Abstract N°: ID-22

Topic: Infectious diseases, parasitic diseases, infestations

The endeavor for standardization of perilesional purified protein derivative (PPD) in the treatment of verruca vulgaris

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Introduction

Immunotherapy with purified protein derivative (PPD) has become an important option for verruca vulgaris, particularly in patients with multiple or recalcitrant lesions. Although several studies support the efficacy of PPD, dosing strategies remain highly variable, limiting reproducibility and hindering the establishment of a unified clinical protocol. Standardizing perilesional dosing could improve treatment consistency, enhance safety, and facilitate broader clinical integration. This study compares two commonly used PPD regimens to determine whether a simplified fixed-dose protocol performs equivalently to variable dosing based on skin test reactivity.

Materials and Methods

A randomized, open-label controlled study enrolled 60 patients with verruca vulgaris. Participants were randomized into either a variable-dose group, in which PPD dose was adjusted according to Mantoux induration, or a fixed-dose group receiving 0.1 mL (5 TU) per session. Treatments were administered every two weeks for six sessions. Fifty-three patients completed the study. Clinical response was categorized as complete clearance, intermediate improvement (50–90 percent), or poor response (<50 percent). Adverse events and potential predictors of outcome, including age, sex, wart burden, wart duration, and lesion location, were analyzed.

Results

Complete clearance was achieved in 25.9 percent of patients receiving variable-dose PPD and 34.6 percent receiving fixed-dose PPD. Overall clinical response (≥50 percent improvement) was similar in both groups (66.7 percent versus 69.2 percent). Adverse events were mild, with transient hyperpigmentation and localized swelling being the most common findings. No systemic reactions occurred, and no significant differences in adverse-event rates were observed between groups. Wart duration was the only significant negative predictor of response; no associations were found with age, sex, wart count, or anatomical site.

Conclusions

Both variable-dose and fixed-dose perilesional PPD demonstrate comparable efficacy and safety in the treatment of verruca vulgaris. The fixed-dose regimen offers a simpler and more reproducible protocol without compromising clinical outcomes. These findings support the adoption of a standardized PPD dosing approach, which may streamline clinical practice and improve treatment uniformity across dermatology centers.

Abstract N°: ID-25

Topic: Infectious diseases, parasitic diseases, infestations

Recalcitrant Dermatophytosis and Cutaneous Infections in Athletes: Behavioural and Environmental Determinants

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Introduction

Recalcitrant dermatophytosis and chronic cutaneous infections are increasingly reported in athletes, yet the behavioural and environmental determinants underlying persistence and recurrence are poorly characterized. High-contact sports, occlusive textiles, and global team mobility create a unique microclimate for fungal transmission and chronicity. This study aimed to identify novel behavioural, grooming, and training-related factors predisposing athletes to recalcitrant dermatophytosis and other cutaneous infections.

Materials and Methods

We conducted a prospective, mixed-methods study over 18 months at two tertiary dermatology centres and three sports academies. Competitive and semi-professional athletes (n = 152) with recalcitrant dermatophytosis or recurrent superficial cutaneous infections (>3 months or ≥2 relapses despite appropriate therapy) were enrolled and compared with age-, sex-, and sport-matched athlete controls without chronic infections (n = 150). All participants underwent structured dermatologic examination, mycological testing (KOH, culture ± PCR), and antifungal susceptibility for dermatophyte isolates. A validated questionnaire captured sports type, textile use, hygiene, grooming, self-medication, equipment sharing, travel patterns, and infection-control practices. Multivariable logistic regression identified independent risk factors. In-depth qualitative interviews (n = 30) explored attitudes, stigma, and decision pathways around skin complaints.

Results

Recalcitrant cases were predominantly from contact and mat-based sports (wrestling, football, martial arts; 68.4%) and indoor turf/gym users (21.7%). Independent behavioural risk factors included: repeated reuse of unwashed compression wear ≥3 times/week (adjusted OR [aOR] 3.12, 95% CI 1.82–5.37), sharing personal items (towels, shin guards, razors; aOR 2.94, 1.69–5.10), use of over-the-counter steroid–antifungal–antibacterial fixed-dose creams (aOR 4.51, 2.38–8.54), and "double-session" training without intermediate showering (aOR 2.21, 1.27–3.86). Novel grooming-related insights included frequent body shaving/waxing at non-medical salons before competitions, use of occlusive kinesio-taping over pre-existing lesions, and reliance on alcohol-based hand and body sanitizers instead of proper washing, all associated with barrier disruption and atypical presentations. Qualitative interviews revealed strong performance and aesthetic pressures, stigma around "weak skin," and a tendency to conceal lesions or self-medicate until function was impaired. Institutional gaps included absence of mat/equipment disinfection protocols in 57% of clubs and lack of any written guidance on skin infection clearance or return-to-play.

Conclusions

Recalcitrant dermatophytosis and cutaneous infections in athletes are driven not only by pathogen factors but by a distinct behavioural and environmental risk constellation—including occlusive textile practices, high-risk grooming, inappropriate self-medication, and weak institutional hygiene frameworks. These findings highlight the need for sport-

specific, behaviourally informed guidelines on screening, counselling, textile and equipment hygiene, and antimicrobial stewardship. An EADV-led consensus incorporating dermatologists, sports physicians, trainers, and federations could meaningfully reduce chronic skin infections and protect both athlete health and performance.

Abstract N°: ID-32

Topic: Infectious diseases, parasitic diseases, infestations

A diagnostic conundrum: primary cutaneous histoplasmosis mimicking benign facial nodules

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Introduction
Histoplasmosis is an uncommon endemic mycosis caused by the dimorphic fungus Histoplasma capsulatum. Cutaneous manifestations are typically associated with disseminated disease, while primary cutaneous histoplasmosis remains exceedingly rare, especially in immunocompetent individuals. Because its clinical morphology overlaps with several common nodular dermatoses, diagnosis is frequently delayed. We report a case of primary cutaneous histoplasmosis presenting solely with progressive facial nodules, highlighting the importance of clinicopathological correlation in atypical cutaneous infections.

Materials and Methods
A 76-year-old immunocompetent male presented with multiple, gradually enlarging, pruritic facial nodules over two months. Lesions began as pin-sized papules and progressed to pea-sized nodules without discharge, systemic symptoms, recent travel, or animal exposure. Examination revealed multiple well-defined skin-coloured nodules on the cheeks, forehead and chin, and a few plaques with central ulceration over the nasal root. Dermoscopic evaluation showed yellow-to-white structureless areas with central keratotic plugs and arborising vessels on an erythematous background. Differential diagnoses included molluscum contagiosum and deep fungal infections. Routine laboratory investigations ruled out immunosuppression. A lesional biopsy was performed.

Results
Histopathology demonstrated a thinned epidermis, dense dermal infiltrates with focal lymphoid aggregates, and numerous PAS-positive yeast forms within histiocytes, with occasional extracellular organisms, confirming Histoplasma capsulatum infection. These findings supported a diagnosis of primary cutaneous histoplasmosis. The patient was initiated on high-dose itraconazole, with notable clinical improvement on follow-up. No evidence of disseminated disease was identified.

Conclusions
Primary cutaneous histoplasmosis is a rare presentation that can mimic more common nodular dermatoses, especially in immunocompetent individuals. Dermoscopy may provide supportive clues, but histopathology remains essential for accurate diagnosis due to the high rate of false-negative cultures and overlapping clinical features. Early recognition and prompt antifungal therapy with itraconazole lead to favourable outcomes. This case emphasises the need to consider deep fungal infections in chronic, atypical facial nodules even in the absence of systemic illness or exposure history.

Abstract N°: ID-41

Topic: Infectious diseases, parasitic diseases, infestations

A Study of Excimer Laser with Itraconazole versus Itraconazole Monotherapy in the Management of Onychomycosis: A Single-Center, Assessor-Blinded, Randomized Control Trial

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Introduction
Onychomycosis, a prevalent and persistent fungal infection affecting nails, can be caused by dermatophytes, yeasts, and non-dermatophyte molds, impacting 5-10% of the global population. Oral medications like itraconazole are commonly used but have drawbacks such as extended treatment duration and side effects. Laser therapy is emerging as a promising alternative to mitigate systemic side effects and address nail abnormalities, and studies have shown its effectiveness in eradicating fungi.

Materials and Methods
The study aimed to evaluate the effectiveness and safety of excimer laser treatment for onychomycosis and compare it with itraconazole alone by evaluating clinical improvement using the onychomycosis severity index (OSI).

Baseline onychomycosis severity was assessed using the OSI conducted by a third-party assessor. Nail scrapings were examined with potassium hydroxide and fungal culture. Oral antifungals were administered for 2-3 months. Group A received oral antifungals monotherapy, while Group B received oral antifungals and underwent excimer laser treatment weekly for 2-3 months with assessments conducted at seven timepoints: baseline, 2nd, 4th, 8th, and 12th weeks before each treatment, and at 16th, 20th, and 24th weeks from baseline.

Results
Fifteen patients (mean age 51.9 ± 15.6 years; 53.3% female) were enrolled, with a mean disease duration of 93 months and an average of five nails affected. Distolateral subungual onychomycosis was the predominant clinical type, most frequently caused by *Candida* and *Aspergillus species*. Both the excimer laser plus itraconazole group and itraconazole monotherapy group showed progressive clinical and mycological improvement during follow-up. By week 16, complete clinical clearance was achieved in 26.7% of patients in the combination group and 40.0% in the monotherapy group with similar results at weeks 20 and 24, while by week 12, 93.3% in both groups were KOH-negative and 100% had negative fungal cultures. No adverse effects were reported. Recurrence occurred in 6.7% in the combination group and two patients 13.3% in the monotherapy group. Dermoscopic features improved in both groups, with no statistically significant differences observed between treatment arms at any time point (all $p > 0.05$).

Conclusions
Excimer laser therapy is a safe and effective adjunct for onychomycosis, achieving outcomes comparable to oral antifungal monotherapy, with high clearance rates, low recurrence, and no adverse effects. The 308-nm excimer laser may be considered a valuable adjunct for patients unresponsive to or unsuitable for systemic therapy and immunocompromised patients.

Abstract N°: ID-52

Topic: Infectious diseases, parasitic diseases, infestations

Therapeutic Role of Acyclovir in Severe Adult Hand, Foot, and Mouth Disease: A Case Report

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Introduction

Hand, Foot, and Mouth Disease (HFMD) is an acute viral exanthem that commonly affects children, particularly those under ten years of age. The infection is frequently caused by Coxsackievirus A16 and Enterovirus 71, members of the Picornaviridae family. The disease is self-limiting, resolving spontaneously within a week to ten days. Adult-onset HFMD, however, remains an uncommon and underreported condition. It may present atypically and with increased severity, including extensive oral ulcerations, painful eruptions, and systemic symptoms. Certain antiviral agents have been empirically used in severe cases. Acyclovir, a guanine analogue, has occasionally shown clinical benefit in adult HFMD. While enteroviruses lack the thymidine kinase enzyme required for acyclovir activation, a few published case reports have suggested that acyclovir may hasten recovery. This report describes a case of severe adult-onset HFMD with extensive oral involvement that responded dramatically to oral acyclovir.

Materials and Methods

A 34-year-old female presented with a two-day history of fever, painful oral ulcers, and swelling of lips and oral mucosa. She noted painful red spots on both hands and a few lesions on the right foot. Her four-year-old child had been diagnosed with HFMD one week earlier. On examination, the patient was dehydrated, hypotensive and febrile (101°F). Oral examination revealed multiple shallow, tender erosions on the buccal mucosa, tongue, and palate. Cutaneous examination showed multiple erythematous macules and vesicular lesions over the palmar surfaces of both hands and lateral aspect of the right foot. Given her symptoms, epidemiological link, and clinical presentation, a diagnosis of HFMD was made. The patient was admitted, and intravenous fluids were started to correct dehydration. Acetaminophen was given for fever. Oral care included the modification of Pandyas regimen to soothe mucosal lesions. Considering the severity of her mucosal involvement, oral acyclovir 400 mg three times daily was started for seven days. Within 48 hours of therapy, the patient reported significant reduction in oral pain and swelling. Fever subsided by the second day, and pharyngitis showed marked improvement. She was discharged in stable condition and followed up after one week, showing complete recovery.

Results

Adult-onset HFMD is an emerging phenomenon. While it remains uncommon, several outbreaks have shown a shift in epidemiology, with more adults being affected in recent years. Adults often experience a more severe course than children, particularly in the presence of extensive mucocutaneous lesions. The differential diagnosis includes herpetic stomatitis, Stevens–Johnson syndrome, aphthous ulcers, erythema multiforme, and fixed drug eruption. Several reports support the possible benefit of acyclovir in adult HFMD. Patil et al. (Indian J Dermatol, 2015) described a similar case of adult-onset HFMD treated successfully with acyclovir, showing complete resolution within four days. Kim et al. (J Korean Med Sci, 2012) also noted accelerated lesion healing in an adult patient following acyclovir initiation. In another case by Lee et al. (Singapore Med J, 2018), severe adult HFMD with painful mucosal involvement improved significantly within two days of acyclovir therapy. Although these are isolated reports, they suggest a reproducible pattern of faster recovery in acyclovir-treated patients.

Conclusions

In our case, acyclovir therapy led to remarkable improvement within 48 hours, allowing early resumption of oral intake and discharge within four days. Similar findings in previously reported cases suggest that acyclovir

may have a beneficial role, either through antiviral or anti-inflammatory mechanisms. Given its safety and availability, acyclovir could be considered as an adjunctive treatment in selected adult HFMD cases with significant morbidity. Further research is warranted to elucidate its mechanism of action, establish treatment protocols, and determine efficacy.

Abstract N°: ID-60

Topic: Infectious diseases, parasitic diseases, infestations

A Case of Recurrent Chromoblastomycosis treated with multiple surgical management options.

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Introduction
Chromoblastomycosis is a chronic, granulomatous, suppurative mycosis of the skin and subcutaneous tissue typically caused by traumatic inoculation of the dematiaceous fungi of the *Herotrichiellaceae*. It is an occupational disease that predominates in the tropical and subtropical regions with lesions often difficult to diagnose due to the polymorphous appearance.

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

Results
A 59-year-old male presents with a 12-month history of an asymmetrical, scaly plaque on the left forearm that has been slowly increasing in size. Lesion is not pruritic or painful and has had no exudate. Past medical history included atrial fibrillation on apixaban, benign prostatic hypertension and cardiac stent. Patient was a retired print worker who enjoyed gardening. 4mm punch biopsy of the left forearm revealed superficial dermal fibrosis with mild pseudoepitheliomatous hyperplasia and granulomatous inflammation with scattered multinucleate histiocytes. There were giant cells with pigmented structures exhibiting moderate staining for PAS, compatible with Medlar bodies suggestive of Chromoblastomycosis. Patient was on rosuvastatin rendering Itraconazole not a possible treatment option and instead underwent curettage and cautery with two bouts cryotherapy freeze and thaw cycle as treatment. Initial 6-month review revealed no evidence of recurrence but 12 month follow up noted crusted area on the distal aspect of the scar. Shave biopsy performed revealed a squamoproliferative lesion with pigmented organisms suggestive of recurrence of chromoblastomycosis. Further excisional biopsy was performed with no evidence of chromoblastomycosis.

Conclusions
This case highlights multiple surgical options for the management of Chromoblastomycosis in patients where medical management is contraindicated. It highlights the therapeutic challenge of this disease due to frequent recurrence of lesions and that repeat biopsy maybe efficacious in monitoring for recurrence.

Abstract N°: ID-94

Topic: Infectious diseases, parasitic diseases, infestations

Ulcerative cutaneous infection caused by extended-spectrum beta-lactamase–producing Morganella morganii: a diagnostic and therapeutic challenge

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Introduction

Morganella morganii is a facultative gram-negative bacillus most commonly associated with urinary tract and intra-abdominal infections. Its involvement in cutaneous infections is uncommon and particularly rare in the setting of chronic ulcers. The emergence of multidrug-resistant strains producing extended-spectrum beta-lactamases (ESBL) represents an increasing therapeutic challenge, especially in vulnerable patient populations.

Materials and Methods

A 48-year-old male with heart failure secondary to cocaine use presented with a five-month history of painful blistering lesions on the lower extremities that progressed to chronic ulcerations with serohematic and purulent exudate. A complete dermatological examination was performed. Two skin samples were obtained for histopathological and microbiological evaluation. Antimicrobial susceptibility testing was carried out using standard methods.

Results

Physical examination revealed a single dermatosis involving both lower extremities with a sporotrichoid pattern, symmetric distribution, and polymorphic presentation. Multiple well-demarcated chronic ulcers with violaceous borders and serohematic-purulent discharge were observed; the largest lesion measured 4 × 3 cm and was markedly painful. Histopathological analysis demonstrated superficial ulceration, intraepidermal abscesses, and perifollicular dermatitis consistent with an infectious process. Microbiological culture isolated *Morganella morganii* subsp. *morganii*, with Gram staining showing abundant polymorphonuclear leukocytes. Antimicrobial susceptibility testing revealed ESBL production with resistance to cephalosporins, aminoglycosides, fluoroquinolones, and aztreonam, and susceptibility limited to carbapenems and piperacillin/tazobactam. Targeted antibiotic therapy was initiated, resulting in significant clinical improvement.

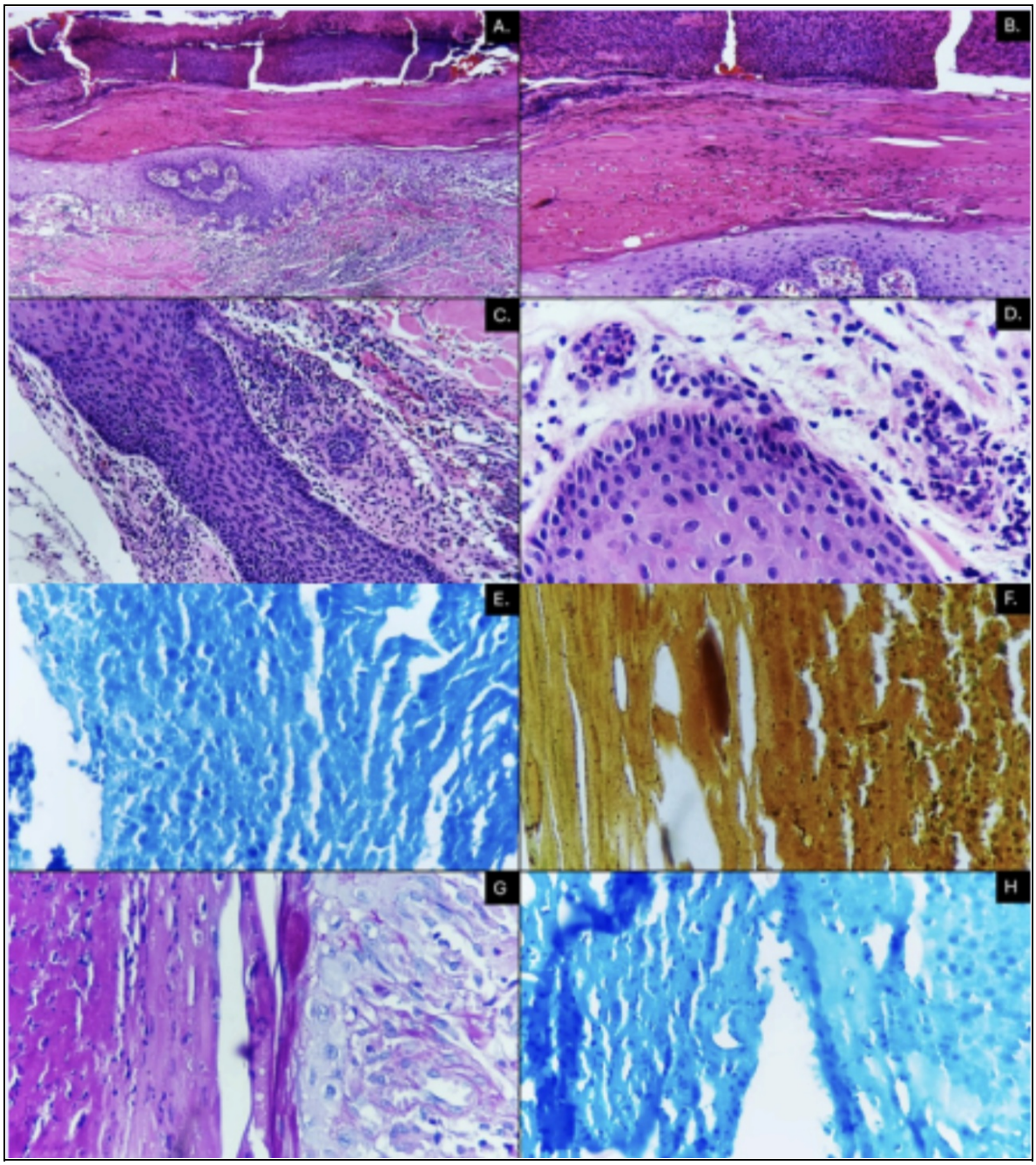

Figure 2. Histopathological findings: (A) Intraepidermal abscess formation (H&E, 4×). (B) Higher magnification showing intraepidermal abscesses (H&E, 10×). (C) Hair follicle surrounded by a dense inflammatory infiltrate (H&E, 10×). (D) Infiltrate composed of mature lymphocytes and neutrophils (H&E, 40×). (E) Fite–Faraco stain: negative for microorganisms (40×). (F) Grocott methenamine silver stain: negative for fungal microorganisms (40×). (G) Periodic acid–Schiff stain: negative for microorganisms (40×). (H) Ziehl–Neelsen stain: negative for acid-fast microorganisms (40×).

Conclusions

This case highlights the importance of comprehensive microbiological evaluation in atypical or chronic cutaneous ulcers, particularly in vulnerable patients. Although infrequent, *Morganella morganii* should be considered a potential pathogen in cutaneous infections. Early identification of multidrug-resistant strains allows for timely optimization of antimicrobial therapy and improved clinical outcomes.

Abstract N°: ID-104

Topic: Infectious diseases, parasitic diseases, infestations

Postoperative Cutaneous Tuberculosis Presenting as Expanding Indurated Cervical Plaques

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Introduction

Cutaneous tuberculosis (CTB) is a rare manifestation of Mycobacterium tuberculosis infection and often mimics other granulomatous dermatoses. Its indolent course and absence of systemic findings may delay diagnosis. We report an atypical postoperative case of CTB presenting as slowly progressive indurated plaques without pulmonary involvement.

Materials and Methods

A 70-year-old woman presented with an asymptomatic indurated erythematous–orange plaque measuring approximately 10 × 10 cm, extending from the right cervical region to the lateral sternum, with a duration of 3 years. A second, morphologically similar but smaller, horizontally oriented plaque measuring 2 × 7 cm had developed over the superior aspect of the primary lesion and had been present for 8 months at the time of admission.

A subcutaneous swelling had appeared in the right cervical–supraclavicular region 1 month before the development of the cutaneous lesions and was surgically excised at an external center. Histopathological examination of the excised lesion was reported as necrotizing granulomatous dermatitis; however, the patient was lost to follow-up thereafter. Shortly after the surgical excision, plaques gradually emerged at the operative site, progressively enlarging over time and occasionally producing purulent discharge. The patient reported no constitutional or respiratory symptoms, had no known exposure to tuberculosis, no history of chronic systemic disease, and was not taking any regular medications. She resided in a rural highland area.

Clinical differential diagnoses included sarcoidosis, lupus vulgaris, and deep fungal infection. Skin biopsy revealed granulomatous inflammation without necrosis, and tissue culture from the lesion grew Mycobacterium tuberculosis complex. Thoracic computed tomography showed cervical, axillary, and mild mediastinal lymphadenopathy without pulmonary parenchymal involvement. Standard antituberculous therapy was initiated, resulting in marked clinical regression.

Results

Classical forms of cutaneous tuberculosis differ according to the route of infection and typically present with well-defined clinical patterns, often accompanied by a history of tuberculosis exposure or systemic disease. In contrast, our case showed several atypical features. The onset following surgical excision suggested a possible iatrogenic inoculation or local reactivation rather than classical endogenous spread. Clinically, the lesions manifested as slowly progressive indurated plaques rather than ulcerative or verrucous lesions commonly associated with invasive CTB.

Histopathological findings were nonspecific and overlapped with other granulomatous disorders, making diagnosis challenging. Definitive diagnosis was achieved only through microbiological culture, highlighting its essential role in atypical granulomatous skin lesions. The absence of pulmonary symptoms and lung involvement further emphasizes that CTB may present as a primarily dermatological condition.

Conclusions

Cutaneous tuberculosis should be considered in chronic granulomatous plaques developing after surgical procedures, even in immunocompetent patients without pulmonary involvement. Microbiological confirmation is crucial for timely diagnosis and effective treatment.

Abstract N°: ID-111

Topic: Infectious diseases, parasitic diseases, infestations

Topical imiquimod for patch-stage epidemic Kaposi sarcoma in a resource-limited setting: a case-based therapeutic approach

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Introduction

Epidemic Kaposi sarcoma (KS) remains a frequent cutaneous malignancy among people living with HIV, particularly in low- and middle-income countries, where access to systemic chemotherapy and radiotherapy may be limited. Early-stage (patch-stage) lesions may be suitable for local therapies. Imiquimod, a topical immune response modifier, has been proposed as a potential treatment option, although evidence supporting its use in epidemic KS remains limited.

Materials and Methods

We report the case of a 32-year-old HIV-positive man with biopsy-confirmed epidemic Kaposi sarcoma presenting with patch-stage cutaneous lesions. Kaposi sarcoma was the initial clinical manifestation, and antiretroviral therapy was initiated subsequently. Treatment consisted of topical imiquimod 5% cream applied three times per week at night under occlusion for a total duration of eight weeks. Clinical response, tolerability, and adverse effects were assessed during follow-up.

Results

After eight weeks of treatment, a marked clinical improvement was observed, characterized by a significant reduction in erythema and lesion infiltration, with no progression to plaque or nodular stages. Treatment was well tolerated. Only mild local inflammatory reactions were observed, and no systemic adverse events were reported.

Conclusions

Topical imiquimod may represent a safe, effective, and low-cost therapeutic option for patch-stage epidemic Kaposi sarcoma, particularly in settings with limited access to standard oncologic therapies. Its use may be considered as a local treatment strategy in selected patients. Further studies are required to better define its role in the management of early-stage disease.

Abstract N°: ID-117

Topic: Infectious diseases, parasitic diseases, infestations

Beyond Psoriasis: Recognizing Crusted Scabies in Patients with Communication Barriers

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Introduction
Crusted (Norwegian) scabies is a rare, highly contagious form of scabies caused by infestation with the ectoparasite Sarcoptes scabiei var. hominis. In patients with Down syndrome, immunological aberrations - specifically T-cell abnormalities - and altered pruritic perception facilitate massive parasitic proliferation [2,3]. Clinically, crusted scabies may overlap with or mimic other dermatologic disorders, including psoriasis, eczema, seborrheic dermatitis, lichen planus, pityriasis rubra pilaris, and cutaneous lymphoma. In high-risk patients, pre-existing dermatoses often obscure the clinical picture, making differentiation between a psoriasis flare and secondary infestation particularly challenging [1]. Our case illustrates how the inability to report pruritus due to severe intellectual disability, combined with pre-existing psoriasis, resulted in a significant diagnostic delay and subsequent clinical deterioration.

Materials and Methods
A case report.

