Abstract N°: ID-73

Topic: Inflammatory skin diseases

An Unusual Vesiculobullous Presentation of Acroangiodermatitis: A Diagnostic Pitfall

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Introduction
Acroangiodermatitis (AAD), also known as pseudo–Kaposi sarcoma, is a reactive vascular dermatosis associated with chronic venous insufficiency or arteriovenous malformations.
We report an unusual presentation of AAD with a prolonged delay in diagnosis.

Materials and Methods
NA

Results
A 53-year-old woman with a history of valvular heart disease had chronic skin lesions on both lower limbs for nine years. She reported pain and a feeling of heaviness in both legs. A previous diagnosis of bullous lichen planus had been made. She had been treated with topical steroids and hydroxychloroquine, without any clinical improvement.
Physical examination revealed two bilateral purpuric, pigmented plaques on the lower limbs, partially ulcerated and topped with vesiculobullous lesions, with focal milia-like scarring. The rest of the physical examination was unremarkable. Doppler ultrasound of the lower limbs revealed venous insufficiency. Histological examination of a skin biopsy showed a subepidermal blister associated with intraepidermal cleavage containing fibrino-hemorrhagic material, along with a polymorphous perivascular inflammatory infiltrate in the dermis. Direct immunofluorescence reported CD31-positive staining of vascular structures, was negative for HHV-8, and showed no linear or intercellular deposits of immunoglobulins or complement. Indirect immunofluorescence was negative. A diagnosis of acroangiodermatitis was established. Regression of the lesions was observed four months after initiation of symptomatic treatment with cicatrizing creams and the use of compression stockings. The patient was subsequently referred to the vascular surgery department for management of chronic venous insufficiency.

Conclusions
Acroangiodermatitis most commonly presents as purpuric macules, papules, or plaques of the lower limbs. The vesiculobullous form is rare and has been reported only once in the literature. When bullous lesions occur in acral locations, alternative diagnoses should be considered, including acquired epidermolysis bullosa, autoimmune bullous dermatoses (such as bullous pemphigoid, bullous lupus erythematosus) etc. These conditions differ in their pathophysiology and management. Histological examination, combined with positive immunohistochemical staining for CD31 and the absence of HHV-8 detection, as observed in our case, supports the diagnosis of AAD. Treatment primarily focuses on the management of underlying venous insufficiency and includes leg elevation, compression therapy with elastic stockings, and, in selected cases, dapsone, as reported in a case achieving complete regression.
The vesiculobullous presentation of acroangiodermatitis is rare and underscores the potential for diagnostic confusion. Clinicians should be aware of this atypical variant to ensure timely recognition and appropriate management.

Abstract N°: ID-147

Topic: Inflammatory skin diseases

Adjunctive Effect of Structured Water Yoga on Disease Severity and Quality of Life in Chronic Plaque Psoriasis

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Introduction

Introduction & Objectives:
Chronic plaque psoriasis is a systemic inflammatory skin disease whose severity and patient well-being are influenced by psychosocial stress. Standard therapies effectively control inflammation, but residual stress and impaired quality of life persist. Water Yoga combines controlled breathing and aquatic movement, which may modulate stress pathways and improve patient-reported outcomes. The objective of this study was to assess the effect of structured Water Yoga as an adjunctive intervention on disease severity and quality of life in adults with chronic plaque psoriasis.

Materials and Methods

Materials & Methods:
A prospective observational study was conducted in adults with stable chronic plaque psoriasis on standard therapy. Participants undertook a structured Water Yoga program (45–50 minutes/day, 5–6 days/week for 6 weeks). Outcomes included Psoriasis Area and Severity Index (PASI), Dermatology Life Quality Index (DLQI), and Perceived Stress Scale (PSS). Safety and tolerability were assessed throughout the study.

Results

Results:
Participants demonstrated a mean reduction in PASI scores at 6 weeks compared with baseline, indicating decreased disease severity. DLQI scores improved, reflecting enhanced quality of life, particularly in domains related to daily activities and emotional well-being. Perceived stress decreased in parallel with clinical improvements. No intervention-related adverse events were observed, and adherence was high. (Graphs and tables can be provided separately per submission requirements.)

