25) partial response, improving sclerosis, Raynaud's symptoms, and finger mobility. PUVA improved skin hardness from 4 to 1–2, increased hand closure by 23.6 mm, and improved the Sclerosis Index by 2.3 points. Narrowband UVB reduced pruritus and papules to near-complete remission in 100% (n=8/8) of patients after 12–15 weekly sessions at 0.7–1.0 J/cm^2 per session. Extracorporeal photopheresis improved skin scores by 57% (n=1 study) at six months and in 59 patients receiving 37.5 cycles demonstrated 86% survival over 20 years (n=51) with reduced fibrosis biomarkers. PDL reduced telangiectasia lesions by 32% and achieved full clearance in 43.5% (n=10/23) of patients, improving Skindex QoL scores by 43.8%, with recurrence in 26% (n=6/23) at 6–36 months. Nd:YAG was effective in refractory telangiectasias after three sessions. Continuous-wave CO_2 laser increased interincisal distance by 4.8 mm at three months, with gains of 2–7 mm (n=5), improving mastication, phonation, and lip flexibility. CO_2 laser resolved pain completely in 57.1% of calcinosis lesions (n=12/21) and partially in 23.8% (n=5/21), with two recurrences at three to four months. Curettage enhanced calcinosis clearance with minimal scarring. LLLT improved pain, ulcer perfusion, and functionality with a VAS change of −7.1 in 100% (n=8/8) of patients over 42 exposures. IPL improved telangiectasia and ulcer perfusion in 70.6% (n=12/17). Reported adverse events were generally mild and included edema (0.2%, n=1), blistering (0.2%, n=1), pigment changes (0.4%, n=2), hyperkeratosis (0.8%, n=4), scarring or pitting (3.2%, n=17), infection (0.4%, n=2), hypotension or GI symptoms (1.1%, n=6), nausea (0.4%, n=2), hemolysis (0.2%, n=1), vasovagal reaction (0.2%, n=1), device clot (0.6%, n=3), and thrombocytopenia (0.2%, n=1). Only 54% of studies reported adverse events.

Conclusions

Energy-based therapies may provide benefits for specific cutaneous manifestations of SSc. PDL appears effective for telangiectasias, UVA1 may improve fibrosis and vascular symptoms, CO_2 laser shows potential for enhancing microstomia and calcinosis, and LLLT and IPL may support ulcer perfusion and pain relief. Recurrence remains a consideration for vascular lesions, and these therapies could serve as adjuncts or alternatives in cases where systemic therapy is limited. Further studies with standardized protocols and comparative designs are needed to define their clinical role.

Abstract N°: ID-110

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Clinical characteristics and treatment patterns of patients undergoing laser hair removal in Albania.

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Introduction
Laser hair removal (LHR) is a widely used dermatologic and cosmetic procedure for the management of unwanted hair and hirsutism. Data describing patient characteristics and treatment patterns in Southeastern Europe are limited, particularly from Albania. Documenting and understanding these characteristics may help guide local clinical practice, assess safety outcomes and identify patient subgroups that may benefit from closer dermatology- endocrinology collaboration.

Materials and Methods
We retrospectively reviewed 150 patients (143 females, 7 males) who underwent laser hair removal treatment using Alexandrite 755 nm and/or Nd:YAG 1064 nm lasers between April 2022 and January 2026. Laser parameters (fluence, pulse width, and spot size) were adjusted according to skin type, hair characteristics, and treatment area. Patients presenting with hirsutism were asked whether they had had been diagnosed with polycystic ovary syndrome (PCOS). Hirsutism subtype was classified after endocrinology consultation, including evaluation of circulating androgen levels.

Results
The mean age of the cohort was 31.1 years. Fitzpatrick skin types were I 8.7%, II 34.0%, III 36.0%, IV 20.7%, and V 1.3% respectively. The most frequently treated areas were the axillae (75.3%) and bikini line (72.7%). Facial treatment was common, with 67 patients receiving upper lip treatment and 63 of 143 females treated on the chin. Treatment parameters were tailored to skin type and hair characteristics. A fluence of 14 J/cm^2 was most commonly applied. Pulse widths of 10 ms and 20 ms were the most frequently selected. Spot sizes of 18 mm and 15 mm were predominantly used in the recorded treatment sessions. Hirsutism was present in 63 female patients (44.1%). Among these, 19 patients (13.3%) had documented polycystic ovary syndrome, while the remainder were classified as idiopathic following endocrine assessment. Treatments were generally well tolerated: transient erythema was most common, minor blistering occurred in 14 patients (9.3%), and one patient (0.7%) experienced urticaria with dermographism. Patients with comorbidities, including one with discoid lupus erythematosus, were treated safely without adverse events. No permanent sequelae or scarring were observed.

Conclusions
This study provides a descriptive overview of patients undergoing LHR in an Albanian clinical setting, highlighting common treatment sites, indications, and safety outcomes. Facial treatment, particularly of the chin and upper lip, was frequent, and idiopathic hirsutism represented a substantial subgroup. These findings support multidisciplinary evaluation and contribute to understanding patient characteristics in routine dermatological practice.

Abstract N°: ID-202

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Clinical and Pathogenetic Aspects of Erythema Multiforme Exudativum

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Introduction

Clinical and Pathogenetic Aspects of Erythema Multiforme Exudativum

Introduction: In recent years, the incidence of erythema multiforme exudativum (EME) has been increasing. According to the literature, EME accounts for 0.5–1% of all dermatological diseases. Some authors associate the etiology of EME with bacterial infections, while numerous publications report herpes-associated EME. A toxic-allergic mechanism of EME development has also been described. However, studies investigating the etiology, pathogenesis, and treatment of EME remain controversial and, in some cases, hypothetical.

Materials and Methods

Materials and Methods: A total of 101 patients who received outpatient and inpatient treatment were examined. Clinical characteristics and disease course were analyzed. A comprehensive set of investigations was conducted to identify pathogenetic features, clinical course characteristics, and mechanisms underlying the development of erythema multiforme exudativum. Hematological parameters were assessed, including IgE levels, eosinophil count, and C-reactive protein. Immunological studies included the determination of interleukins IL-1, IL-4, IL-6, IL-8, IL-10, as well as interferon levels. Polymerase chain reaction (PCR) and enzyme-linked immunosorbent assay (ELISA) were performed to detect herpes simplex virus types 1, 2, 3, and 4.

Results

Results: Among the 101 examined patients with EME, 48 were men and 53 were women. Among 68 patients tested by ELISA, 49 (72%) had IgG antibodies to herpes simplex virus type 1, and 12 (17.6%) to herpes simplex virus type 2. Analysis of triggering factors revealed that disease onset occurred against the background of acute respiratory infection in 12 (11.9%) patients. In 6 (5.9%) patients, skin rashes developed after a viral respiratory infection, and the same number after tonsillitis. In 14 (13.7%) patients, the onset coincided with active herpesvirus eruptions, while 10 (9.9%) patients considered hypothermia to be the provoking factor. At initial presentation, generalized skin eruptions were observed in 72 patients, while 29 patients had a localized process involving the oral mucosa and lips. The size of morphological elements ranged from 0.3 to 2.0 cm: 0.3–0.5 cm in 46 (45.5%) cases, 0.5–1.0 cm in 48 (47.5%), and up to 2.0 cm in 7 (6.9%) cases. The rash elements appeared as erythematous-squamous spots of round or predominantly oval shape, with slightly edematous margins and a mildly pigmented center in 65 (64.3%) cases. Erythematous lesions with vesicle formation were observed in 54 (53.4%) cases. Lesions were bright red in 88 (87.1%) patients, pink with a brownish tint in 10 (9.9%), and pinkish-red in 3 (2.9%). Rash localization most commonly involved the trunk in 64 (63.3%) patients, extremities in 37 (36.6%), oral mucosa in 35 (34.3%), neck in 16 (15.8%), chest in 20 (19.8%), shoulders and forearms in 12 (11.8%), back in 7 (6.9%), abdomen in 19 (18.8%), and thighs in 11 (10.8%). Residual hyperpigmented macules remained at sites of lesion resolution. During the course of the disease, eruptions appeared in recurrent, wave-like

episodes. Two episodes were reported by 39 patients, three episodes by 13 patients. The duration of dermatosis ranged from 2 to 17 weeks.

Conclusions

Conclusion: A provoking factor was identified in 50 (49.5%) patients with erythema multiforme exudativum. In 35 (34.3%) patients, clinical manifestations began with lesions of the oral mucosa and lips. Disease onset was associated with previous viral illnesses or occurred during respiratory infections. The findings of this study support a differentiated approach to the treatment of EME and contribute to the development of diagnostic algorithms and subsequent etiological and pathogenetic therapy.

Abstract N°: ID-209

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Cutaneous Manifestations of Complete Melkersson–Rosenthal Syndrome with Unusual Cranial Nerve Involvement: A Case Report

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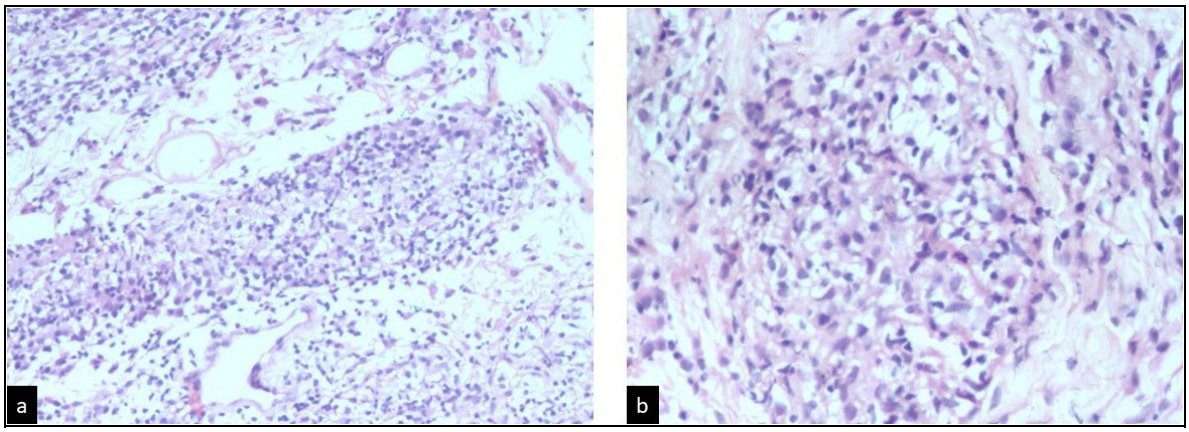
Introduction
Melkersson–Rosenthal syndrome (MRS) is a rare granulomatous disorder classically defined by the triad of recurrent orofacial swelling, facial nerve palsy, and fissured tongue. Cutaneous manifestations, particularly orofacial edema and granulomatous cheilitis, often represent the earliest and most prominent features. Neurological involvement is usually limited to unilateral facial nerve palsy, while bilateral facial nerve and glossopharyngeal nerve involvement is exceedingly rare. Early recognition of dermatological signs is crucial for accurate diagnosis and timely intervention. We report a case of Melkersson–Rosenthal syndrome presenting with bilateral facial and glossopharyngeal nerve involvement.

Materials and Methods
A 34-year-old woman presented with recurrent periorbital and lower lip swelling for eight months, which became persistent over the preceding two months. Over the last three months, she developed slurred speech, drooling, nasal regurgitation, and intermittent headaches. Cutaneous examination revealed firm, non-tender periorbital edema, macrocheilia, and a midline fissured tongue. Routine hematological investigations, HRCT thorax, and MRI brain were unremarkable. Infectious, autoimmune, and other granulomatous disorders were excluded through serological and special investigations. Punch biopsies from the lower lip and chin were performed, and histopathological analysis was carried out using hematoxylin–eosin staining.

Results
Histopathological examination demonstrated non-caseating granulomas composed of epithelioid histiocytes and lymphocytes within the dermis, consistent with granulomatous cheilitis. Special stains for infectious organisms were negative, confirming the diagnosis of Melkersson–Rosenthal syndrome. Neurological evaluation revealed bilateral facial nerve weakness along with an absent gag reflex, indicating glossopharyngeal nerve involvement. The patient was treated with oral prednisolone (0.5 mg/kg/day), resulting in partial improvement of facial swelling and neurological deficits. She was subsequently transitioned to oral thalidomide as a steroid-sparing agent, with continued clinical improvement.



(a) Deep dermal non-caseating granulomas with associated dermal edema, composed predominantly of epithelioid histiocytes and lymphocytes (haematoxylin and eosin, ×100). (b) Higher-magnification view demonstrating well-formed epithelioid granulomas without evidence of necrosis (haematoxylin and eosin, ×400).

Conclusions

This case underscores the importance of cutaneous manifestations as the initial presentation of Melkersson–Rosenthal syndrome, associated with the rare occurrence of bilateral facial and glossopharyngeal nerve involvement. Recognition of dermatological features such as recurrent orofacial edema and fissured tongue is essential for early diagnosis. Prompt initiation of immunosuppressive therapy may prevent permanent cranial nerve deficits. Dermatologists should remain vigilant for atypical neurological involvement in MRS, as early intervention significantly improves outcomes.

Abstract N°: ID-240

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Prurigo pigmentosa associated with diabetic ketoacidosis: a case report and literature review

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Introduction

Prurigo pigmentosa is a rare inflammatory dermatosis characterized by the abrupt onset of intensely pruritic, reticulated erythematous papules that evolve into hyperpigmented lesions. Although its pathogenesis remains poorly understood, the condition has been strongly associated with metabolic states involving ketosis, particularly diabetic ketoacidosis (DKA) and ketogenic diets. Cutaneous manifestations may precede or accompany systemic symptoms, making prurigo pigmentosa an important dermatologic clue for identifying underlying metabolic disturbances. Skin involvement in DKA is uncommon, and prurigo pigmentosa represents a rare but significant sign of ketosis.