Results
A 35-year-old female with Down syndrome and severe intellectual disability was referred for evaluation of progressive skin lesions. Due to her cognitive impairment, the patient was unable to communicate or characterize subjective complaints; however, skin lesions had been observed by caregivers since 2010, when the patient was diagnosed with psoriasis. Physical examination revealed widespread erythematous plaques on the scalp, trunk, and extensor surfaces of the limbs (BSA >20%), accompanied by prominent palmoplantar keratoderma and dystrophic, hyperkeratotic nails. In the absence of a reported pruritus, the presentation was initially interpreted as an exacerbation of psoriasis vulgaris. Treatment with calcipotriol/betamethasone foam and systemic acitretin 20 mg/day was initiated. Although a transient clinical response was observed, the patient's condition subsequently regressed, prompting an increase in acitretin to 30 mg/day. Despite dose escalation, skin lesions progressed to erythroderma with extensive exfoliation. Biological therapy with adalimumab was then initiated; however, following the first administration, the patient developed a febrile fever and was diagnosed with pneumonia, necessitating the immediate cessation of the TNF-alpha inhibitor. Due to treatment resistance and worsening of a clinical skin condition, a 5 mm punch biopsy was performed. Histopathological analysis of the skin biopsy revealed massive *Sarcoptes scabiei* infestation within the stratum corneum, accompanied by serum crusts (plasma inclusions) and neutrophilic infiltrates. The epidermis exhibited significant acanthosis and spongiosis. In the superficial dermis, a prominent perivascular inflammatory infiltrate consisting of lymphocytes, plasma cells, and eosinophils was observed. These findings are pathognomonic and confirm the definitive diagnosis of crusted (Norwegian) scabies. Antiscabietic therapy was initiated with topical permethrin 5% for seven consecutive days, combined with oral ivermectin 200 micrograms/kg on days 1, 2, and 8. Following successful parasitic eradication, guselkumab was introduced to manage the underlying psoriasis.

Conclusions

Crusted scabies frequently masquerades as refractory psoriasis in patients with Trisomy 21, driven by underlying immunological and sensory aberrations that facilitate hyperinfestation. Treatment-resistant dermatosis in high-risk patients necessitates urgent diagnostic re-evaluation. Microscopic or histopathological screening is mandatory to optimize therapeutic outcomes, ensure the appropriate use of systemic agents, and maintain epidemiological safety within healthcare environments.

Abstract N°: ID-151

Topic: Infectious diseases, parasitic diseases, infestations

Navigating the Emergency of Ecthyma Gangrenosum: A Systematic Review of Pathogen Diversity and Septicaemia Status and the Call for a Broader Definition

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Introduction
Ecthyma gangrenosum is considered an emergency dermatological condition and is classically defined as a *Pseudomonas aeruginosa*-associated necrotic skin lesion in immunocompromised patients with septicemia. Emerging evidence suggests a broader spectrum of causative pathogens and cases without concurrent septicemia. This review aims to reassess the pathogen diversity and septicemia status in EG, advocating for a more inclusive clinical definition.

Materials and Methods
A PRISMA-compliant systematic review was conducted, screening databases such as PubMed, EMBASE, Scopus, and Web of Science. 162 studies (311 patients) reporting EG with confirmed pathogen identification were included. Data on pathogen types, septicemia presence, immune status, lesion location, and management were extracted and analyzed.

Results
Pathogen diversity was observed, with *Pseudomonas aeruginosa* being the most common pathogen (72.2%), followed by 27.8% implicated other pathogens (MRSA: 4.9%, fungi: 3.7%, *E. coli*: 4.3%). Septicemia was present in 61.7% of cases and 71.0% were immunocompromised. Recovery rates varied by pathogen type, with *P. aeruginosa* cases having an 81.1% recovery rate, while fungal infections had a significantly lower recovery rate (47.4%). Mortality was highest with fungal pathogens (52.6% vs. *P. aeruginosa*: 15.1%).

Conclusions
This review highlights the diverse microbial etiology of EG and challenges the traditional view of the condition being solely linked to *Pseudomonas aeruginosa* bacteremia. It advocate redefining EG as a pathogen-agnostic, necrosis-driven entity to improve diagnosis and management.

Abstract N°: ID-216

Topic: Infectious diseases, parasitic diseases, infestations

Type 1 Lepra Reaction Mimicking Angioedema with Facial Nerve Palsy in Borderline Tuberculoid Leprosy

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Introduction

Leprosy reactions represent acute immune driven inflammatory episodes that predominantly affect patients within the borderline spectrum and are a major cause of sudden nerve dysfunction. Type 1 lepra reaction typically manifests as inflammation of established lesions with associated neuritis. Facial involvement presenting as acute edematous swelling is distinctly uncommon and may closely resemble allergic or infective conditions, leading to diagnostic delay. We describe an unusual presentation of Type 1 lepra reaction mimicking angioedema, complicated by facial nerve palsy.

Materials and Methods

A 36-year-old male from a leprosy-endemic region presented with acute facial swelling, bilateral periorbital edema, and painful erythematous cutaneous lesions. Detailed dermatological and neurological examinations were performed, including peripheral nerve assessment. Laboratory evaluation included slit-skin smear for acid-fast bacilli, and a skin biopsy was subjected to histopathological examination using hematoxylin and eosin staining.

Results

Clinical examination revealed a solitary, tender, erythematous, edematous plaque involving the upper half of the face, extending from both cheeks to the vertex of the scalp, associated with diffuse periorbital edema and loss of philtral hair. Multiple additional tender erythematous plaques were present over the trunk and extremities in an asymmetrical distribution, showing induration, xerosis, and patchy hair loss. Several hypopigmented patches demonstrated partial loss of touch and temperature sensation.

Peripheral nerve examination showed marked thickening of the left greater auricular and left ulnar nerves. Facial nerve assessment revealed loss of forehead wrinkling, lagophthalmos, and deviation of the angle of the mouth to the right, consistent with left-sided lower motor neuron facial nerve palsy. No motor or sensory deficits were detected in the limbs.

Slit-skin smear was negative for *Mycobacterium leprae*. Histopathological examination demonstrated marked dermal edema with loosening of epithelioid granulomas and dense perineural lymphocytic infiltration, consistent with a Type 1 lepra reaction in the borderline tuberculoid spectrum. Following initiation of systemic corticosteroid therapy, significant reduction in facial edema and cutaneous inflammation was observed within one week.

Conclusions

Type 1 lepra reaction can rarely present as angioedema like facial swelling with acute facial nerve involvement, posing a significant diagnostic challenge. Awareness of this atypical presentation is essential to prevent misdiagnosis and treatment delay, which may result in irreversible nerve damage. This case broadens the recognized clinical spectrum of Type 1 lepra reactions and highlights the importance of detailed neurological evaluation in patients presenting with acute facial edema in endemic settings.

Abstract N°: ID-233

Topic: Infectious diseases, parasitic diseases, infestations

Nationwide trends in scabies diagnoses in Korea before, during, and after the COVID-19 pandemic

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Introduction
Several countries reported increases in scabies diagnoses during the COVID-19 pandemic, raising questions about whether these observations reflected true epidemiologic changes or shifts related to healthcare disruption. Interpretation of short-term or institution-based data remains challenging for conditions such as scabies, which are sensitive to healthcare access and diagnostic timing.

Materials and Methods
We analyzed nationwide monthly scabies diagnoses using data from the Korean Health Insurance Review and Assessment Service (HIRA) Healthcare Big Data Hub between January 2016 and December 2024. Trends were compared across three periods: pre-pandemic (2016–2018), pandemic period with extensive non-pharmaceutical interventions (2019–2021), and post-pandemic period (2022–2024). Temporal trends, seasonal patterns, and age- and sex-specific distributions were examined.

Results
Scabies diagnoses decreased markedly during the pandemic period compared with the pre-pandemic baseline. Despite reduced diagnostic volume, the characteristic seasonal pattern—autumn peaks and spring nadirs—was preserved. During the post-pandemic period, diagnoses gradually returned toward pre-pandemic levels without exceeding baseline incidence. Although overall case numbers declined, the proportion of patients aged ≥60 years increased from 34.3% to 48.6%, and the proportion of female patients increased from 56.6% to 62.0% during the pandemic period.

Conclusions
Nationwide long-term data indicate that scabies did not increase during the COVID-19 pandemic in Korea but instead declined and subsequently normalized. The observed demographic redistribution suggests differential effects of the pandemic on healthcare utilization and exposure patterns. These findings provide important context for interpreting short-term international reports and underscore the value of population-based longitudinal data in understanding scabies epidemiology.

Abstract N°: ID-269

Topic: Infectious diseases, parasitic diseases, infestations

Recurrent Herpes Zoster in Young Adult as a Clinical Clue for Undiagnosed HIV: A Case Report

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Introduction

Reactivation of the Varicella-Zoster Virus (VZV) is a consequence of declining cell-mediated immunity; consequently, Herpes Zoster (HZ) is part of concern in the elderly and individuals with compromised immune systems. Human Immunodeficiency Virus (HIV) remains a significant global public health burden. HIV is a retrovirus that causes immune suppression and dysregulation primarily via depletion of CD4+ lymphocytes and CD4+ cells of monocytic lineage. The incidence of recurrent HZ is reported in 0.0 – 18.2 % of immunocompromised individuals. The risk of HZ recurrence was increased for individuals aged 40–49 years, and then increased further in each decade of life up to 80 years of age. The recurrence Herpes Zoster in young adult is uncommon and the risk of HZ correlates inversely with CD4+ T-cell counts. The risk is higher among those who ever experienced a low CD4+ T-cell count nadir, and immunocompromised status is a critical independent risk factor.

Materials and Methods

A 25-year-old man presented with painful erythematous patches and vesicles on his left side of neck and left ear. He had a history of HZ involving the left hand two years prior. A Tzanck smear confirmed the presence of multinucleated giant cells. Given that recurrent HZ is uncommon in young, presumably immunocompetent individuals, the patient underwent counselling and screening for underlying immunodeficiency. Voluntary Counselling and Testing (VCT) revealed a reactive anti-HIV result. Laboratory findings showed a CD4+ count of 402 cells/µL, a CD8+ count of 1,908 cells/µL, and a significantly low CD4:CD8 ratio. The patient was treated with oral valacyclovir 1,000 mg three times daily for seven days and oral methylprednisolone 4 mg three times daily. Additionally, antiretroviral therapy (ART) was initiated, comprising a fixed-dose combination of dolutegravir, lamivudine, and tenofovir disoproxil fumarate once daily.

Results

The lesions healed significantly after 10 days of follow-up with no evidence of post-herpetic neuralgia, Ramsay-Hunt Syndrome, or other complications. The early diagnosis of HIV allowed for the immediate initiation of ART alongside antiviral treatment, leading to clinical improvement and the prevention of further complications. While HZ is prevalent among the elderly, its recurrence in the younger population warrants further investigation. Recurrent HZ may serve as an early sentinel clue for an immunosuppressive process in patients under 45 years of age. In this case, the rarity of recurrent HZ in a young adult prompted a successful investigation for underlying immunosuppression.

Conclusions

Literature remains scarce regarding recurrent HZ in young adults. This case demonstrates that such a presentation is a crucial clinical marker for underlying immunosuppression, most notably HIV infection. Early identification of these risk factors is essential, as it facilitates the timely initiation of appropriate targeted therapies, such as ART, thereby significantly improving the patient's long-term prognosis.

Abstract N°: ID-270

Topic: Infectious diseases, parasitic diseases, infestations

Delayed Diagnosis of Scabies Presenting as Atopic Dermatitis and Progressing to Crusted Scabies in an Infant

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Introduction

Crusted scabies is a rare, severe form of scabies characterized by massive infestation of *Sarcoptes scabiei* with extensive hyperkeratotic and crusted lesions. Scabies is a well-known “great imitator” that can mimic various dermatologic conditions, including atopic dermatitis, which itself has heterogeneous clinical manifestations depending on severity and chronicity. This overlap often leads to misdiagnosis and delayed treatment, particularly in infants, increasing the risk of transmission and severe complications. Early and accurate diagnosis is therefore essential.

Materials and Methods

A 5-month-old female infant presented with a one-month history of progressive skin lesions. Initial lesions consisted of erythematous macules and papules on the face and extensor surfaces and were diagnosed as atopic dermatitis at a local clinic, with transient improvement following topical mometasone therapy. Lesions later recurred, became generalized, and developed thick crusts. Detailed history, physical examination, dermoscopy, microscopic examination of skin scrapings, and laboratory investigations were performed. Household history revealed similar pruritic symptoms in both parents and an older sibling, all sharing the same sleeping environment.

Results

The infant was irritable with intense nocturnal pruritus and sleep disturbance. Examination revealed diffuse erythematous macules and papules involving the entire body, including the face, with widespread excoriations and thick hyperkeratotic yellowish crusts. While early features closely resembled infantile atopic dermatitis, disease progression revealed characteristics suggestive of scabies, including nocturnal pruritus, rapid lesion dissemination, extensive crusting, and household involvement. Dermoscopy showed curved burrows with a noodle-like appearance, gray-edged line sign, and delta glider sign followed by a jet contrail, along with prominent scales and crusts—findings typical of scabies and absent in atopic dermatitis. Microscopic examination confirmed the presence of adult mites and eggs. Laboratory results demonstrated leukocytosis ($12.7 \times 10^3/\mu L$) with eosinophilia (12.3%). Anthropometric assessment revealed underweight status with wasting, consistent with moderate acute malnutrition and weight loss during illness. Due to extensive involvement, irritability, and poor oral intake, inpatient treatment was initiated. Therapy included topical 5% permethrin, keratolytic and anti-scabetic compounded topical agents, adjunctive low-potency topical corticosteroid after initiation of anti-scabetic therapy, supportive skin care, and continued breastfeeding. Marked clinical improvement occurred by day three, and complete resolution was achieved within three weeks. All household contacts were treated simultaneously, and environmental decontamination was implemented.

Conclusions

This case underscores the importance of considering scabies in infants presenting with eczematous lesions and severe pruritus. Clinical overlap with atopic dermatitis frequently leads to misdiagnosis and delayed treatment, especially when topical corticosteroids are initiated without excluding infectious causes. Delayed recognition may exacerbate infestation

and contribute to progression to crusted scabies. Effective management requires early diagnosis, appropriate anti-scabetic therapy, optimized skin care, concurrent treatment of household contacts, and environmental control to prevent recurrence and transmission.

Abstract N°: ID-315

Topic: Infectious diseases, parasitic diseases, infestations

Erythema nodosum as initial sign of acute Borrelia burgdorferi infection

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Introduction

Lyme borreliosis is a frequently encountered tick-borne infection worldwide, caused by a spirochete from the Borrelia burgdorferi genoscpecies. In most cases, the initial sign of Lyme disease is the pathognomonic symptom - erythema migrans rash appearing at the site of the thick bite. Other described cutaneous manifestations besides erythema migrans – such as erythema nodosum (an acute nodular septal panniculitis), papular urticaria, granuloma annulare, psoriatic changes, lichen striatus et atrophicans, Henoch-Schönlein purpura, and morphea – could potentially present as an initial/first sign of acute Borrelia burgdorferi infection.

Materials and Methods

Serological testing for Lyme disease is only reliable after the initial stages of the disease. Additional PCR or serological examinations such as ELISA, immunoblot, indirect immunofluorescence examination could be performed. The diverse cutaneous manifestations of Lyme disease can lead to delays or ineffectiveness in treatment, as these symptoms may not be promptly identified as signs of the infection. Therefore, a comprehensive evaluation of the three key aspects - clinical findings, serology, and histology - is essential and should be considered collectively.

We present a 78-year-old female with an acute form of Borrelia infection following a thick bite, manifesting as erythema nodosum on the lower extremities (Fig.1a-d).

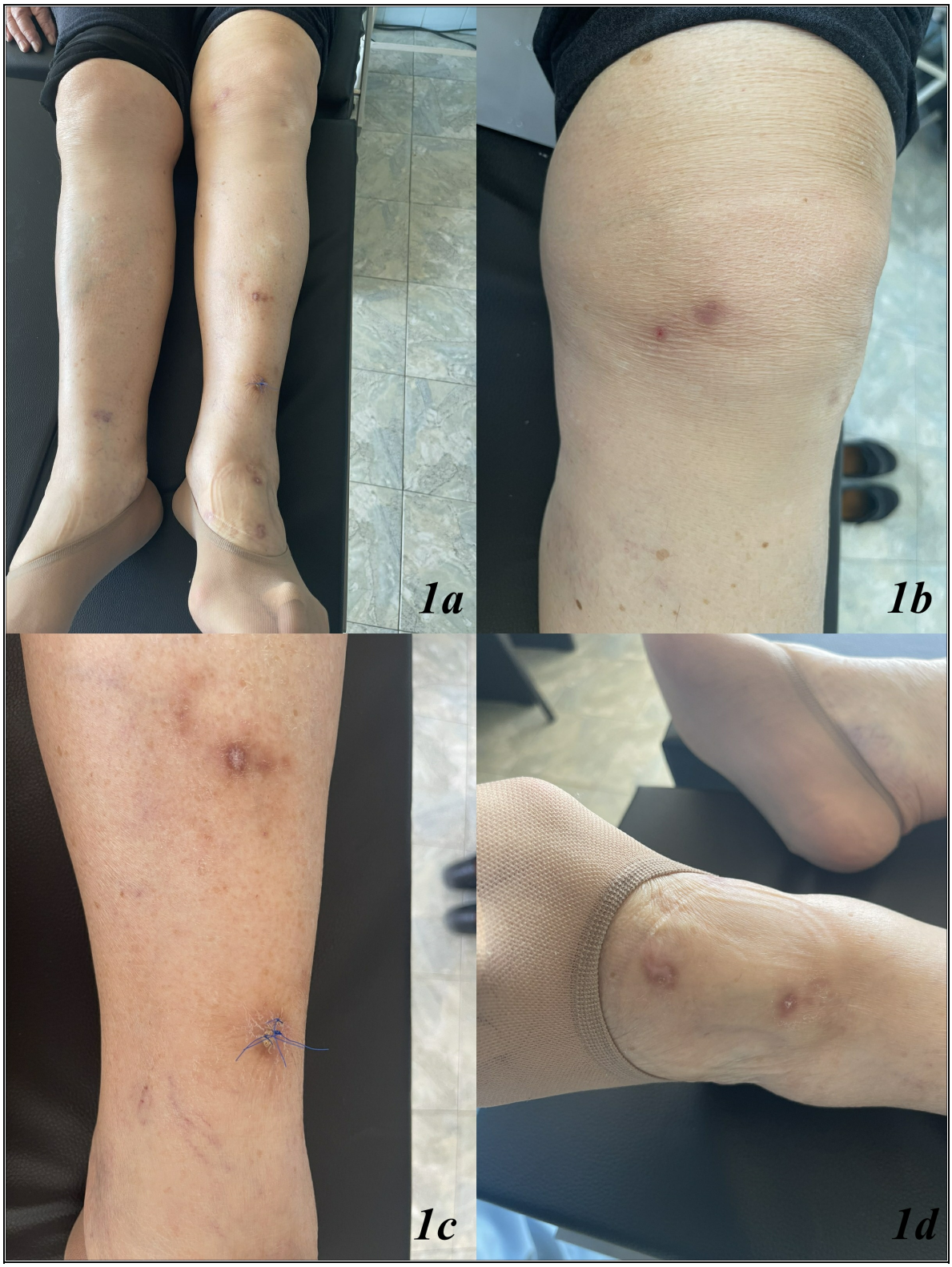

Fig.1a-d: Multiple erythematous-edematous lesions with crusts located on the left and right lower extremities, pretibial area (a-d). The punch biopsy was conducted from an erythema nodosum lesion located in the lower pretibial area of the left lower extremities (c).

Results

Serology confirmed the presence of Borrelia infection, and the histological findings were indicative of erythema nodosum (fig.2a,b). The patient initially received anti-inflammatory and antibiotic medications. Reverse development of the nodules was observed after therapy with ceftriaxone, methylprednisolone, esomeprazole, and local dressings with povidone-iodine. For outpatient care, her regimen consisted of systemic reduction of the corticosteroid therapy, esomeprazole, and doxycycline. Due to the potential triggering of erythema nodosum by valsartan, it was recommended switching to an alternative medication.

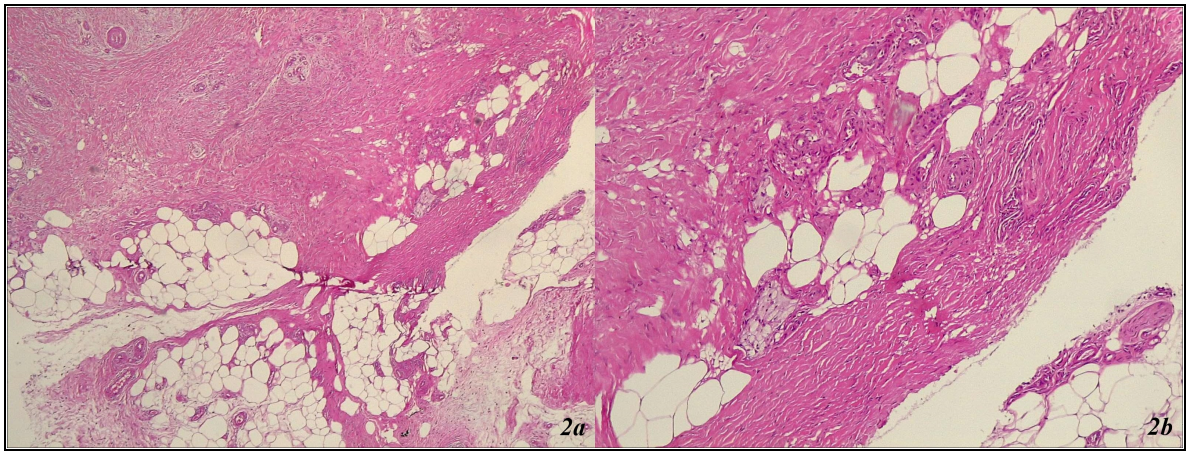

Fig.2a,b: Erythema nodosum: marked orthohyperkeratosis, irregular acanthosis, significant fibrosis throughout the dermis, septal panniculitis with the formation of dense collagen sheaths extending deep into the hypodermis. 2a: Septal panniculitis x 40 x HE - septal panniculitis with small foci of inflammatory cells extending into the adjacent fat lobules. 2b: Septal panniculitis x 100 x HE - fibrotic collagen bundles, forming thick septal compartment, extending into the adjacent lobular fat with small groups of lymphocytes and a few histiocytes.

Conclusions

The rarity of erythema nodosum as an initial or first sign of acute Borrelia infection is being discussed.

Abstract N°: ID-332

Topic: Infectious diseases, parasitic diseases, infestations

A walk in the Park: Acrodermatitis chronica atrophicans

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Introduction

A 60-year-old woman presented with a three year history of progressive, diffuse erythema which extended over the left leg with areas of altered sensation. Examination revealed an extensive, purplish-red, confluent patch extending from the left forefoot to the thigh and buttock. The affected skin had a shiny atrophic appearance with tightening, resulting in mild restriction of ankle dorsiflexion. A biopsy showed demonstrated an interstitial and perivascular lymphocytic infiltrate with occasional plasma cells. These findings were initially considered suggestive of mycosis fungoides (MF). A second opinion was sought, where histology showed a marked T-cell lymphocytic infiltrate in both the epidermis and dermis, with evidence of epidermotropism and lymphocytes tagging along the basal epidermis. The patient was referred to a tertiary skin tumour unit for suspected mycosis fungoides. Upon further histological review, however, the features were deemed consistent with morphea. The presence of a CD8 positive infiltrate and associated epidermal changes was recognised as characteristic of morphea.

On review of the history the patient frequently walked in local parks which are tick endemic areas and thus Lyme serology was requested. Borrelia serology (IgM and IgG) confirmed Lyme borreliosis, leading to a final diagnosis of Acrodermatitis chronica atrophicans (ACA). Acrodermatitis chronica atrophicans (ACA) is a late-stage, chronic manifestation of Lyme borreliosis that primarily affects the distal extremities and is characterised by progressive cutaneous atrophy. She was treated with a 2 month course of doxycycline, as discussed with microbiology, and showed a good clinical response. She was also reviewed by the neurology team who ruled out complications such as sensory peripheral neuropathy. This case highlights the importance of considering ACA in the differential diagnosis of chronic erythematous or atrophic skin lesions, particularly in individuals with a history of exposure to tick-endemic regions. Prompt recognition and appropriate antibiotic therapy are essential to prevent long-term complications of Lyme borreliosis.

Abstract N°: ID-340

Topic: Infectious diseases, parasitic diseases, infestations

Nationwide Retrospective Study of Tinea Capitis in Denmark: All Laboratory-Confirmed Cases in 2023

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Introduction

Tinea capitis (TC) is a dermatophyte infection of hair and scalp. The dermatophytes causing TC are divided into anthropophilic (transmission between humans), zoophilic (from animals) and geophilic (from soil) species according to host preference.

In Europe, a shift in species responsible for TC has been observed over the past two decades. Previously, TC was typically caused by zoophilic species such as *Microsporum (M.) canis*, but in recent years many cases are caused by more contagious anthropophilic species such as *Trichophyton (T.) tonsurans, M. audouinii* and *T. violaceum*. The shift is hypothesized to be caused by increased immigration and international travel that have facilitated the dissemination of anthropophilic species from Africa, Asia and the Middle East to Europe.

However, the previous epidemiological studies documenting this shift in Europe have been limited to regional data or selected laboratories. To our knowledge a complete nationwide study has not previously been conducted. Furthermore, the epidemiology in Denmark has not been documented the past 20 years, and the annual prevalence of TC in Denmark has never been determined.

The primary objective of the study is to determine the annual prevalence and the species distribution of dermatophytes in samples from hair and scalp in 2023 identified nationwide in Denmark.

Materials and Methods

Data on confirmed dermatophyte-positive scalp and hair specimens collected between 01.01.2023-31.12.2023 were extracted from all Danish centers performing dermatophyte diagnostics.

The inclusion criteria were laboratory confirmed dermatophyte-positive samples identified by either culture or polymerase chain reaction (PCR) from scalp hair and/or skin scrapings of the scalp region. We included data regarding fungal species, diagnostic methods, age, sex, and social security number of patients to account for repeated tests from the same individual.

From the obtained data we performed descriptive statistics to characterize dermatophyte species responsible for TC

nationwide in Denmark and the annual prevalence in 2023 was calculated.

Results

In total 295 positive dermatophyte samples from the scalp were detected from 167 individuals of which 125 were children and 42 were adults. The median (interquartile range (IQR)) age of the patients was 8 (5-18) years and the sex distribution was 56.9% males and 43.1% females. For children under 18 years the median (IQR) age was 6 (4-9) years, and the sex distribution was 54.4% boys and 45.6% girls. For adults the median (IQR) age was 37 (26-56) years, and the sex distribution was 64.3% men and 35.7% women (see Table 1).

Culture was used in 22.2% and PCR was used in 88.2% of patients. The sample type sent for identification was scalp skin scrapings in 64.7%, hair in 16.2%, combination of scalp skin scrapings and hair in 19.2% of patients.

Species specific diagnosis was possible in 146 of the 167 individuals. The most common species isolated was *T. violaceum* (37.7%), followed by *M. canis* (18.5%), and *T. tonsurans* (11.6%). In children the most common species were *T. violaceum* (44.3%), *M. canis* (23.5%) and *M. canis*/ *M. audouinii* (7.8%), and in adults it was *T. tonsurans* (29.0%), *T. rubrum*/ *T. soudanense* (25.8%) and *T. violaceum* (12.9%) (see Table 1). Some PCR kits could not distinguish between two closely related species such as *M. canis*/ *M. audouinii* and *T. rubrum*/ *T. soudanense*. Therefore, the PCR results were presented as the two species combined.

Dermatophyte species*	**Total (n = 146)**	**Children (n = 115)**	**Adults (n = 31)**
Microsporum audouinii, n (%)	4 (2.7%)	4 (3.5%)	0 (0.0%)
Microsporum canis, n (%)	27 (18.5%)	27 (23.5%)	0 (0.0%)
*Microsporum canis/audouinii, n (%)***	10 (6.8%)	9 (7.8%)	1 (3.2%)
Microsporum gypseum, n (%)	1 (0.7%)	1 (0.9%)	0 (0.0%)
Trichophyton benhamiae, n (%)	1 (0.7%)	1 (0.9%)	0 (0.0%)
*Trichophyton indotineae, n(%)****	1 (0.7%)	1 (0.9%)	0 (0.0%)
Trichophyton interdigitale, n (%)	3 (2.1%)	0 (0.0%)	3 (9.7%)
*Trichophyton interdigitale/mentagrophytes, n (%)***	3 (2.1%)	1 (0.9%)	2 (6.5%)
Trichophyton mentagrophytes, n (%)	1 (0.7%)	1 (0.9%)	0 (0.0%)
Trichophyton rubrum, n (%)	9 (6.2%)	6 (5.2%)	3 (9.7%)
*Trichophyton rubrum/soudanense, n (%)***	15 (10.3%)	7 (6.1%)	8 (25.8%)
Trichophyton tonsurans, n (%)	17 (11.6%)	8 (7.0%)	9 (29.0%)
Trichophyton violaceum, n (%)	55 (37.7%)	51 (44.3%)	4 (12.9%)
*Trichophyton tonsurans/equinum, n (%)***	1 (0.7%)	0 (0.0%)	1 (3.2%)

Table legend: Species distribution of all positive dermatophyte hair and scalp samples from Denmark in 2023 from 146 of 167 patients where species specific diagnosis was possible. *Two patients had a double dermatophyte infection of the scalp with 2 different species. **Some species are registered as either one of two species because, because some of the PCR kits could not differentiate between the two species, which are closely related with only a few differences in base pairs. ***The patient had dermatophytosis on both the scalp and leg. PCR from both samples showed T. interdigitale/mentagrophytes. From the leg sample culture and subsequent sequencing of the isolate revealed T. indotineae. Sequencing was not possible for the scalp sample. We assume that the scalp was infected with the same isolate of T. indotineae as the leg.