Conclusions

Conclusions:
Adjunctive Water Yoga was associated with clinically meaningful improvements in psoriasis severity, quality of life, and perceived stress in adults with chronic plaque psoriasis on standard therapy. These findings support further controlled studies to clarify mechanisms and optimize protocols for integrative management in dermatologic practice.

Abstract N°: ID-148

Topic: Inflammatory skin diseases

Impact of a Structured Lifestyle Intervention on Treatment Adherence and Quality of Life in Chronic Inflammatory Dermatoses

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Introduction
Chronic inflammatory skin diseases often follow a prolonged and fluctuating course, affecting not only the skin but also patients' emotional well-being, sleep, daily functioning, and engagement with treatment. Psychological stress and impaired quality of life are well-recognized contributors to disease burden and poor long-term outcomes. Despite effective pharmacologic therapies, treatment adherence remains a major challenge in dermatologic practice. Supportive lifestyle-based interventions addressing behavioral and psychosocial factors may improve patient participation in care and overall quality of life.
Objectives -
To evaluate whether a structured lifestyle intervention, used as an adjunct to routine dermatologic treatment, improves treatment adherence and quality of life in patients with chronic inflammatory dermatoses.

Materials and Methods
This prospective observational study included adults with chronic inflammatory dermatoses receiving stable standard dermatologic therapy. Participants underwent a structured lifestyle intervention program comprising patient education, stress-management strategies, and low-impact physical activity. Sessions were conducted for approximately 45 minutes, 5–6 days per week, over a 6-week period. Treatment adherence and quality of life were assessed using validated instruments, including the Dermatology Life Quality Index (DLQI). Sleep quality and patient-reported satisfaction were also recorded. Safety and tolerability were monitored throughout the study period.

Results
Following the intervention period, participants demonstrated improved adherence to prescribed dermatologic treatment compared with baseline. Quality-of-life scores showed meaningful improvement, particularly in domains related to daily activities, sleep, and emotional well-being. Participants also reported better engagement with treatment plans and reduced perceived stress. The intervention was well tolerated, with high compliance and no intervention-related adverse events observed.

Conclusions
A structured lifestyle intervention appears to be a safe and practical adjunct to routine dermatologic care, associated with improved treatment adherence and enhanced quality of life in patients with chronic inflammatory dermatoses. Addressing behavioral and psychosocial factors alongside standard therapy may help optimize long-term dermatologic outcomes. Further controlled studies are warranted to confirm these findings.

Abstract N°: ID-178

Topic: Inflammatory skin diseases

Blaschko Linear Lichen Planus of the Face

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Introduction

Lichen planus (LP) is a chronic, immune mediated mucocutaneous inflammatory disorder characterized by planar, purple, polygonal, pruritic papules and plaques. Cutaneous LP is a rare dermatosis with a prevalence of 0.5–1%, and typically affects adults aged 30–60 years.