Materials and Methods

A 19-year-old male with no significant medical history presented to the emergency department with a one-week history of progressive fatigue, dyspnea, abdominal pain, and recurrent vomiting. On examination, he was confused (GCS 14) and tachycardic (130 bpm), with stable blood pressure and oxygen saturation. He was afebrile and showed no signs of infection.
Dermatologic examination revealed pruritic, erythematous papules arranged in a characteristic reticular pattern on the trunk, which had appeared abruptly over the previous 48 hours. Within 72 hours, these lesions evolved into hyperpigmented macules while maintaining their reticulated configuration, consistent with prurigo pigmentosa. The patient denied adherence to a ketogenic diet and had no prior diagnosis of diabetes.
Dermoscopy showed reticular pigmentation, a negative pigment network, erythema, and telangiectatic vessels.
Laboratory investigations revealed severe hyperglycemia (408 mg/dL), metabolic acidosis, glycosuria, and ketonuria, confirming the diagnosis of diabetic ketoacidosis. Treatment with intravenous fluids and insulin was promptly initiated.
Histopathological examination of a skin biopsy demonstrated neutrophilic perivascular infiltrates and spongiosis, supporting the diagnosis of prurigo pigmentosa. Following correction of the metabolic abnormalities, the patient's systemic symptoms improved, and the skin lesions gradually resolved.

Results

Prurigo pigmentosa typically presents as pruritic, reticulated erythematous papules localized to the trunk, which rapidly evolve into hyperpigmented lesions. Histological findings support its classification as an inflammatory dermatosis. Dermoscopic features vary according to lesion stage, ranging from vascular pink structures in early lesions to granular pigmentation in resolving stages.
Although prurigo pigmentosa is most frequently reported in individuals following ketogenic diets, its association with DKA remains rare. The underlying mechanism is not fully understood, but metabolic shifts related to ketosis, increased ketone production, and oxidative stress are thought to trigger the inflammatory response. In this case, the absence of dietary triggers or prior diabetes suggests that DKA alone was sufficient to induce the condition. The resolution of cutaneous lesions following metabolic correction further supports a direct link between prurigo pigmentosa and ketosis.

Conclusions

This case highlights prurigo pigmentosa as an uncommon yet important dermatologic manifestation of diabetic ketoacidosis, particularly in patients without a known history of diabetes. Early recognition of its characteristic skin findings can facilitate prompt diagnosis and management of underlying metabolic disturbances, thereby improving clinical outcomes. Increased awareness of this association may allow clinicians to identify ketosis-related conditions earlier and initiate timely treatment.

Abstract N°: ID-241

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Case Report – A confirmed case of Euthyroid Pretibial Myxoedema and the use of dermoscopy as a tool in aiding diagnosis

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Introduction

Pretibial myxoedema (PTM) is a rare autoimmune dermopathy characteristically associated with Grave's Disease (and rarely Hashimoto's thyroiditis), documented to be commonly associated with elevated concentrations of thyroid-stimulating hormone receptor (TSH-R) antibodies (1). In this report, we describe the case of a 77-year-old lady without previous thyroid disease, normal thyroid function tests and negative TSH-R antibodies with biopsy confirmed PTM. Although there are case of euthyroid PTM reported in the literature, many are notable for being in patients with previous thyroid disease or intervention, or abnormal thyroid function results during the course of their care (2-7). In addition, the use of dermoscopy in these cases is typically omitted. The objectives of this report are twofold: firstly, to contribute to the literature describing PTM in euthyroid patients with normal TSH titers, absent TSH-R antibodies, and no previous thyroid disease (8); and secondly—and importantly—to highlight the utility of dermoscopy in supporting diagnosis in these rare cases, potentially avoiding unnecessary biopsies.

Materials and Methods

This patient, who had a background of Chronic Obstructive Pulmonary Disease and Polymyalgia Rheumatica, presented to the urgent skin cancer clinic with bilateral anterior lower leg skin changes. She described a six-week history of marked redness and mild soreness of the shins. She denied any systemic symptoms consistent with thyroid disease. On examination, she had bilateral thickened erythematous and hyperpigmented skin that was limited to the anterior shins with some associated oedema. Dermoscopic examination revealed scale on a background of shiny white lines and amorphous white areas with red dots. Clinical examination found no other features of thyroid disease.

Results

Initial blood tests revealed normal TSH of 2.55 mIU/L and normal TSH receptor antibodies of 1.6 IU/L. Skin biopsy was performed and this demonstrated increased dermal mucin consistent with a diagnosis of pretibial myxedema. The skin changes remain unchanged after 6 months and repeat thyroid function tests remain normal.

Conclusions

This case report highlights that PTM is an important consideration even in patients lacking any thyroid abnormality in their history or investigation results. In addition, whilst current literature frequently demonstrates biopsy results in absence of dermoscopy, this case underlines the dermoscopic findings supportive of a diagnosis of PTM, consistent with those described in the literature (9). Use of this readily available tool may negate the requirement for routine use of biopsy in cases where the diagnosis of PTM is unclear.

Abstract N°: ID-247

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

The Skin-Brain Axis: Exploring Neuroinflammation's Role in Dermatological and Neurological Disorders

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Introduction

The skin–brain axis describes bidirectional neuroimmune communication in which psychological stress alters skin inflammation and, conversely, chronic cutaneous inflammation can influence central nervous system (CNS) function. Psoriasis is increasingly linked to neurodegenerative disease risk, including Alzheimer's disease (AD), through shared inflammatory pathways.The aims of this literature review is to explore mechanistic links between psoriasis and AD across the skin–brain axis, and summarise emerging diagnostic and therapeutic implications for dermatology.

Materials and Methods

A comprehensive literature search was conducted using PubMed, Google Scholar, ScienceDirect, Scopus, and Web of Science to identify peer-reviewed English-language articles relevant to neuroimmune interactions, psoriasis, Alzheimer's disease, neuroinflammation, immune signaling, biomarkers, and treatment within the skin–brain axis context.

Results

Stress-mediated activation of the hypothalamic–pituitary–adrenal axis and neuropeptides (corticotropin-releasing hormone, cortisol and substance P) modulate keratinocyte, mast-cell and T-cell activity, amplifying cutaneous inflammation. Circulating cytokines central to psoriasis—IL-17, IL-23, TNF-α and IL-6—are also implicated in Alzheimer's Disease-associated neuroinflammation and may contribute to BBB dysfunction and downstream microglial and astrocyte activation. Systemic inflammatory burden is further shaped by common comorbidities (obesity, type 2 diabetes, hypertension and dyslipidaemia), which may accelerate later-life cognitive decline. Therapeutic overlap is emerging: biologics targeting TNF-α or IL-17 and agents modulating JAK-STAT signalling may plausibly attenuate inflammatory crosstalk across skin and CNS compartments. Diagnostic innovation includes skin-based detection of pathological tau/amyloid signatures and AI-assisted phenotyping to refine classification and support personalised risk stratification.

Conclusions

The skin–brain axis represents a dynamic neuroimmune interface with shared inflammatory pathways underlying chronic skin and neurodegenerative diseases. Targeting common cytokines offers dual therapeutic potential. Advances in skin biomarkers and AI diagnostics provide new avenues for integrated management. Prospective longitudinal studies are needed to clarify causality, validate clinically actionable skin biomarkers, and determine whether systemic anti-inflammatory treatment modifies long-term cognitive outcomes. Dermatology-led screening for neuropsychiatric symptoms and collaborative care pathways may improve holistic patient management.

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Abstract N°: ID-312

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Erythrodermic sarcoidosis with systemic involvement during vaccination for COVID-19: possible links to molecular mimicry

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Introduction

Post-vaccinal and parainfectious activation of the immunity with subsequent development of a certain immunological disease is not rare in the clinical practice. This concept is mentioned in relation to molecular/antigenic mimicry. To this day, the pathogenesis of sarcoidosis and sarcoid-type reactions remains a mystery. Moreover, they can be a warning sign of changes in tissue homeostasis, whether they are infectious, noninfectious- immunological, tumor-related, drug related etc.

Materials and Methods

We present a rare case of a patient with erythrodermic sarcoidosis (Fig.1a-d) with systemic involvement (pericarditis, supraventricular tachycardia, hepatitis, iritis/iridocyclitis, pulmonary fibrosis/bihilar lymphadenopathy, and arthritis) developed after receiving the ChadOx1-S vaccine for COVID- 19.

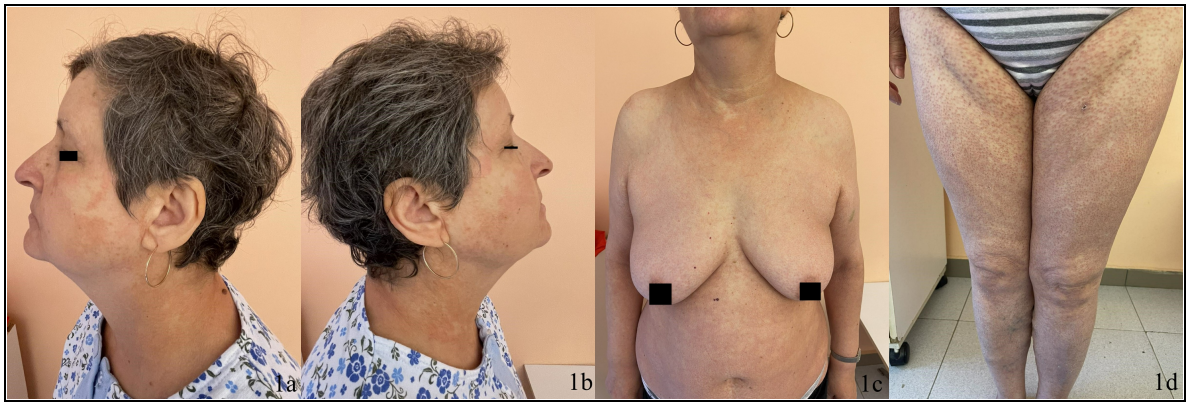

Fig.1a-d: Small erythematous papules with follicular and parafollicular localization, confluating between each other, occupying the face (a,b), torso (c), and lower (d) limbs, in the form of erythrodermia.

Results

Histology revealed cutaneous sarcoidosis (Fig.2a-d).Systemic immunosuppressive therapy with Methylprednisolone was introduced according to a scheme (in a reduction mode with an initial dose of 40 mg/day intravenously) in combination with topical Pimecrolimus 1% cream twice a day.

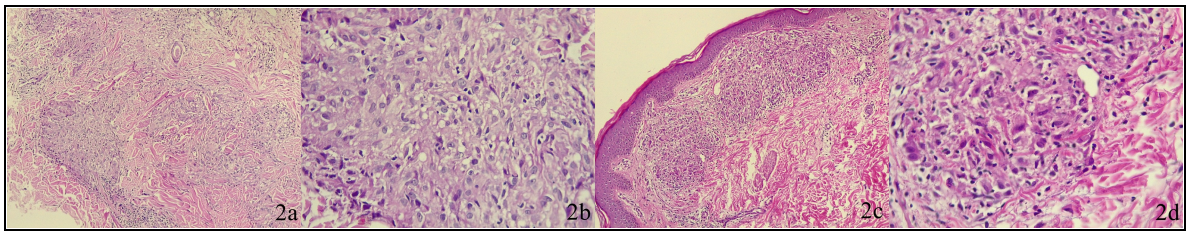

Fig.2a-d: cutaneous sarcoidosis: orthohyperkeratosis horizontally alternating with parakeratosis, uniform acanthosis with elongation and confluence of the distal parts of the epidermal ridges, diffuse sarcoid granuloma band of epithelioid cells and lymphocytes with single Langhans-type giant cells in the upper and middle dermal segments. 2a: 1450 x 100 (H&E) - sarcoid granulomas composed of well-differentiated syncytium of epithelioid cells, delimited by a lymphoid shaft, located in the middle dermal segment 2b: 1450 x 400 (H&E) - epithelioid cells with centrally located oval nuclei with evenly distributed chromatin and large bright cytoplasms 2c: 1451x100 (H&E) - well-differentiated sarcoid granulomas located in papillary dermis 2d: 1451x400 (H&E) - sarcoid granuloma represented by epithelioid cells with centrally located nuclei and light cytoplasm

Conclusions

Rapid improvement of the symptoms was observed within the first two days of treatment (Fig.3a-d). According to the scientific literature, the presented patient turns out to be the first case of erythrodermic sarcoidosis (with systemic involvement), described as a side effect after vaccination and/or administration of a certain medicinal form.

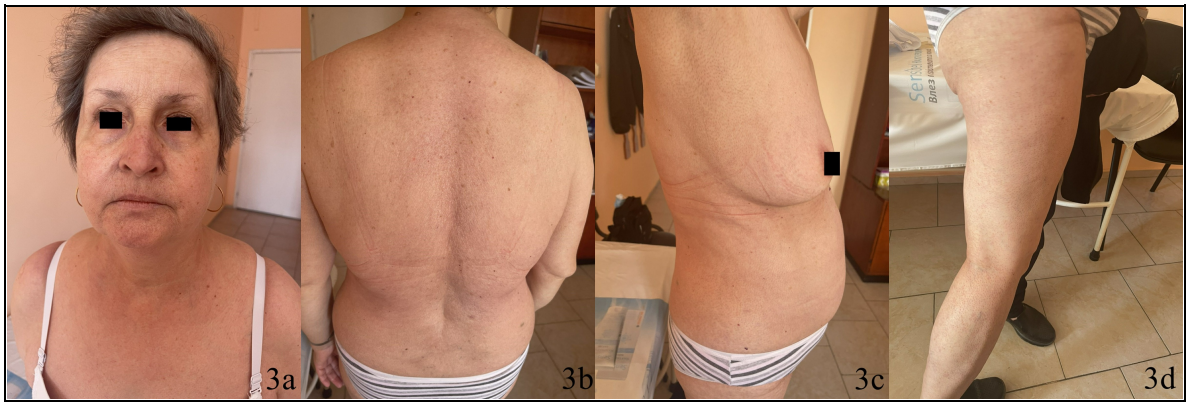

Fig.3a-d: Patient's outcome after successful treatment for sarcoidosis. No signs of suberythrodermia

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ATHENS 7 - 9 MAY

Abstract N°: ID-341

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Simultaneous Occurrence of Sweet Syndrome and Necrobiosis Lipoidica in Patient with Several Cancers

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[2]Sofia University Saint Kliment Ohridski, Faculty of Medicine, Department of Internal Diseases, Pharmacology and Clinical Pharmacology, Pediatrics, Epidemiology, Infectious Diseases, and Skin Diseases, Sofia, Bulgaria
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Introduction

Acute neutrophilic dermatosis, also known as Sweet syndrome, is a rare disorder that can arise from various etiologies, and in some cases, remains idiopathic. Malignancy-associated Sweet syndrome is uncommon and is often misdiagnosed for years before the correct diagnosis is established.