Conclusions

The species responsible for TC in Denmark have undergone a notable shift. In 1993 and 2003, TC was primarily caused by *M. canis* accounting for 84.0% and 56.8% of cases, respectively. By 2023, *M. canis* represented merely 18.5-25.3% of cases, with anthropophilic species constituting the primary etiological agents of TC across both pediatric and adult populations in Denmark accounting for at least 71.2% of cases, in parallel with other European countries.

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Topic: Infectious diseases, parasitic diseases, infestations

Atypical presentation of Tuberculosis Verrucosa Cutis: A case of Diagnostic Challenge

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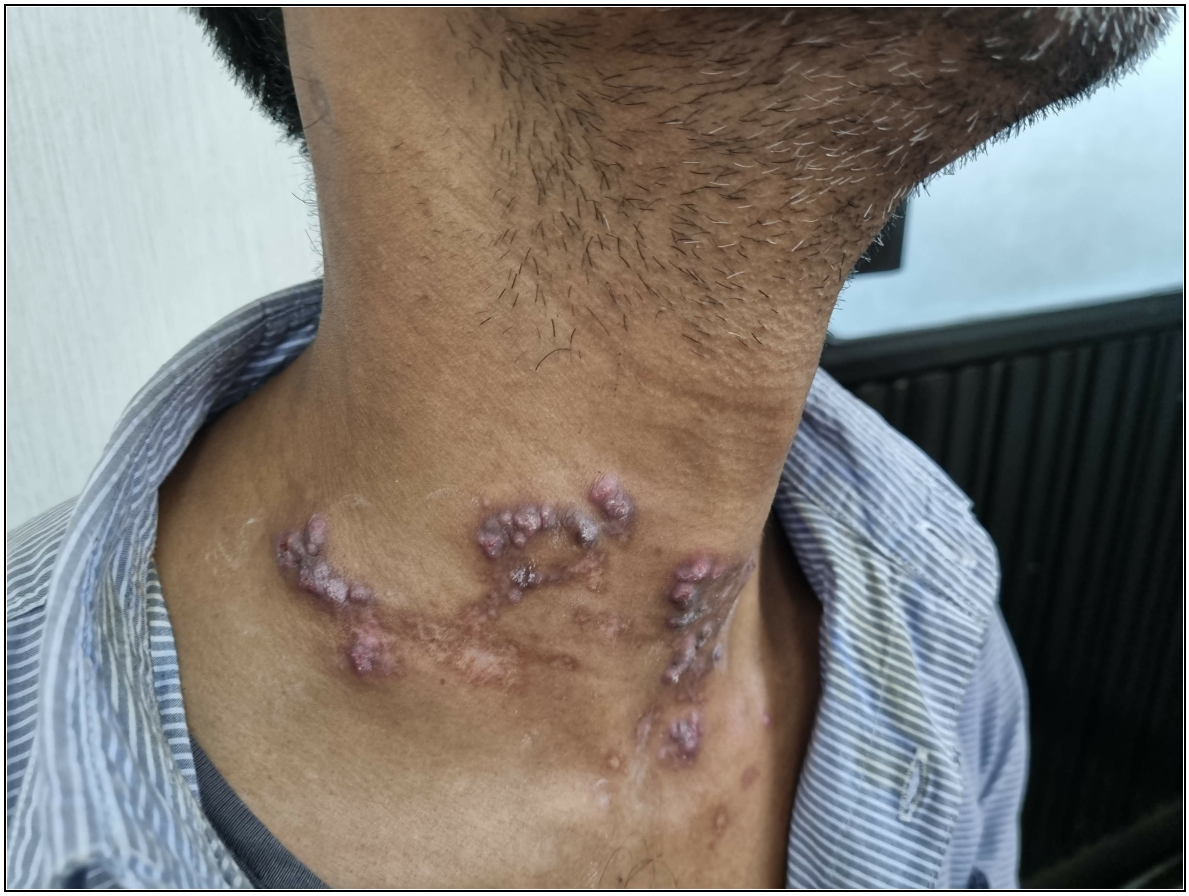
Introduction

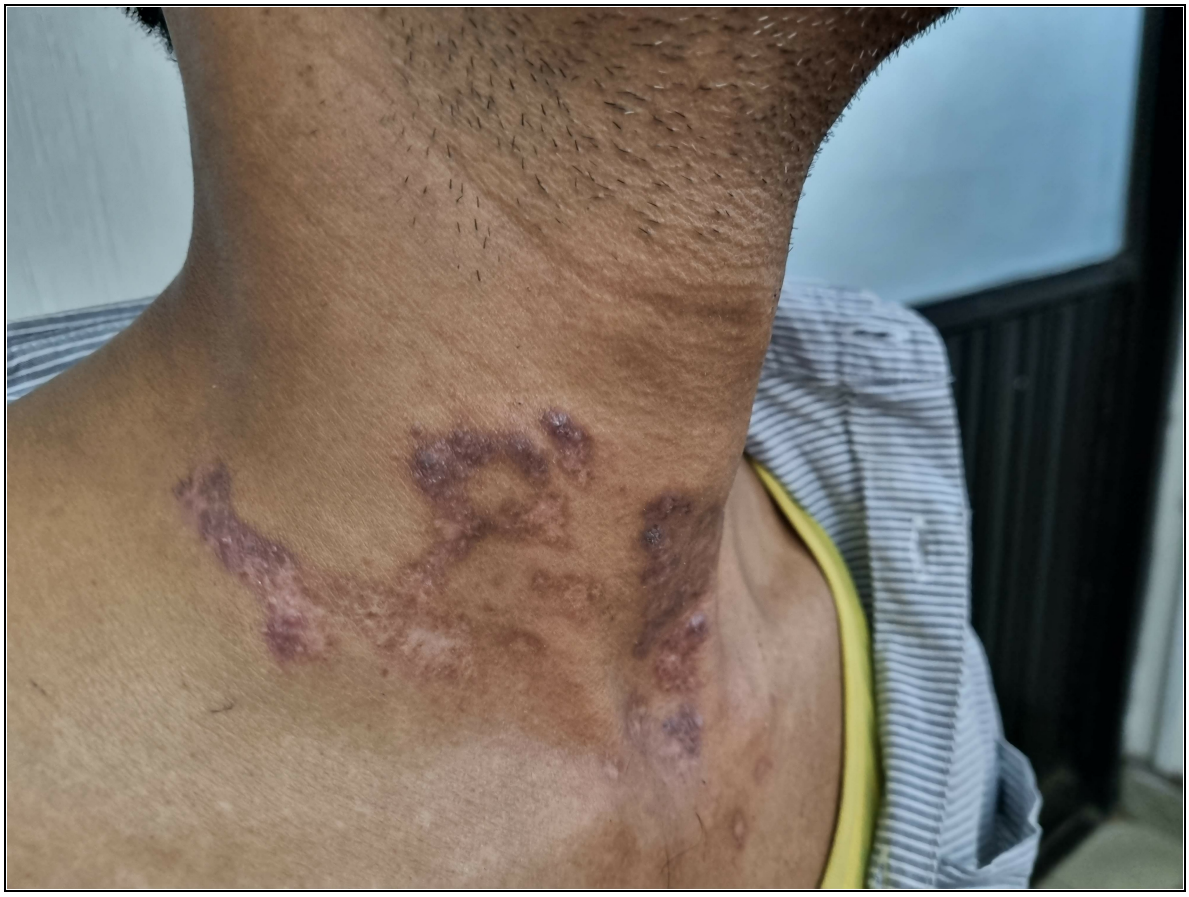
Cutaneous tuberculosis (TB) represents a minor subset (approximately 1.5%) of extrapulmonary TB. Tuberculosis verrucosa cutis (TVC) is a rare form of cutaneous TB arising from exogenous inoculation in individuals with prior sensitization and robust cell-mediated immunity. Despite a global decline in incidence, atypical cases continue to emerge, involving uncommon anatomical locations and presenting with perplexing clinical presentations. These atypical presentations can significantly delay diagnosis and contribute to increased morbidity. This report describes a case of TVC with an atypical presentation that resulted in misdiagnosis and prolonged treatment with ineffective medications.



Materials and Methods

A 35-year-old male presented at the dermatology outpatient clinic with multiple asymptomatic erythematous to hyperpigmented papulonodular lesions arranged in serpiginous pattern over the front of the neck with occasional purulent discharge for 1½ years. Within this time, he had received treatment with various antibiotics multiple times from different physicians, but unfortunately, there was no significant improvement. The patient denied any history of chronic cough, weight loss, fever, or night sweats, and reported no family or household history of TB. Routine blood tests,

including complete blood count (CBC), liver function tests, renal function tests, and blood sugar levels, were performed and the results were found to be within normal limits. Lesional skin biopsy for histopathology showed pseudoepitheliomatous hyperplasia of the epidermis and dermal infiltration of acute and chronic inflammatory cells with few non-caseating granulomas. The tuberculin test was positive. Chest X-ray showed right-sided pleural effusion. Based on these findings, the diagnosis of TVC was made. Anti-tubercular treatment was initiated, and the patient exhibited significant clinical improvement after one month of therapy.



Results

Direct skin inoculation with M. tuberculosis and M. bovis through abrasions is one way to contract TVC. As a result, TVC lesions are primarily found in anatomical areas that are vulnerable to trauma, such as on the hands in adults and the lower extremities in children. The involvement of the neck as seen in our case is extremely rare. In addition, TVC commonly presents as well demarcated verrucous plaque with or without central clearing. However, the presentation of the disease in our case deviated from this typical picture.

Conclusions

The atypical presentation of TVC at an unusual site likely contributed to the delayed diagnosis in this case. This underscores the critical importance of considering cutaneous tuberculosis in the differential diagnosis of chronic suspicious lesions, even when involving uncommon anatomical locations, particularly among patients coming from endemic regions.

Abstract N°: ID-430

Topic: Infectious diseases, parasitic diseases, infestations

Acquired generalize icthyosis preceding the diagnosis of leprosy : A case report

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Introduction

Leprosy is a chronic granulomatous infectious disease caused by Mycobacterium leprae, classically presenting with hypopigmented or erythematous anaesthetic skin lesions and peripheral neuropathy. The host's cell-mediated immunity determines the clinical spectrum of leprosy, ranging from tuberculoid to lepromatous forms, as described in the Ridley–Jopling classification. Leprosy remains a great mimicker, and atypical presentations pose a diagnostic challenge. Ichthyosiform manifestation is a known presentation and often associated with lepromatous leprosy, resulting from diffuse autonomic nerve damage leading to anhidrosis and xerosis. Leprosy presenting as generalized ichthyosis is rare; here, we present a patient who presented with acquired generalized ichthyosis, which preceded the diagnosis of leprosy. Despite global elimination efforts, leprosy remains a significant cause of preventable deformity and disability, warranting early and accurate diagnosis.

Materials and Methods

69 years old male patient presented with diffuse scaling of the body for one year duration without any background history of dermatological or medical conditions. Scaling has worsened over time, and on further questioning, he came up with a history of bilateral hand and foot numbness for three years duration, which he has ignored throughout. He had no clinical features to suggest hypothyroidism and was not on any long-term medications. He has been a driver for about 30 years, and his son, who lives in a separate household nearby, was treated for leprosy about two years ago.

On examination, he had generalized ichthyosis with large brown scales over the bilateral upper and lower limbs and small scales over the trunk. There was madarosis, and he appeared older than his stated age. There was no goitre, lymphadenopathy, significant ear lobe thickening, or any hypopigmented patches noted. There was atrophic scarring over the dorsum of the toes, and neurological examination revealed impaired pain sensation over the bilateral hands and bilateral lower limbs up to mid-calf level in a glove and stocking pattern. Bilateral ulnar and common peroneal nerves were thickened, and there was no associated motor weakness; the reflexes were intact. The other system examination was normal. With the neurological involvement, leprosy was suspected and investigated along that line.

Results

Thyroid profile and other basic blood investigations were normal. Slit skin smears obtained from bilateral ear lobes and eyebrows came as positive with high bacillary index (5+ and 6+). Skin biopsies were obtained from three sites, and all the biopsies showed superficial dermal diffuse infiltration of foamy macrophages with a Grenz zone at the dermo-epidermal junctional region, with some focal large aggregates of foamy cells in mid and lower dermis, suggestive of borderline lepromatous leprosy. Based on that, multibacillary multidrug therapy (MB-MDT) was started with physiotherapy and occupational therapy.

Conclusions

Leprosy is a chronic granulomatous infection with a wide range of clinical manifestations and classically presents as hypopigmented or erythematous patches or diffuse skin infiltration with mononeuritis multiplex or symmetrical polyneuropathy, depending on the host's cell-mediated immune response. Ichthyosiform presentation is a rare but important manifestation. The presence of madarosis with glove and stockings type sensory neuropathy raised the suspicion of leprosy, and this case highlights how acquired ichthyosis may be the dominant cutaneous manifestation in leprosy. Early recognition is crucial as timely initiation of multi-drug therapy can halt the disease progression and prevent deformity.

Abstract N°: ID-440

Topic: Infectious diseases, parasitic diseases, infestations

Atypical Presentation of Adult Varicella with Palmoplantar Involvement

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Introduction

Varicella is an acute viral exanthem resulting from primary infection with *varicella-zoster virus* and is characterized by a centripetally distributed, polymorphic vesicular eruption predominantly involving the face, scalp, and trunk, with relative sparing of the extremities. Palmoplantar involvement is considered a rare and atypical manifestation, particularly in children and immunocompetent adults. Such involvement may lead to diagnostic confusion with other vesiculobullous or viral dermatoses, including hand-foot-mouth disease and erythema multiforme. Herein, we present two adult cases of varicella with palmoplantar involvement to highlight this uncommon clinical presentation and its diagnostic implications.

Materials and Methods

Two immunocompetent adult patients with clinically diagnosed primary varicella infection were evaluated. Clinical features, prodromal symptoms, lesion morphology, and anatomical distribution were analyzed. Diagnosis was based on typical clinical presentation and disease course. Relevant literature on palmoplantar involvement in varicella was reviewed for comparison.

Results

The first patient was an 18-year-old male who presented fever, sore throat, and flu-like symptoms followed by a generalized eruption. Dermatological examination revealed polymorphic vesicular, impetiginized, and crusted papules involving the face, oral mucosa, scalp, trunk, extremities, and notably the palms and soles.

The second patient was a 31-year-old female who presented with prodromal flu-like symptoms followed by widespread polymorphic vesicular and crusted papules affecting the scalp, face, trunk, and palmoplantar regions. Neither patient had underlying immunosuppression or significant comorbidities.

Both cases demonstrated classic varicella lesions at different evolutionary stages, with atypical palmoplantar involvement. We started oral aciclovir treatment in our patients and advised to self-isolate during the contagious period. The clinical course was benign, and lesions resolved without complications in one week.

Conclusions

Palmoplantar involvement in varicella is a rare but possible manifestation in immunocompetent adults. These cases emphasize that varicella should be considered in the differential diagnosis of palmoplantar vesicular eruptions, even in healthy adults. Awareness of atypical presentations may prevent misdiagnosis and unnecessary investigations, contributing to a broader understanding of the clinical spectrum of adult varicella.

Abstract N°: ID-491

Topic: Infectious diseases, parasitic diseases, infestations

The Role of the IL-10 G-1082A Polymorphism in the Development of Severe Recurrent Genital Herpes

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Introduction

One of the main factors determining the severity of recurrent genital herpes (RGH) is the balance between pro- and anti-inflammatory cytokines, where interleukin-10 (IL-10), a key anti-inflammatory cytokine that modulates immune responses in herpesvirus infection, plays a central regulatory role.
It is known that genetic polymorphisms in the IL-10 gene are associated with resistance to certain human herpesviruses. IL-10 inhibits the synthesis of several pro-inflammatory cytokines and promotes antibody production and cytotoxic T-cell formation. The aim of this study was to determine the frequency of IL-10 G-1082A alleles and genotypes in patients with severe recurrent genital herpes.

Materials and Methods

A total of 124 individuals of both sexes were included. The main group consisted of patients with recurrent genital herpes (n=62), and the control group included healthy individuals (n=62). Venous blood was collected for DNA extraction. Genomic DNA was isolated using a two-step blood cell lysis method. Genotyping was performed using PCR with allele-specific primers and agarose gel electrophoresis.

Results

In patients with severe RGH, the frequency of the G allele was significantly higher than in controls (77.42% vs 66.13%; χ^2=3.901, p=0.048). Thus, the G allele may be considered a risk factor for severe disease. The A allele was less frequent in patients (22.58%) compared to controls (33.87%) with OR=0.569 (95% CI 0.325–0.999), indicating a possible protective role.
The GG genotype was significantly more common in patients (56.45%) than controls (33.87%) with OR=2.531 (95% CI 1.223–5.236). The GA genotype was less frequent among patients (41.94% vs 64.52%; OR=0.397). The AA genotype was rare and equally distributed.

Conclusions

The findings demonstrate a significant association between the GG genotype and severe recurrent genital herpes, suggesting the G allele as a genetic risk marker while GA may confer protection.

Abstract N°: ID-502

Topic: Infectious diseases, parasitic diseases, infestations

Ecthyma Gangrenosum Complicated by Pulmonary Embolism: A Case Report

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Introduction

Ecthyma gangrenosum (EG) is a potentially life-threatening infection, usually occurring in immunocompromised patients, characterized by a rapidly evolving necrotic ulcer with erythematous or violaceous borders.[1,2] Lesions typically start as painless, erythematous macules/ patches that progress to pustules, hemorrhagic vesicles, and finally ulcerate with subsequent necrosis. EG often involves the axillae or the anogenital region, but might affect other sites.[1,2] It is classically associated with *P. aeruginosa* bacteremia, although non-bacteremic forms resulting from direct inoculation have been described.[1,2] Other bacteria (such as *S. aureus*, *S. pyogenes*, *A. hydrophila*, *C. freundii)*, fungi or viruses might cause EG.[1,2]

Materials and Methods

We report a case of a Caucasian patient with EG complicated by pulmonary embolism.

Results

A 66-year-old underweight male presented with a massive ulceration on the left calf and multiple smaller ulcers around the left ankle and knee, which developed over the past five days. The lesions had a retiform shape, violaceous borders and exhibited positive Celsian signs. The ulcers were exudative, presenting necrosis and fibrin-coated areas. Medical history included a prior pulmonary embolism (PE) and warm autoimmune hemolytic anemia. He denied taking any medication.

Wound cultures grew *P. aeruginosa*, *S. aureus* and *C. freundii*, confirming EG. The patient received broad-spectrum intravenous antibiotics, probiotics, analgesics, proton pump inhibitors, prophylactic parenteral anticoagulants, extensive surgical debridement, and daily wound care, resulting in clinical improvement with partial epithelialization of the ulcers and discharge after 35 days.

Two weeks later, he was readmitted with acute dyspnea and developed a painless, erythematous-violaceous, reticular patch with overlying pustules and indurated, orange peel skin on his left anteromedial thigh.

Contrast-enhanced CT revealed PE, bilateral femoral deep vein thrombosis (DVT) and pleural, pericardial and peritoneal effusions. Laboratory findings included leukocytosis with neutrophilia, severe Coombs-positive anemia, elevated inflammatory markers, thrombocytopenia, coagulation abnormalities and severe hypoproteinemia. Screening for malignancies was negative except for an elevated CA-125 (attributed to the effusions) and a modified serum protein electrophoresis revealing IgG monoclonal gammopathy. Screening tests for HIV infection were negative. Blood cultures grew *B. fragilis*, while cultures from the calf ulcers revealed multidrug-resistant *A. baumannii*.

Differential diagnosis for the thigh lesion included incipient EG (secondary to *B. fragilis* bacteremia) and livedo reticularis, potentially resulting from intraluminal thrombosis due to DVT or monoclonal gammopathy.

Targeted intravenous antibiotics were administered, later modified due to *C.difficile* colitis. Thrombotic and hematologic conditions were managed accordingly. Wound care included topical antiseptics and topical silver sulfadiazine (later replaced with silver dressings). The patient was eventually discharged in improved condition, with ongoing epithelialization of the calf lesions and a complete resolution of the thigh lesion.

Conclusions

Ecthyma gangrenosum requires prompt recognition and aggressive treatment due to its high morbidity and mortality. Although commonly caused by *P. aeruginosa*, other pathogens might be responsible. Physicians should screen for underlying immunodeficiencies, including HIV infection, hematologic disorders, malignancy or malnutrition.

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Abstract N°: ID-511

Topic: Infectious diseases, parasitic diseases, infestations

Telogen effluvium associated with deep myiasis caused by the Dermatobia hominis larva

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Introduction

Myiasis is characterized by the invasion of dipteran insect larvae (*Diptera*) into the tissues of mammals, including humans, and is predominantly found in Central and South America. Deep myiasis is typically caused by the *Dermatobia hominis* fly. Only very few cases of this pathology have been described in European regions, making diagnosis verification difficult and the importance of collecting history of international travels.

Materials and Methods

The woman addressed for medical assistance to a dermatologist in 2022 with complains of thinning hair. She was diagnosed with androgenetic alopecia (AGA) and prescribed appropriate therapy. In March 2024, the patient presented again with complaints of active hair loss. Anamnestic data collection revealed that the patient had a persistent low-grade fever, developing since February 2024, accompanied by weakness, increased fatigue, and signs of telogen effluvium (TE). Shortly before the onset of these symptoms, the patient had visited the Iguazu Falls on the border of Brazil and Argentina. The region is known for its endemicity for a number of transmissible diseases. Given her previous experience with multiple mosquito bites, the patient did not pay due attention to this incident.

Results

Skin examination revealed a single, smooth-surfaced, rounded nodule in the inguinal-femoral region, approximately 1 cm in diameter, with a visually detectable central point, presumably the larval exit site. Trichoscopic examination of the scalp revealed isolated, empty hair follicle openings (yellow dots) and the growth of pointed new hairs over the entire scalp. Clinical and biochemical blood tests were unremarkable. Ultrasound of the thigh revealed a soft tissue foreign body with signs of granuloma formation. A parasitologist at the infectious diseases clinical hospital diagnosed a foreign body in the left pelvic region and dermatomyositis (dermatobiosis). The foreign body was removed and identified as *Dermatobia hominis* (based on the clinical presentation and personal history, namely, living in an endemic region). At a follow-up visit three months later, the patient's body temperature had returned to normal, hair loss had ceased, the hair pull test was negative, and trichoscopic examination revealed the growth of new, pointed hairs.

Conclusions

Prolonged exposure to the larvae contributes to the development of a chronic inflammatory process in the tissues, accompanied by local irritation, erythema, and itching. In some cases, general intoxication with an elevated body temperature and a deterioration in general health are observed. The body's toxic-inflammatory response to parasitic

infestation can provoke hair loss, similar to the TE type. This clinical case demonstrates a rare case of cutaneous myiasis caused by Dermatobia hominis fly larvae, which presents with unusual symptoms, including prolonged hair loss. Early diagnosis and elimination of the provoking factor prevented serious complications and quickly restored the patient's quality of life. This case highlights the importance of a thorough epidemiological history and dermatological examination when evaluating patients with unexplained diffuse hair loss, particularly with concomitant fever.

Abstract N°: ID-535

Topic: Infectious diseases, parasitic diseases, infestations

Persistence Of Leprosy Granuloma After 13 Years Of Multi-Drug Therapy: A Rare Case Report

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Introduction

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

Materials and Methods

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

Results

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

Conclusions

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

Abstract N°: ID-546

Topic: Infectious diseases, parasitic diseases, infestations

The Hidden Sequel: Delayed-Onset Erythema Nodosum Leprosum After Leprosy Therapy

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Introduction

Erythema nodosum leprosum (ENL), or type 2 lepra reaction, is a severe immune-mediated inflammatory complication of multibacillary leprosy and major contributor to disease-related morbidity. ENL most commonly occurs during multidrug therapy (MDT) for lepromatous disease, often with systemic symptoms such as fever, malaise, and arthralgia. Delayed-onset ENL arising years after treatment is rare, and presentations limited to cutaneous lesions without systemic features are uncommon. Such atypical presentations may obscure diagnosis and delay appropriate management. We present a case highlighting this diagnostic challenge.

Materials and Methods

A 73-year-old man presented with an acute eruption of tender erythematous nodules and plaques over the face, trunk, and extremities. There were no associated constitutional symptoms. He had been diagnosed with multibacillary leprosy five years earlier and had received 9 months of MDT at a different institution in Singapore. At presentation, there was no clinical evidence of leprosy relapse, including absence of new neuropathy, nerve thickening, or insensate lesions. Initial investigations revealed mild leucocytosis and cholestatic liver enzyme derangement, while microbiological cultures and viral studies were negative.

Histological examination of skin biopsy demonstrated a dense superficial and deep dermal inflammatory infiltrate comprising neutrophils, lymphocytes, and macrophages. Occasional macrophages contained granular acid-fast material consistent with fragmented organisms. Dermal vessels showed fibrinoid change, and direct immunofluorescence revealed granular fibrin and C3 deposition, supporting immune complex-mediated vasculitis. Notably, no intact acid-fast bacilli were identified, arguing against active leprosy relapse. Slit skin smears were negative. Initiation of systemic corticosteroids resulted in rapid clinical improvement, confirming the diagnosis of ENL. He was subsequently restarted on MDT due to previously inadequate duration of treatment and remained well at the time of his most recent consultation.

Results

Distinguishing delayed-onset ENL from leprosy relapse and other inflammatory or infective mimics is critical, as management strategies are dichotomous: relapse requires antimicrobial therapy, while ENL responds to anti-inflammatory treatment. Systemic symptoms are often considered a hallmark of ENL, and their complete absence is extremely uncommon; delayed onset several years after MDT is also rare. Both of these confounders, present in our patient, can delay recognition and increase the risk of misdiagnosis. Histopathological correlation was essential in establishing the diagnosis.

Conclusions

This case underscores the diagnostic challenges posed by delayed-onset or isolated cutaneous ENL, emphasising the

importance of maintaining a high index of suspicion in patients with previously treated leprosy. Heightened awareness and careful clinicopathological correlation are essential to ensure timely diagnosis, appropriate management, and reduced morbidity.

Abstract N°: ID-553

Topic: Infectious diseases, parasitic diseases, infestations

Herpes Zoster Ophthalmicus Post-Botox Injection: A Case Report

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Introduction
Herpes Zoster Ophthalmicus (HZO) is a rare but serious condition caused by the reactivation of the varicella-zoster virus in the ophthalmic branch of the trigeminal nerve.

Materials and Methods
We present a case of a 40-year-old medically free female who developed symptoms suggestive of herpes zoster ophthalmicus after receiving a Botulinum toxin type A (BoNT-A) injection. The patient presented with a burning sensation on the right side of the forehead, extending below the right eye and temporal scalp area, which started 5 days post-Botulinum toxin type A (BoNT-A) injection. Despite azithromycin and ibuprofen, the symptoms persisted. On examination, an edematous erythematous plaque over the ophthalmic dermatome with crustation was noted, leading to the diagnosis of herpes zoster ophthalmicus.

Results
The patient was initiated on acyclovir 800 mg five times a day along with acyclovir cream application at the affected site. A follow-up after 7 days revealed significant improvement with the patient reporting no further complaints.

Conclusions
This case highlights a rare occurrence of herpes zoster ophthalmicus following Botulinum toxin type A (BoNT-A) injection. Timely diagnosis and appropriate antiviral therapy such as acyclovir are essential in managing this condition effectively.