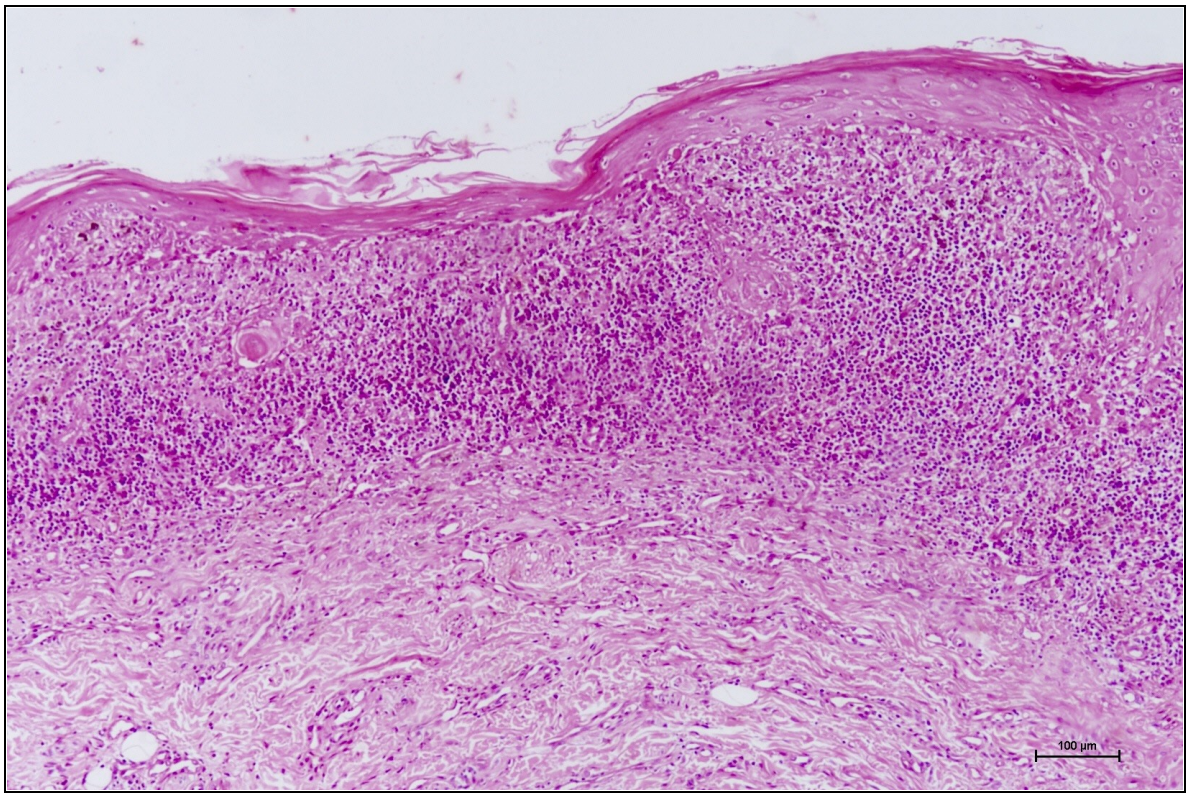
The clinical spectrum of LP can be broadly grouped into cutaneous, appendageal and mucosal forms, with additional subtypes defined by the morphology and distribution patterns of individual lesions. Cutaneous lichen planus predominantly affects the flexor surfaces of the extremities. But in rare cases it may become generalized or present in a blaschkoid, intertriginous or dermatomal pattern. In this report, a blaschko linear lichen planus of the face will be presented.

Materials and Methods

A 30 year old man presented for evaluation of a progressively worsening, pruritic and persistent linear plaque on the left lateral chin, which had been present for approximately three years. Dermatologic examination revealed a well-demarcated, erythematous to violaceous linear plaque measuring approximately 3×1 cm on the left lateral chin. Patchy alopecia barbae was also readily apparent in the affected area.

Results

Dermoscopy revealed a dull red-to-violaceous background with prominent white crossing lines compatible with Wickham striae. A central sero-crust was present, while pigment network and perifollicular changes were absent. He had no known systemic diseases and there was no history of newly initiated medications or vaccinations within the past three months. His past medical history was unremarkable and his family history was noncontributory. Punch biopsy from left lateral chin, found compact orthokeratosis, irregular acanthosis, basal layer vacuolar degeneration with scattered Civatte bodies and a dense band like lichenoid lymphocytic infiltrate obscuring the dermoepidermal junction *and* melanin incontinence in the superficial dermis. Our patient is currently under follow-up and is being treated with topical and intralesional corticosteroids.



Lichenoid interface dermatitis with basal vacuolar change, Civatte bodies, and dense band-like lymphocytic infiltrate.

Conclusions

LP is a chronic inflammatory mucocutaneous disorder that most commonly occurs in middle-aged individuals. The pathogenesis of LP is multifactorial and not yet fully understood; genetic susceptibility, environmental influences, immune dysregulation and exposure to drugs or infectious agents collectively contribute to T cell mediated injury of basal keratinocytes. LP classical histopathology is characterized by epidermal hyperkeratosis without parakeratosis and apoptotic keratinocytes, which are known as Civatte bodies. Additional findings include wedge-shaped hypergranulosis with saw-tooth rete ridges, a dense band-like lymphocytic infiltrate at the dermoepidermal junction and pigment incontinence with increased melanophages.

Linear LP, first described by Devergie in 1894, is characterized by unilateral lesions that follow the lines of Blaschko. Blaschko lines reflect the migration pathways of epidermal cells during embryonic development. Clinically, previous reports describe a comparable linear pattern along Blaschko lines, most frequently involving the mandibular area. Although a direct link between specific antigens and Blaschkoid LP has not been established, the literature describes several instances in which Blaschkoid LP emerged following vaccinations, occurred in association with underlying neoplasms or recurred during consecutive pregnancies. This has led to the hypothesis that the Blaschkoid pattern of LP may be predetermined during embryogenesis, predisposing affected individuals to develop lesions once an antigenic stimulus is encountered later in life. In our patient, however, no clear precipitating factor could be identified.The clinical course is typically benign and self-limited. Topical corticosteroids are first line therapy, with systemic or immunomodulatory treatments reserved for refractory cases.