Necrobiosis lipoidica is an inflammatory granulomatous skin disorder often associated with diabetes mellitus, but it may also occur in patients with hypertension, thyroid disease, other inflammatory conditions, or even in otherwise healthy individuals. Rare associations with malignancy have also been described.

Materials and Methods

We report the case of a 64-year-old male presenting with the simultaneous occurrence of Sweet syndrome and Necrobiosis lipoidica (Fig.1a-d) on the background of pulmonal and bladder cancer. Infectious, drug-induced, and inflammatory etiologies of the disease were excluded as possible inductors. Routine investigations revealed a pulmonary tumor, alongside a past medical history of low-grade urothelial papillary carcinoma.

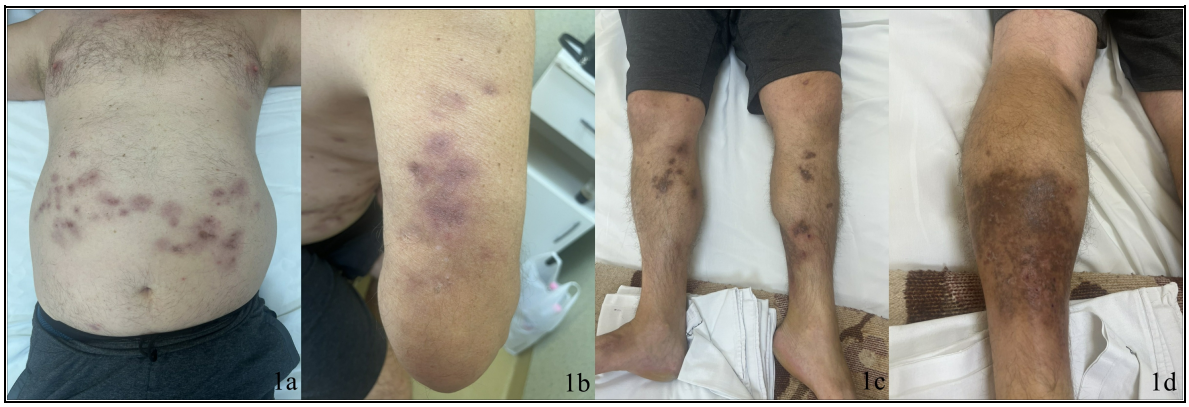

Figure 1a-d: Plaques of various sizes with fibrotic changes and post-inflammatory pigmentation in the abdominal area (a,) and right upper extremity (a). On the right and left lower legs (c,d), erythematous plaques and nodules are present, some covered with hemorrhagic crusts.

Results

Histology was compatible with acute neutrophilic febrile dermatosis / Sweet syndrome (Fig.2a,b). Histology from the left lower leg was compatible with Necrobiosis lipoidica (Fig.2c,d).

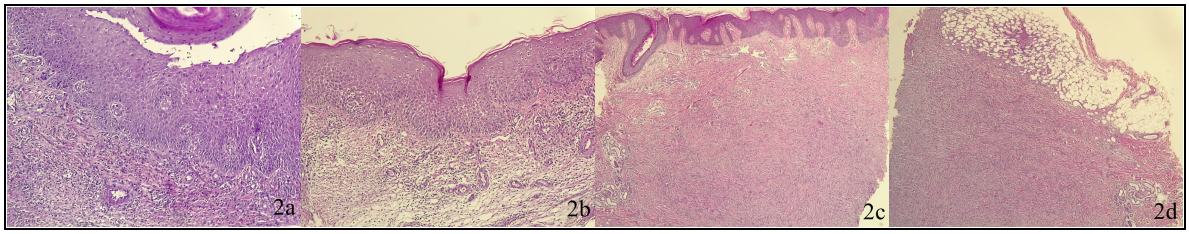

Figure 2a-d: Acute neutrophilic febrile dermatosis / Sweet syndrome: abundant parakeratosis, irregular acantholysis, pronounced neutrophil extravasation, moderate interstitial mixed inflammatory infiltrate with many segmentonuclear neutrophils throughout the dermis, fibrinoid necrosis (a) of small-caliber vessels with foci of neutrophilic abscesses in the middle dermal compartment (a,b). Necrobiosis lipoidica (c,d). 2a: fibrinoid necrosis x SS x 100 x HE 2b: Sweet syndrome x 100 x HE 2c: Necrobiosis lipoidica x HE x 40 2d: Necrobiosis lipoidica - septal panniculitis x HE x 100

Conclusions

The presence of multiple neoplasias was considered as the most likely causative factor for the exacerbation of Sweet syndrome.

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Abstract N°: ID-352

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Pseudoglucagonoma Syndrome: Necrolytic Migratory Erythema in a Patient with Dysbalance between Omega-6/Omega-3 Fatty Acids and multi drug intake: A Rare Presentation in a Bulgarian Patient

Simona Kordeva*[1], James Patterson[2], Valentina Broshtilova-Nikolova[3], Konstantin Tchernev Jr[4], Georgi Tchernev[1, 4]

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Introduction

Pseudoglucagonoma syndrome is an extremely rare condition characterized by necrolytic migratory erythema (NME) in the absence of a glucagon- secreting tumor. NME has been associated with a variety of underlying conditions, including hepatocellular dysfunction, nutritional deficiencies, and etc.

Materials and Methods

We report a rare case of a 69-year-old male diagnosed with pseudoglucagonoma syndrome. Dermatological examination revealed a disseminated polymorphic rash involving the face, trunk, upper and lower limbs (fig.1a-e).

Regarding the polymorphic rash distributed across the entire body and accompanied by mild pruritus, several conditions were considered in the differential diagnostic plan, including the possibility of an overlap syndrome. The main differential diagnoses included erythema necroliticum migrans, parapsoriasis, erythema annulare, and mycosis fungoides. Four skin biopsies were obtained from different lesions.

The condition was likely triggered by the patient's polymedication for type 2 diabetes mellitus and arterial hypertension. His medical history was notable for metabolic syndrome, hepatic steatosis, and hyperuricemia.

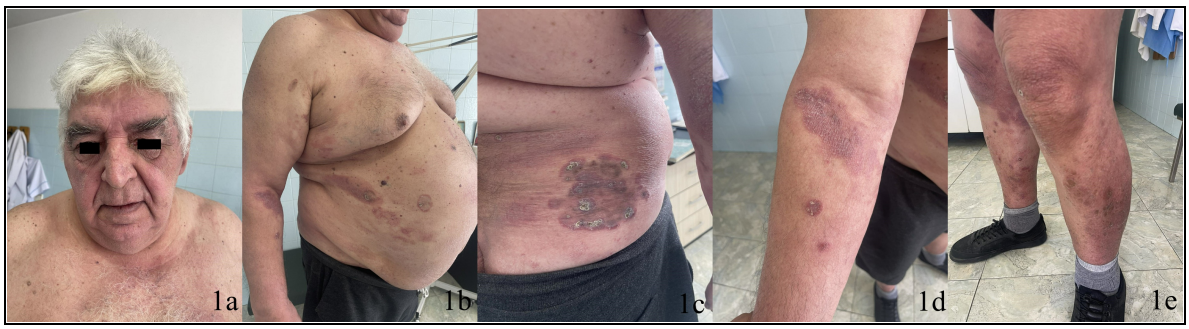

Fig.1a-e: Dermatological findings 1a: Diffuse erythema on the face, in a sun-exposed area, accompanied by scaling. Actinic and seborreic keratoses can be observed on the face and neck areas. 1b: Erythematous plaques of various sizes with fine desquamation are present. Annular lesions with a prominent, active erythematous edge and central clearing, often accompanied by peripheral scaling, are also observed. In addition, pigmented maculopapular plaques are noted. 1c: A well-demarcated plaque, measuring approximately 10-12 cm I diameter, violaceous in color, with a hyperpigmented center, located in the left lower back region. Peripheral hyperpigmented edge with silvery scales and crusting erosions in some areas

are seen. 1d,e: Well-demarcated violaceous to erythematous patches and plaques with scaling and hyperpigmentation are seen in the right upper extremity (d) and both lower leg (e) regions.

Results

Histology confirmed NME without evidence of glucagonoma (fig.2a-c).

Additional dysbalance in the fatty acid levels were noted. Following the discontinuation of the suspected culprit medications, the patient showed rapid clinical improvement.

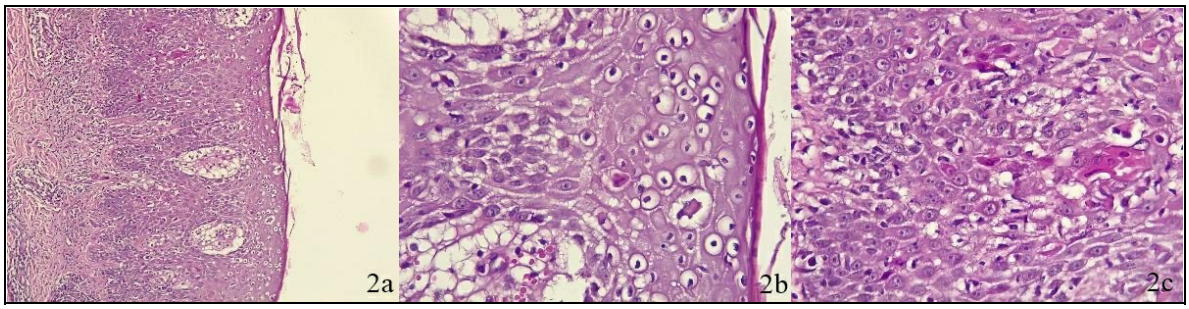

Fig.2a-c: Histology panel: Erythema necrolyticum migrans: 2a: ENM x 100 x HE parakeratosis, abundent apoptotic cells, psoriasiform hyperplasia, and prominant angioplasia in the papillary dermis. 2b: ENM x 200 x HE apoptotic cells in the superficial epidermal segment 2c: ENM x 200 x HE neutrophil exocytosis and papillary dermis angioplasia

Conclusions

A new classification of NME is proposed, and a multifactorial pathogenesis is suggested in the context of the pseudoglucagonoma syndrome development.

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ATHENS 7 - 9 MAY

Abstract N°: ID-398

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Indolent Scalp Nodule as a Sentinel of Systemic Spread: Cutaneous Metastasis from Invasive Breast Carcinoma

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

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

Introduction

Cutaneous metastasis is an uncommon manifestation of internal malignancies and usually indicates advanced systemic disease. Breast carcinoma is the most common primary tumor associated with cutaneous metastases in women. The clinical appearance of these lesions is variable and may resemble benign dermatological conditions, resulting in delayed diagnosis. We report a case of cutaneous metastasis to the scalp from invasive breast carcinoma presenting as a slow-growing, asymptomatic nodule

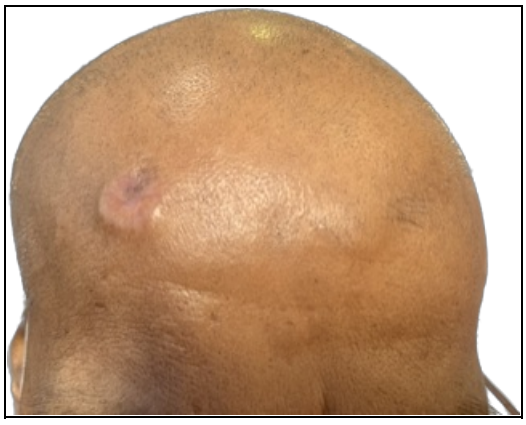
Materials and Methods

A 69-year-old female was diagnosed with left-sided invasive breast carcinoma in 2019 and underwent left mastectomy with axillary clearance, followed by adjuvant chemotherapy and radiotherapy. She has been on tamoxifen therapy. Since 2022, she was known to have lung and anterior chest wall bone metastases.

She presented with a single, skin-colored, asymptomatic lump over the right side of the scalp for one year, without any history of rapid enlargement or ulceration. There were no similar lesions elsewhere on the body.

Cutaneous examination revealed a well-defined, skin-colored nodule measuring approximately 2 cm in diameter over the upper right forehead, with multiple overlying telangiectasias. There was no pigmentation, perilesional halo, scaling, or associated cervical lymphadenopathy.

A skin incisional biopsy was performed, followed by histopathological examination and immunohistochemistry. Polymerase chain reaction (PCR) testing for Leishmania was also carried out to exclude infectious etiologies.



Results

Histopathological examination revealed infiltration of the dermis by malignant tumor cells arranged in nests and cords, consistent with metastatic carcinoma. Immunohistochemistry showed CK7 positivity in tumor cells and CK20 negativity. E-cadherin demonstrated membranous positivity in tumor cells. These findings were consistent with cutaneous metastatic deposits from the previously diagnosed invasive breast carcinoma. Leishmania PCR was negative

Conclusions

This case underscores the importance of considering cutaneous metastasis in the differential diagnosis of solitary, asymptomatic skin nodules in patients with a history of malignancy. Even in the absence of rapid progression or ulceration, biopsy and immunohistochemical evaluation are essential for early diagnosis and appropriate oncological management.