Abstract N°: ID-621

Topic: Infectious diseases, parasitic diseases, infestations

Extensive dermatophytosis associated with topical corticosteroid use: A case report

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Introduction

Dermatophytoses are common superficial fungal infections affecting the skin, hair and nails, with a wide spectrum of clinical presentations ranging from localized benign lesions to extensive and severe forms. The inappropriate use of topical corticosteroids, particularly through self-medication, may alter the clinical appearance, delay diagnosis and promote fungal dissemination, leading to atypical and more severe presentations

Materials and Methods

We report the case of a 19-year-old woman presenting with diffuse pruritic erythematous lesions due to extensive dermatophytosis induced by topical corticosteroid misuse.

Results

We report the case of a 19-year-old female patient with no significant medical history who presented with diffuse pruritic erythematous skin lesions evolving for two weeks. The disease initially started with a single erythematous, scaly, pruritic circinate lesion on the trunk. The patient self-medicated with a potent topical corticosteroid, which resulted in rapid worsening of the initial lesion and progressive spread to the trunk, hands and back, followed by involvement of the inguinal folds and buttocks within five days. Clinical examination revealed multiple erythematous scaly plaques with vesiculo-papular borders, centrifugal extension and polycyclic confluent patterns, consistent with extensive dermatophytosis. Biological investigations, including complete blood count and HIV serology, were normal. Topical corticosteroids were discontinued and systemic antifungal therapy with oral terbinafine (250 mg twice daily), combined with topical antifungal treatment, was initiated for six weeks. The outcome was favorable with complete regression of lesions, leaving residual post-inflammatory hyperpigmentation.

Conclusions

This case highlights the deleterious role of inappropriate topical corticosteroid use in the aggravation and dissemination of dermatophytosis. Self-medication may mask typical clinical features, delay diagnosis and transform a simple fungal infection into an extensive disease. Any pruritic erythematous scaly lesion should raise suspicion of a fungal origin before initiating corticosteroid therapy.

Abstract N°: ID-729

Topic: Infectious diseases, parasitic diseases, infestations

Peculiarities of humoral immunity in cases of infiltrative-suppurative trichophytia in children

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Introduction

Recently, the prevalence of fungal diseases among children has increased, particularly those caused by dermatomycetes, highlighting the growing relevance of dermatomycology. Infiltrative-suppurative trichophytia (IST) is often accompanied by immune dysregulation and fungal sensitization. The objective of this study was to investigate the features of the humoral immune response by assessing serum levels of secretory immunoglobulin A (sIgA), total IgA, IgE, and IgG antibodies to *Candida albicans* in children with IST.

Materials and Methods

Sixty children aged 2–18 years diagnosed with infiltrative-suppurative trichophytia were examined, including 35 (58.3%) boys and 25 (41.7%) girls. All patients underwent clinical, microbiological, mycological, immunological, and statistical assessments. Serum levels of total IgA, secretory IgA, total IgE, and specific IgG antibodies to *Candida albicans* were measured using enzyme-linked immunosorbent assay (ELISA). The control group consisted of 30 practically healthy children.

Results

ELISA analysis demonstrated a 2.7-fold increase in serum sIgA levels in children with IST (7.6 ± 0.5 mg/ml) compared with controls (2.8 ± 0.03 mg/ml; $p < 0.05$). Total IgA concentration was also significantly elevated (7.4 ± 0.4 mg/ml versus 3.8 ± 0.03 mg/ml), representing a 1.9-fold increase ($p < 0.05$). Specific IgG antibodies to *Candida albicans* increased 10.6-fold (0.8 ± 0.2 pg/ml) compared with controls (0.07 ± 0.03 pg/ml; $p < 0.001$).

Mycological examination of fecal biosubstrates revealed increased colonization by *Candida* species exceeding 2×10^3 CFU/g, whereas healthy children demonstrated a mean level of 351 CFU/g ($p < 0.05$), indicating invasive intestinal candidiasis. A positive correlation was identified between specific IgG to *Candida albicans* and sIgA ($r = +0.46$), as well as total IgA ($r = +0.48$). Total IgE levels were also significantly higher in patients with IST (205 ± 8.2 IU/ml) compared with controls (63.2 ± 1.4 IU/ml; $p < 0.05$), reflecting pronounced involvement of mast cells and basophils in allergic inflammation.

Conclusions

In infiltrative-suppurative trichophytia, the humoral immune response is characterized by immunological hyperreactivity involving class A and E antibodies. Along with primary etiological agents, *Candida albicans* acts as an important trigger of

immune activation, contributing to fungal sensitization, persistence of infection, and the development of secondary immune deficiency.

Abstract N°: ID-757

Topic: Infectious diseases, parasitic diseases, infestations

Humoral Immune Response Characteristics in Children with Infiltrative-Suppurative Trichophytia

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Introduction
Recently, the prevalence of fungal diseases among children has increased, particularly those caused by dermatomycetes, highlighting the growing relevance of dermatomycology. Infiltrative-suppurative trichophytia (IST) is often accompanied by immune dysregulation and fungal sensitization. The objective of this study was to investigate the features of the humoral immune response by assessing serum levels of secretory immunoglobulin A (sIgA), total IgA, IgE, and IgG antibodies to Candida albicans in children with IST.

Materials and Methods
Sixty children aged 2–18 years diagnosed with infiltrative-suppurative trichophytia were examined, including 35 (58.3%) boys and 25 (41.7%) girls. All patients underwent clinical, microbiological, mycological, immunological, and statistical assessments. Serum levels of total IgA, secretory IgA, total IgE, and specific IgG antibodies to Candida albicans were measured using enzyme-linked immunosorbent assay (ELISA). The control group consisted of 30 practically healthy children

Results
ELISA analysis demonstrated a 2.7-fold increase in serum sIgA levels in children with IST (7.6 ± 0.5 mg/ml) compared with controls (2.8 ± 0.03 mg/ml; $p < 0.05$). Total IgA concentration was also significantly elevated (7.4 ± 0.4 mg/ml versus 3.8 ± 0.03 mg/ml), representing a 1.9-fold increase ($p < 0.05$). Specific IgG antibodies to Candida albicans increased 10.6-fold (0.8 ± 0.2 pg/ml) compared with controls (0.07 ± 0.03 pg/ml; $p < 0.001$).
Mycological examination of fecal biosubstrates revealed increased colonization by Candida species exceeding 2×10^3 CFU/g, whereas healthy children demonstrated a mean level of 351 CFU/g ($p < 0.05$), indicating invasive intestinal candidiasis. A positive correlation was identified between specific IgG to Candida albicans and sIgA ($r = +0.46$), as well as total IgA ($r = +0.48$). Total IgE levels were also significantly higher in patients with IST (205 ± 8.2 IU/ml) compared with controls (63.2 ± 1.4 IU/ml; $p < 0.05$), reflecting pronounced involvement of mast cells and basophils in allergic inflammation

Conclusions
In infiltrative-suppurative trichophytia, the humoral immune response is characterized by immunological hyperreactivity involving class A and E antibodies. Along with primary etiological agents, Candida albicans acts as an important trigger of immune activation, contributing to fungal sensitization, persistence of infection, and the development of secondary immune deficiency

Abstract N°: ID-795

Topic: Infectious diseases, parasitic diseases, infestations

Psoriasis vulgaris and herpes simplex

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Introduction

The herpes simplex virus (HSV) may be not only a nosological disease but also a secondary infection which may affect the severity of the course of other dermatoses.

On time diagnostic's and proper therapy of the psoriasis progression help related specialists prevent occurrence of such diseases. Therefore, the goal of our research is to provide comprehensive examination of the persons suffering from psoriasis, especially those with the severe or atypical course of the disease, in order to detect herpetic infection and improve further treatment of these patients.

Materials and Methods

During 2020–2025 years 14 patients with the proved diagnosis of psoriasis have been observed in our clinical laboratory (general, biochemical and immunological blood test, ELISA).

Results

In the course of clinical-anamnestic examination of the patients with psoriasis, we obtained the following results: form of psoriasis: localised - for 4% of patients, widespread eruptions – for 79% with the affected area 25–68%, psoriasis arthropatica–in 11% of cases with the skin lesion - to 72% -psoriasis stages: progressive - for 39.7% of people, stationary for 60.3%; age of dermatosis: from 7 months to over 32 years; family psoriasis: for 29% of people; provoking factors: stress situations - in 37.2% of cases, alcohol abuse – in 5.9%, microbial and viral factor - for 18.4% of people, traumata - 11.8%. The causes of the disease were not specified by 26, 7% of people; course of the disease: for 81% of people it was characterized by susceptibility to the frequent exacerbation and for 19% - stable remission was not observed for a long time.

Evenly of the changes in the immunological blood test and revealing of HSV for 76% of the patients with psoriasis have lead us to prescribing antiviral preparations in the therapy. The duration of the treatment was defined individually for each patient. In the dynamics of the treatment for the patients with psoriasis certain immune indices change as follows: the humoral immunity indices decrease; the amount of the T-helper cells increases; the percent of the T-suppressor cells decreases; the number of undifferentiated O cells in the blood sample increases; IgM synthesis increases; the circulatory immune complexes increase considerably.

Conclusions

Changes detected in the indices of both humoral and cellular arms of the immune system for the patients with psoriasis is an indirect evidence of the negative influence of provoking factors and concomitant pathology on the intensity of immune answer in their organisms resulting in the creation of immunodeficiency.

Abstract N°: ID-920

Topic: Infectious diseases, parasitic diseases, infestations

When rosacea hides herpes zoster: unilateral facial pain and peripheral facial nerve palsy

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Introduction

Herpes zoster may present with atypical clinical manifestations, particularly in the absence of classic vesicular eruptions. Diagnosis can be challenging when symptoms occur in patients with pre-existing inflammatory facial dermatoses such as rosacea, which may mask early signs of viral reactivation.

Materials and Methods

We report the case of a 46-year-old woman with a history of facial rosacea, hypertension, and depression who presented with acute facial erythema associated with burning and tightening sensations. Although the erythema was bilateral and consistent with her underlying rosacea, neuropathic symptoms were strictly unilateral and involved a single hemiface.

A detailed clinical examination was performed. No fever, pruritus, ocular pain, or signs of secondary infection were observed. Concomitantly, the patient developed an ipsilateral peripheral facial nerve palsy. Based on the association of unilateral neuropathic pain and facial nerve involvement, a clinical diagnosis of suspected herpes zoster reactivation was made.

Results

Despite the absence of typical vesicular lesions, the unilateral neuropathic pain associated with peripheral facial nerve palsy strongly supported herpes zoster reactivation. No virological investigations were performed.

Empiric treatment with oral antiviral therapy and systemic corticosteroids was initiated. Rapid clinical improvement was observed within a few days, with resolution of neuropathic symptoms and progressive recovery of facial nerve function.

Conclusions

Herpes zoster may be masked by inflammatory facial dermatoses such as rosacea, leading to diagnostic uncertainty. Unilateral neuropathic pain associated with peripheral facial nerve palsy should prompt consideration of herpes zoster, even in the absence of characteristic skin lesions. Early empiric antiviral treatment may significantly improve neurological outcomes.

Abstract N°: ID-934

Topic: Infectious diseases, parasitic diseases, infestations

Scalp-Limited Scabies in an Infant Following Incomplete Prophylactic Treatment

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Introduction
Scabies is a common contagious ectoparasitic infestation caused by *Sarcoptes scabiei* var. *hominis*. In infants, scalp, facial, and neck involvement is more frequent than in older children and adults, which may lead to atypical presentations and delayed diagnosis. We report an infant with scalp-limited scabies after incomplete post-exposure treatment within a household outbreak.

Materials and Methods
A 1.5-year-old child presented with a 1-month history of pruritus confined to the scalp. One month earlier, all household members had been diagnosed with scabies and treated. Although asymptomatic at that time, the child was advised to receive age-appropriate post-exposure scabicidal treatment, including scalp application. The family omitted scalp application because of concerns about possible hair damage.
Subsequently, scalp-only pruritus developed, without lesions on the trunk, extremities, or intertriginous areas and without systemic symptoms. At an external center, the child received topical corticosteroids for presumed inflammatory dermatosis, without improvement.

Results
Dermatologic examination showed scalp-limited excoriations and mild erythema, with no typical lesions elsewhere. UV dermoscopy demonstrated findings compatible with scabies infestation. Considering the epidemiologic context (recent household scabies), distribution pattern, dermoscopic findings, and non-response to topical corticosteroids, scalp-limited scabies was diagnosed. The atypical localization was considered likely related to incomplete initial treatment, particularly omission of scalp coverage.

Conclusions
In infants, scabies should be included in the differential diagnosis of isolated scalp pruritus, even without classic generalized involvement. This case highlights the importance of strict adherence to age-specific treatment instructions, including scalp coverage in young children, to reduce persistent/localized infestation and diagnostic delay.

Abstract N°: ID-936

Topic: Infectious diseases, parasitic diseases, infestations

Lepromatous Leprosy Mimicking Rheumatoid Arthritis: A Clinical and Diagnostic Pitfall

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Introduction

Leprosy remains a relevant diagnostic challenge due to its broad clinical spectrum and ability to mimic chronic inflammatory diseases[1]. In the lepromatous form, impaired cellular immunity leads to a high bacillary load and systemic involvement, with often atypical and insidious presentations, particularly in elderly patients[2]. The coexistence with rheumatoid arthritis (RA) represents a significant clinical pitfall, as both conditions may present with symmetric polyarthritis, peripheral neuropathy, and morning stiffness, resulting in diagnostic delays[1,4].

In patients with RA, prolonged use of immunosuppressive therapies may mask the cutaneous and neurological manifestations of leprosy or precipitate reactional states that simulate disease exacerbations. This overlap contributes to underdiagnosis, especially in multibacillary forms, in which delayed treatment is associated with an increased risk of irreversible disabilities[2,4].

We report a case of lepromatous leprosy that remained unrecognized for years in a patient with long-standing RA, highlighting the importance of maintaining leprosy in the differential diagnosis of refractory rheumatologic presentations, particularly in endemic regions, and emphasizing the value of simple diagnostic tools, such as slit-skin smear microscopy, in clarifying atypical clinical scenarios[3,4].

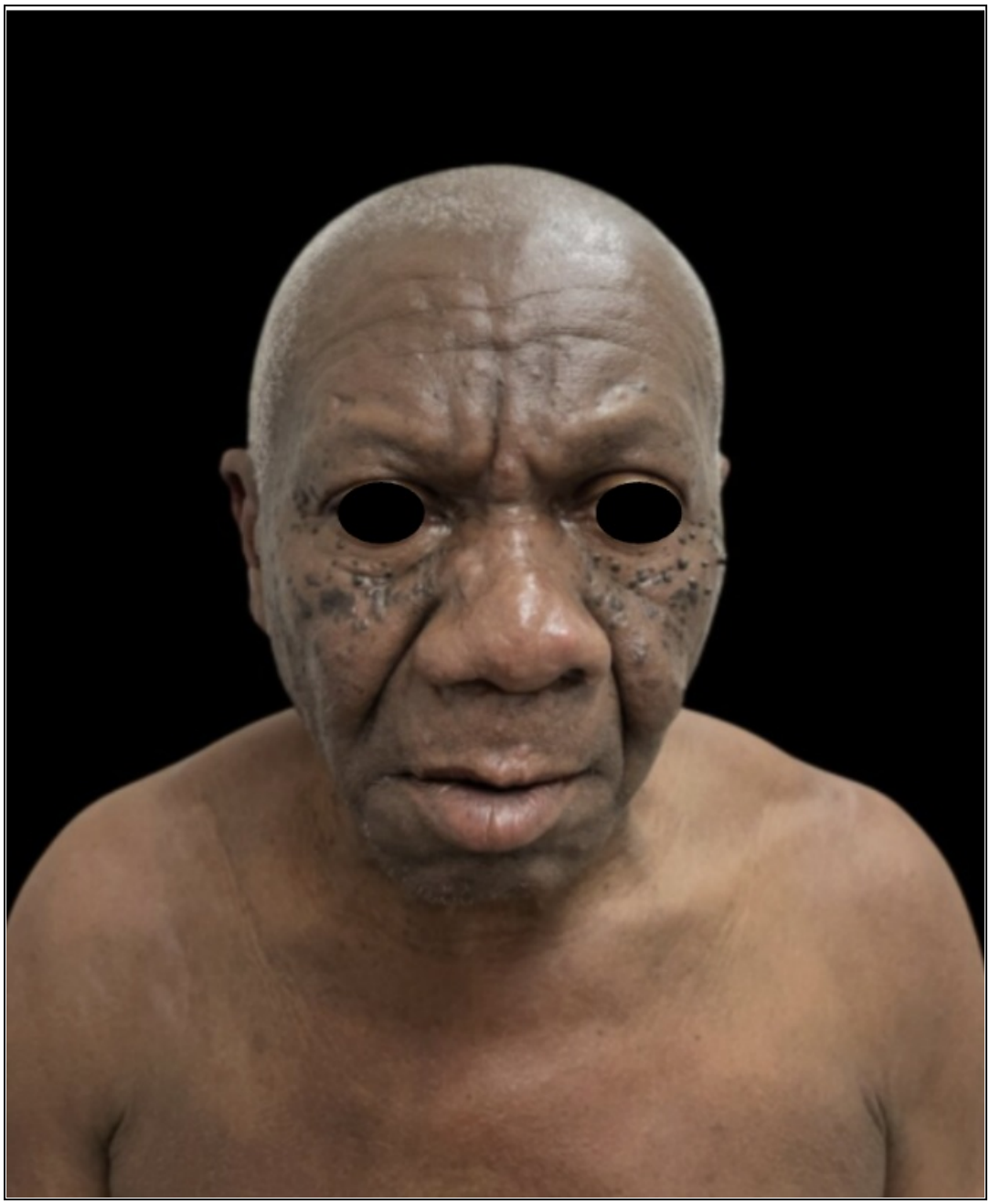

Image 1

Materials and Methods

Case report of a patient with previous RA diagnosis evaluated for suspected leprosy. Clinical dermatological and neurological examinations were performed, along with bacilloscopy of intradermal smears for diagnostic confirmation. Serial laboratory examinations were conducted during clinical follow-up.

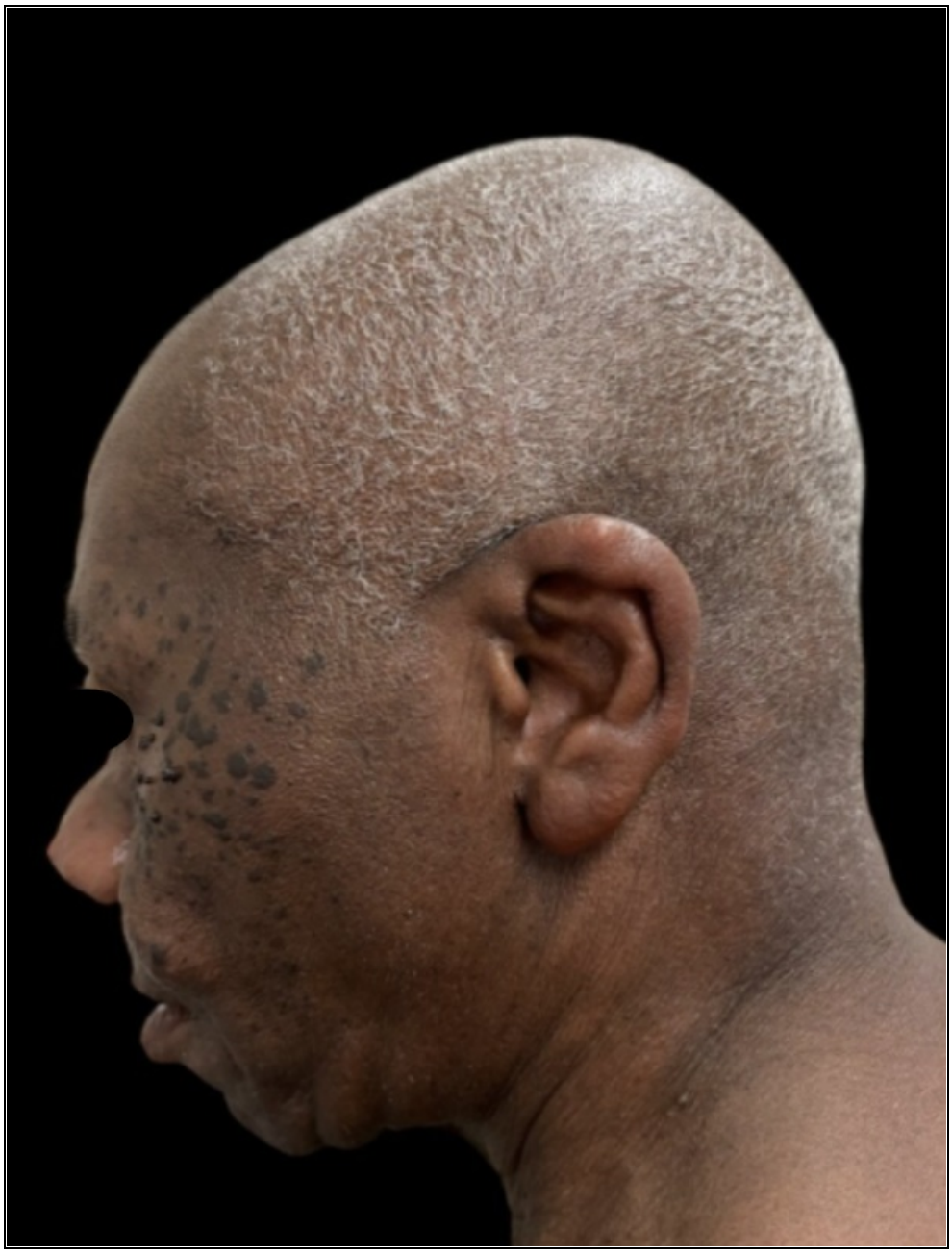

Image 2

Results

A 68-year-old male patient with RA was referred to Dermatology following ultrasound findings suggestive of lepromatous leprosy. He reported chronic foot numbness and disseminated nodular skin lesions previously attributed to RA. Examination revealed multiple hyperchromic papules, madarosis, leonine facies, and infiltration of ear cartilage and ankles (Image 1, 2, 3, 4). Neurological evaluation showed bilateral ulnar nerve thickening and hypoesthesia predominantly in the right lower limb. Bacilloscopy from elbows, ears, and left digital lesion was positive (++++), confirming lepromatous leprosy diagnosis. Two months after diagnosis, multidrug therapy (MDT) for 12 months was initiated. One month later, hemolytic anemia developed, requiring dapsone discontinuation and replacement with ofloxacin. Eight months after MDT initiation, lower limb edema appeared, treated with thalidomide and prednisone, with differential diagnoses of RA activity and Type II leprosy reaction considered.

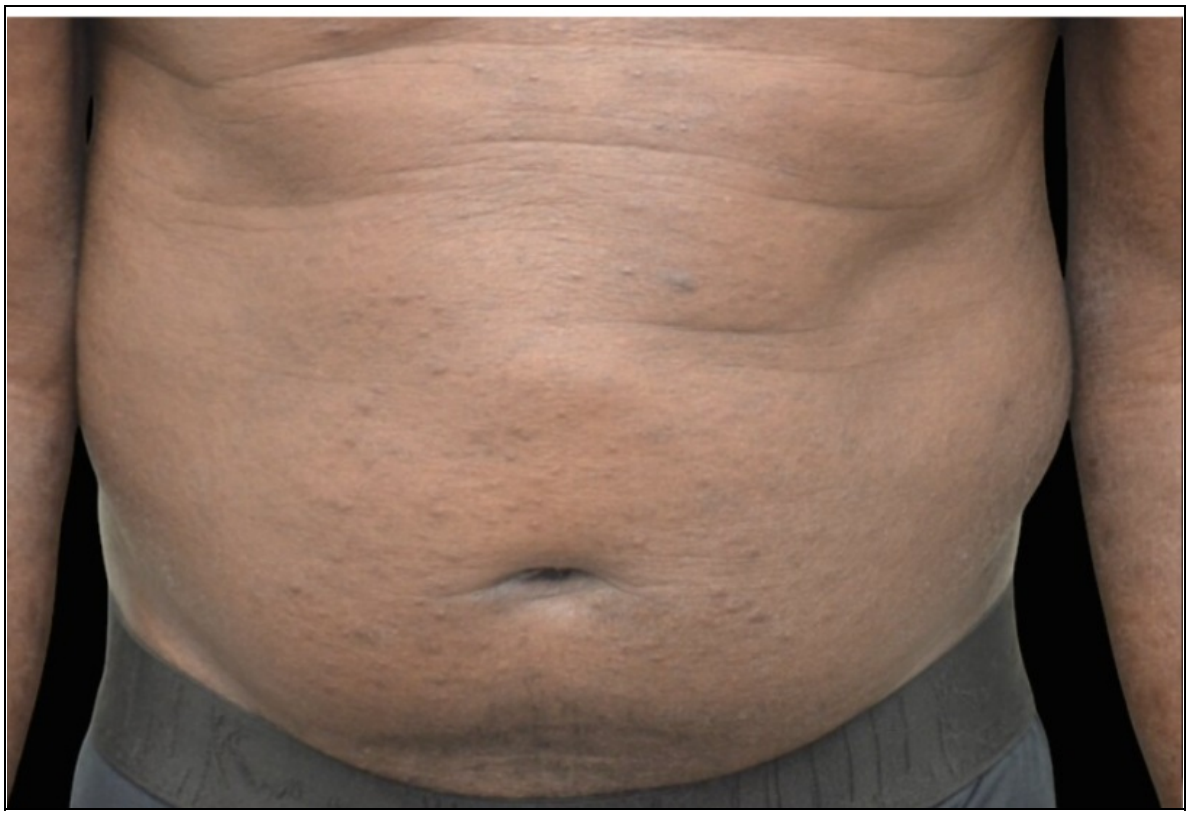

Image 3

Conclusions

The diagnosis of leprosy can be particularly challenging in patients with chronic inflammatory diseases such as RA due to overlapping articular and neurological manifestations. This similarity contributes to diagnostic delays, especially in multibacillary forms.

Prolonged immunosuppressive therapy in RA may impair cellular immunity, favoring bacillary proliferation and progression to the lepromatous pole while attenuating classical inflammatory signs of *Mycobacterium leprae* infection. Consequently, leprosy may remain unrecognized until advanced stages, increasing the risk of complications.

In the present case, a long-standing history of RA led to the initial attribution of cutaneous and neurological findings to the underlying rheumatologic disease, delaying the diagnosis of lepromatous leprosy. Management was further complicated by dapsone-induced hemolytic anemia, requiring treatment modification, and by the need to differentiate between RA activity and type 2 leprosy reaction.

This report reinforces the importance of maintaining leprosy in the differential diagnosis of atypical or refractory rheumatologic presentations, particularly in elderly patients from endemic areas. A high index of clinical suspicion and individualized diagnostic and therapeutic strategies are essential to prevent diagnostic delays and irreversible consequences.

Image 4 References - 1. Cruz VA, Tavares ACG, Araújo AM, Feitosa MSC, Carvalho JS, Gomes CM, et al. Musculoskeletal manifestations in leprosy. Best Pract Res Clin Rheumatol. 2025;39(2):102039. doi:10.1016/j.berh.2025.102039. PMID:39915143. 2. Cruz VA, Albuquerque CP, Guimarães MFB, Dionello CF, Ribeiro SLE, Souza VA, et al. New insights at the interface between leprosy and immune-mediated rheumatic diseases. Front Med (Lausanne). 2023;10:1239775. doi:10.3389/fmed.2023.1239775. PMID:37822467. 3. Oliveira JSS, Reis ALM, Margalho LP, Lopes GL, Silva AR, Moraes NS, et al. Leprosy in elderly people and the profile of a retrospective cohort in an endemic region of the Brazilian Amazon. PLoS Negl Trop Dis. 2019;13(9):e0007709. doi:10.1371/journal.pntd.0007709. PMID:31479442. 4. Salvi S, Chopra A. Leprosy in a rheumatology setting: a challenging mimic to expose. Clin Rheumatol. 2013;32(10):1557–63. doi:10.1007/s10067-013-2276-5. PMID:23645094. PMCID:PMC3778233.