Abstract N°: ID-207

Topic: Inflammatory skin diseases

Treatment response of inflammatory linear verrucous epidermal nevus (ILVEN) to oral alitretinoin

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Introduction
Inflammatory linear verrucous epidermal nevus (ILVEN) is a benign nevus characterized by Blaschko-linear psoriasiform lesions and marked resistance to conventional treatments, likely due to its origin in somatic mutations causing genetic mosaicism. While CO_2 laser and surgical excision show promise, post-procedure scarring limits their effectiveness. Oral alitretinoin, an approved treatment for refractory chronic hand eczema, may similarly benefit ILVEN by exerting anti-inflammatory and immunomodulatory effects on keratinocytes.

Materials and Methods
We present two female biopsy-proven ILVEN patients who showed dramatic improvement with alitretinoin.

Results
The first patient, a 21-year-old female suspected of epidermal nevus syndrome with cardiomegaly and left-sided congenital hemihypertrophy, presented with a ten-year history of persistent pruritic, verrucous plaques on the left palm and sole. After 30 mg/d alitretinoin treatment, pruritus and lesion thickness improved rapidly within a month, with sustained benefits during continued use. The second patient, a 24-year-old female with atopic dermatitis, had an eleven-year history of pruritic, verrucous patches on the right neck and lower back that recurred despite treatment with topical therapies and CO_2 laser. Following 30 mg/d alitretinoin initiation, symptoms lessened, and the plaques flattened completely within five months. Both patients reported no adverse reactions related to alitretinoin treatment.

Conclusions
In contrast to most retinoids, alitretinoin is able to bind all six retinoid receptors, and alitretinoin may exert its effect via synergistic activation of multiple retinoid receptors. We propose alitretinoin as a novel, effective, and well-tolerated therapy for ILVEN, which is resistant to most conventional treatments.

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Abstract N°: ID-297

Topic: Inflammatory skin diseases

Graham-Little-Piccardi-Lassueur syndrome and its relation to Antigen mimicry

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Introduction

Graham-Little-Piccardi-Lasseur syndrome (GLPLS) is a rare lichenoid dermatosis classified as a variant of follicular lichen planus, also known as classic lichen planopilaris. The condition is characterized by the triad of cicatricial scalp alopecia, noncicatricial alopecia in the axillary and groin regions, and numerous follicular papules distributed across the body (Fig.1a-d).

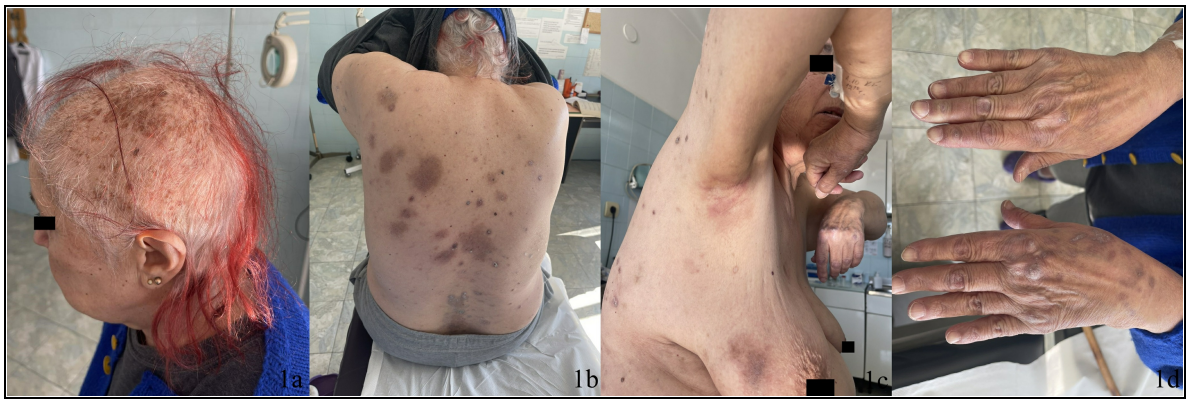

Fig.1a-d: Dermatological findings: 1a: Capillitium: diffuse cicatricial alopecia with plaque-like areas of desquamation; 1b: Numerous livid hypertrophic papules and nodules with fine desquamation on the the trunk 1c: Reduced body hair, in the right axilla (noncicatricial alopecia). 1d: Numerous livid hypertrophic papules and nodules with fine desquamation on the right and left hands