Abstract N°: ID-412

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Indolent Scalp Nodule as a Sentinel of Systemic Spread: Cutaneous Metastasis from Invasive Breast Carcinoma

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

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

Introduction

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Materials and Methods

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Abstract N°: ID-460

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Dermatological manifestations in Cronkhite–Canada syndrome: insights from a case report

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Introduction

Cronkhite–Canada syndrome is a rare, non-hereditary condition characterized by diffuse gastrointestinal polyposis associated with prominent ectodermal manifestations. The triad of acquired cutaneous hyperpigmentation, diffuse non-scarring alopecia, and nail dystrophy may precede, accompany, or reveal gastrointestinal involvement. Recognition of this clinical constellation is crucial for early diagnostic orientation in this multisystem disorder.

Materials and Methods

We report the case of a 70-year-old woman referred for dermatological evaluation because of progressive diffuse hyperpigmentation evolving over three months. A comprehensive dermatological examination was performed, followed by multidisciplinary investigations to identify an underlying systemic condition.

Results

Clinical examination revealed diffuse hyperpigmentation predominantly involving the palms, back, and limbs, occasionally interspersed with hypopigmented areas. Non-scarring frontoparietal alopecia was observed, associated with eyebrow loss and generalized body hair thinning. Nail examination showed involvement of all twenty nails, characterized by xanthonychia, onychomadesis, and pachyonychia. Each nail displayed a thin, flexible proximal triangular zone followed by a thickened, striated, dystrophic distal plate.

These cutaneous and nail abnormalities occurred in a context of general fatigue, weight loss, and chronic watery diarrhea. Biological investigations suggested a malabsorption syndrome. Imaging revealed polypoid thickening of the gastrointestinal tract, and endoscopic evaluation demonstrated multiple colonic polypoid lesions. Histopathological analysis confirmed a hamartomatous polyposis consistent with Cronkhite–Canada syndrome.

Conclusions

This case highlights the pivotal role of dermatological examination in the recognition of rare systemic diseases. The association of acquired hyperpigmentation, diffuse alopecia, and atypical nail dystrophy should prompt consideration of Cronkhite–Canada syndrome, even outside traditionally affected populations. Early identification of this ectodermal triad can guide timely gastrointestinal investigation and multidisciplinary management, which are essential to improve prognosis in this complex disorder.

Abstract N°: ID-611

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

When Interferon Blockade Backfires: Anifrolumab-Induced Lichenoid Eruption

Ioana Denise Badea*[1], Lorena Anisa Apostol[1], Monica Moza[1], Larisa Alexandra Mateescu[1], Costina Cristiana Mutu[1, 2], Elena Daniela Serban[1, 2], Stefana Bucur[1, 2], Maria Magdalena Constantin[1, 2]

[1]Colentina Clinical Hospital, Dermatology II, Bucharest, Romania
[2]Carol Davila University of Medicine and Pharmacy, Bucharest, Romania

Introduction

Systemic lupus erythematosus (SLE) is a chronic autoimmune disease frequently associated with cutaneous involvement. Anifrolumab, a monoclonal antibody targeting the type I interferon receptor, has demonstrated efficacy in patients with moderate to severe SLE, including improvement of cutaneous manifestations. Although its overall safety profile is considered favorable and certain cutaneous adverse events have been reported, post-marketing data on rare or atypical cutaneous reactions remain limited.

Lichenoid drug eruptions represent immune-mediated interface dermatitis reactions and, to date, have not been reported in association with anifrolumab therapy. We present a case of lichenoid dermatitis temporally associated with anifrolumab treatment in a patient with SLE.

Materials and Methods

We report the case of a 60-year-old female diagnosed with SLE in 2014. Her disease course was characterized by typical mucocutaneous manifestations, including malar rash, V-neck erythema, and oral ulcers, associated with arthralgias. Previous systemic therapies included oral corticosteroids, complicated by Cushing syndrome and steroid-induced myopathy; azathioprine, discontinued due to leukopenia; and hydroxychloroquine, withdrawn on two occasions because of retinal toxicity.

In November 2024, due to active disease with a SLEDAI score of 10, biologic therapy with anifrolumab was initiated.

Results

Approximately two months after treatment initiation, in January 2025, the patient reported the appearance of multiple small, slightly elevated, round-to-oval lesions, violaceous at the periphery with a brownish center. The eruption initially involved intertriginous areas and the abdominal region, followed by subsequent generalization. The lesions were asymptomatic, with no associated pruritus.

Given the differential diagnosis, including cutaneous lupus flare and drug-induced eruption, a skin biopsy was performed. Histopathological examination revealed features consistent with chronic lichenoid dermatitis, including minimal hyperorthokeratosis with focal parakeratosis, areas of hypergranulosis and irregular acanthosis, basal vacuolar degeneration with numerous apoptotic keratinocytes, and a moderate band-like lymphohistiocytic infiltrate in the superficial dermis. Rare neutrophils and very rare eosinophils were also observed. These findings were interpreted as suggestive of a lichenoid drug reaction.

Anifrolumab was discontinued, and systemic corticosteroid therapy was initiated with gradual dose tapering. Complete clinical remission of the cutaneous eruption was achieved, with no recurrence following drug withdrawal.

Conclusions

We describe a previously unreported lichenoid drug eruption temporally associated with anifrolumab therapy in a patient with systemic lupus erythematosus. The diagnosis was supported by the temporal relationship, compatible

histopathological findings, and complete resolution after treatment discontinuation, while other potential causes were excluded.
Considering the role of type I interferon signaling in cutaneous immune regulation, lichenoid dermatitis represents a biologically plausible adverse event. This clinical case expand the spectrum of potential cutaneous adverse reactions to anifrolumab and underscores the importance of dermatological surveillance in patients treated with biologic therapies for SLE.

Abstract N°: ID-734

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Embryologic Interpretation of Cutaneous Signature Birthmarks

Maria Christodoulou*[1], Petros Kakoullis[2], Panayiotis Vasiloudes[1]

[1]Academic Alliance in Dermatology & Olympian Clinical Research,, Tampa, United States
[2]Medical School of Patras, Patra, Greece

Introduction

This abstract analyzes data collected over a quarter century on the predilection sites of certain common and rare cutaneous pathologies, signature birthmarks (lesions recognizable without biopsy), melanomas, and other inflammatory, benign, and malignant conditions.

Materials and Methods

Data were collected on the anatomic predilection sites of Melanoma, Severely Dysplastic Nevi, Spitz Nevi, Spindle Cell Lipoma, Blue Nevus, Pigmentary demarcation lines, Nevus Lipomatosus, Linear Verrucous Epidermal Nevus, Leiomyoma, Leiomyosarcoma, Pilomatrixoma, Lichen Striatus, Combined Nevus (Blue nevus and Compound nevus), Cutaneous non-metastatic Adenocarcinoma, Linear Morphea, Porokeratosis, Linear Discoid Lupus Erythematosus, Melanocytoma, Rhabdomyosarcoma, Glomangioma, Dermatofibrosarcoma and other rare isolated benign and malignant conditions.

Results

Our observational studies indicate that most predilection sites follow a Blaschko-linear pattern, especially the **FIRST BLASCHKO LINE** formed during neural crest fusion. The highest predilection is seen along the Blaschko line connecting fingers to fingers, which is consistent/or the same with the **FIRST BLASCHKO LINE to form**.

This line varies by body proportions, occurring at C5/C6 in taller patients versus C7/Th1 in shorter patients. Shoulder width influences cranial or caudal distribution.

Other predilection sites include Blaschko lines connecting toes-to-toes with variations based on body proportions, gender, and genetic conditions like Ehlers-Danlos Syndrome or Neurofibromatosis.

Lastly, the peri-umbilical Blaschko lines show a cluster of increased pathology, though preliminary data lack statistical significance

Conclusions

Our data showed that cutaneous pathology involving keratinocyte, melanocyte, fibrocyte, and other cell lineages is most common on the Blaschko Lines connecting: a) Index to Index Finger, b) Big Toe to Big Toe, and c) The Peri-Umbilical one.

Consequently, the points of initial neural crest fusion (FIRST BLASCHKO LINE TO FORM), limb formation (UPPER & LOWER EXTREMITIES), and the umbilicus/umbilical Blaschko Line are susceptible to increased pathology. Therefore, clinical evaluation of lesions, especially nevi suspected to be melanoma, should involve increased scrutiny and a lower biopsy threshold.

Abstract N°: ID-769

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Trauma-Induced Hemorrhagic Bullae as an Early Cutaneous Clue to Multiple Myeloma–Associated Systemic AL Amyloidosis: A Case Report

Ömer Faruk Tolun*[1], Muazzez Cigdem Oba[1], Serdal Uğurlu[2], Aykut Ferhat Çelik[3], Ovgu Aydin[4], Ayşe Mine Önenerk Men[4], Ayşe Salihoğlu[5], Büşra Demir[2], Zehra Şahin[4], Tuncay Ataş[6]

[1]Istanbul University-Cerrahpasa,Cerrahpasa Faculty of Medicine, Dermatology and Venereology, Istanbul, Türkiye
[2]İstanbul University-Cerrahpaşa, Cerrahpaşa Faculty of Medicine, Division of Rheumatology, Department of Internal Medicine, İstanbul, Türkiye
[3]İstanbul University-Cerrahpaşa, Cerrahpaşa Faculty of Medicine, Division of Gastroenterology, Department of Internal Medicine, İstanbul, Türkiye
[4]İstanbul University-Cerrahpaşa, Cerrahpaşa Faculty of Medicine, Department of Pathology, İstanbul, Türkiye
[5]İstanbul University-Cerrahpaşa, Cerrahpaşa Faculty of Medicine, Division of Hematology, Department of Internal Medicine,, İstanbul, Türkiye
[6]İstanbul University-Cerrahpaşa, Cerrahpaşa Faculty of Medicine, Department of Internal Medicine, İstanbul, Türkiye

Introduction

Primary systemic amyloidosis (AL amyloidosis) is a rare plasma cell disorder caused by extracellular deposition of monoclonal immunoglobulin light chains, resulting in progressive multiorgan dysfunction. The heart, kidneys, nervous system, gastrointestinal tract, and skin are the most commonly involved organs. Cutaneous manifestations are observed in approximately 25–40% of patients and may represent the earliest and most visible signs of the disease. Typical findings include spontaneous or trauma-induced purpura, hemorrhagic bullae, skin fragility, periungual erythema, nail dystrophy, and mucosal hemorrhagic lesions. Because of its heterogeneous clinical presentation, diagnosis is often delayed. Early recognition of characteristic skin findings is therefore crucial for timely diagnosis and appropriate treatment.

Materials and Methods

We report a case of a 50-year-old woman with no known chronic disease who presented with a 1.5-year history of painful, trauma-induced hemorrhagic bullae involving the oral mucosa and tongue. One year later, similar hemorrhagic bullous lesions developed on the dorsal aspects of both hands **(Fig. 1b)**, followed by nail dystrophy and periungual erythema **(Fig. 1c)**. Prior to hospital admission, non-blanching red–purple purpuric lesions appeared on the face and upper chest **(Fig. 1a)**. A complete dermatologic, systemic, laboratory, histopathologic, and hematologic evaluation was performed.

Results

The patient also reported severe systemic symptoms, including watery diarrhea (8–10 episodes/day), dysphagia, anorexia, and unintentional weight loss of approximately 30 kg within one year. Laboratory tests revealed normocytic anemia (hemoglobin 8–9 g/dL), mild renal dysfunction, proteinuria (900 mg/day), hypogammaglobulinemia, and a markedly abnormal serum free light chain ratio (κ/λ: 23.78). Rheumatologic markers and coagulation tests were normal. Gastrointestinal endoscopy showed friable, nodular, and easily bleeding mucosa in the stomach and colon, compatible with gastrointestinal amyloid involvement. Cardiac evaluation revealed pericardial effusion, suggesting cardiac amyloidosis.

Skin biopsy demonstrated Congo red–positive acellular amyloid deposition. Immunohistochemical staining was positive for kappa light chains and negative for lambda, confirming cutaneous AL amyloidosis.**(Fig. 1d)**. Hematologic evaluation showed markedly elevated serum free kappa light chains, and bone marrow aspiration and biopsy were consistent with multiple myeloma.

Conclusions

Based on clinical, laboratory, histopathologic, and multiorgan involvement findings, the patient was diagnosed with multiple myeloma–associated primary systemic AL amyloidosis, and treatment with daratumumab, bortezomib, and cyclophosphamide was initiated.

Primary systemic AL amyloidosis is a potentially fatal disease with diverse clinical manifestations and frequent diagnostic delay. Trauma-induced hemorrhagic bullae and spontaneous purpura are highly characteristic cutaneous warning signs that may precede systemic diagnosis. This case emphasizes the pivotal role of dermatologic findings, supported by histopathology, in the early recognition of systemic amyloidosis and highlights the importance of integrating cutaneous, gastrointestinal, and cardiac findings for timely multidisciplinary management.

Abstract N°: ID-819

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Myelodysplasia Cutis: Diagnostic Challenge and Prognostic Significance

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[1]ULS São José, Dermatovenerology, Lisbon, Portugal

Introduction
Myelodysplasia cutis is a recently described dermatologic entity associated with myelodysplastic syndrome (MDS), characterized by dermal infiltration of immature myeloid cells in the absence of criteria for leukemia cutis. Its clinical recognition is difficult due to nonspecific morphology, but emerging evidence suggests it may function as an early cutaneous marker of hematologic evolution. We report a case of myelodysplasia cutis in a patient with MDS, emphasizing its diagnostic and potential prognostic relevance.

Materials and Methods
We reviewed the clinical and histopathological records of the patient. Diagnosis was based on clinical morphology, immunohistochemical profile, and integration with the underlying hematologic disease. Therapeutic response and clinical course were documented.