Abstract N°: ID-959

Topic: Infectious diseases, parasitic diseases, infestations

Assessing the impact of dermatophytosis on Quality of Life using DLQI: A Real-world cross-sectional study from India

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Introduction

Dermatophytosis has emerged as a chronic, recurrent, and high-burden dermatosis in India, with increasing reports of extensive involvement and treatment difficulty. Although clinical assessment is routinely performed, patient-reported quality-of-life (QoL) evaluation is inconsistently integrated into practice. This multicentric real-world study assessed the QoL burden of dermatophytosis using the Dermatology Life Quality Index (DLQI) and examined its association with demographic, clinical, occupational, comorbidity, and treatment-related factors.

Materials and Methods

A cross-sectional study was conducted between April to October 2025 involving clinically diagnosed dermatophytosis patients attending outpatient department from 325 centers across India with Independent Ethics Committee approval. Primary endpoint of the study was to assess DLQI in these patients whereas secondary endpoints included association between DLQI and other factors like; age, sex, clinical subtype, lesion site and burden, occupation, comorbidities, and treatment regimens.

Results

We analysed the data of 2776 patients who met the inclusion criteria highlighting predominance of male (57%). The median DLQI was 12 (IQR 8–17), indicating a **very large impact** of dermatophytosis on daily life. QoL impairment increased progressively with disease extent, demonstrating a clear severity impact correlation relationship between lesion burden and DLQI ($p<0.001$). DLQI differed significantly across age groups ($p<0.001$) and was markedly higher in patients with facial ($p<0.001$) and trunk/back involvement ($p<0.001$). Occupations associated with high sweat and friction exposure showed the greatest impairment ($p=0.003$). Systemic comorbidities—including obesity, diabetes, hepatic, cardiac, and renal disorders were consistently associated with worse DLQI (all $p<0.001$). Treatment regimens significantly influenced patient-reported outcomes ($p<0.001$), with super-bioavailable itraconazole combined with topical therapy demonstrating the most favorable quality-of-life profile.

Table 1: Clinical Determinants of DLQI (n = 2,776) and practice and Patient Factors Affecting DLQI

Parameter	Category	Median DLQI (IQR)	p-value
Overall	All patients	12 (8–17)	
Age	18–30 yrs	11 (8–16)	<0.001*
	31–45 yrs	13 (8–18)	
	46–60 yrs	13 (9.8–17)	
	>60 yrs	10 (5–16)	
Subtype	Tinea corporis	13 (9–18)	0.006*
	Tinea cruris	12 (7–18)	
	Tinea pedis	12 (10–17)	
	Onychomycosis	12 (8–16)	
	Tinea manuum	13 (9–18)	
Lesion site	Face (Yes)	16 (12–21)	<0.001*
	Trunk/back (Yes)	14 (10–18)	
Lesion count	1	10 (6–18.8)	<0.001*
	2–3	11 (7–16)	
	4–5	14 (10–17)	
	>5	17 (5–20)	
Occupation	High sweat/friction	14 (9–18)	0.003*
	Sedentary indoor	12 (6–17)	
	Domestic/non-working	13 (7–17)	
	Mixed exposure	12 (9–16)	
	Healthcare workers	10 (8–10.3)	
Comorbidities	Obesity (Yes)	14 (10–20)	<0.001*
	Hypertension (Yes)	14 (10–18)	
	Diabetes (Yes)	15 (11–19)	
	Hepatic dysfunction (Yes)	16 (11–22)	
	Cardiac disorder (Yes)	15 (11–22)	
	Renal disorder (Yes)	17 (14–19)	
Treatment	SBA itraconazole + topical	11 (6–17)	<0.001*
	SBA itraconazole alone	13 (10–18)	
	Itraconazole + topical	12 (5–17)	
	Itraconazole alone	13 (10–18)	

DLQI: Dermatology Life Quality Index; IQR: Interquartile range; SBA: Super-bioavailable; Data are presented as median (interquartile range); P-values were calculated using the Kruskal–Wallis test for comparisons involving more than two groups and the Mann–Whitney U test for two-group comparisons; Post-hoc pairwise comparisons were performed using Bonferroni adjustment where applicable; A p-value <0.05 was considered statistically significant.

Conclusions

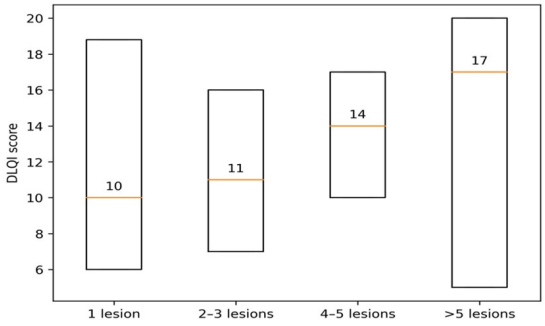
In conclusion, patients with dermatophytosis experienced a moderate impairment in quality of life. DLQI scores varied significantly across several clinical and demographic factors, indicating that disease burden is not uniform and is strongly influenced by lesion characteristics, comorbidities, and treatment patterns. Age showed a significant association with DLQI, implicating greater psychosocial and functional disruption in working age groups.

All subtypes of dermatophytosis influenced DLQI, indicating disruptive nature of disease and limitations in daily activities. Regarding site of involvement, facial lesions were associated with the highest DLQI, underscoring the role of visibility and stigma in worsening quality of life. Involvement of the trunk/back also increased DLQI, suggesting broader or symptomatic disease contributes to impairment. Patients with comorbidities showed greater impairment, indicating that systemic illness may amplify symptom severity, treatment complexity, chronicity, and psychosocial burden.

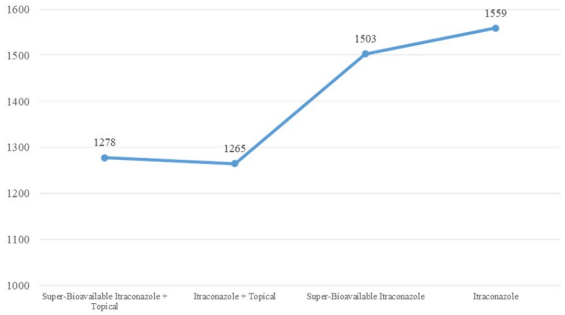
Finally, treatment modality played important role in dermatophytosis. Pattern suggests that combined approaches, particularly with SBA itraconazole may be associated with better patient-perceived outcomes, potentially reflecting improved symptom control or faster relief.

In summary, quality-of-life impairment in these patients is most pronounced with facial involvement, higher lesion counts, high sweat/friction occupations, and systemic comorbidities, while certain treatment combinations appear associated with lower DLQI. These findings emphasize the importance of individualized management, prioritizing patients with visible/extensive disease and medical comorbidities for more intensive treatment and supportive counselling.

Severity impact correlation between lesion burden and DLQI



Mean Rank Distribution of DLQI across treatment regimens



Lower mean rank = better quality-of-life outcome; Mean rank distribution of DLQI across antifungal treatment regimens demonstrating superior quality-of-life outcomes with super-bioavailable itraconazole plus topical therapy ($p < 0.001$)

Abstract N°: ID-974

Topic: Infectious diseases, parasitic diseases, infestations

Cutaneous Leishmaniasis in Central Sri Lanka: Epidemiology, Clinical Spectrum, Diagnosis and Management at a Tertiary Care Hospital

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Introduction
Cutaneous leishmaniasis (CL) is a re-emerging parasitic dermatosis in Sri Lanka. Understanding regional epidemiological patterns, clinical morphology, and diagnostic yield is essential for optimizing early diagnosis, management strategies, and disease control.

Materials and Methods
A retrospective observational study was conducted at the Dermatology Unit, National Hospital Kandy, including patients diagnosed with cutaneous leishmaniasis from June 2023 to June 2025. Demographic data, lesion characteristics, duration of disease, diagnostic investigations, and treatment modalities were extracted from medical records and analyzed descriptively using SPSS.

Results

Eighty patients were included in the analysis. The cohort comprised 54% males and 46% females, with ages ranging from 10 to 87 years (mean 42.5 years). The most affected age group was 41–60 years (35%). Most patients were Sinhalese (95%), with the highest proportion residing in the Galagedara Medical Officer of Health area (26%).

Lesions predominantly involved the head and neck region (41%), followed by the upper limbs (30%) and lower limbs (20%). Plaques were the most common clinical morphology (80%), followed by papules (12.5%) and ulcers (7.5%). Lesion duration ranged from 0.5 to 48 months, demonstrating a positively skewed distribution (skewness 3.39). Most patients presented within 3–6 months of onset (35%), while 17% presented after more than 12 months. The mean lesion duration was 6.2 months, with a median of 4 months.

Slit skin smear microscopy was positive in 30% of patients, while histopathological confirmation was obtained in 50% of cases. Among biopsied lesions, Donovan bodies were identified in 34%, granulomatous inflammation in 25%, and plasma cell infiltrates in 86%. Polymerase chain reaction testing was performed selectively and was positive in 13.8% of patients.

Treatment modalities included intralesional sodium stibogluconate (45%), topical metronidazole (16%), intralesional metronidazole (8%), cryotherapy (4%), and combination regimens incorporating sodium stibogluconate or itraconazole. Most patients achieved satisfactory clinical resolution, with no major adverse effects documented.

Conclusions
Cutaneous leishmaniasis remains endemic in Central Sri Lanka, predominantly affecting middle-aged individuals. Plaque-type lesions involving exposed sites, particularly the head, neck, and upper limbs, were the most frequent presentation. Delayed presentation beyond six months was common. Intralesional therapies, especially sodium stibogluconate and metronidazole, were effective and well tolerated. Strengthening regional surveillance, improving access to early diagnosis, and promoting timely local treatment may reduce disease morbidity and transmission.

Abstract N°: ID-988

Topic: Infectious diseases, parasitic diseases, infestations

Investigating Black Pseudochromhidrosis: A Case Report in a Young Female Patient

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Introduction

Chromhidrosis is an extremely rare disorder characterized by the secretion of intrinsically colored sweat resulting from the accumulation of lipofuscin pigment in apocrine glands. In contrast, pseudochromhidrosis occurs when initially colorless sweat becomes discolored upon contact with external agents such as chromogenic bacteria, fungi, medications, chemicals, paints, or dyes on the skin surface. Although both conditions present with colored sweat, their underlying mechanisms, diagnostic approaches, and management strategies differ significantly. Accurate differentiation is therefore essential to ensure appropriate treatment and to avoid unnecessary investigations.

Materials and Methods

A 20-year-old female presented with a seven-day history of asymptomatic black discoloration on her skin, primarily affecting her palms and soles. She reported that the discoloration could be easily removed with soap and water but would reappear within an hour. Her medical history was unremarkable, and she denied recent use of medications, unusual foods, or supplements in the month prior to consultation. Clinical examination revealed an odorless black secretion that could not be manually expressed from the eccrine glands of the palms. Wood's light examination showed no fluorescence. The patient's urine, stool, saliva, and tears appeared normal. Blood and urine analyses were within normal limits, and microscopic examination and cultures of skin scrapings tested negative for fungi and bacteria. Given the clinical presentation, a presumptive diagnosis of pseudochromhidrosis secondary to bacterial infection was made. The patient was treated with topical clindamycin, oral erythromycin (500 mg twice daily), and antiseptic soap for ten days. Complete resolution occurred within a week, with no recurrence observed during a three-month follow-up period.

Results

This case of pseudochromhidrosis highlights the importance of a meticulous diagnostic approach in dermatology, especially when confronted with atypical presentations of sweat discoloration. Although pseudochromhidrosis poses no direct health risks, it can cause significant psychological distress and social embarrassment. Diagnosis primarily depends on a thorough clinical history and appropriate antibiotic treatment. However, if cultures yield negative results and antibiotic therapy proves ineffective, a comprehensive medical history and a broader diagnostic strategy are crucial for identifying alternative causes of chromhidrosis. In this instance, antibiotics were still administered due to concerns about potential false negatives in supportive testing. These false negatives were likely the result of improper sampling techniques and the use of suboptimal transport media.

Conclusions

Accurately identifying pseudochromhidrosis and distinguishing it from chromhidrosis is of paramount importance. By maintaining a heightened level of clinical vigilance and implementing a systematic diagnostic approach, clinicians can

effectively manage pseudochromhidrosis, thereby alleviating patient distress and preventing unwarranted medical interventions.

Abstract N°: ID-991

Topic: Infectious diseases, parasitic diseases, infestations

Subcutaneous Basidiobolomycosis Masquerading as Cellulitis on the Forearm of an Elderly Woman

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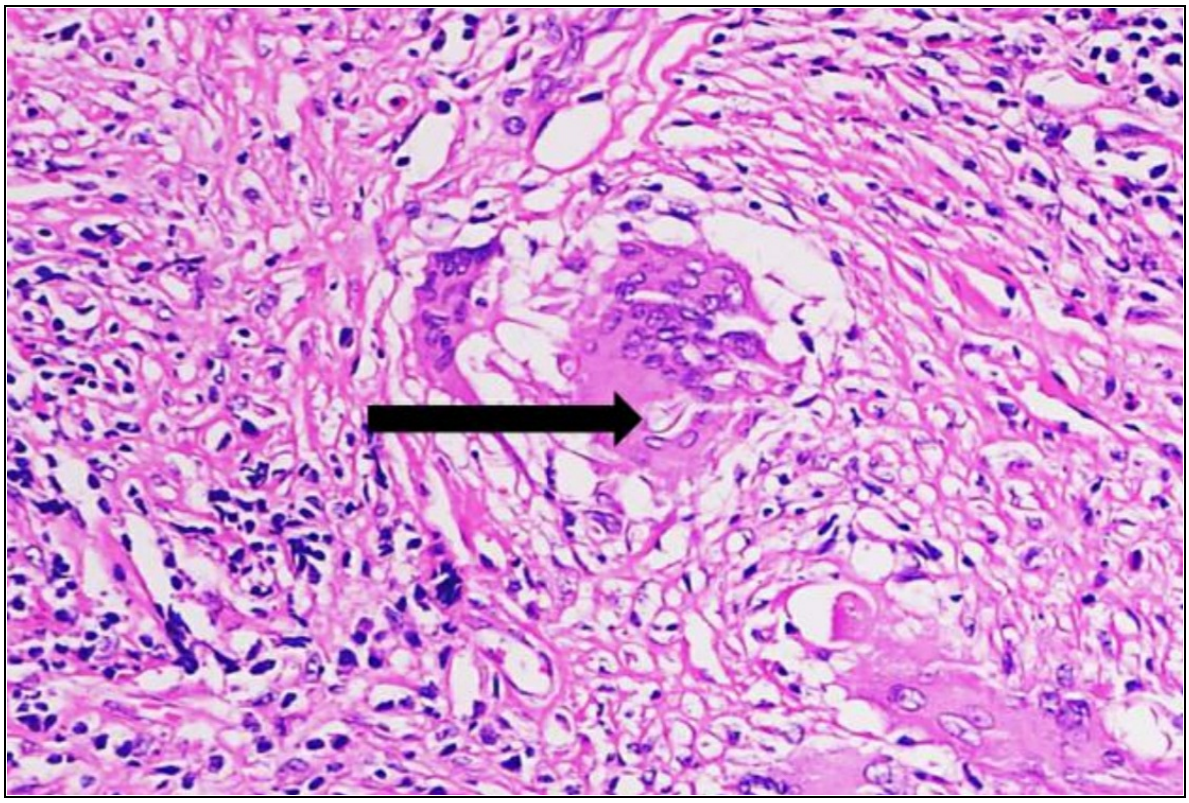
Introduction

Subcutaneous basidiobolomycosis is a rare, chronic granulomatous fungal infection caused by *Basidiobolus ranarum*. While typically found in the girdle area and proximal extremities of immunocompetent children and young adults in tropical regions, its presentation in elderly patients and on distal limbs is infrequent, often leading to significant diagnostic delays.

Materials and Methods

Case Presentation: A 70-year-old woman from South East Asia presented with a 4-month history of a progressively enlarging swelling on her right forearm. The lesion was initially erythematous, warm and tender, mimicking cellulitis. Despite multiple courses of broad-spectrum antibiotics, incision and drainage procedures, and a two-month trial of anti-tubercular therapy based on a non-specific initial biopsy, the condition remained unresponsive. Physical examination revealed a 20-cm erythematous, woody-hard, non-tender swelling on the right forearm, with pitting edema over the right hand and fingers. The swelling had a smooth, rounded, and sharply defined proximal border allowing easy finger insinuation underneath. Differential diagnoses included cellulitis with lymphedema,
subcutaneous zygomycosis, and soft tissue tumor.

Diagnosis: A deep punch biopsy eventually revealed dense inflammatory infiltrates in the lobules of panniculus composed of neutrophils, eosinophils, lymphocytes and giant cells, with areas of fat necrosis and microabscess formation. Special stains (periodic acid- Schiff and Grocott-Gomori methenamine silver) showed broad, aseptate hyphal structures surrounded by acute inflammatory cells inside the giant cells. Although fungal cultures and KOH mounts were negative, a common occurrence in this condition, the histopathological findings confirmed a diagnosis of subcutaneous basidiobolomycosis.



Hematoxylin and eosin staining of biopsy (40X) showing broad-aseptate hyphal structures inside giant cells surrounded by acute inflammatory cells.

Results

Management and Outcome: The patient was treated with oral itraconazole (200 mg twice daily). Due to her age and concurrent hypertension (treated with ACE inhibitors), a saturated solution of potassium iodide (SSKI) was avoided to prevent the risk of hyperkalemia. Within three months of antifungal therapy, the induration softened and the swelling showed significant resolution.

Conclusions

This case underscores the importance of maintaining a high index of suspicion for basidiobolomycosis in patients presenting with chronic, indurated subcutaneous swellings in tropical climates, even when the patient's age or the anatomical location is atypical. It highlights the utility of the "finger insinuation" sign and the critical role of histopathology when fungal cultures fail to yield results.

EA SYMPOSIUM DV 2026
ATHENS 7 - 9 MAY

Abstract N°: ID-1058

Topic: Infectious diseases, parasitic diseases, infestations

From Silent Lesion to Severe Anemia: The Clinical Journey of an Adolescent with Multibacillary Leprosy

Barbara Brunca*[1], Sofia Mitidieri[1], Giulia Goedert[1], Renan Doin[1], Ana Luiza Silva[1], Amanda Ribeiro[1], Mariana Jundurian[1], Marina Kawano[1], Livia Matida Gontijo Leal[1]

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Introduction

Leprosy, caused by *Mycobacterium leprae*, remains a public health challenge, particularly in endemic regions. Diagnosis in pediatric and adolescent populations is a key indicator of active disease transmission. Although the number of new cases in individuals under 15 years has declined, multibacillary (MB) forms still predominate and are associated with a higher risk of permanent disabilities. Diagnosis is primarily clinical and may be confirmed by slit-skin smear microscopy and histopathology. The World Health Organization recommends multidrug therapy (MDT) for MB leprosy, consisting of rifampicin, clofazimine, and dapsone; however, dapsone is frequently associated with hematological adverse effects, including hemolytic anemia.[1] This report describes an adolescent with multibacillary leprosy and delayed diagnosis who developed severe dapsone-induced anemia during MDT, requiring therapeutic modification.[2]

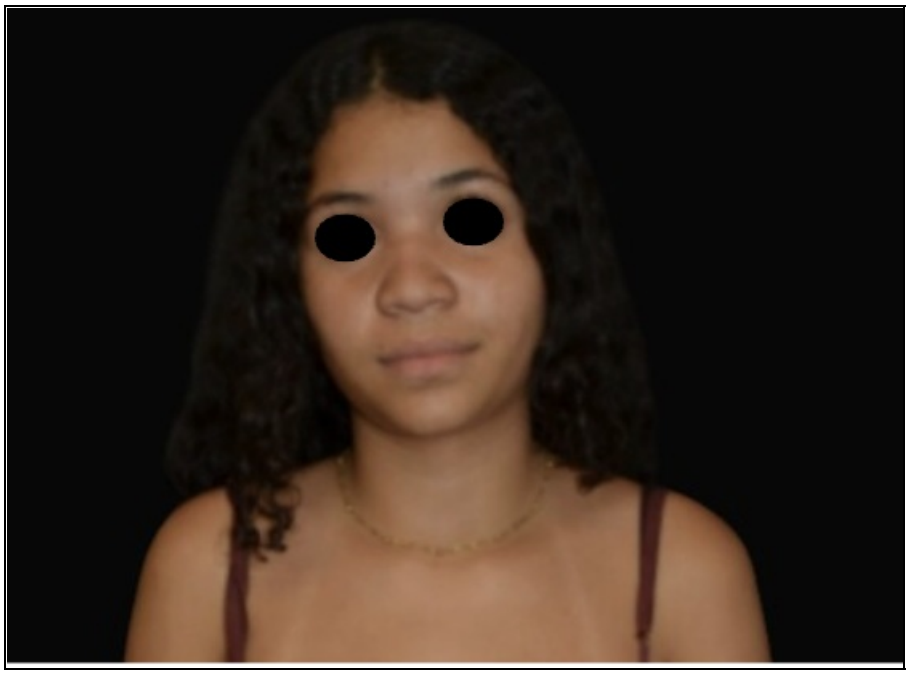

Image 1

Materials and Methods

This is a case report of a 13-year-old female patient evaluated at a dermatology service for suspected leprosy. Clinical dermatological and neurological examinations were performed. Diagnostic investigation included skin biopsies with histopathological analysis and Fite-Faraco staining, as well as slit-skin smear microscopy for acid-fast bacilli detection.

Serial laboratory tests were conducted during follow-up to monitor treatment safety and detect hematological adverse effects during multidrug therapy.

Image 2

Results

A 13-year-old female presented with an erythematous lesion on the left thigh that had appeared eight years prior, followed by progressive development of lesions on the extremities associated with sensory loss. A history of childhood contact with a family member affected by leprosy was reported. Dermatological examination revealed multiple erythematous infiltrated plaques measuring 0.5–6 cm on the extremities and dorsum, a hypochromic macule on the left thigh, and a violaceous plaque on the left arm (Image 1, 2, 3, 4). Hypoesthesia was confirmed in affected areas, with no palpable peripheral nerve thickening. Histopathological examination demonstrated chronic granulomatous dermatitis with lymphohistiocytic infiltrate. Fite-Faraco staining revealed acid-fast bacilli within macrophages, and slit-skin smear microscopy was positive, confirming the diagnosis of multibacillary leprosy, dimorphous–Virchowian form. MDT for MB leprosy was initiated one month after diagnosis. Quarterly laboratory monitoring showed a progressive decline in hemoglobin levels from 12.2 g/dL to 9.0 g/dL, accompanied by mild leukopenia. After four months of treatment, the patient developed clinical symptoms of anemia, including weakness, headache, and pallor. Dapsone was discontinued seven months after MDT initiation and replaced with minocycline at a dose of 100 mg/day. Following substitution, hemoglobin and reticulocyte levels normalized, with complete resolution of symptoms. No platelet or hepatic abnormalities were observed. The patient completed 12 months of MDT with good adherence and marked clinical

improvement.

Image 3

Conclusions

Multibacillary leprosy in adolescents represents an important marker of ongoing disease transmission and poses significant diagnostic and therapeutic challenges, particularly in cases with subtle or longstanding lesions. This case illustrates the impact of delayed diagnosis and highlights dapsone-induced hemolytic anemia as a potentially severe complication of MDT, even in the absence of known predisposing factors.[1] Rigorous clinical and hematological monitoring during MDT is essential for early detection and management of adverse drug reactions.[2] Timely therapeutic adaptation, including substitution of dapsone with an effective alternative such as minocycline, is crucial to ensure treatment continuity, optimize clinical and hematological outcomes, prevent disability development, and guarantee long-term patient safety.[1,2]

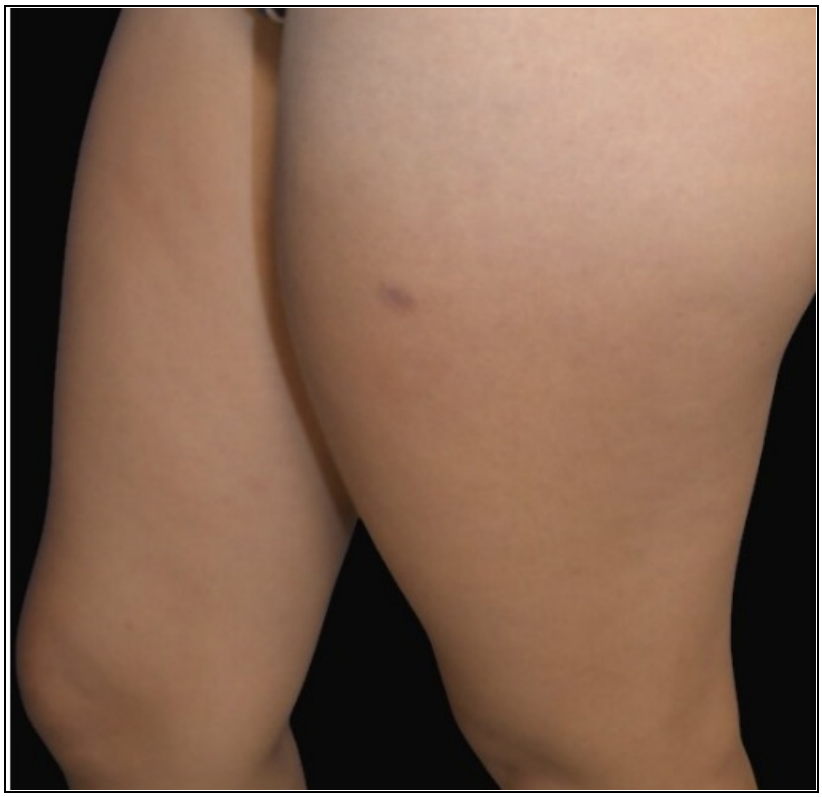

Image 4 References 1. Souza BCM, Veasey JV, Valinoto GCJ. Dapsone-induced methemoglobinemia in a child with leprosy. A Bras Dermatol. 2025;100(2):391–394. doi:10.1016/j.abd.2024.05.006. PMID: 39619233. 2. Hilder R, Lockwood D. The adverse drug effects of dapsone therapy in leprosy: a systematic review. Lepr Rev. 2020;91(3):232–243. doi:10.47276/lr.91.3.232. PMID: 33025733.

Abstract N°: ID-1067

Topic: Infectious diseases, parasitic diseases, infestations

Safety and Efficacy of Needling Techniques for Cutaneous Warts: A Systematic Review

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Introduction

Cutaneous warts are caused by the human papillomavirus infection of keratinocytes. Conventional therapies such as topical salicylic acid and cryotherapy may fail to yield satisfactory results. Needling techniques have emerged as a novel treatment strategy for difficult-to-treat warts. However, there is a lack of a systematic evaluation of the safety and efficacy of this novel technique. This review summarizes current evidence on the safety and efficacy of needling techniques for cutaneous warts.

Materials and Methods

Following PRISMA guidelines, MEDLINE, Embase, Scopus, and CENTRAL were searched from inception to July 2025. Participants of any age, gender, or ethnicity with cutaneous warts affecting any given body region who were treated with needling technique were included. Intralesional injections delivered using needling techniques were excluded. A total of 27 studies were included (Table 1).