Materials and Methods

We present a 64-year-old female with clinically and histologically confirmed GLPLS. Two biopsies were conducted, resulting in lichen planopilaris/ pseudopelade Brocq and lichen planus hypertrophicus (Fig.2a-c).

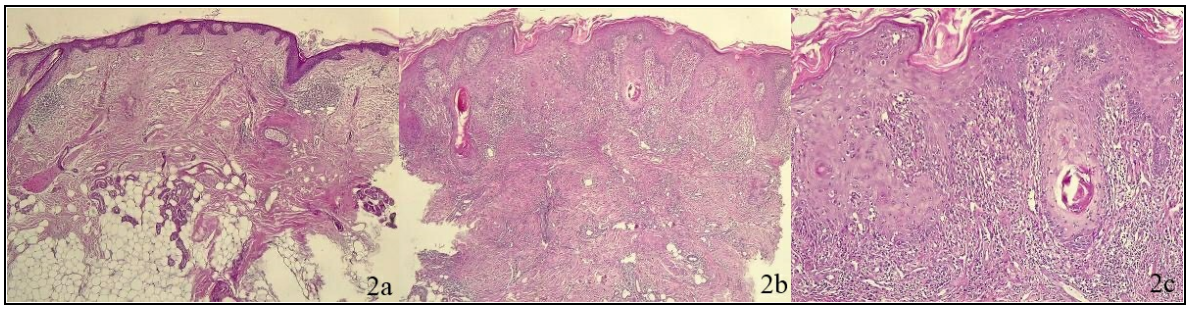

Fig.2a-c: Histology findings: A - pronounced ortho- and follicular hyperkeratosis, uneven acanthosis, and a reduced number of sebaceous glands throughout the dermis, replaced by diffuse fibrous tracts. A retained hair follicle fragment was covered by a lichenoid inflammatory reaction, with round cells destroying the external epithelial sheath. These findings were consistent with lichen planopilaris/ pseudopelade Brocq; B,C - marked ortho- and follicular hyperkeratosis, irregular acanthosis alternating with pseudoepitheliomatous hyperplasia, vacuolar degeneration of basal keratinocytes, and a lichenoid lympho-plasmacytic inflammatory infiltrate obscuring the dermo-epidermal junction and lining the papillary dermis. These findings were consistent with lichen planus hypertrophicus 2a: cicatricial alopecia HE x 40 2b: Lichen planus hypertrophicus HE x 40 2c: Lichen hypertrophicus HE x 100

Results

Initial therapy included loratadine and topical clobetasol propionate. Due to the suspicion of possible drug-induced autoimmunity, the antihypertensive therapy, which consisted of valsartan, bisoprolol, spironolactone, and chlorthalidone, was discontinued and replaced with moxonidine. Urinary infection caused by Escherichia coli and dental infection were noted. Prescribed outpatient treatment included acitretin, bilastine, and topical prednisolone for the scalp. Improvement was observed in the lesions located on the trunk and upper and lower extremities following betamethasone/salicylic acid ointment was prescribed, and methylprednisolone aceponate cream. Re-application or return of the old systemic medication on an outpatient basis resulted in a worsening/exacerbation of the clinical picture and a re-need to change medication. It is this fact that suggests that polymedication could also be considered as a trigger of lichen planus and its subforms such as GLPLS.

Conclusions

The hypothesis about antigen / molecular mimicry, based on the surrounding alterations in tissue homeostasis as a potential trigger factor for autoimmunity is being discussed, with a specific focus on infectious and drug-induced forms of lichen planus, as well as Graham-Little-Lasseur syndrome.