Results
A 66-year-old man with MDS presented with a three-week history of a non-pruritic, symmetric, erythematous eruption beginning on the hands and extending to the upper limbs. He denied fever or recent medication changes. Physical examination revealed poorly demarcated, infiltrated macules and papules with a smooth surface, predominantly affecting the hands and forearms, with few lesions on the lower limbs.
Histology showed a superficial perivascular and interstitial mononuclear infiltrate with a Grenz zone and mild dermal edema. The infiltrate was composed primarily of CD3+ T lymphocytes, with scattered immature myeloid cells expressing CD68 and myeloperoxidase. Based on the clinicopathologic correlation, a diagnosis of myelodysplasia cutis was made. The dermatosis did not respond to topical corticosteroids but resolved completely with systemic prednisolone (20 mg/day), followed by tapering.
The patient subsequently progressed to secondary acute myeloid leukemia.

Conclusions
Myelodysplasia cutis is a rare but clinically important cutaneous manifestation of MDS- the recognition is crucial, not only for diagnosis but also for its potential role as an early marker of disease progression. Timely identification and dermatologic-histopathologic correlation may prompt closer hematologic surveillance and influence therapeutic decisions.

Abstract N°: ID-883

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

When Cold Strikes: A Case of Pernio Erythema

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[1]SUUMC DR CAROL DAVILA, DERMATOLOGY, DERMATOLOGY, BUCHAREST, Romania

Introduction

Pernio (chillblains or perniosis) is an inflammatory disorder clinically characterized by an eruption consisting of single or multiple macules, papules, or nodules, with a color ranging from erythematous to bluish-violet. In severe cases, vesicles or crusts may be observed. The lesions are most commonly symmetrically distributed on the distal extremities of the toes and fingers, and less frequently on the heels, nose, or ears. Exposure to cold and damp conditions represents the main risk factor for perniosis. The condition may occur independently (idiopathic pernio) or in patients with associated underlying diseases. The development of pernio has been reported in patients with hematologic disorders, autoimmune diseases, viral hepatitis, or malignancies. Management primarily consists of avoidance of precipitating factors. Patients should be advised to keep the affected areas warm by wearing appropriate insulating clothing and by avoiding unprotected exposure to cold. In adults with refractory pernio, treatment with nifedipine is recommended.

Materials and Methods

A 79-year-old female patient with a known diagnosis of myelodysplastic syndrome (refractory anemia with excess blasts), currently undergoing treatment with azacitidine, presented to the clinic with an eruption consisting of erythematous-violaceous macules, papules, and plaques located on the nose and on the dorsal aspects of the fingers and toes. The lesions first appeared approximately one year prior, with exacerbations following cold exposure (November–December) and periods of remission, and were associated with pruritus and a burning sensation. The patient complained about the lack of appropriate central heating in her apartment, living in very low temperature for 2 weeks. Laboratory investigations revealed a moderate inflammatory syndrome, normocytic normochromic anemia, thrombocytopenia, and lymphopenia with eosinopenia and basopenia, findings explained by the associated hematologic disease. Additional tests performed to exclude other associated conditions, including ANA, c-ANCA, p-ANCA, and cryoglobulins, were negative. Histopathological examination demonstrated a superficial and deep lymphohistiocytic infiltrate with a perivascular distribution and periadnexal accentuation (eccrine glands), as well as dermal edema, findings supportive of the diagnosis of pernio erythema.

Results

In the present case, only the recommendation of avoidance of precipitating factors, including the use of appropriate protective clothing and avoidance of exposure to cold and damp environments was advised. The lesions progressively improved, with a reduction in erythema and local discomfort, and no new lesions developed.

Conclusions

Although pernio erythema is frequently idiopathic, it may occur in patients with known hematologic disorders, such as myelodysplastic syndrome, representing a cutaneous manifestation associated with the underlying disease. The present

case illustrates that inflammatory cutaneous lesions may accompany pre-existing hematologic pathology, highlighting the importance of a comprehensive clinical evaluation and recognition of these manifestations as part of the overall disease spectrum.

Abstract N°: ID-925

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Dermatologic Pitfalls of CEAP C4 Chronic Venous Disease

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Introduction

Chronic venous disease (CVD) is a common condition with a wide spectrum of cutaneous manifestations. C4-stage disease, characterized by skin changes such as stasis dermatitis and hyperpigmentation, is frequently underrecognized in routine dermatology practice, despite representing a critical stage preceding ulcer development. This case aims to highlight the dermatologic features of CEAP C4 disease while emphasizing the importance of early recognition and multidisciplinary management.

Materials and Methods

We report the case of a 34-year-old male with morbid obesity and hypertension who presented with a two-year history of progressive bilateral brownish discoloration and eczematous changes of the distal lower limbs. Physical examination revealed symmetrical perimalleolar hyperpigmentation with a sharp cut-off at Wallace's line, mild ankle edema, and indurated skin with fine scaling, consistent with stasis dermatitis. No signs of acute inflammation, ulceration, or alternative inflammatory or infectious dermatoses were observed. Based on systematic clinical observation, longitudinal follow-up, and the documented evolution of the skin findings over time, the disease was classified as CEAP C4a. Disease severity was assessed using the Venous Clinical Severity Score (VCSS).

Results

The brown discoloration was consistent with hemosiderin deposition within dermal macrophages, with a sharp cut-off at Wallace's line. Cutaneous findings were consistent with stasis dermatitis, and no signs of acute inflammation were identified; therefore invasive diagnostic procedures such as skin biopsy were not considered necessary in the absence of clinical alarm features. If performed, histopathological examination would be expected to demonstrate typical features of chronic venous disease, including dermal hemosiderin deposition, capillary proliferation, and mild chronic inflammatory changes. Conservative management, including compression therapy, venotonic agents, and appropriate skin care, was recommended. Topical corticosteroids were not initiated, as there were no clinical features suggestive of an acute inflammatory flare. The patient was scheduled for close follow-up to monitor disease progression.

Conclusions

This case highlights a diagnostic pitfall in dermatology practice, where CEAP C4 chronic venous disease may be misinterpreted as eczema or other inflammatory dermatoses. Recognition of venous-specific cutaneous features, such as hemosiderin-related hyperpigmentation and a sharp demarcation at Wallace's line, is essential for accurate diagnosis. Early identification of CEAP C4 skin changes allows timely initiation of appropriate conservative management and may help prevent progression to venous ulceration. Dermatologists play a key role in recognizing these findings and

facilitating early, multidisciplinary management of chronic venous disease. This case underscores the importance of observation-based diagnostic patterns in dermatologic evaluation of chronic venous disease.

Abstract N°: ID-948

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Successful Trifarotene Treatment of Atypical Kyrle's Disease: Case Report and Systematic Review of Topical Therapies

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Introduction

Kyrle's disease (KD), also referred to as hyperkeratosis follicularis et parafollicularis in cutem penetrans, is a rare perforating dermatosis marked by transepidermal elimination of keratotic material. Clinically, it presents as pruritic, hyperkeratotic papules with central plugs, typically on the extensor surfaces of the lower limbs. Kyrle's disease is frequently associated with systemic conditions such as chronic renal failure, particularly in patients undergoing hemodialysis, as well as poorly controlled diabetes mellitus or hepatic dysfunction. It is classified within the spectrum of acquired perforating dermatoses. Accurate diagnosis is essential, as KD may indicate underlying metabolic or systemic disturbances requiring multidisciplinary management. Though its exact pathogenesis remains unclear, KD is believed to result from abnormal responses to epidermal trauma and faulty keratinization. Despite its chronicity and diagnostic challenges, evidence-based topical therapies remain limited. This study aims to present an atypical, resistant KD case in a healthy young adult treated with trifarotene and to systematically review all topical therapeutic strategies reported to date, offering practical insights for managing KD, especially in patients with systemic comorbidities unsuitable for systemic therapy.

Materials and Methods

A systematic review was conducted to evaluate the efficacy of topical therapies in the treatment of Kyrle's disease, including EMTREE and MESH approaches, conducted according to the PRISMA guidelines. Searching was as broad as possible from the inception of the database until December 2025. Studies were included if they presented individual case reports or case series involving histologically confirmed Kyrle's disease treated with topical agents. Exclusion criteria encompassed reviews and articles lacking specific therapeutic outcomes. After screening, 8 articles presenting 10 individual patient cases were included in the final analysis based on predefined eligibility criteria. Additionally, a novel case of trifarotene-treated Kyrle's disease in a healthy 26-year-old male was reported and analyzed.

Results

A 26-year-old man with localized, treatment-resistant Kyrle's disease and no underlying systemic comorbidities was diagnosed based on dermoscopic and histopathologic findings, which revealed a keratotic plug with accompanying granulomatous inflammatory infiltrate. Complete remission of KD lesions without residual pigmentation or scarring was achieved following 8 weeks of once-daily application of topical trifarotene 0.005%, marking the first documented success of this fourth-generation RAR-γ agonist in KD management. Literature review identified 10 other cases treated with various topical therapies, including tretinoin, triamcinolone, clobetasol, tacrolimus and keratolytics. Outcomes varied from partial response to full remission, with retinoids being the most frequently employed. Notably, most cases involved significant comorbidities such as chronic kidney disease and diabetes.

Conclusions

Trifarotene demonstrates promising efficacy and safety in treating Kyrle's disease, especially in patients unsuitable for systemic treatment. Its RAR-γ selectivity aligns with KD pathogenesis, targeting hyperkeratosis and inflammation while minimizing systemic exposure. Trifarotene also affects newer therapeutic pathways, such as proteolysis, skin hydration, and cellular adhesion. Its combined antiproliferative and anti-inflammatory properties render it especially suitable for follicular-based perforating dermatoses like KD. This case expands the therapeutic landscape for KD and underlines the importance of individualized, dermato-histopathologically guided treatment. The comprehensive review of topical approaches serves as a practical reference for clinicians managing this challenging condition.

Abstract N°: ID-993

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Antioxidant capacity and its association with clinical severity of melasma

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Introduction
Melasma is a chronic acquired hyperpigmentation disorder characterized by a relapsing course and limited response to standard therapies. Oxidative stress has been proposed as a contributing factor in melanocyte activation and persistence of hyperpigmentation; however, its relationship with clinical severity of melasma remains insufficiently clarified.
The aim of this study was to evaluate the association between systemic oxidative stress markers and clinical severity of melasma

Materials and Methods
Twenty two patients with clinically diagnosed melasma were enrolled in the study. Clinical severity was assessed using the Melasma Area and Severity Index (MASI). Systemic oxidative status was evaluated by measuring reactive oxygen metabolites (d-ROMs) as a marker of oxidative load and total antioxidant capacity (PAT) as an indicator of antioxidant defense. Correlation analysis between oxidative stress markers and MASI scores was performed using Spearman’s rank correlation coefficient. A p-value < 0.05 was considered statistically significant.

Results
Our findings indicate a heterogeneous oxidative stress profile among patients, with elevated d-ROMs levels and reduced antioxidant capacity detected in a substantial proportion of cases. Spearman correlation analysis revealed no statistically significant association between d-ROMs levels and MASI scores ($r_s = 0.24$, $p = 0.51$). In contrast, total antioxidant capacity (PAT) showed a moderate inverse association with clinical severity of melasma, approaching statistical significance ($r_s = -0.63$, $p = 0.052$), indicating a tendency toward higher MASI scores in patients with lower antioxidant capacity.

Conclusions
Reduced systemic antioxidant capacity rather than increased oxidative load alone may be associated with greater clinical severity of melasma. Assessment of antioxidant status could provide additional information for individualized evaluation of patients with melasma and may support the rationale for adjunctive antioxidant-based strategies in melasma management.

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Abstract N°: ID-1158

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Dermatomyositis overlap syndrome associated with systemic lupus erythematosus: a case report

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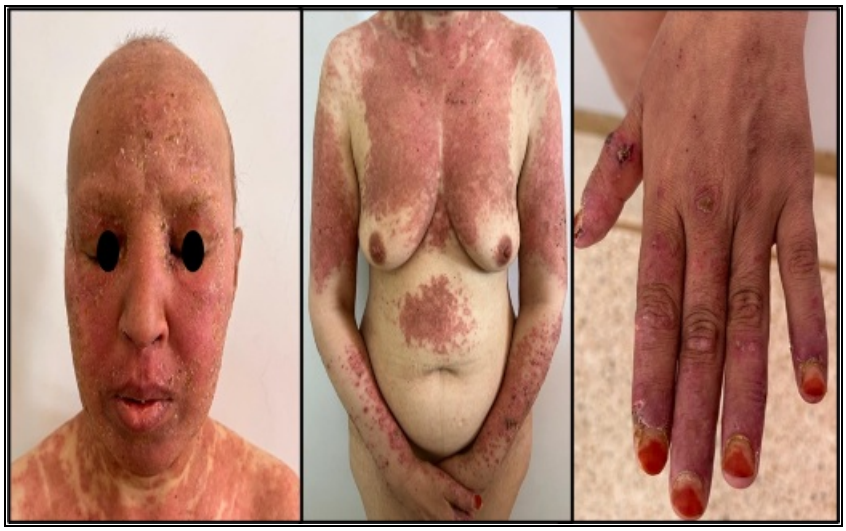
Introduction

Dermatomyositis (DM) is an idiopathic inflammatory myopathy characterized by inflammatory infiltrates affecting skeletal muscles and skin, with typical skin lesions, the most common of which are Gottron's papules, Gottron's sign, and heliotrope rash. Systemic lupus erythematosus (SLE) is an autoimmune disease that can affect all organs and tissues. We report the case of a patient who developed an overlap syndrome between dermatomyositis and SLE.

Materials and Methods

A 38-year-old woman with no medical history had been monitored since 2023 for amyopathic dermatomyositis. Treatment with hydroxychloroquine was initiated, but compliance was partial. The patient was then lost to follow-up for 9 months before being readmitted for a relapse of her condition. Clinical examination revealed facial erythema, a shawl sign, Gottron's papules, a manicure sign, and linear erythema over the joints of the hands. There was no muscle involvement: the Gowers sign was negative. The patient also presented with alopecia, obvious photosensitivity, and monoarthralgia of the left knee. Perinail dermoscopy revealed megacapillaries associated with tortuous vessels and microhemorrhages. The EMG was normal and the immunological workup showed positive ANAs, anti-DNA, anti-Sm, and anti-RNP antibodies, and the biological assessment showed autoimmune anemia and VS/CRP dissociation. The patient was placed on prednisone 1 mg/kg/day and hydroxychloroquine 400 mg/day. The outcome was favorable, marked by a clear regression of the skin lesions.