Table 1. Summary of Safety and Clinical Response with Needling for Cutaneous Warts. CR, complete response; PR, partial response; NOR, no response; NR, non-reported; 5-ALA-PDT, 5-aminolevulinic acid-photodynamic therapy

Technique (%, n/N)	Technique Description	Study Design (n/N)	Previously Failed Therapies (n)	Mean Duration of Warts (Months)	Needle Type (n/N)	Remission Rate/Clinical Response (CR % [n/N], PR % [n/N], NOR % [n/N])	Mean Follow-up Period (Weeks)	Adverse Events (n)
Monotherapy (38.73%, 404/1043)								
Falknor's needling technique (53.96%, 218/404)	Multiple needles are repeatedly punctured from the wart surface to the subcutaneous fat layer to induce immune regulation against verrucae-causing viruses.	RCT (2/5), prospective non-randomized study (2/5), case series (1/5)	Salicylic acid (19), radiosurgery or autoimplantation (12), combined salicylic acid and cryotherapy (10), cryotherapy (2), natural/homeopathic remedies (2)	26	26-gauge needle (4/5), 27-gauge needle (1/5)	CR 62.12% (123/198), PR 14.65% (29/198), NOR 23.23% (46/198)	14	Mild pain/bruising/slight discomfort (16), secondary infections (9), pain (5)

Microneedling (7.43%, 30/404)	A device with multiple very fine needles creates superficial microchannels into the dermis to induce better topical absorption, immune activity, and wound healing.	RCT (1/1)	Cryotherapy (8), keratolytic (3), electrocautery (2), surgery (1)	36	Dermapen 3 (Avon UK) (1/1)	CR 70.00% (21/30), PR 16.67% (5/30), NOR 13.33% (4/30)	24	Pain (7)
Single-needle puncturing	One needle creates multiple	RCT (3/6), case series (1/6),	Non-specified over the counter	14	25-gauge needle (2/6),	CR 26.92% (42/156), NR, NR	67	Mild pain (4), acute discomfort (3), gastrointestinal
(38.61%, 156/404)	punctures up to the subcutaneous fat layer. Often results in fewer punctures and less tissue trauma than the Falknor's needling technique.	nonrandomized trial (1/6), retrospective cohort study (1/6)	treatments (22), podiatrist (18), general practitioner (9), nitric acid or folk remedies (7), self-filing/debridement (3), duct tape (2), hospital freeze treatment (1), cautery, laser, salicylic acid, excision, cryotherapy, steroids, antibiotics, cantharidin, antivirals, duct tape (unspecified)		26.5-gauge needle (1/6), 24-gauge needle (1/6), 21-gauge needle (1/6), 18 to 25-gauge needles (1/6)			tract yeast infection (1)
Combination Therapy (61.27%, 639/1043)								
Microneedling patch with topical bleomycin (3.28%, 21/639)		RCT (1/1)	NR	NR	Microneedle patch (an array of 100 microneedles each with a length of 250 μm on a total area of 49 square metres) (1/1)	CR 61.90% (13/21), PR 38.10% (8/21), NOR 0.00% (0/21)	16	Delayed response (3), hyperpigmentation (1), scar (1), nail dystrophy (1), infection (1)

Microneedling with curettage and topical 5-ALA-PDT (2.03%, 13/639)	Prospective single-arm clinical trial (1/1)	10% 5-ALA-PDT (3)	12	Microneedle device with 12 needles (1/1)	CR 92.31% (12/13), PR 7.69% (1/13), NOR 0.00% (0/13)	17	Temporary pain (13), temporary erythema (10), severe pain (4), crusting (4), hyperpigmentation (1), ulceration (1)
Microneedling with mitomycin (4.69%, 30/639)	RCT (1/1)	NR	NR	Microneedle device with unspecified needle size/number (1/1)	CR 76.67% (23/30), PR 3.33% (1/30), NOR 20.00% (6/30)	NR	Pain (25)
Microneedling with topical 5-fluorouracil (4.69%, 30/639)	RCT (1/1)	Keratolytic (5), surgery (4), cryotherapy (2), electrocautery (1)	36	Dermapen 3 (Avon UK) (1/1)	CR 86.67% (26/30), PR 3.33% (1/30), NOR 10.00% (3/30)	24	Pain (6)
Microneedling with topical bleomycin (15.02%, 96/639)	RCT (7/7)	Cryocautery (9), chemical treatment (6), combined cryotherapy and pulsed-dye laser treatments (1), combined monthly liquid nitrogen, topical salicylic acid, daily zinc, nightly tape occlusion, and intralesional candida injections	42	Microneedle device with 1 cm diameter tip (4/7), microneedle device with unspecified needle size (2/7), Dermapen (1/7)	CR 82.29% (79/96), NR, NR	16	Pain (24), erythema (16), edema & induration (5), mild hyperpigmentation (2)

		(1), combined topical salicylic acid, laser therapy, cryotherapy, excisions, candida injection immunotherapy, fluorouracil, and oral zinc (1)					

		zinc (1), electrocautery (1)					
Microneedling with topical methotrexate gel (5.16%, 33/639)	RCT (1/1)	Topical keratolytic (5), cryotherapy (1), electrocautery (1)	6	Dermapen (Ostar rechargeable Dermapen, OB-DG 03 N; Ostar Beauty Sci-Tech Co., Beijing, China) (1/1)	CR 52.94% (18/34), PR 23.53% (8/34), NOR 23.53% (8/34)	12	Pain (22), erythema (7), hypopigmentation (2), blister (1)
Single-needle puncturing with bleomycin sulfate (10.33%, 66/639)	Case series (1/1)	Cryotherapy, salicylic acid, and surgery (unspecified)	NR	30-gauge needle (1/1)	CR 84.85% (56/66), PR 15.15% (10/66), NOR 0.00% (0/66)	24	NR
Single-needle puncturing with topical 5-fluorouracil (4.69%, 30/639)	RCT (1/1)	NR	NR	26-gauge needle (1/1)	CR 86.67% (26/30), PR 6.67% (2/30), NOR 6.67% (2/30)	24	Pain (17), bleeding (8), burning sensation (4)
Single-needle puncturing with topical bleomycin (18.78%, 120/639)	Prospective study (2/3), RCT (1/3)	Cryotherapy (53), unspecified previous treatment (43), chiropody (7), topical salicylic acid (3), surgery (3), pulsed dye laser (2), electrosurgery (1), radiotherapy (1)	22	27-gauge needle (1/3), 26-gauge needle (1/3), monolet needle (1/3)	CR 89.17% (107/120), PR 5.83% (7/120), NOR 5.00% (6/120)	18	Pain (18), transient regional pruritus (5), swelling (3), mild hyperpigmentation (1), Raynaud's phenomenon of fingers & toes (1)
Single-needle puncturing with topical formic acid (11.27%, 72/639)	RCT (1/2), placebo-controlled, nonrandomized, open trial (1/2)	NR	15	26-gauge needle (1/2), 24-gauge needle (1/2)	CR 73.61% (53/72), NR, NR	12	Temporary mild burning sensation (58), secondary infections including pain, erythema, and seropurulent discharge (6)
Single-needle puncturing with topical trichloroacetic acid (19.87%, 127/639)	RCT (3/3)	Unspecified previous treatment (52), Collomack (1)	NR	26-gauge needle (2/3), insulin syringe (1/3)	CR 52.76% (67/127), PR 29.92% (38/127), NOR 17.32% (22/127)	16	Pain (30), transient regional pruritus (6), swelling (5), burning sensation (4), ulceration (2)

Results

Among 1,043 included patients, 38.7% were treated with needling techniques alone and 61.3% with needling techniques and an adjunctive agent. Warts were most frequently treated on the feet (70.0%) and hands (19.1%) with a mean follow-up of 26.1 weeks (range, 0-288).

Mean clearance rates of monotherapies and combination therapies were 46.0% (range, 26.9%-70.0%) and 75.1% (range, 31.8%-92.3%), respectively. Followed by Falknor's needling (clearance rate 56.4%; total 218 patients), microneedling (70.0%; 30) was the most effective monotherapy, which involved simultaneous vertical applications of 12 fine needles at a penetration depth of 2mm. On average, 4.7±1.2 treatment cycles with sessions every two weeks were completed over 9.3 weeks (follow-up, 6 months). For combination therapy, microneedling with curettage and topical 5-aminolevulinic acid-photodynamic therapy (5-ALA-PDT, 92.3%, 12/13) was the most effective: three treatment cycles with sessions every three weeks were completed over nine weeks (mean follow-up, 4.3 months). Minor adverse events (pain/burning/erythema) were reported in 37.4% of cases.

Conclusions

Needling techniques are generally safe for treating recalcitrant cutaneous warts with favorable clearance rates of 26.9%-92.3%, supporting their consideration as a promising addition to the current therapeutic armamentarium. Their use in current clinical practice is limited by inconsistent treatment regimens and lack of head-to-head comparisons between various techniques and with conventional therapies. Future studies involving larger cohorts and standardized needling protocols are warranted to better inform clinicians on the optimal use of this treatment.

Abstract N°: ID-1074

Topic: Infectious diseases, parasitic diseases, infestations

Dermoscopic identification of tungiasis: key structures for rapid diagnosis

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Introduction

Tungiasis is a cutaneous parasitosis caused by the penetration of the female flea *Tunga penetrans* into the skin. Endemic in tropical regions, it is increasingly diagnosed in travelers returning from endemic areas. Although diagnosis is mainly clinical, dermoscopy can play a crucial role by revealing characteristic structures that allow rapid and accurate identification of the parasite.

Materials and Methods

A 28-year-old male presented with two papular lesions measuring 5 and 6 mm on the anterior plantar region of the left foot, with several months of evolution following travel to an endemic area. Clinically, the lesions appeared as yellowish papules with a central black dot. Dermoscopic examination was performed to further characterize the lesions and support the diagnostic hypothesis.

Results

Dermoscopy revealed a well-defined, homogeneous whitish-yellow halo surrounding the lesion, associated with gray-blue areas and a central orifice containing a light-brown structure. The whitish-yellow halo was consistent with the distended abdomen of the embedded parasite containing eggs, while the gray-blue areas likely represented internal parasitic structures, such as the exoskeleton or digestive tract. The light-brown structure visible within the central orifice was compatible with the posterior segment of the parasite. Curettage was performed, followed by application of silver nitrate, resulting in complete clinical resolution. Histopathological examination revealed acral skin containing an intradermal parasitic structure with communication to the surface, in which skeletal muscle fragments, digestive tract, and eggs were identified, confirming the diagnosis of tungiasis.

Conclusions

This case highlights the value of dermoscopy in the rapid diagnosis of tungiasis by enabling visualization of characteristic parasitic structures and their correlation with histopathological findings. Awareness of these dermoscopic features may assist dermatologists in promptly recognizing tungiasis in travelers returning from endemic regions, thereby reducing diagnostic delay and preventing potential complications.

Abstract N°: ID-1084

Topic: Infectious diseases, parasitic diseases, infestations

Chromomycosis: A Case Report and Review

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Introduction
Chromomycosis is a chronic granulomatous mycosis caused by pigmented dematiaceous fungi, typically acquired through traumatic inoculation. It is endemic in tropical and subtropical regions and is considered a neglected tropical disease, often diagnosed late due to its indolent course.

Materials and Methods
case report and literature review

Results
We present the case of a 74-year-old woman from Equatorial Guinea with a soft, granulomatous, non-adherent nodular lesion measuring 3 x 3 cm on the left cheek, which had been present for one year. A punch biopsy revealed granulomatous inflammation with muriform cells, characteristic of chromomycosis. Complete surgical excision of the lesion confirmed the diagnosis histologically, demonstrating spherical fungal structures with pigmented walls. The panfungal PCR identified *Peniophora spp.*. No recurrence was observed during subsequent follow-up.

Conclusions
Chromomycosis is a chronic mycosis that should be included in the differential diagnosis of persistent skin lesions, particularly in patients from endemic areas. Diagnosis relies on the identification of muriform cells in biopsy and culture. Treatment varies depending on lesion extent, with surgical excision being an effective option in selected cases.

Abstract N°: ID-1101

Topic: Infectious diseases, parasitic diseases, infestations

Refractory Extensive Epidermomycosisis in a Young Woman Revealing HIV Infection: Therapeutic Challenge and Emerging Antifungal Resistance

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Introduction
Epidermomycosisis a common superficial fungal infection that is generally benign and easily treated. However, the emergence of extensive, atypical, and treatment-resistant forms has been increasingly reported, representing a growing therapeutic challenge. We report a case of extensive, refractory epidermomycosis revealing HIV infection and highlighting the issue of antifungal resistance.

Materials and Methods
N/A

Results
A 28-year-old woman presented with a 6-month history of diffuse annular erythematous–violaceous plaques, with active borders, confluent in places, and intensely pruritic, involving most of the integument, without mucosal or nail involvement. Her partner had a history of high-risk sexual behavior and frequent travel to Southeast Asia.

Differential diagnoses included erythema annulare centrifugum, subacute cutaneous lupus erythematosus, sarcoidosis, and extensive epidermomycosis. Routine laboratory investigations were normal. Mycological examination identified *Trichophyton interdigitale*. HIV serology was positive, leading to the diagnosis of extensive epidermomycosis revealing HIV infection.

The patient was started on antiretroviral therapy, combined with topical and oral terbinafine 250 mg/day for one month, without clinical improvement. Oral itraconazole at 200 mg/day for two months was subsequently initiated, with persistent therapeutic failure, suggesting antifungal resistance. Dose escalation to 400 mg/day for one month resulted in complete resolution of the lesions, with only residual post-inflammatory hyperpigmentation.

Conclusions
Extensive, refractory epidermomycosis in a young patient should prompt consideration of underlying immunosuppression.
Terbinafine resistance, increasingly reported in Asia, should be suspected in cases of therapeutic failure. International travel facilitates the dissemination of resistant strains, altering local epidemiological patterns. Itraconazole represents an effective therapeutic alternative in these cases.

Abstract N°: ID-1125

Topic: Infectious diseases, parasitic diseases, infestations

ADH2 Drives Metabolic Reprogramming and Fluconazole Tolerance in Candida albicans

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Introduction

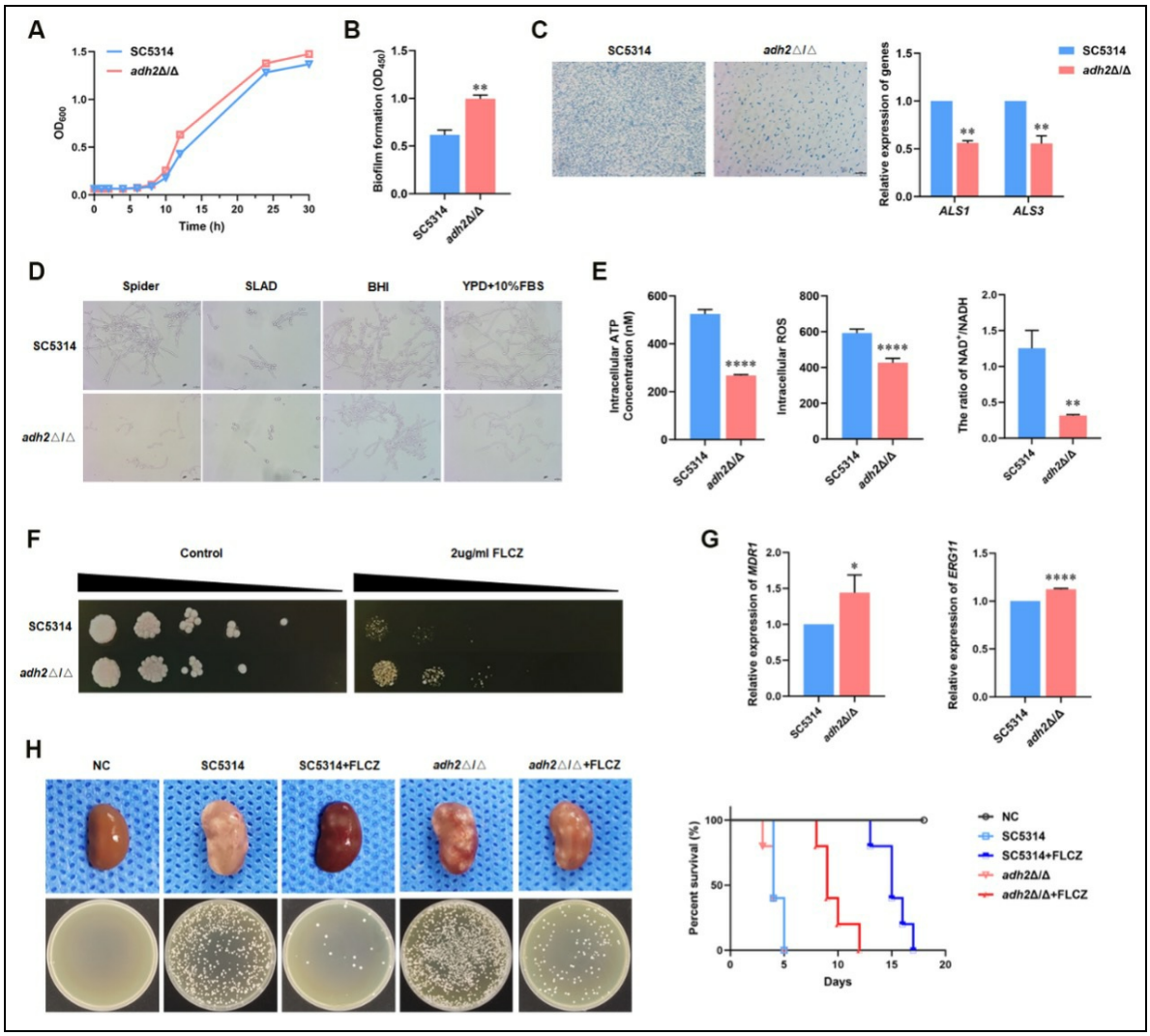
Metabolic adaptation is increasingly recognized as a key determinant of fungal virulence and antifungal resistance. *Candida albicans*relies on flexible redox and energy metabolism to survive host environments and azole exposure. Although alcohol dehydrogenases regulate these processes, the role of ADH2 in fungal pathogenicity and fluconazole tolerance remains poorly understood.To elucidate the contribution of ADH2 to metabolic homeostasis, virulence-associated phenotypes, and fluconazole susceptibility in Candida albicans.

Materials and Methods

ADH2 knockout (*adh2*Δ/Δ) strains were generated in the SC5314 background. Growth, adhesion, filamentation, and biofilm formation were assessed in vitro. Metabolic status was evaluated by intracellular ATP levels, mitochondrial membrane potential, reactive oxygen species (ROS), and NAD^+/NADH ratios. Fluconazole susceptibility was examined by phenotypic assays and expression of resistance-related genes. Pathogenicity and treatment response were further evaluated in a murine model of systemic candidiasis.

Results

Loss of *ADH2* profoundly altered fungal metabolism and pathogenic traits. *ADH2*-deficient strains displayed enhanced growth and biofilm metabolic activity, accompanied by impaired adhesion and filamentation (Fig A-D). Metabolic analyses revealed reduced ATP production, decreased ROS levels, and a significantly lowered NAD^+/NADH ratio (Fig E), indicating disrupted mitochondrial and redox homeostasis. Fluconazole susceptibility was reduced following ADH2 disruption, and the *ADH2* knockout strain exhibited marked upregulation of efflux pump genes (*MDR1*) and *ERG11* (fig F-G). In vivo, *ADH2* deletion was associated with increased fungal burden and reduced fluconazole therapeutic efficacy (Fig H).



(A) Growth curves; (B) XTT-based biofilm assay; (C) Adhesion capacity and adhesion-related gene expression; (D) Hyphal formation in liquid media; (E) ATP levels, ROS production, and NAD^+/NADH ratio; (F) Spot assay for fluconazole susceptibility; (G) Expression of MDR1 and ERG11; (H) Renal fungal burden and survival in vivo.

Conclusions

ADH2 functions as a metabolic regulator linking redox balance, biofilm formation, and azole tolerance in *Candida albicans*. Disruption of ADH2 promotes metabolic reprogramming and fluconazole tolerance, ultimately enhancing pathogenicity. These findings highlight fungal metabolic pathways as potential targets for improving antifungal strategies.

Abstract N°: ID-1129

Topic: Infectious diseases, parasitic diseases, infestations

Erythema Nodosum Leprosum as a Sentinel of Triple Mycobacterial Disease: Diagnostic and Therapeutic Challenges in Concurrent Lepromatous Leprosy, Pulmonary Tuberculosis, and Cutaneous Tuberculosis

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Introduction
Erythema nodosum leprosum (ENL) is a severe, immune complex–mediated inflammatory Type 2 reaction and a primary driver of morbidity in lepromatous leprosy. Both leprosy and tuberculosis are caused by intracellular mycobacteria, sharing overlapping epidemiological patterns and immunological mechanisms. However, the concurrent manifestation of ENL, pulmonary tuberculosis (PTB), and cutaneous tuberculosis is exceedingly rare, posing formidable diagnostic and therapeutic dilemmas.

Materials and Methods
A 21-year-old woman was referred from the Pulmonology Department presenting with painful erythematous nodules disseminated across the body, accompanied by fever and arthralgia. Physical examination revealed purulent lesions with scarring in the bilateral axillary and inguinal regions. The patient was initially hospitalized for pulmonary tuberculosis. Subsequent clinical evaluation identified multiple tender nodules and suppurative lesions. Diagnoses of severe ENL in lepromatous leprosy, scrofuloderma, and PTB were confirmed through clinical findings, slit-skin smears (bacteriological index 2+, morphological index 29%), and histopathological analysis—which showed granulomas, foamy macrophages, neutrophil-rich infiltrates, and Langhans-type giant cells. Chest imaging and molecular testing (GeneXpert/TCM) confirmed active PTB.

Results
Management required an integrated approach to address multibacillary (MB) leprosy, severe ENL, and active tuberculosis simultaneously. The leprosy regimen utilized Multidrug Therapy (MDT-MB) but excluded rifampicin for 12 months, as rifampicin was already administered via the anti-tuberculosis (OAT) regimen to prevent drug duplication and mitigate resistance risks. During OAT, the patient received dapsone and clofazimine, completing 12 doses within an 18-month window, with standard MDT-MB resuming post-OAT. Severe ENL was managed with intravenous methylprednisolone (31.25 mg every 12 hours) for 7 days, followed by oral prednisolone (initial dose 40–60 mg/day) tapered to a maintenance dose of 5–10 mg/day. Systemic corticosteroids served as first-line therapy to suppress inflammatory pathways, including neutrophil chemotaxis and proinflammatory cytokines (TNF-α and IFN-γ). The PTB and scrofuloderma were treated with a standard four-drug regimen (HRZE) for 2 months, followed by a 4-month continuation phase (HR).

Conclusions
ENL may act as a clinical sentinel for severe immune dysregulation in the context of multiple mycobacterial coinfections. This rare triad of lepromatous leprosy, PTB, and cutaneous tuberculosis underscores the necessity of comprehensive clinicopathological evaluation and multidisciplinary coordination. Despite the patient's complex immunological state, the

use of systemic corticosteroids was essential to prevent irreversible neuropathy and systemic complications.

Abstract N°: ID-1154

Topic: Infectious diseases, parasitic diseases, infestations

Crusted Scabies in Severe Malnutrition: A Case Highlighting Diagnostic and Therapeutic Challenges

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Introduction

Crusted scabies is a rare and highly contagious variant of scabies characterized by massive mite proliferation, extensive hyperkeratosis, and an increased risk of secondary infection and institutional transmission. It predominantly affects individuals with impaired host defenses, poor hygiene, and severe malnutrition. Delayed diagnosis may result in systemic complications, outbreaks in healthcare settings, and increased mortality. This case highlights key diagnostic features, therapeutic challenges, infection control considerations, and clinical outcomes in a severely malnourished patient with crusted scabies.

Materials and Methods

A 43-year-old woman presented with a three-month history of generalized thickened, scaly skin lesions associated with severe nocturnal pruritus. Dermatological examination revealed diffuse hyperkeratotic, crusted plaques with erosions and excoriations involving the face, trunk, and extremities. The patient was markedly underweight with clinical features of poor nutritional status. Diagnostic evaluation included complete hematologic and biochemical investigations, chest imaging, and microscopic examination of skin scrapings using potassium hydroxide (KOH) preparation. Given the high infectivity, strict contact precautions and environmental decontamination were implemented. Management consisted of repeated doses of oral ivermectin combined with topical permethrin 5%, adjunctive keratolytic therapy to reduce crust burden, wound care, nutritional rehabilitation, and treatment of secondary bacterial infection. Multidisciplinary care involving dermatology, internal medicine, and nutrition services was provided.

Results

Microscopic examination confirmed the presence of *Sarcoptes scabiei* mites, eggs, and fecal pellets, consistent with crusted scabies. Laboratory investigations demonstrated anemia, leukocytosis, eosinophilia, hypoalbuminemia, and electrolyte imbalances, reflecting severe malnutrition and systemic inflammatory response. During treatment, progressive reduction of hyperkeratosis, crusting, and pruritus was observed. Follow-up skin scrapings showed a declining parasite burden, supporting therapeutic response. Most cutaneous lesions demonstrated marked clinical improvement. Despite dermatological improvement, the patient developed severe systemic complications, including gastrointestinal bleeding and acute kidney injury, leading to clinical deterioration. The presence of multiple systemic comorbidities likely contributed to the unfavorable outcome. These complications necessitated intensive supportive management and ultimately resulted in a poor overall prognosis

Conclusions

Crusted scabies should be strongly suspected in patients presenting with diffuse hyperkeratotic dermatoses and severe

malnutrition. Microscopic confirmation remains essential for diagnosis and monitoring treatment response. Effective management requires combined systemic and topical antiscabietic therapy, keratolytic support, and strict infection control measures to prevent institutional outbreaks. Despite appropriate dermatological therapy, overall prognosis may remain poor in the presence of advanced systemic comorbidities. Early recognition, multidisciplinary management, and holistic care are critical to improving outcomes and preventing complications and transmission.

Abstract N°: ID-1161

Topic: Infectious diseases, parasitic diseases, infestations

Successful Treatment of Crusted Scabies Using Topical Therapy in a Child with Acute Lymphoblastic Leukemia

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Introduction

Crusted scabies is a rare and severe form of scabies characterized by extensive hyperkeratosis and heavy mite infestation, most commonly affecting immunocompromised individuals, including patients with hematological malignancies. Systemic ivermectin is generally recommended as first-line therapy due to the high parasite burden and risk of treatment failure with topical agents alone. However, in certain clinical situations, topical therapy may be considered as an alternative approach.

Materials and Methods

We report the case of a 10-year-old girl with a body weight of 32 kg who had acute lymphoblastic leukemia and was undergoing chemotherapy, presenting with generalized hyperkeratotic and scaly skin lesions accompanied by nocturnal pruritus. The diagnosis was established based on clinical evaluation, microscopic examination of skin scrapings using 10% potassium hydroxide, and dermoscopic assessment. The patient was treated with a combination of topical scabicidal therapy and keratolytic agents to enhance drug penetration, along with supportive topical treatments, environmental decontamination, and simultaneous treatment of close contacts.

Results

Dermatological examination revealed diffuse hyperkeratotic plaques, crusts, papules, and generalized scaling. Microscopic examination demonstrated *Sarcoptes scabiei*, eggs, and scybala, while dermoscopy showed the characteristic delta-wing jet sign. The treatment regimen consisted of topical permethrin 5% combined with keratolytic agents, including salicylic acid 3% and sulfur precipitatum 4%, to reduce hyperkeratosis, as well as topical corticosteroids and emollients to control inflammation and restore the skin barrier. After one week of therapy, marked reduction in scaling and pruritus was observed, with no development of new lesions. Follow-up at three weeks showed further clinical improvement, and repeat microscopic examination was negative for mites, eggs, and scybala.

Conclusions

Although systemic ivermectin is widely recommended as first-line therapy for crusted scabies, particularly in immunocompromised patients, this case demonstrates that intensive topical treatment combined with keratolytic agents can achieve both clinical and parasitological resolution when appropriately administered. Adequate reduction of hyperkeratosis played a critical role in enhancing scabicidal penetration and treatment efficacy, allowing effective mite eradication without the need for systemic therapy. The favorable outcome observed in this patient supports the concept

that therapeutic decisions should be guided by clinical response rather than rigid adherence to standard protocols. In selected patients, especially when close monitoring is feasible, topical therapy alone may represent a safe, effective, and sufficient treatment strategy. This case underscores the importance of individualized management and highlights that systemic ivermectin may not be mandatory when topical regimens demonstrate clear and sustained therapeutic success.

Abstract N°: ID-1164

Topic: Infectious diseases, parasitic diseases, infestations

Cutaneous larva migrans: a clinical and dermoscopic study of a case treated with albendazole

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Introduction

Cutaneous larva migrans (CLM) is a parasitic infestation of the skin caused by the penetration of hookworm larvae, parasites commonly found in the feces of infected dogs and cats. This condition occurs mainly in tropical areas, after exposure to contaminated soil, particularly when walking barefoot on sand where infected animals are present. We report a case of cutaneous larva migrans.

Materials and Methods

The patient was a 23-year-old woman who consulted for a pruritic erythematous rash that had appeared two days earlier. Clinical examination revealed bilateral lesions on the ankles and backs of the feet, erythematous, sinuous, and serpiginous, topped with tense blisters containing a lemon-yellow fluid, accompanied by erosions and scabs. The symptoms appeared two days after the patient spent a day near a dam on damp sandy ground.