Abstract N°: ID-305

Topic: Inflammatory skin diseases

Therapeutic success of tofacitinib in recalcitrant generalised granuloma annulare :A case series

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Introduction
Granuloma annulare (GA) is a necrobiotic granulomatous disorder that is usually resistant to treatment, especially the generalised form.Existing treatments like pathergy,oral ROM pulse or Aprimalst ,etc. Tofacitinib has recently shown promise in the treatment of non-infective granulomatous dermatosis. we aimed to evaluate the response of generalised GA to oral tofacitinib 5-11mg OD monotherpy.

Materials and Methods
This was a retrospective case series in patients of generalised GA who were treated with oral tofacitinib 5 mg twice a day in a tertiary care centre in west India. Baseline clinical details and histopathological findings were reviewed. Treatment response was noted in the form of clearance of lesions (complete or partial) along with the time taken to achieve the maximum response.

Results
We tried Tofa in five patients who did not respond to other methods after lab tests .All started response in 3-4 th month of treatment and showed partial to near complete clearance by 6-12 months without any side effects.No side effects noted in any case.we reduced dose by half after response and then twice a week for 2-3 months before stopping.

Conclusions
Tofacitinib, a JAK-STAT inhibitor is beneficial in treating GA, especially in those with generalised and recalcitrant disease.

Abstract N°: ID-345

Topic: Inflammatory skin diseases

Granuloma Annulare successfully treated with Dimethyl Fumarate

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Introduction

Granuloma annulare (GA) is a benign inflammatory disease associated with a variety of underlying conditions, yet often appearing without any identifiable cause. The generalized form of this disease can be persistent and result in disfigurement. Dimethyl-fumarate (DMF) has been occasionally used in the treatment of generalized GA.

Materials and Methods

A 77-year-old female patient was referred to us for a GA that had appeared 12 years previously. During clinical examination, there were multiple annular erythematous plaques, with sharp demarcation and central involution with hypopigmentation and atrophy. The lesions were mostly distributed on the face, neck and scalp and were up to 8cm diameter. The patient complained of pruritus and burning sensation during the active phase of her disease. The remaining clinical examination was unremarkable.

Her medical history included hypertension and dyslipidemia treated with valsartan/hydrochlorothiazide and rosuvastatin respectively. The aforementioned medications were initiated after the first appearance of GA and therefore no causality association could be supported. No allergies were also reported.

Over the past 12 years the diagnosis of GA had been confirmed with multiple lesional punch biopsies. A recent biopsy from the periphery of a skin lesion was also remarkable for palisading granulomas consisting of histocytes and epithelioid cells, along with a few giant cells and neutrophils. Laboratory investigation was negative for hepatitis viruses, human immunodeficiency virus, diabetes mellitus and thyroid disease. Immunological testing revealed antinuclear antibodies (ANA) at a titer of 1:160, anti-double-stranded DNA antibodies at 1:20, and elevated IgE levels. The criteria for Systemic Lupus Erythematosus were applied, resulting in a score of 6 out of 10, which does not meet the diagnostic threshold. Mantoux testing was negative. Computer tomography scans revealed no evidence of solid malignancies. Serum Angiotensin-Converting Enzyme levels were negative, ruling out sarcoidosis

Results

For the GA the patient had been treated in the past with courses of topical corticosteroids as well as hydroxychloroquine, without clinical improvement. DMF was initiated, as according to psoriasis guidelines, with an initial dose of 30 mg/day which was titrated up to 240mg/day. During treatment initiation and dose escalation the patient suffered from abdominal pain that became unbearable when she tried to increase the dose of MMF above the level of 240mg/day. However, at this dose and within 6 weeks of initiating therapy the pruritus and burning started to subside and after 14 weeks the clinical presentation of the lesions had improved and no new lesions had appeared. The maintenance dose of DMF has been adjusted to 240/120mg on alternate days for the last 12 months, with disease activity remission.

Conclusions

Systemic therapy with DMF may be effective in disseminated GA and should be considered as a therapeutic option in selected patients.