Clinical photos illustrating facial erythema, shawl sign, Gottron's papules, manicure sign, and erythema in the joints of the hands.

Results

Dermatomyositis is an autoimmune disease characterized by various skin manifestations such as heliotrope erythema, Gottron's papules on the metacarpophalangeal and interphalangeal joints, cuticular dystrophy, the shawl sign, and the V sign, which are characteristic skin manifestations. In our case, the patient had similar skin manifestations, which are

consistent with the above-described data. The diagnosis of SLE is based on a combination of typical clinical manifestations and positive serology. Given the wide heterogeneity of clinical manifestations, several sets of classification criteria have been developed over time.
Numerous studies have shown that idiopathic inflammatory myopathies including DM, can be confused with other autoimmune connective tissue diseases, and cutaneous lupus erythematosus, with or without systemic manifestations, is one such autoimmune disease that can overlap with DM. Our patient responded well to prednisone and hydroxychloroquine which is consistent with the findings of Dabour et al., who observed a questionable improvement in the symptoms of their patient being treated with prednisone, rituximab, and immunoglobulins, after resisting several treatments, including methotrexate, azathioprine, and mycophenolate mofetil. Immunomodulators such as hydroxychloroquine can favorably regulate the immune system in SLE without increasing the risk of infection or malignancy. It is the cornerstone of medical treatment for lupus and should be used in all patients unless there is a clear contraindication. It is the only drug that has been shown to increase survival in patients with lupus. However, steroids affect all components of the immune system. At high doses or when administered in pulses, they are important for quickly eliminating the autoimmune response in life-threatening or organ-threatening manifestations, but they should be avoided as much as possible when taken orally because even

Conclusions

This case illustrates the diagnostic and therapeutic complexity of overlap syndromes, particularly between DM and SLE. The polymorphic clinical presentation, combining skin manifestations of DM and clinical and biological signs of lupus, highlights the importance of thorough evaluation. The favorable outcome with prednisone and hydroxychloroquine confirms the efficacy of this combination. Nevertheless, the scarcity of data on this entity necessitates better documentation to guide management and establish more precise therapeutic recommendations.

Abstract N°: ID-1173

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Cutaneous IgG4-Related Disease: Red Flags, Diagnostic Pitfalls, and Emerging Therapeutic Strategies

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Introduction
IgG4-related disease (IgG4-RD) is an emerging systemic fibroinflammatory disorder increasingly recognized across multiple specialties. Cutaneous involvement, although rare, remains underdiagnosed due to its ability to mimic vasculitis, sclerosing dermatoses, or lymphoproliferative disorders. Recognition of cutaneous IgG4-RD is crucial, as skin manifestations may represent an early sign of systemic disease.

Materials and Methods
A targeted literature review of publications from the past five years was conducted using PubMed, Scopus, ScienceDirect, and Elsevier. Eligible articles included original studies, case series, and reviews addressing cutaneous manifestations of IgG4-RD. Diagnostic criteria (histopathology, immunohistochemistry, serology) and treatment outcomes were extracted and analyzed.

Results
Cutaneous IgG4-RD most commonly presents as firm nodules or pseudotumoral infiltrates on the face and extremities. Histopathology demonstrates storiform fibrosis, dense lymphoplasmacytic infiltrates, and elevated $IgG4^+$ plasma cells with an IgG4/IgG ratio >40%. Systemic corticosteroids provide rapid responses but relapses are frequent. Rituximab and targeted biologics have shown promise in refractory cases, though controlled data remain limited.

Conclusions
Cutaneous IgG4-RD should be systematically considered in chronic infiltrative and pseudotumoral dermatoses. Early recognition is essential, as skin lesions may precede systemic involvement and guide timely intervention. Standardized diagnostic algorithms and prospective therapeutic studies are needed to optimize patient outcomes.

Abstract N°: ID-1187

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Socioeconomic Conditions and Psychosocial Impact of Leprosy in a Developing Country

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Introduction
Leprosy, caused by *Mycobacterium leprae* and *Mycobacterium lepromatosis*, remains a public health concern in developing countries, where its persistence is closely associated with socioeconomic disadvantage. Economic barriers, social vulnerability, and limited access to healthcare services contribute to delayed diagnosis, ongoing transmission, and adverse psychosocial outcomes.

Materials and Methods
An observational, descriptive, cross-sectional study with a mixed-methods approach was conducted between July and October 2025. A non-probabilistic convenience sample of 34 patients diagnosed with leprosy was included. Data were collected using a structured 33-item questionnaire addressing socioeconomic characteristics, perceived discrimination, emotional impact, and healthcare access, complemented by clinical record review. Data analysis was performed using spreadsheet software and statistical analysis software.

Results
Participants demonstrated marked socioeconomic vulnerability, with incomes substantially below the basic living standard, frequent dependence on family support, predominantly primary and secondary educational levels, and high rates of unemployment and informal labor. Most participants reported owning their homes, residing in urban settings, and having access to basic services, with healthcare mainly provided on an outpatient basis. Discrimination was most commonly perceived in community and workplace environments. Emotional impact was significant, with more than half reporting feelings of sadness, loneliness, and fear of rejection. Lepromatous leprosy was the predominant clinical form, and disability was present in over half of the patients. Access to psychological care was limited.

n = 34 patients

Indicator	Result
Average age	52.2 ± 17.6 years
Income < basic food basket	79.40%
Unemployment/informal work	55.90%
Education ≤ high school	73.50%
Consultations for emergencies only	35.30%
Lepromatous leprosy (MB)	52.90%
Physical disability	52.90%
Perceived discrimination	20.60%
Emotional distress	56.10%
No psychological support	82.40%
With family support	82.40%

Figure 1. Characterization of Patients with Leprosy: Key Socioeconomic and Clinical Indicators

Conclusions

Adverse socioeconomic conditions continue to play a central role in the persistence of leprosy by limiting timely access to healthcare, reinforcing stigma, and negatively affecting mental health. Socioeconomic precariousness not only increases vulnerability to disease but also delays diagnosis and treatment, resulting in higher rates of disability. The limited availability of psychological support represents a critical gap in care, underscoring the need for integrated medical, social, and mental health interventions.

Abstract N°: ID-1199

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

From skin barrier to skin brain: Targeting neuro-inflammation as the next frontier in chronic dermatoses

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Introduction

Chronic inflammatory dermatoses such as acne vulgaris, atopic dermatitis, rosacea, and chronic pruritus are characterized by relapsing–remitting courses that are often disproportionate to visible clinical signs. Psychological stress, emotional triggers, and heightened skin sensitivity frequently precede disease exacerbations, suggesting a role beyond classical immune-mediated inflammation. Increasing evidence supports the concept of the skin as a neuro-immuno-endocrine organ, where cutaneous nerves actively participate in inflammatory signaling. Neuro-inflammation, mediated through neuropeptides and neurogenic immune activation, may represent a critical yet underrecognized driver of disease persistence and recurrence.

Materials and Methods

A narrative review of current literature was performed focusing on neurogenic inflammation in dermatology. Experimental, histopathological, and clinical studies evaluating the role of sensory nerve fibers, neuropeptides (including substance P, calcitonin gene-related peptide, nerve growth factor, and vasoactive intestinal peptide), and neuro-immune interactions were analyzed. Data were reviewed across common dermatoses including acne, atopic dermatitis, rosacea, and chronic pruritus. Clinical observations regarding stress-induced flares, symptom–sign mismatch, and therapeutic response patterns were integrated to assess the relevance of neuro-inflammation as a therapeutic target.

Results

Evidence demonstrates increased nerve fiber density, elevated neuropeptide expression, and enhanced neuro-immune crosstalk in multiple chronic dermatoses. Neurogenic mediators were shown to activate keratinocytes, mast cells, endothelial cells, and immune cells, amplifying inflammation independent of classical immune triggers. In acne, stress-induced neuropeptide release promoted sebocyte proliferation and inflammatory cytokine production. In rosacea, neurovascular dysregulation contributed to flushing and heightened sensitivity. Atopic dermatitis and chronic pruritus exhibited strong associations between neural activation, itch perception, and inflammation. Conventional therapies primarily targeting immune pathways often failed to address this neurogenic component, contributing to incomplete disease control and relapse.

Conclusions

Neuro-inflammation serves as a crucial link between psychological triggers and cutaneous inflammatory responses in chronic dermatoses. Recognizing the skin–brain axis expands the therapeutic landscape beyond immune suppression to include neuromodulatory and barrier-protective strategies. Targeting neurogenic inflammation may improve disease stability, symptom control, and patient quality of life, representing a promising frontier in modern dermatologic therapy.

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Abstract N°: ID-1219

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Isotretinoin as a Modulator of Acne-Associated Dysmetabolism

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Introduction
Isotretinoin is frequently prescribed to treat moderate to severe nodulocystic acne, resistant to other therapies, but its metabolic impact remains equivocal. While it increases lipid-based insulin resistance surrogates, such as triglyceride-glucose index, meta- analysis show no rise in HOMA-IR, with cohort studies confirming no increased diabetes risk. This ambivalence suggests that isotretinoin may not cause metabolic dysfunction but interacts with the dysmetabolic state already existing in severe acne. We propose isotretinoin acts as a modulator of this pre- existing condition, therefore explaining divergent biomarker results while proclaiming clinical safety.

Materials and Methods
We conducted an integrative review of the literature with evidence being synthesized from genetic and clinical studies defining the dysmetabolic phenotype of severe acne, interventional trials and meta-analyses evaluating isotretinoin's effects on lipid ratios, triglyceride- glucose index, HOMA-IR, and adiponectin and large-scale pharmaco-epidemiological studies assessing diabetes risk. This analytical perspective has been influenced by clinical observation in the management of isotretinoin-treated patients. A novel pathophysiological model is proposed to reconcile these findings.

Results
Analysis confirms that severe acne is associated with baseline insulin resistance and atherogenic dyslipidemia. Isotretinoin treatment consistently induces a significant increase in non-insulin surrogate markers of insulin resistance, notably the triglyceride- glucose index ($p<0.001$ in cohort studies). In contrast, meta-analyses show no significant net change in HOMA-IR. Large-scale pharmaco-epidemiological data confirms no increased risk of incident diabetes. A key, consistent finding across meta-analyses is a significant elevation in serum adiponectin (SMD 0.86, 95% CI 0.48-1.25), an insulin-sensitizing adipokine, following isotretinoin therapy.

Conclusions
In conclusion, evidence suggests that isotretinoin modulates a pre-existing dysmetabolic background in severe acne. Its pronounced lipid effects appear to amplify this underlying phenotype, while its consistent adiponectin response may offer a counter-regulatory mechanism. Consequently, our clinical approach prioritizes lipid monitoring while offering evidence-based reassurance about diabetes risk, leading to more reassuring conversations with our patients.

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Abstract N°: ID-1264

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Periorbital purpura: a key cutaneous clue in systemic AL amyloidosis with cardiac involvement

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Introduction

Systemic AL amyloidosis is a rare disorder caused by extracellular deposition of misfolded light chain fibrils. Cardiac involvement is common and predicts poor prognosis, often leading to heart failure and arrhythmias. Cutaneous manifestations are less frequent but may provide early diagnostic clues. Periorbital purpura, also known as (raccoon eyes), is rare but highly suggestive. This case highlights the diagnostic value of dermatological signs in systemic amyloidosis.

Materials and Methods

A 39-year-old man with known cardiac AL amyloidosis presented with dyspnea, asthenia, and purpuric lesions on the eyelids over one month. Clinical examination revealed bilateral periorbital purpura consistent with the (raccoon eyes) sign, macroglossia with scattered petechiae on the tongue, nail abnormalities including longitudinal striations and total onycholysis, and dental involvement. The surrounding skin was intact, and the patient had no history of anticoagulant or antiplatelet therapy or recent trauma. Although a skin biopsy was planned to confirm amyloid deposition, it could not be performed before the patient's death. The combination of classic cutaneous signs provided a nearly pathognomonic indication of systemic AL amyloidosis, especially in the context of cardiac symptoms.

Results

Systemic AL amyloidosis is characterized by extracellular deposition of monoclonal light chains, most commonly lambda, produced by a small plasma cell clone. The disease is clinically heterogeneous due to multisystem involvement, particularly affecting the heart, kidneys, liver, nerves, and gastrointestinal tract. Cardiac involvement is the main prognostic factor, often leading to restrictive cardiomyopathy and arrhythmias. Cutaneous manifestations such as periorbital purpura result from vascular fragility caused by amyloid deposition and are frequently associated with macroglossia, nail, and dental abnormalities. Diagnosis ideally relies on tissue biopsy demonstrating Congo red-positive amyloid deposits with immunohistochemical or immunofluorescent typing. Non-invasive biopsies such as abdominal fat or minor salivary glands can be performed first. Detection of a monoclonal serum or urine protein complements the workup. Treatment focuses on suppressing the underlying plasma cell clone with targeted chemotherapy, and organ responses vary, with cardiac deposits regressing slowly.

Conclusions

Periorbital purpura, macroglossia, nail changes, and dental involvement are highly suggestive cutaneous signs of systemic AL amyloidosis. Recognition of these manifestations by dermatologists is essential, as it guides further evaluation, supports multidisciplinary management, and informs prognosis. Early awareness of these clinical features strengthens the dermatologist's role in the holistic care of patients with systemic amyloidosis.

Abstract N°: ID-1342

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Spectrum of Dermatological Consultations in Hematopoietic Stem Cell Transplant Recipients- A retrospective study

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Introduction

Recipients of hematopoietic stem cell transplantation (HSCT) can have a diverse array of cutaneous complications like infections, drug rashes, regimen-related toxicities and engraftment syndrome. Among these, acute cutaneous graft-versus-host disease (GVHD) is a significant and frequent complication. Accurate diagnosis is essential to prevent unwarranted immunosuppression. We conducted this retrospective chart review to study the spectrum of dermatological consultations and to evaluate the impact of specialist dermatology consultation on post-HSCT patients.