Dermoscopy revealed pink and purple areas without structure, linear, serpiginous, and sinuous, corresponding to larval migration. Multiple red and purple dots were visible along the migration path. Gaps were separated by whitish septa, and a pale white, unstructured veil was visible in the center. A pale brown, unstructured, elliptical translucent area was observed, showing white lines projecting into yellow-brown structures like partitions, giving it a segmented appearance. There was also a reddish-brown crust in the center. We considered the diagnosis of larva migrans given the context of the lesions' appearance and their sinuous appearance. The patient was treated with Albendazole at a dose of 400mg twice daily for 3 days.

Three weeks after treatment, the outcome was favorable, although slight residual hyperpigmentation persisted. The pruritus also disappeared within the first 48 hours after treatment began. On dermoscopy, almost all of the images initially observed had disappeared. A brownish background remained, with a whitish veil in the center.

Results

CML is clinically characterized by a serpiginous and migratory rash, usually associated with itching. Although lesions can develop on any exposed part of the body, the feet are the most affected site. The natural progression of the disease is limited because the larvae lack the enzymes necessary to cross the basement membrane and reach the gastrointestinal tract to reproduce. However, treatment may be necessary to relieve symptoms and eliminate the parasites. The treatments of choice for CML include topical thiabendazole, oral albendazole, and ivermectin. These agents are effective in eliminating the larvae and relieving the associated symptoms.

The diagnosis is primarily clinical. The use of dermoscopy in the diagnosis of CML is not yet well established. The morphological characteristics observed using this technique are controversial and require further research to determine their clinical usefulness in the management of this parasitic skin condition. As for biopsy, it is of very little use in making the diagnosis.

Conclusions

In conclusion, cutaneous larva migrans is a dermatological condition found mainly in tropical areas, characterized by a sinuous erythematous and pruritic lesion. Dermoscopy is emerging as a promising tool to facilitate the early and accurate diagnosis of this condition.

Abstract N°: ID-1211

Topic: Infectious diseases, parasitic diseases, infestations

Therapeutic Adjustment of Leprosy Treatment in a Patient with Concomitant Tuberculosis

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Introduction
Leprosy and tuberculosis are chronic mycobacterial infections that may coexist in endemic areas. The concurrence of both diseases presents a therapeutic challenge, particularly in determining appropriate antimicrobial regimens, as rifampicin plays a central role in the treatment of both conditions. Careful adjustment of leprosy therapy is required in patients who are already receiving rifampicin as part of tuberculosis treatment to avoid suboptimal dosing, drug resistance, and adverse effects. This report highlights clinical considerations in adjusting leprosy treatment in the setting of concomitant tuberculosis

Materials and Methods
This study describes the case of a 36-year-old woman presenting with chronic hypoesthetic erythematous skin lesions, crusted ulcers on the lower extremities, facial changes, peripheral neuropathy, and progressive back pain. Clinical evaluation included comprehensive dermatological and neurological examinations, slit-skin smear, histopathological analysis, laboratory investigations, and radiological imaging. Acid-fast bacilli examination and histopathology were performed to confirm leprosy, while radiological assessment and microbiological culture were used to evaluate suspected tuberculosis. The patient was treated with modified multidrug therapy for leprosy in conjunction with standard antituberculosis treatment based on microbiological findings.

Results
Clinical examination revealed diffuse erythematous macules with sensory loss, leonine facies, madarosis, and peripheral nerve enlargement. Slit-skin smear demonstrated a multibacillary pattern with high bacterial and morphological indices. Histopathological analysis showed dermal granulomas composed of foamy histiocytes with abundant acid-fast bacilli, consistent with lepromatous leprosy. Further evaluation identified *Mycobacterium tuberculosis* through microbiological culture of purulent material, supported by radiological findings suggestive of extrapulmonary involvement. In this report, the patient received standard antituberculosis therapy (OAT) with the RHZE regimen, consisting of rifampicin 150 mg, isoniazid 75 mg, pyrazinamide 400 mg, and ethambutol 275 mg. Consequently, the standard rifampicin–ofloxacin - minocycline regimen for leprosy was modified. As rifampicin had already been adequately administered through antituberculosis treatment, leprosy therapy was adjusted to ofloxacin (400 mg) – and minocycline (100 mg) without additional rifampicin. During follow-up, clinical improvement of cutaneous lesions and stabilization of systemic symptoms were observed.

Conclusions

Coinfection of *Mycobacterium leprae* and *Mycobacterium tuberculosis* is an uncommon but clinically significant entity that requires heightened diagnostic awareness. Early recognition is essential to prevent inappropriate rifampicin monotherapy and subsequent antimicrobial resistance. Rifampicin is the most potent bactericidal agent against *Mycobacterium leprae* and is typically administered intermittently in leprosy treatment regimens. However, in patients with concomitant tuberculosis receiving daily rifampicin, additional rifampicin for leprosy is unnecessary and may increase the risk of adverse effects and inappropriate dosing. In such cases, modification of leprosy therapy by omitting rifampicin while continuing companion drugs represents a rational and evidence-based approach. Individualized treatment adjustment is essential to ensure therapeutic efficacy and safety in patients with overlapping mycobacterial infections.

Abstract N°: ID-1237

Topic: Infectious diseases, parasitic diseases, infestations

To Treat or Not to Treat: A Pediatric Case of Suspected *Mycobacterium marinum* Skin Infection with Spontaneous Resolution

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Introduction

Mycobacterium marinum is an atypical mycobacterium that causes infection after exposure of traumatized skin to contaminated natural waters, swimming pools, or aquariums. The gold standard for diagnosis is pathogen isolation by culture, which is positive in only 70-80% of cases. The complementary tests include histopathological findings, tuberculin and QuantiFERON tests. Tuberculin test can be positive in both *M. tuberculosis* and atypical mycobacterium infections, and QuantiFERON test may also be positive in infections with certain species of atypical mycobacteria that share common antigens with *M. tuberculosis*, such as *M. marinum*. Management options include antibiotic therapy, surgery or observation, though no official guidelines exist. We present a case of a healthy 3-year-old boy with a one-and-a-half-month history of painful, livid, centrally umbilicated papules and crusted pustules on the upper plantar surfaces of his soles. He had no regional lymphadenitis or other systemic symptoms. He had no history of trauma, barefoot walking, exposure to aquariums, swimming pools, or natural waters, nor had he travelled abroad. No family members had similar lesions. He had no known allergies and was vaccinated according to the national immunization schedule.

Materials and Methods

Following failure of empirical therapy with systemic antibiotics (amoxicillin-clavulanate) and topical agents (fusidic acid cream, mupirocin ointment, gentamicin-betamethasone cream), a broad differential diagnosis was pursued to exclude infectious, vasculitic, connective tissue, and neoplastic (cutaneous lymphoma) causes. Diagnostic evaluation included antimicrobial swabs, extensive laboratory tests (complete blood count with differential, C-reactive protein, erythrocyte sedimentation rate, kidney and liver function tests, lactate dehydrogenase, serum and urine protein electrophoresis with immunofixation, ANA (HEp-2) and ENA panel, ANCA profile, complement C3 and C4 levels, QuantiFERON test), and skin biopsy.

Results

Microbiological swabs for pathogenic bacteria, fungi, herpes-, and enteroviruses were negative. Laboratory findings were unremarkable, except for thrombocytosis (550×10^9/L) and elevated lactate dehydrogenase(6.92). Histopathology revealed extensive granulomatous inflammation of the dermis and subcutis, with formation of non-caseating granulomas. Special stains for fungi, bacteria, and mycobacteria remained negative, and direct immunofluorescence was non-specific. Cultures and PCR testing for *M. tuberculosis* and atypical mycobacteria were negative. However, both QuantiFERON and tuberculin tests were positive. Chest radiography was normal.

Conclusions

Based on the clinical presentation and diagnostic findings, infection with *M. marinum* was suspected. A multidisciplinary team of dermatologists and paediatric specialists planned further management, considering the host, disease severity, and lesion location. A repeat biopsy for atypical mycobacterium culture and targeted therapy with azithromycin and

trimethoprim/sulfamethoxazole were proposed, with adjustments pending biopsy results. However, as the patient experienced spontaneous and complete resolution of lesions, neither intervention was undertaken. After eighteen months of follow-up, no recurrence was observed. This case highlights that atypical cutaneous mycobacterial infections should be considered even in healthy children without a clear history of exposure. A broad diagnostic approach is essential, as microbiological tests, including culture, may be negative. The spontaneous regression observed in our case raises the question of whether prolonged antibiotic therapy is always necessary in selected immunocompetent patients, suggesting that, under certain circumstances, a watchful waiting approach may be justified. However, further clinical experience is needed to establish clearer guidelines for the optimal management of these rare and diagnostically challenging infections.

Abstract N°: ID-1311

Topic: Infectious diseases, parasitic diseases, infestations

Transforming Chronic Dermatophytosis Care Through Digitally Supported Longitudinal Monitoring: Real-World Outcomes from a Prospective Cohort

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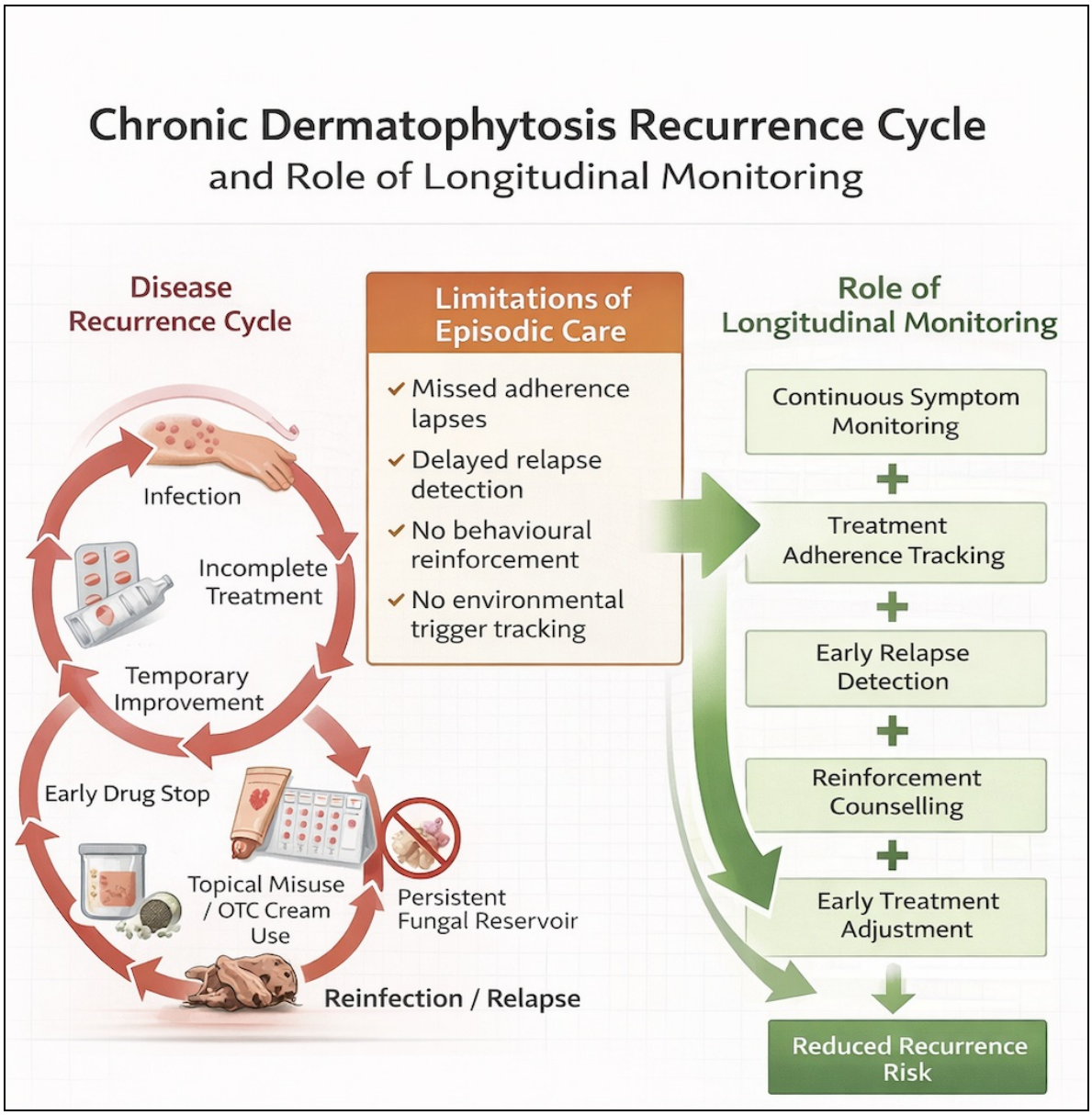
Introduction

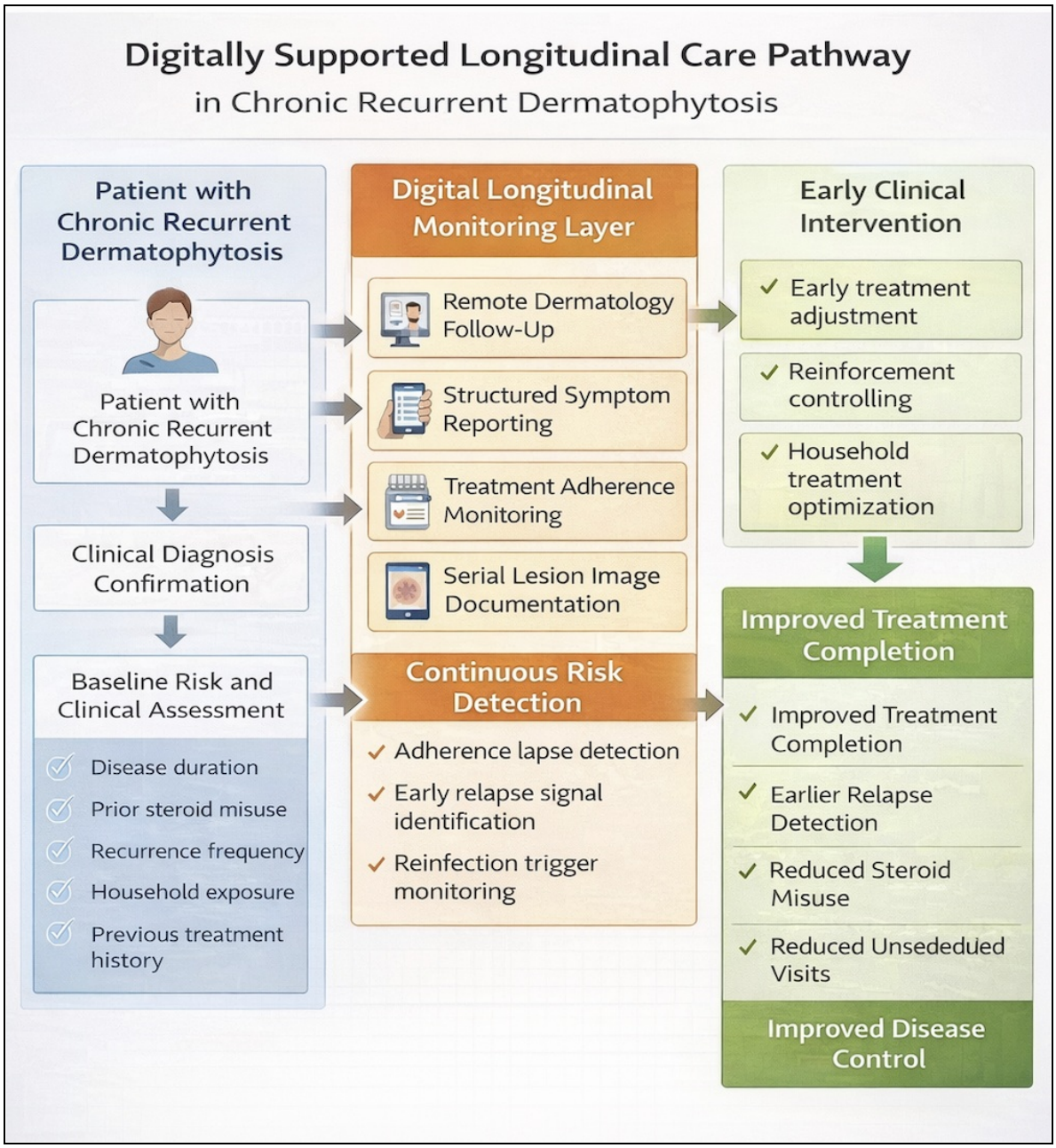
Chronic recurrent dermatophytosis remains a significant therapeutic and public health challenge in high-prevalence regions and is increasingly driven by inappropriate topical corticosteroid use, incomplete treatment courses, delayed clinical reassessment, and persistent environmental or household reservoirs. Conventional episodic dermatology care models frequently fail to address behavioural, environmental, and longitudinal disease drivers, contributing to treatment failure and recurrence. Continuity-focused digitally supported care pathways provide an opportunity to improve treatment monitoring, reinforce adherence behaviours, and enable earlier recognition of disease relapse. However,real-world outcome data evaluating structured digital longitudinal monitoring models in chronic dermatophytosis remain limited.



Conceptual representation of behavioural, treatment-related, and environmental drivers contributing to chronic dermatophytosis recurrence and the potential role of longitudinal monitoring in interrupting the recurrence cycle.

Materials and Methods

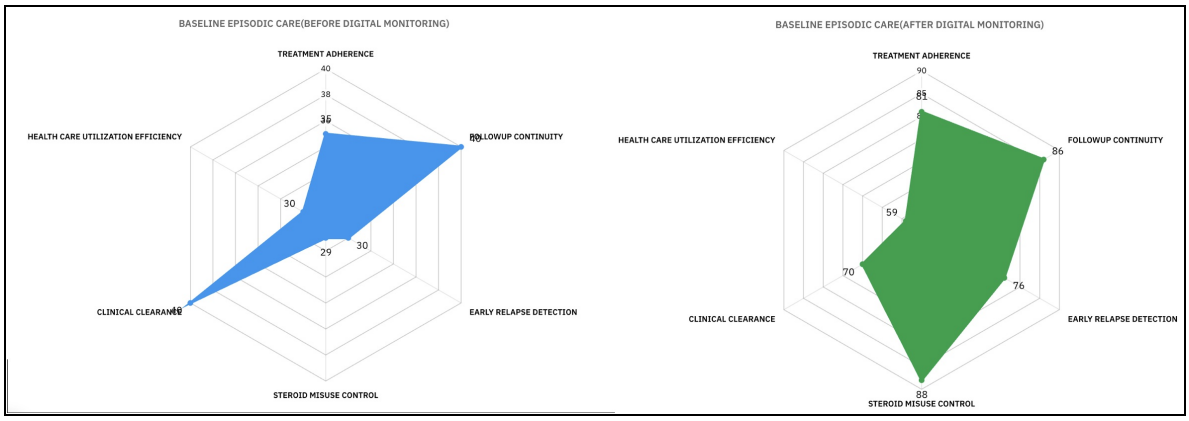
This prospective observational cohort study included 83 adults with clinically diagnosed chronic recurrent dermatophytosis enrolled into a structured digitally supported longitudinal care pathway. The intervention integrated remote dermatology follow-up consultations, standardized symptom and treatment adherence reporting, serial lesion image documentation, and protocol-driven patient education delivered through a mobile health interface. The model emphasized continuous disease monitoring rather than episodic consultation-based care. Participants were followed longitudinally to assess treatment completion, recurrence rates, time to clinical reassessment, and healthcare utilization. Outcomes were compared with documented baseline care patterns from prior treatment cycles be



Conceptual Framework of Recurrence Disruption Using Digitally Supported Longitudinal Monitoring in Chronic Dermatophytosis

Results

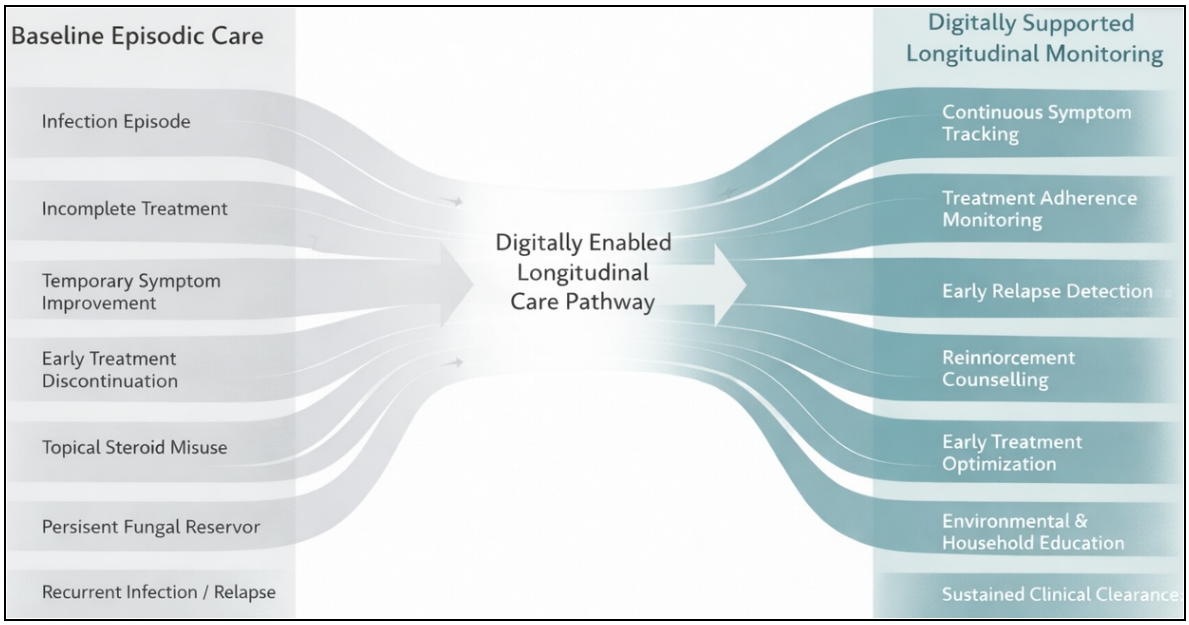
Digital engagement was high, with 85.5% of participants completing scheduled longitudinal follow-ups, reflecting strong patient acceptance of continuous monitoring models. **Treatment completion improved significantly from 34.9% during prior conventional care cycles to 80.7% under digitally supported care**. Sustained clinical clearance was achieved in 69.9% of participants. Recurrence occurred in 30.1% of participants; however, 76.0% of recurrences were detected early through structured symptom tracking and serial lesion image reporting,allowing earlier therapeutic intervention. **Median time to clinical reassessment reduced from 18 days in baseline care to 4 days during digital monitoring**. **Unscheduled in-person visits decreased by 41.3%**, with most disease flares successfully managed through guided remote clinical review. **Prior misuse of topical corticosteroid-containing preparations was reported in 71.1% at baseline and declined to 12.0%** during follow-up, suggesting improved treatment behaviour reinforcement. Mean participant age was 34.6 ± 9.8 years, with female participants comprising 56.6% of the cohort. The digitally supported model also facilitated earlier identification of adherence lapses and potential reinfection triggers, allowing timely patient counselling and treatment reinforcement.



Composite Clinical Outcome Profile After Digitally Supported Longitudinal Monitoring

Conclusions

Digitally enabled longitudinal care for chronic recurrent dermatophytosis was feasible, scalable, and associated with significant improvements in treatment adherence, earlier relapse detection, and reduced unscheduled healthcare utilization. Integration of structured digital monitoring and patient engagement strategies into routine dermatology practice may help address behavioural, treatment-related, and environmental drivers of dermatophytosis recurrence in high-burden settings. These findings highlight the potential of digitally integrated longitudinal care models to redefine chronic infectious dermatology management by bridging adherence gaps, enabling proactive relapse detection, and improving real-world patient outcomes at scale.



Sankey diagram illustrating transition of patient outcomes and care behaviours from baseline episodic care to digitally supported longitudinal monitoring in chronic dermatophytosis

Abstract N°: ID-1378

Topic: Infectious diseases, parasitic diseases, infestations

The Pruritic Puzzle: Recognizing Gianotti-Crosti Syndrome in Children

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Introduction

Acute papulovesicular eruptions are common in pediatric dermatology and may result from viral, allergic, or idiopathic causes. **Gianotti-Crosti syndrome (GCS)** is a rare, self-limiting acral papular eruption typically triggered by viral infections. Early recognition is essential to differentiate it from other pediatric dermatoses and guide appropriate management.

Results

We report the case of a previously healthy 10-year-old boy who presented with a **2-week history** of pruritic skin lesions. The eruption initially appeared on the lower limbs and subsequently spread to the upper limbs and face. There was **no associated fever**. Physical examination revealed a well-appearing, active child. Dermatological assessment demonstrated **multiple translucent to pink papules and vesicles**, coalescing into plaques with secondary excoriations, predominantly on the **extensor surfaces of the upper and lower extremities**. Individual lesions measured 2–5 mm in diameter, with some showing a flat-topped morphology. Based on the clinical features and distribution, a diagnosis of **Gianotti-Crosti syndrome** was established.

The patient received **symptomatic treatment** with oral antihistamines and regular application of emollients. Follow-up showed **good clinical improvement**, with resolution of pruritus and gradual healing of lesions without complications.

Conclusions

This case highlights a **classic presentation of Gianotti-Crosti syndrome** in a school-aged child. The acral distribution, monomorphic papules, and absence of systemic symptoms are key diagnostic features. The syndrome is usually **self-limiting**, but symptomatic treatment can improve patient comfort. Awareness of its clinical pattern allows **accurate diagnosis, avoidance of unnecessary investigations, and appropriate parental reassurance**. Viral triggers, particularly Epstein-Barr virus or hepatitis B, underline the immunological basis of the eruption, reflecting a **transient virus-induced cutaneous hypersensitivity**.

Abstract N°: ID-1395

Topic: Infectious diseases, parasitic diseases, infestations

Measles: Epidemiological, Clinical, Therapeutic, and Evolutionary Profile

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Introduction
Measles is a highly contagious viral infection that remains a major global public health problem despite the availability of an effective vaccine. The World Health Organization (WHO) has reported a resurgence of cases linked to a decline in vaccination coverage following the COVID-19 pandemic.
This study aims to evaluate the epidemiological, clinical, paraclinical, and outcome characteristics of measles cases managed at Mohammed VI University Hospital in Oujda.

Materials and Methods
This is a retrospective, descriptive study conducted at CHU Oujda between January 1 and August 30, 2025. It included all patients under 16 years of age managed either as outpatients or inpatients for measles, diagnosed based on epidemiological criteria (contact with a confirmed case or belonging to an epidemic cluster) or serological criteria (presence of specific IgM antibodies).
Patients presenting with mucocutaneous eruptions explained by causes other than measles—particularly drug eruptions, rickettsial infections, or other exanthematous fevers—were excluded.
Epidemiological, clinical, paraclinical, and outcome data were collected and analyzed from medical records and notification forms.

Results
The study included 39 patients with a mean age of 4 years and 9 months, ranging from 6 months to 16 years.
Vaccination status was documented in only 20.5% of cases and was not reported in 79.5% of patients, while 35.9% reported the presence of similar cases among close contacts.
Clinical analysis showed that all patients presented with a generalized maculopapular, morbilliform rash with a descending progression from the face to the trunk, back, and limbs. In all cases, the rash was preceded by an influenza-like syndrome and fever. Clinical examination revealed a positive Koplik sign in 17.9% of cases and conjunctival involvement in 79.5% of patients. Respiratory signs were found in 35 patients (89.7%), mainly cough (97.1%) and dyspnea (65.7%). Digestive symptoms were observed in 6 patients (15.4%), dominated by abdominal pain (66.7%), diarrhea (33.3%), and vomiting (33.3%).
Complicated forms were identified in 34 patients, including pulmonary involvement in 23 cases, digestive involvement in 6, immunological involvement in 25, and neurological involvement in 2 patients.
Measles serology was performed in 35 patients and was positive in 35 (89.7%). PCR testing, which allows virological confirmation, was not available in our hospital and therefore was not performed.
The majority of patients (51.3%) were managed on an outpatient basis with symptomatic treatment including antipyretics, vitamin A supplementation, and hydration, along with home isolation. Nineteen patients (48.7%) required hospitalization.