Materials and Methods

A retrospective chart review was conducted on all consecutive HSCT recipients who underwent specialist dermatology consultation for cutaneous eruptions at a tertiary care centre between January 1, 2024, and December 31, 2024. Data were extracted regarding patient demographics, transplant characteristics, rash morphology, symptom profiles, and histopathologic findings. The primary outcome measures included the final dermatologic diagnosis and the frequency of management changes following consultation. Statistical analysis using Fisher's Exact Test was performed to evaluate the association between pruritus and a final confirmed diagnosis of GVHD based on composite clinical, histological, and therapeutic response criteria.

Results

The study included 112 patients (mean age 26.33 ± 18.1 years; 36 females) with 156 distinct rash episodes. More than 1 episode of rash was seen in 31.2% (n=35) patients. Donor sources included haploidentical (44), matched sibling (38), matched unrelated (25) and matched related donors (5).

The median time to rash onset was 19 days (range 1-330 days). Erythematous maculopapular rash was the most common morphological presentation accounting for 23.7% (37/156 cases) (25 GVHD; 12 non-GVHD), while skin-coloured follicular papules were observed in 26 cases (19 GVHD; 7 non-GVHD). The other morphologies included flexural hyperpigmentation and desquamation, predominantly seen in regimen-related toxicity, lichenoid rash seen in overlap GVHD, non-inflammatory edema blisters, urticarial wheals etc.

The most common final diagnosis was skin Infections (63 cases) followed by GVHD (44 cases), followed by Regimen-related toxicity (22 cases). The infective rashes presented with varied morphologies: viral infections included herpes zoster/varicella (n=10) which presented with a vesiculobullous rash, and viral exanthems (n=4) which presented as a maculopapular rash. Other infective etiologies included local bacterial infections (n=12), candidiasis (n=8), and superficial fungal infections including tinea and onychomycosis.

Pruritus was an important finding suggestive of GVHD rash. It was present in 40.6% (63/155) of episodes. 55.6 percent

(35/63) of pruritic rashes were confirmed as GVHD, compared to only 19.5% (8/41) of non-pruritic rashes (P <0.05).

Dermatology consultation led to the addition of topical steroids in 41.6% (65/156) of cases (GVHD as well as non-GVHD) and adjuvant NBUVB phototherapy in 53% (23/43) of GVHD cases. The decision to initiate or modify systemic steroids was made by the primary haematology team. The overall mortality rate was 23.2%, with the cause of death primarily attributed to refractory GVHD and sepsis

Conclusions

The cutaneous eruptions in post HSCT patients have varied morphology. The spectrum of the skin eruptions in dermatological consultation is different from that seen in cohort studies, as the case is referred only for those cases where the primary treating doctor needs a specialist input for diagnosis and/or management. Pruritus is a useful predictor of cutaneous GVHD, distinguishing it from close mimics. Specialist dermatology consultation improves diagnostic accuracy, guiding the appropriate use of skin-directed therapies like phototherapy and minimizing unnecessary systemic immunosuppression in post-HSCT patients.

Abstract N°: ID-1375

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Anogenital dermatoses in patients with chronic pelvic pain syndrome: clinical observations and diagnostic pitfalls

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Introduction

Chronic pelvic pain syndrome (CPPS) represents a complex multidisciplinary clinical entity in which diagnostic evaluation is predominantly focused on urological, gynecological, and proctological conditions. Cutaneous disorders of the anogenital region are frequently overlooked despite their potential contribution to persistent pain, burning sensations, and discomfort. Atypical clinical presentation, predominance of subjective symptoms, and minimal visible inflammatory changes often result in diagnostic delay and prolonged symptomatic treatment without dermatological verification. The aim of this study was to analyze the clinical and diagnostic characteristics of anogenital dermatoses in patients with CPPS based on a series of clinical observations and to identify practical diagnostic clues relevant for interdisciplinary clinical practice.

Materials and Methods

A single-center descriptive observational study was conducted in the form of a case series including patients with CPPS in whom anogenital dermatoses were identified during dermatological examination. Clinical and anamnestic data, characteristics and duration of pain syndrome, morphology and distribution of anogenital skin lesions, predominant subjective symptoms, and previous therapeutic approaches were analyzed. Skin biopsy was performed when clinically indicated. Additionally, the relationship between pain severity and clinical activity of the cutaneous process was assessed.

Results

The analyzed clinical observations revealed a spectrum of inflammatory and immune-mediated anogenital dermatoses in patients with CPPS, including lichen sclerosus, lichen planus, eczema, localized neurodermatitis, and genital psoriasis. A considerable proportion of patients demonstrated long-standing symptoms and insufficient response to multiple previous therapeutic approaches prescribed within related medical specialties. In several cases, no direct correlation was observed between pain intensity and the clinical severity of skin lesions. Pronounced pain and burning sensations could dominate the clinical picture despite minimal visible cutaneous changes, contributing to significant diagnostic delay. In clinically atypical presentations, skin biopsy proved valuable for establishing the correct dermatological diagnosis.

Conclusions

Anogenital dermatoses represent a significant and underrecognized component of chronic pelvic pain syndrome. The lack of correlation between cutaneous disease activity and pain intensity constitutes a major diagnostic pitfall and may lead to prolonged ineffective treatment. Inclusion of a dermatological assessment in the diagnostic algorithm for patients with CPPS -particularly in cases of persistent pain, burning sensations, and resistance to standard therapy - is clinically justified and may optimize both diagnostic accuracy and therapeutic outcomes. These clinical observations highlight the importance of thorough anogenital skin examination even in the presence of minimal visible changes.

Abstract N°: ID-1388

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Environmental and Socioeconomic Determinants of Systemic Lupus Erythematosus Risk: A Machine Learning Study Using Canadian Population Data

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Introduction

Systemic lupus erythematosus (SLE) is a complex autoimmune disease for which genetic susceptibility alone may not fully explain disease onset. Environmental, behavioral, and socioeconomic factors may also play an important role in shaping SLE risk. This study evaluated whether factors from the environmental and social context can predict SLE diagnosis using linked population-based and geospatial data.

Materials and Methods

We conducted a matched case–control study nested within the Canadian Partnership for Tomorrow's Health (CanPath), a nationwide prospective cohort of adults aged 30–74 years between 2009 and 2015. SLE status was defined as a self-reported physician diagnosis at baseline or follow-up. Patients with SLE was matched 1:1 to a control without SLE by age and sex. Baseline six-character residential postal codes were linked to neighbourhood-level environmental exposures curated by the Canadian Urban Environmental Health Research Consortium (CANUE), including climate indicators, air pollutants, greenness indices, built environment features, and area-level socioeconomic indices. Individual patient-level covariates included demographics, smoking, and alcohol consumption. Extreme Gradient Boosting (XGBoost) models were trained using a 70/30 train–test split. The primary model included environmental and social variables while the sensitivity analyses also incorporated family history for autoimmune or skin conditions and comorbidities.

Results

A total of 985 patients with SLE were included in the study and matched to controls for a total of 1,970 patients. The mean (SD) age was 52.8 (10.0) years and 88.8% were female. Ever smoking was reported by 53.8% of patients with SLE relative to 46.9% controls with current smoking prevalence of 19.2% for patients with SLE relative to 10.2% for controls. Most common comorbidities included arthritis, hypertension, and diabetes with patients with SLE reporting higher comorbidity prevalence overall (83.4% vs 61.1%). The primary model demonstrated modest but consistent discrimination of SLE status, with a bootstrapped test AUC of 0.64. Key predictors clustered around extreme climatic conditions, residential context, and socioeconomic vulnerability where colder and wetter environments, including lower minimum temperatures, fewer heat events, and greater precipitation predicted higher risk of SLE. Residential greenness was also an important predictor. Smoking status emerged as an important predictor and clustered with material deprivation measures. Ambient nitrogen dioxide (NO_2) showed higher risk of SLE at lower concentrations followed by plateauing risk.

In sensitivity analyses, addition of SLE family history improved model performance (test AUC 0.66), with family history ranking among the top predictors alongside environmental factors. Incorporation of comorbidities substantially

increased discrimination (test AUC 0.79), though key environmental features remained influential.

Conclusions

The study found that factors from patients' environmental and socioeconomic context predicted meaningfully risk of SLE beyond genetic susceptibility, including climate, residential, and deprivation-related factors, with smoking acting as a marker of broader structural vulnerability. Although clinical factors improved predictive performance, environmental exposure was important in predicting risk of SLE for a substantial proportion of patients. These findings support a broader conceptualization of SLE as a disease influenced by social and environmental context and highlight opportunities for prevention strategies targeting modifiable exposures.

Abstract N°: ID-1506

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Cutaneous Revelation of Sarcoidosis within a Post-Traumatic Keloid

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Introduction

The skin often betrays a deeper, older history. In some patients with systemic sarcoidosis, forgotten scars become the stage for an inflammatory resurgence. While rare, cutaneous involvement within a keloid scar is highly evocative of the disease. We present a case of localized reactivation of silent hepatic sarcoidosis, revealed by papular infiltration of an old surgical scar.

Materials and Methods

A 52-year-old female patient, previously treated for hepatic sarcoidosis several years prior, presented with intense pruritus and the emergence of red papules on a keloid scar located on her hip. The scar originated from surgery for a femoral fracture years earlier. Clinical examination revealed an infiltrated, erythematous keloid, which was slightly indurated and tender upon palpation.

A targeted skin biopsy revealed **non-caseating epithelioid granulomas** without necrosis, characteristic of sarcoidosis. Staining for mycobacteria and fungi returned negative results. A comprehensive metabolic panel was performed: liver enzymes, calcium levels, ACE (Angiotensin-Converting Enzyme), and CRP were all within normal limits. No clinical or biological signs of recurrent hepatic sarcoidosis were identified; the involvement appeared strictly localized to the skin.

Results

The localization of sarcoidosis within an old scar is a rare but well-documented clinical phenomenon. It may manifest in isolation or serve as a harbinger of a systemic flare-up. In this instance, the presentation was purely cutaneous, occurring on a post-traumatic scar. This suggests a local reactivation potentially driven by immunological mechanisms or "tissue inflammatory memory."

Management consisted of **intralesional injections of triamcinolone acetonide**, resulting in a marked reduction of pruritus and the regression of papules within a few weeks. No systemic corticosteroid therapy was required.

Conclusions

The recurrence of sarcoidosis within a keloid scar represents a distinct and often deceptive clinical form. Diagnosis relies on skin biopsy, and localized treatment can be highly effective. This case highlights the importance of long-term dermatological surveillance in patients with a history of systemic sarcoidosis, even in the absence of an apparent relapse. The favorable outcome, without hepatic recurrence or biological anomalies, reinforces the localized nature of this presentation.

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Abstract N°: ID-1511

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Unilateral Leg Lymphedema Revealing Prostate Adenocarcinoma in an Elderly Patient

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Introduction

Lymphedema is characterized by chronic tissue swelling resulting from the accumulation of lymphatic fluid. While often a sequel to surgery or infection, it can occasionally serve as a clinical harbinger of a more serious underlying pathology, such as malignancy. In elderly patients, prompt recognition of these signs is crucial for directing appropriate diagnostic and therapeutic interventions.

Materials and Methods

We were consulted regarding an 80-year-old male hospitalized in the nephrology department for **obstructive acute kidney injury**. The patient had already undergone the placement of a **double-J (JJ) stent** to drain the urinary tract.

Upon dermatological examination, significant edema of the right leg was noted. Clinical evaluation revealed a positive **Stemmer's sign** and "cushion sign," strongly suggestive of lymphedema. Laboratory results showed a CRP of **45 mg/L**, and a clean catch block (ECBU) identified an **E. coli infection**, which was subsequently treated with Bactrim.

Given the clinical triad of unilateral lymphedema, urinary obstruction, and advanced age, a neoplastic origin was suspected. Diagnostic imaging confirmed a **prostate adenocarcinoma**, which accounted for both the lymphatic obstruction and the obstructive renal failure.

Results

The presentation of unilateral lymphedema in an elderly individual mandates a thorough investigation for secondary causes. Key diagnostic indicators include: Asymmetric swelling, issue induration and a positive Stemmer's sign (inability to pinch the skin at the base of the second toe).
In this case, the renal impairment was secondary to urinary tract obstruction caused by the prostatic tumor. While the urinary tract infection required targeted antibiotic therapy and the JJ stent provided immediate relief from the obstruction, definitive management of the prostate adenocarcinoma remained the priority. Addressing the primary tumor is essential to prevent the progression of lymphedema and further systemic complications.

Conclusions

This case underscores that unilateral lymphedema may be the primary clinical manifestation of an underlying malignancy. A swift and meticulous evaluation allows for the identification of the root cause, management of acute complications, and optimization of long-term care. In our patient, the clinical suspicion of a tumor was validated by imaging, revealing that the prostate adenocarcinoma was the unifying diagnosis for both the lymphedema and the obstructive renal failure.

Abstract N°: ID-1545

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Lymphocytic-Variant Hypereosinophilic Syndrome as a Diagnostic and Therapeutic Challenge: Report of Two Cases with Cutaneous Involvement

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Introduction

The lymphocytic variant of hypereosinophilic syndrome (L-HES) is an uncommon eosinophilic disorder characterized by sustained eosinophilia driven by aberrant clonal T lymphocytes producing eosinophil-promoting cytokines. Cutaneous involvement is frequent and may precede hematologic diagnosis, often mimicking inflammatory dermatoses and delaying appropriate treatment. Management is challenging, as conventional therapies such as systemic corticosteroids or interferon may be ineffective. Recently, Janus kinase (JAK) inhibitors have emerged as a promising therapeutic strategy in refractory cases.

Materials and Methods

We report two male patients with severe cutaneous involvement secondary to eosinophilic disorders. The first case corresponds to a 62-year-old patient who presented with progressive erythroderma, severe pruritus, and palmoplantar keratoderma refractory to multiple systemic therapies, including corticosteroids, immunosuppressants, and biologics. Histopathology revealed psoriasiform dermatitis with eosinophilic infiltrates, and further hematologic evaluation demonstrated a clonal T-cell population with T-cell receptor (TCR) rearrangement, leading to the diagnosis of lymphocytic-variant hypereosinophilic syndrome.

The second case involves a 70-year-old male who initially presented with a 4-month history of erythema and pruritus on the trunk. Multiple skin biopsies showed psoriasiform dermatitis with scattered eosinophils, and the patient failed to respond to systemic corticosteroids. He subsequently progressed to generalized erythroderma with intense pruritus and persistent hypereosinophilia. Bone marrow biopsy revealed hypereosinophilia and atypical lymphocytes. Molecular analysis demonstrated TCR rearrangement in peripheral blood, confirming T-cell clonality and establishing the diagnosis of L-HES.

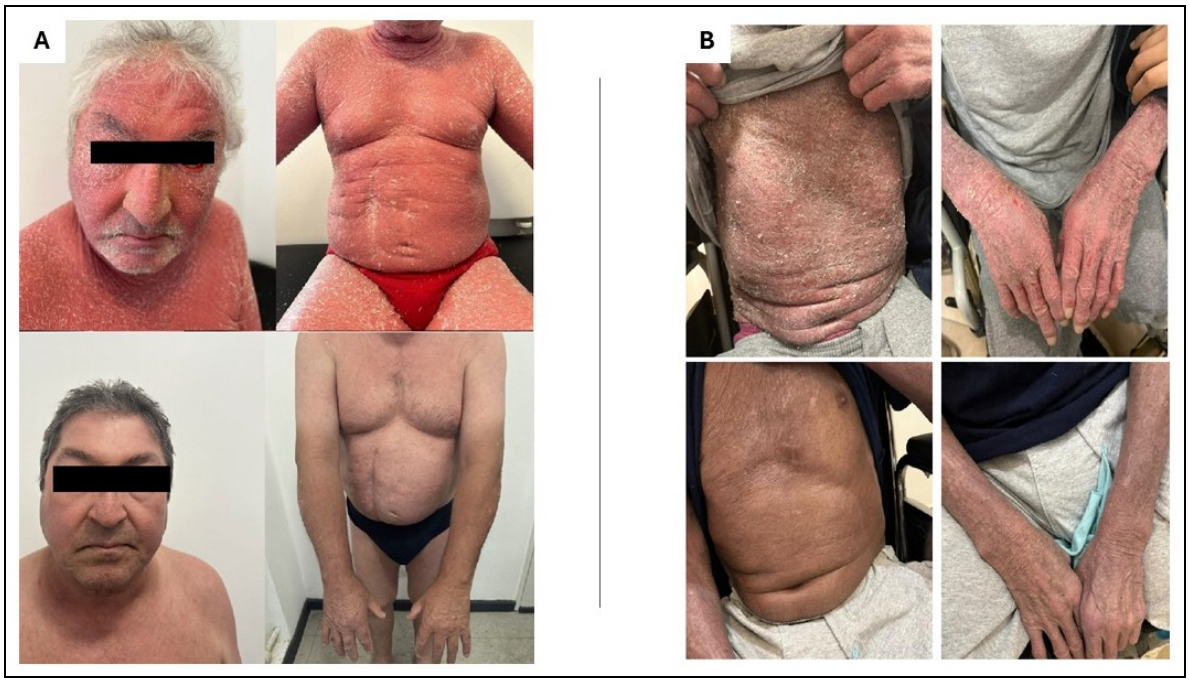
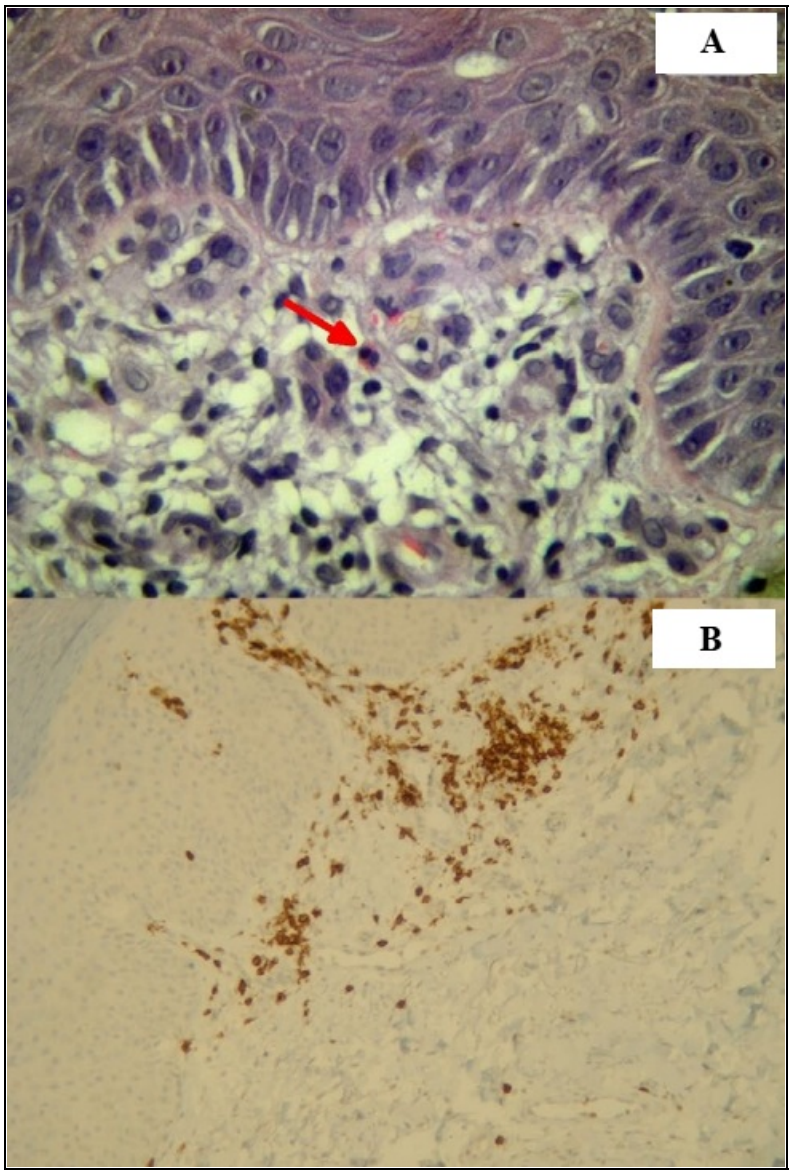


Figure 1. (A) Patient 1 before and after treatment. Upper panels show diffuse erythroderma with marked scaling prior to therapy; lower panels demonstrate complete clinical resolution after treatment, including hair repigmentation. (B) Patient 2 before and after treatment. Upper panels depict generalized erythroderma with diffuse desquamation before therapy; lower panels show marked improvement with resolution of erythema and scaling.

Results

In the first case, treatment with ruxolitinib at a dose of 15 mg twice daily led to rapid and sustained clinical improvement, with resolution of erythroderma and pruritus, normalization of eosinophil counts, and reduction of serum IgE levels, without significant adverse events.

In the second case, first-line therapy with subcutaneous interferon failed to achieve clinical or hematologic response after one month. Given the refractory disease course, ruxolitinib was initiated at 15 mg twice daily, resulting in marked clinical improvement of cutaneous manifestations and pruritus, along with progressive control of eosinophilia.



(A) High-power skin biopsy showing psoriasiform epidermal changes with scattered eosinophils (red arrow) within a mononuclear inflammatory infiltrate (H&E, 40×). (B) Immunohistochemistry demonstrating a $CD3^+$ T-cell infiltrate. Similar histopathological findings were observed in skin biopsies from both patients.

Conclusions

These cases highlight the diagnostic complexity of lymphocytic-driven eosinophilic disorders presenting with predominant cutaneous involvement and their frequent refractoriness to conventional therapies. JAK inhibition with ruxolitinib represents an effective and well-tolerated therapeutic option in patients with steroid- and interferon-refractory disease. Our experience supports growing evidence from case series and international guidelines suggesting a central role of the JAK–STAT pathway in the pathogenesis of lymphocytic-variant eosinophilic disorders and underscores the need for early recognition and targeted treatment strategies.

Abstract N°: ID-1549

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

Hemodialysis-Related Intravascular Hemolysis Presenting With Acute Purpuric Skin Lesions: A Case Report

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Introduction
Hemodialysis-related intravascular hemolysis is a rare but potentially life-threatening complication. Its acute presentation can mimic severe dermatologic or hematologic emergencies, such as Stevens–Johnson syndrome (SJS) and disseminated intravascular coagulation (DIC). This case report highlights a diagnostic pitfall where sudden purpuric skin lesions during hemodialysis served as the primary clinical manifestation of intravascular hemolysis.

Materials and Methods
A 63-year-old woman on maintenance hemodialysis developed abrupt lip numbness and generalized non-blanching erythematous-purpuric lesions during the second hour of a dialysis session. Dialysis was immediately suspended, and intravenous pheniramine was administered. Due to persistent cutaneous findings and the risk of systemic instability, the patient was transferred to the emergency department for further evaluation.

Results
Initial evaluation considered DIC and SJS; a skin biopsy was obtained. Early blood samples were severely hemolyzed and initially non-interpretable. DIC was subsequently deemed unlikely based on clinical stability and a low DIC score. Repeat investigations supported a diagnosis of intravascular hemolysis, revealing markedly elevated LDH (~2500 U/L), low haptoglobin, and a hemoglobin decline of approximately 2 g/dL from baseline. A history of recurrent arteriovenous fistula occlusions suggested a mechanical contribution from the dialysis circuit. Following stabilization, dialysis was resumed with a heparin-free circuit primed and flushed with normal saline, resulting in no recurrence of symptoms. The skin lesions resolved completely within 48 hours.

Conclusions
Acute purpuric eruptions occurring during hemodialysis should prompt immediate consideration of dialysis-related intravascular hemolysis, rather than only primary dermatologic emergencies. Early recognition is critical to prevent life-threatening complications such as hyperkalemia and acute anemia. Modification of the dialysis technique and circuit may be effective in preventing recurrence and ensuring patient safety.

Abstract N°: ID-1572

Topic: Dermatology and internal medicine, including skin manifestations of systemic diseases

From Psoriasis-mimicking Lesion to Lupus Diagnosis: A Case of Mis Leading Scalp Manifestation

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Introduction

Scalp involvement is a common feature in systemic lupus erythematosus, occurring in up to 60% of discoid lupus erythematosus (DLE) cases.

However, scalp DLE can clinically mimic other inflammatory conditions, particularly psoriasis.

Both diseases may present with overlapping features including erythema, scaling, and alopecic patches, making clinical differentiation challenging.

Misdiagnosis may delay appropriate treatment and lead to irreversible scarring alopecia.

We report a case of DLE masquerading as scalp psoriasis, where dermoscopy played a key role in establishing the correct diagnosis.

Materials and Methods

A 68-year-old male patient was initially admitted to the rheumatology department for evaluation of polyarthritis.

The skin examination revealed a cutaneous manifestation consisting of an alopecic scaly plaque on the scalp, initially suggestive of psoriasis given the clinical context.

The patient was subsequently transferred to our dermatology department for further management.

Dermoscopic examination revealed large yellow dots, scattered brown-gray pigmentation, and whitish areas, raising diagnostic uncertainty regarding psoriasis. A dermoscopy-guided skin biopsy was performed, showed hyperkeratosis, follicular plugging, basement membrane thickening, and a dense perivascular and periadnexal infiltrate , complemented by direct immunofluorescence (DIF) showing a positive lupus band test with granular deposition of IgG, IgM, and C3 at the dermoepidermal junction , which confirmed the diagnosis of discoid lupus erythematosus .

Further workup demonstrated positive antinuclear antibodies (ANA) with a titer of 1:1600. Renal involvement was also documented.

Based on the ACR/EULAR 2019 classification criteria, a diagnosis of systemic lupus erythematosus (SLE) was established with a total of points superior of 10

Therapeutic management consisted of hydroxychloroquine and topical corticosteroids.

The patient showed favorable clinical response with complete hair regrowth within two months.

Results

This case highlights three critical aspects in the diagnostic approach to scalp inflammatory disorders: clinical mimicry, rarity of psoriasiform presentation in DLE, and the pivotal role of dermoscopy.The initial clinical presentation of a scaly alopecic plaque in a patient with polyarthritis naturally oriented the diagnosis toward psoriasis, particularly given the well-established association between psoriasis and psoriatic arthritis.However, this clinical overlap represents a diagnostic pitfall, as premature diagnostic closure may lead to inappropriate management and progression to irreversible scarring alopecia in DLE cases.While DLE typically presents with well-defined erythematous plaques with adherent scales and follicular plugging, a psoriasis-mimecking presentation remains uncommon and poorly documented in the literature. Classical DLE features include central atrophy, peripheral hyperpigmentation, and scarring alopecia, distinctly different from the thick silvery scales characteristic of psoriasis. This atypical presentation of DLE emphasizes the importance of maintaining a broad differential diagnosis.Dermoscopy proved instrumental in redirecting the diagnostic workup in our case. The dermoscopic triad of large yellow dots (representing follicular keratotic plugs), scattered brown-gray pigmentation (post-inflammatory changes), and whitish areas (follicular scarring) is highly suggestive of DLE and contrasts with psoriatic dermoscopic features such as uniformly distributed red dots and glomerular vessels.

Conclusions

This case illustrates the diagnostic challenge posed by atypical presentations of discoid lupus erythematosus mimicking scalp psoriasis, particularly in patients with underlying rheumatologic manifestations. Dermoscopy represents an invaluable non-invasive tool that can identify specific patterns to differentiate DLE from psoriasis, thereby guiding appropriate biopsy and preventing diagnostic delay.