Conclusions
This study highlights the epidemiological profile of measles, which remains a threat due to insufficient vaccination coverage and can lead to severe complications. It underscores the importance of early diagnosis, appropriate management, and strengthening vaccination programs to prevent future outbreaks.

Abstract N°: ID-1411

Topic: Infectious diseases, parasitic diseases, infestations

Beyond Pulmonary Disease - A Case Series of Pediatric Cutaneous Tuberculosis

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Introduction

Tuberculosis is a chronic granulomatous bacterial infection caused by the bacterium named Mycobacterium tuberculosis, rarely by M bovis. It is mainly divided into pulmonary and extra-pulmonary forms. It is still a major cause of concern in public health, especially in developing countries like India. Cutaneous Tuberculosis accounts for approximately 0.1 - 2% of outpatient departmental visits in India. Pediatric cutaneous tuberculosis cases account for 18-54% of all cutaneous TB cases diagnosed in India. The pediatric population is especially more vulnerable to cutaneous tuberculosis because of decreased immunity and other social factors such as malnutrition, overcrowding, and poverty. Household contacts are a major source of infection in pediatric cutaneous tuberculosis. Hereby, we report a case series of 8 pediatric cutaneous tuberculosis patients.

Materials and Methods

All paediatric patients with age < 18 years attending the Dermatology Outpatient Department, who were clinically suspected of having cutaneous tuberculosis were screened. A detailed history, thorough examination, Mantoux test, Erythrocyte Sedimentation Rate (ESR) and Histopathological examination were conducted for each case. Viral markers were done in every case to look for immunodeficiency. Other investigations like Fine Needle Aspiration Cytology (FNAC), Bacterial and Mycobacterial culture and sensitivity, Interferon-Gamma Release Assay (IGRA) and staining methods like Gram Staining and Ziehl-Neelsen staining were ordered in selected cases. A total of 8 patients with a confirmed diagnosis of Cutaneous Tuberculosis were included in the case series.

Results

This case series comprises of 8 pediatric patients with cutaneous tuberculosis. Out of the total 8 cases, 3 cases were diagnosed as Lupus vulgaris, the other 3 as scrofuloderma, and a single case of Tuberculosis verrucosa cutis and Papulonecrotic Tuberculid each. Out of total 8 patients, 5 were males, and 3 were females. 5-10 years of age was the most common age group affected. An immunosuppressive state was ruled out in all cases. The most common site affected was lower limbs. Majority patients revealed a positive Mantoux test. All patients were prescribed 6 months of antitubercular therapy with a good response to therapy. Majority patients reported a close contact with Tuberculosis-affected individuals. Patients affected with Scrofuloderma reported lymphoreticular system involvement. Single case of Scrofuloderma needed surgical management along with routine antitubercular therapy. 1 patient with Lupus vulgaris required an extended 3 months course of antitubercular therapy.

Conclusions

Cutaneous TB has a varied presentation and a high degree of clinical suspicion is needed to diagnose the condition. Early diagnosis and treatment will lead to a decrease in disease burden, as early treatment is likely to stop the transmission of the disease to unaffected individuals, especially children. It is also imperative to perform a Drug

Sensitivity Test (DST) in non-responding / slow responding cases. It is also important to trace the source of infection and screening of all close contacts would lead to early case detection and treatment.

Abstract N°: ID-1422

Topic: Infectious diseases, parasitic diseases, infestations

Cutaneous manifestations associated with Helicobacter pylori Infection: a mini-systematic review and advanced diagnostic reasoning framework

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Introduction
Helicobacter pylori infection is one of the most prevalent chronic bacterial infections worldwide and is classically associated with gastrointestinal disorders, including chronic gastritis, peptic ulcer disease, and gastric malignancies. Beyond its digestive involvement, increasing evidence suggests that Helicobacter pylori may exert systemic immunological effects, potentially contributing to extra-gastrointestinal manifestations, including dermatological conditions. Several inflammatory skin diseases have been reported in association with Helicobacter pylori infection. The objective of this review was to analyze cutaneous manifestations reported in association with Helicobacter pylori infection, and to evaluate the strength of evidence supporting these associations, exploring potential pathophysiological mechanisms, and to propose a structured diagnostic reasoning framework to guide Helicobacter pylori assessment in dermatological practice.

Materials and Methods
A mini-systematic narrative review was conducted using PubMed databases. Articles published between January 2000 and December 2024 were included. Search terms combined Helicobacter pylori, skin manifestations, chronic urticaria, rosacea, psoriasis, atopic dermatitis, and dermatology. Eligible publications included observational studies, interventional studies evaluating eradication therapy, case series, and review articles. Data extraction focused on dermatological diagnosis, Helicobacter pylori detection methods, response to eradication therapy, and proposed immunological mechanisms. Findings were synthesized qualitatively.

Results
The literature demonstrates a consistent association between Helicobacter pylori infection and chronic spontaneous urticaria, with several studies reporting partial or complete remission following eradication therapy. Evidence regarding rosacea, psoriasis, and atopic dermatitis remains heterogeneous, with variable clinical responses after treatment. Proposed mechanisms include chronic immune activation, increased systemic inflammatory mediators, molecular mimicry, and modulation of the gut–skin axis. Notably, improvement of skin symptoms following eradication therapy has been reported even in the absence of gastrointestinal complaints. This review highlights the importance of considering Helicobacter pylori infection as a potential contributing factor in selected dermatological conditions, particularly chronic spontaneous urticaria refractory to conventional therapy. While current evidence does not support systematic screening in all patients with inflammatory dermatoses, a reasoning-based approach integrating clinical context, disease chronicity, and treatment resistance may justify targeted testing.

Conclusions
Helicobacter pylori infection may contribute to the pathogenesis or persistence of certain inflammatory skin diseases, most notably chronic spontaneous urticaria. Structured diagnostic reasoning allows rational integration of Helicobacter pylori assessment into dermatological practice. Dermatologists should consider targeted Helicobacter pylori testing in patients with chronic or treatment-resistant inflammatory dermatoses, particularly chronic urticaria, while maintaining evidence-based dermatological management. Dermatologists should collaborate with gastroenterologists to ensure appropriate diagnostic evaluation and eradication strategies.

Abstract N°: ID-1442

Topic: Infectious diseases, parasitic diseases, infestations

Association of baseline and post-treatment total immunoglobulin E and eosinophil levels with post-scabietic pruritus

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Introduction

Scabies is a highly pruritic parasitic disease caused by *Sarcoptes scabiei.* Intense nocturnal pruritus is a characteristic clinical manifestation of the disease. In scabies, pruritus results from inflammatory and allergic reactions triggered by the host immune responses to the mite and its antigens. It is caused by a combination of IgE-mediated (type I) and cell-mediated (type IV) hypersensitivity reactions. Elevated immunoglobulin E (IgE) levels and eosinophilia are commonly associated with parasitic infections and allergic reactions. The aim of the study was to evaluate the levels of total IgE and eosinophil counts in patients with scabies before and after treatment, and to assess their association with post-scabietic pruritus.

Materials and Methods

The prospective observational cohort study included 73 patients with scabies attending a specialized dermatology center from January 2025 to December 2025. Scabies was confirmed by dermoscopy. Only patients with primary, classic scabies were included. Patients with a previous history of scabies (recurrent scabies or reinfection), other parasitic infections, allergic disorders, or those receiving antihistamines or systemic immunosuppressive therapy were excluded. Total serum IgE levels and eosinophil counts were measured at baseline and at the 1-month follow-up after successful therapy. Successful treatment was defined as the absence of active clinical signs after completion of therapy. Post-scabietic pruritus was defined as persistent pruritus in the absence of active clinical and dermoscopic signs of scabies. Patients were stratified according to the presence or absence of post-scabietic pruritus. Data were analyzed using IBM SPSS Statistics, version 27.0 ($p < 0.05$).

Results

A total of 73 patients with a mean age of 37.73 ± 23.43 years were included; 35 (47.9%) were females and 38 (52.1%) were males. Post-scabietic pruritus was observed in 32 patients (43.8%), with a mean duration of 19.43 ± 7.31 days, whereas 41 patients (56.2%) did not develop post-scabietic pruritus. The mean total IgE levels before treatment in the post-scabietic pruritus group were 630.74 ± 39.34 IU/mL and 321.21 ± 23.69 IU/mL in the non-post-scabietic pruritus group. The median eosinophil counts were 0.89 (IQR 0.81) $x10^9$/L in the post-scabietic pruritus group and 0.01 (IQR 0.02) $x10^9$/L in the non-post-scabietic pruritus group. Baseline total IgE levels were significantly higher in patients who developed post-scabietic pruritus than in those who did not (Student's t-test, $t=6.7$; $df=52.23$; $p < 0.001$). Baseline eosinophil counts were also significantly higher in patients who developed post-scabietic pruritus (Mann-Whitney U test, $U=1305$, $p < 0.001$). Post-scabietic pruritus showed a significant positive correlation with baseline total IgE levels and eosinophil counts (Spearman's rank correlation, $\rho=0.534$, $p < 0.001$). At the 1-month follow-up after treatment, the mean total IgE levels in the post-scabietic pruritus group were 264.03 ± 22.51 IU/mL and 137.32 ± 30.12 IU/mL in the non-post-scabietic pruritus group. The median eosinophil counts were 0.31 (IQR 0.27) $x10^9$/L in the post-scabietic

pruritus group and 0.00 (IQR 0.01) x10^9/L in the non-post-scabietic pruritus group. At the 1-month follow-up after treatment, differences in total IgE levels and eosinophil counts between patients with and without post-scabietic pruritus were not statistically significant.

Conclusions

Post-scabietic pruritus was a frequent finding after scabies treatment and demonstrated a significant correlation with elevated baseline total IgE levels and eosinophil counts. These results suggest that baseline immune hypersensitivity responses to scabies before treatment may play a role in post-scabietic pruritus. At the 1-month follow-up after treatment, no statistically significant differences in total IgE levels and eosinophil counts between groups were observed, suggesting that successful therapy may diminish immune responses over time.

Abstract N°: ID-1450

Topic: Infectious diseases, parasitic diseases, infestations

Atypical Disseminated Varicella with Respiratory Compromise in an Immunocompetent Adult : A Diagnostic Challenge

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Introduction

Varicella-Zoster virus (VZV) infection is typically a self imiting childhood illness characterized by polymorphic vesicular eruptions. However, atypical presentations in adults may manifest with monomorphic vesicles, hemorrhagic lesions, bullae or necrotic crusts, often mimicking drug eruptions or other viral exanthems, thereby delaying diagnosis and management.

Materials and Methods

This work represents a single-patient descriptive case report conducted in a tertiary care teaching hospital in dermatology department. A 40 year old previously healthy male presented with 6-7 days of high grade fever followed by vesicular eruption and progressive dyspnea. Examination done after obtaining proper informed consent revealed tachycardia, tachypnea, hypoxia (spo2 64-85% on oxygen) and numerous monomorphic vesicles over the face, trunk and extremities. Bilateral basal crepitations were noted. There was no history of prior varicella, recent vaccination, drug intake or comorbid illness.

Results

Histopathology showed intraepidermal blistering with viral cytopathic changes. Tzanck smear demonstrated multinucleated giant cells and serum varicella IgM was positive. Chest radiograph revealed bilateral ground-glass infiltrates suggestive of ARDS with features of pneumothorax. The patient was treated with intravenous acyclovir and supportive respiratory care, resulting in clinical improvement.

Conclusions

Disseminated adult varicella may present with monomorphic vesicles and life threatening pulmnary complications. Early dermatologic recognition, bedside diagnosis and prompt antiviral therapy are critical to reduce morbidity and mortality.

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Abstract N°: ID-1486

Topic: Infectious diseases, parasitic diseases, infestations

Challenging Scenarios in patients of Leprosy

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Introduction

Leprosy continues to pose a significant public health challenge in endemic countries. Although multidrug therapy has markedly reduced the disease burden, complications such as lepra reactions, secondary infections, and treatment-related adverse effects remain major causes of morbidity. Early recognition of these complex presentations and timely multidisciplinary management is essential to prevent complications and disability.

Materials and Methods

This case series highlights unusual and challenging presentations of leprosy and its complications encountered in clinical practice.

Results

Case 1:

A 42-year-old male, a known case of Hansen's disease on multidrug therapy(MDT) and oral corticosteroids, presented with itchy annular erythematous plaques over the body, fever with chills, edema of hands and feet, and severe myalgia with difficulty in walking. Cutaneous examination showed annular erythematous to hyperpigmented scaly plaques and diffuse erythema. Histopathological examination was suggestive of erythema nodosum leprosum. The patient was also found to have dapsone-induced hepatitis and anaemia, along with left partial claw hand. Further evaluation for generalised skin and mucosal pigmentation and persistent weakness revealed secondary adrenal insufficiency, which was managed with gradual tapering of steroids and endocrinology consultation. This case highlights the complexity of lepra reactions and treatment complications in patients of leprosy.

Case 2:

A 70-year-old female, presented with ulcerative crusted lesions on right foot for 3 months with recurrent secondary bacterial infections under treatment with prolonged course of oral antibiotics without significant improvement. On Dermatology referral, Cutaneous examination revealed foul smelling ulcerative lesions on right foot with necrotic crusts. Further evaluation revealed presence of hypopigmented patches on trunk and lower extremities with decreased sensation over dorsum of right foot. Histopathology of hypopigmented patches confirmed diagnosis of borderline lepromatous leprosy. Patient was treated with MDT and supportive treatment.

Case 3:

A 30-year-old female, a treated case of lepromatous leprosy with recurrent ENL, presented with fever, multiple pustules and ulcerative lesions over the face and extremities, and edema of hands and feet. Histopathology showed features consistent with ulceronecrotic ENL, and pus culture revealed secondary bacterial infection. The patient was managed with intravenous antibiotics, corticosteroids, and supportive therapy. Ulcero-necrotic ENL is an uncommon and severe variant of type 2 lepra reaction that may lead to significant morbidity if not treated

Case 4:

A 23-year-old female, a treated case of lepromatous leprosy with recurrent ENL, presented with an acute onset of painful hemorrhagic bullae over the thigh associated with fever and edema. Investigations and clinical findings were suggestive of severe soft tissue infection with secondary bacterial involvement. The patient required surgical debridement, intravenous antibiotics, and modification of immunosuppressive therapy, followed by wound care and planned reconstructive management. This case emphasizes the risk of severe infections in patients receiving long-term immunosuppressive therapy for lepra reactions.

Conclusions

Complications like recurrent lepra reactions, secondary cutaneous and systemic infections, related to prolonged corticosteroid or immunosuppressive therapy in leprosy patients are often overlooked. A high index of suspicion for atypical presentations and associated systemic infections is essential, especially in endemic regions. Early diagnosis, appropriate modification of therapy, and multidisciplinary management play a crucial role in reducing morbidity and preventing long-term disability in such complex cases.

Abstract N°: ID-1487

Topic: Infectious diseases, parasitic diseases, infestations

Exogenous Acral Hyperpigmentation Induced by a Beetle: A Misunderstood Diagnosis

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Introduction

Acral hyperpigmentation can have a variety of etiologies, including benign or malignant melanocytic causes, trauma or exogenous exposure. Beetles, a family of coleopteran insects in the Scarabaeoidea super-family, can induce skin pigmentation through contact with their defensive secretions. We present here the case of acral hyperpigmentation induced by a beetle.

Materials and Methods

A 15-year-old female patient, with no significant medical history, consulted for recent-onset hyperpigmentation affecting the left big toe, as well as the 3rd and 4th toes. Upon questioning, she reported finding an insect in her shoe prior to the affected site showing symptoms. Clinical examination revealed well-demarcated brown to blackish macules, each surrounded by a lighter halo, without any associated cutaneous or systemic abnormalities. Dermoscopy showed pigmentation following the parallel ridge pattern. The diagnosis of acral hyperpigmentation secondary to an accidental friction of a beetle was established. The patient was reassured, and clinical monitoring was advised.

Results

Beetles eject a pigmented chemical substance rich in hydrocarbons and quinine when they feel threatened. This dark-red secretion can migrate under the skin, causing local hyperpigmentation. Few similar cases have been documented in the literature, including a series of reports from North Africa and two individual case reports from Europe.

The clinical lesions caused by beetles appear as well-defined brown macules, often surrounded by a lighter-colored halo, which may be red or brown. As in our patient's case, the areas most frequently affected are the big toe and the plantar surface of the foot, areas often exposed when wearing shoes or walking barefoot. Differential diagnoses for these pigmented acral lesions include acral purpura associated with systemic conditions such as cryoglobulinemia, vasculitis, or Raynaud's phenomenon as subcorneal trauma and acral melanoma. Dermoscopic examination of the lesions reveals a distinctive pattern of parallel ridges. This observation can lead to confusion, as this pattern is also found in more serious conditions such as acral melanoma, making clinical diagnosis sometimes difficult. In case of doubt, an anatomopathological examination could reveal the presence of exogenous pigments within the stratum corneum of the epidermis.

The approach is mainly based on clinical monitoring as hyperpigmentation typically improves on its own within a few weeks. In symptomatic cases, topical corticosteroids can help alleviate inflammation. It is important to reassure patients, as this benign condition usually does not require further investigation.

Conclusions

Exogenous acral hyperpigmentation induced by beetle contact is a benign and self-limited condition. It may clinically and

dermoscopically mimic more serious diagnoses such as acral melanoma. Careful history taking and recognition of its characteristic features are essential to avoid unnecessary investigations.

Abstract N°: ID-1512

Topic: Infectious diseases, parasitic diseases, infestations

Behind Appearances: An Unusual Presentation of Cutaneous Tuberculosis

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Introduction

Cutaneous tuberculosis is a rare form of tuberculosis that can present with highly variable and misleading clinical manifestations. Its polymorphic appearance may mimic several inflammatory or granulomatous dermatoses, leading to diagnostic delays. Early recognition remains challenging, particularly in atypical forms without systemic involvement. We report an uncommon case of chronic cutaneous tuberculosis initially suggestive of an inflammatory skin disorder.

Materials and Methods

A 68-year-old woman presented with a two-year history of persistent erythematous papulo-pustular lesions involving the nasal bridge, perinasal areas, inner cheeks, and upper lip. The lesions were partially scaly and had recently been associated with dysphonia. Several differential diagnoses were considered, including granulomatous rosacea, sarcoidosis, lupus, vasculitis, rhinoscleroma, and Churg-Strauss syndrome. Two skin biopsies were performed: one for histopathological examination and another for molecular analysis using GeneXpert testing. Standard laboratory investigations and clinical assessment were also conducted.

Results

Histological examination revealed an ulcerated acanthotic epidermis with a dense dermal infiltrate composed of epithelioid and giant cell granulomas with central necrosis, associated with lymphocytes, plasma cells, and altered neutrophils. No vascular or follicular lesions were observed, and routine pathogen screening was negative. Molecular testing using GeneXpert identified Mycobacterium tuberculosis, confirming the diagnosis. Based on these findings, first-line antitubercular therapy was initiated, leading to progressive clinical improvement.

Conclusions

This case highlights the importance of considering cutaneous tuberculosis in the differential diagnosis of chronic granulomatous dermatoses, even in the absence of typical clinical signs or positive routine microbiological tests. Atypical presentations may mimic various inflammatory conditions, delaying appropriate management. Skin biopsy with histopathological analysis remains a key diagnostic tool, and molecular techniques can provide valuable confirmation. Early recognition and treatment are essential to ensure favorable outcomes.

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Topic: Infectious diseases, parasitic diseases, infestations

Erysipeloid Cutaneous Leishmaniasis of the Face Mimicking Bacterial Cellulitis: A Diagnostic Pitfall

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Introduction

Cutaneous leishmaniasis is a parasitic disease with a wide range of clinical presentations. While classical ulcerative forms are well recognized, atypical variants may closely mimic inflammatory or infectious dermatoses. The erysipeloid form is uncommon and may simulate acute bacterial dermohypodermitis, particularly when involving the face, leading to diagnostic delay and inappropriate treatment.

Materials and Methods

We report a single clinical observation of an immunocompetent young adult presenting with an acute inflammatory facial plaque. Clinical evaluation, biological investigations, imaging studies, and parasitological examination were performed as part of routine diagnostic work-up. Diagnosis was confirmed by direct parasitological skin smear.

Results

A 25-year-old man presented with a painful erythematous and edematous plaque involving the nasal region, evolving over several days, without fever or systemic symptoms. The medical history revealed a pre-existing chronic crusted papulo-nodular lesion at the nasal margin, unresponsive to multiple courses of topical and systemic antibiotics.

Clinical examination showed a warm, infiltrated, erysipelas-like facial plaque with superficial crusting. Despite significant spontaneous pain, the patient reported decreased sensitivity to palpation of the affected area. Laboratory investigations demonstrated normal white blood cell count and negative inflammatory markers. Facial imaging revealed preseptal periorbital cellulitis, leading to initial empirical intravenous antibiotic therapy.

Due to the absence of biological inflammatory response, lack of clinical improvement under antibiotics, and the presence of a chronic antecedent lesion, a parasitological skin smear was performed. The examination was positive for *Leishmania* spp., establishing the diagnosis of erysipeloid cutaneous leishmaniasis.

Conclusions

Erysipeloid cutaneous leishmaniasis represents a rare but important diagnostic pitfall, particularly when presenting as an acute facial inflammatory plaque. In endemic settings, the absence of systemic inflammation, antibiotic failure, chronic pre-existing lesions, and sensory abnormalities should prompt consideration of parasitic etiologies. Early parasitological confirmation is essential to avoid misdiagnosis and unnecessary antibiotic exposure.

Abstract N°: ID-1585

Topic: Infectious diseases, parasitic diseases, infestations

The Great Imitator of Pruritic Dermatoses: Scabies

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Introduction
Scabies can mimic a broad range of chronic pruritic dermatoses, particularly in eczematized or steroid-modified presentations. As a result, diagnosis may be delayed for months or years, leading to unnecessary systemic treatments, persistent symptoms, psychosocial burden, and ongoing transmission. We aimed to describe patterns of delayed diagnosis in refractory pruritic eruptions later confirmed as scabies and to highlight the value of dermoscopy, UV dermoscopy, and targeted microscopy.

Materials and Methods
We report a real-world consecutive case series of 5 adults with persistent, treatment-refractory pruritic eruptions who were ultimately diagnosed with scabies. Collected variables included symptom duration, prior diagnoses, previous topical/systemic treatments, dermoscopic and UV dermoscopic findings, microscopic confirmation, and treatment outcomes. Skin scrapings were obtained from dermoscopically selected lesions and examined for mites, eggs, or scybala.

Results
Diagnostic delay ranged from several months to 3 years. Initial diagnoses included lichen planus–spectrum disease, prurigo nodularis, chronic spontaneous urticaria, and atopic dermatitis. Before correct diagnosis, patients had received multiple ineffective systemic treatments, including methotrexate, systemic corticosteroids, cyclosporine, omalizumab, dupilumab, isotretinoin, and phototherapy. Dermoscopy identified scabies-compatible burrows/mite signs in all cases; UV dermoscopy provided additional support in selected lesions (including ball-sign findings). Targeted microscopy confirmed infestation in all 5 patients. Following anti-scabetic therapy (oral ivermectin with adjunctive topical sulfur or permethrin when indicated), clinical resolution was achieved in all cases, typically within 1–3 weeks. One patient developed a severe neurologic adverse event temporally associated with ivermectin exposure; symptoms resolved after hospitalization, supportive neurologic management, and alternative topical anti-scabetic treatment.

Conclusions
Scabies remains a major diagnostic imitator in chronic pruritus and may lead to prolonged misdiagnosis and unnecessary systemic immunomodulation. A structured pathway—early dermoscopy, UV support when available, and dermoscopy-guided microscopy—improves diagnostic accuracy in complex cases and can reduce avoidable morbidity. In persistent or atypical pruritic eruptions, scabies should be actively excluded before escalation to systemic therapy.

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Topic: Infectious diseases, parasitic diseases, infestations

Diagnostic Challenges in Cutaneous Tuberculosis: A Case Study

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Introduction

Cutaneous tuberculosis is recognized in dermatology as a “great imitator,” as its lesions may resemble numerous other diseases, including bullous variants mimicking pemphigoid or pemphigus.

Materials and Methods

CASE REPORT:

A 67-year-old patient presented with polymorphic skin lesions persisting for 5 years. Initially, the lesions manifested as disseminated bullous eruptions, prompting diagnostic evaluation for autoimmune blistering diseases. Indirect immunofluorescence testing revealed no antibodies against desmoglein 1 or 3 or against BP180 antigen, and direct immunofluorescence (DIF) was negative. Histopathological examination demonstrated features of a chronic, nonspecific inflammatory process without findings characteristic of autoimmune blistering disorders. After approximately 3 years of disease duration, the bullous lesions evolved into erythematous-nodular lesions with a tendency toward ulceration and spontaneous resolution, leaving scars and hyperpigmentation. The lesions involved the trunk and extremities, with greatest severity on the abdomen, lower legs, forearms, and elbow regions. The patient reported no associated symptoms and did not identify any apparent triggering factors.

Results

Laboratory investigations revealed mild normocytic anemia and slightly elevated inflammatory markers. Tumor markers were within normal limits. Serologic testing for HBV, HCV, and HIV infections was negative, as was the Wassermann reaction (syphilis screening test). p-ANCA and c-ANCA antibodies were not detected, thereby excluding systemic vasculitis. Chest radiography demonstrated irregular opacification in the lower field of the right lung, initially interpreted as most likely atelectatic changes. A follow-up chest X-ray several months later showed linear fibrotic opacities in both middle lung fields. Based on the clinical presentation, a preliminary diagnosis of lymphomatoid papulosis was considered, pending verification after completion of diagnostic testing. Additional skin biopsies were obtained for histopathological evaluation. Initial histopathology primarily suggested necrobiosis lipoidica; however, subsequent analysis of additional tissue samples indicated that the overall histologic picture was consistent with chronic inflammation featuring formation of tuberculosis-like granulomatous tissue. Further diagnostic work-up for *Mycobacterium tuberculosis* infection was performed. Both the QuantiFERON test and PCR assay were positive.

Conclusions

The nonspecific clinical presentation, variability in lesion morphology, and the rarity of cutaneous tuberculosis make establishing the correct diagnosis challenging. In the presented case, multiple skin biopsies for histopathological evaluation, extensive laboratory, imaging, microbiological, and molecular testing were required. Only correlation of clinical findings with ancillary test results and comprehensive differential diagnostic work-up enabled establishment of the correct diagnosis and initiation of appropriate therapy.

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Topic: Infectious diseases, parasitic diseases, infestations

Ivermectin Monotherapy May Leave a Vulnerable Window in Scabies Treatment: A Case Series Supporting Short Topical Bridging

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Introduction

Oral ivermectin is often preferred in scabies because it is practical and easier to use than whole-body topical regimens. However, early relapse is increasingly encountered in real-world settings. We aimed to describe a consistent relapse pattern in patients referred after failure of sequential monotherapies and to evaluate outcomes after combination rescue treatment.

Materials and Methods

We conducted a single-center case series of five immunocompetent patients with dermoscopy-confirmed classic scabies who were referred to our clinic after prior treatment failure. Before referral, all patients had received topical monotherapy first and then oral ivermectin monotherapy (200 µg/kg on day 0 and day 7), with only transient improvement. At presentation, relapse was defined by recurrent pruritus and new burrows and reconfirmed dermoscopically. At our center, all patients received rescue combination therapy: repeat oral ivermectin (200 µg/kg, repeated after 7 days) plus a 72-hour consecutive whole-body sulfur-based topical regimen. Adherence and concurrent treatment of close contacts were verified; clinical and dermoscopic outcomes were documented.

Results

All five patients relapsed after sequential monotherapies (topical alone, then ivermectin alone), with recurrence occurring within 10–20 days from ivermectin initiation. Dermoscopy reconfirmed active infestation in every case at relapse. After rescue combination therapy, complete clinical and dermoscopic clearance was achieved in all patients within two weeks, with no recurrence during 8-week follow-up.

Conclusions

In this series, sequential monotherapy was associated with early relapse, whereas short-contact combination bridging achieved rapid and durable short-term control. These findings do not diminish the clinical value of ivermectin but suggest that monotherapy may be insufficient in selected high-risk settings.