Abstract N°: ID-471

Topic: Inflammatory skin diseases

Erythromelalgia as a Manifestation of Small-Fiber Neuropathy: A Diagnostic Challenge

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Introduction

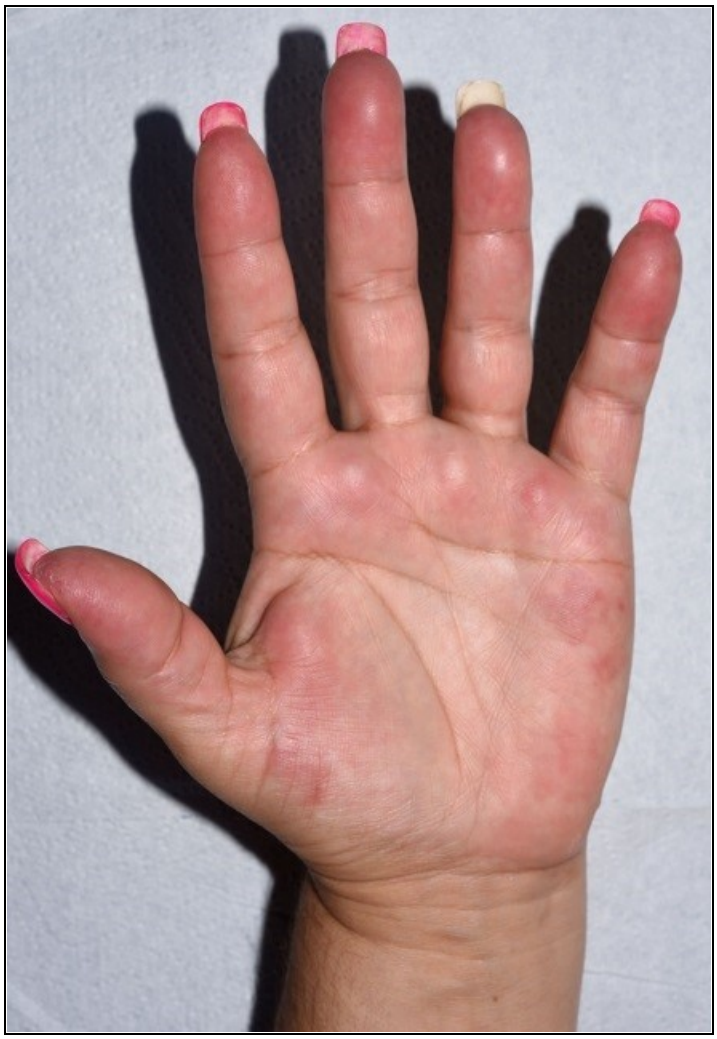
Erythromelalgia (EM) is a rare, chronic and debilitating condition characterized by recurrent episodes of burning pain, erythema, and increased skin temperature, primarily affecting the extremities. EM arises from a combination of nociceptive dysfunction and vascular dysregulation, leading to severe sensory disturbances and microvascular abnormalities. The condition is classified into primary and secondary forms. Primary EM is often linked to SCN9A mutations affecting the NaV1.7 sodium channel, while secondary EM may result from autoimmune, hematological, neurological, or vascular disorders. Increasing evidence supports an association between secondary EM and small fiber neuropathy (SFN), a disorder involving Aδ and C fibers responsible for pain and autonomic function.

Materials and Methods

We report three cases of severe secondary EM associated with SFN. All patients underwent clinical evaluation, laboratory investigations, neurophysiological studies (EMG/ENMG), quantitative sensory testing (QST), and skin biopsy for intraepidermal nerve fiber density (IENFD). Additional diagnostic work-up was performed to identify potential underlying etiologies.

Results

Case 1. A 53-year-old female patient with EM of the hands (fig 1 and 2) and feet, associated with palmar hyposensitivity. Quantitative Sensory Testing (QST) was abnormal at the ankle (L5). Skin biopsy showed reduced intraepidermal nerve fiber density (7.27/mm) with a preserved thigh/ankle ratio (0.73), confirming a small fiber neuropathy (SFN). Blood work and vascular assessments were normal.
Case 2. A 45-year-old male patient, treated for palmoplantar psoriasis with methotrexate and ixekizumab, consulted for paroxysmal episodes of EM with plantar hyperhidrosis and paresthesias of varying intensity (2 to 8/10 on the VAS), without thermal or pain sensitivity loss. EMG and QST were normal, while skin biopsy confirmed SFN. Lidocaine infusions and oral duloxetine were initiated with beneficial effect.
Case 3. A 56-year-old female patient presenting with EM predominantly affecting the thenar eminences. ENMG was normal. QST revealed altered thermal detection thresholds. Skin biopsy showed reduced intraepidermal nerve fiber density at the ankle (3.65/mm; normal = 10.0), indicating distal involvement consistent with SFN of non-dysimmune origin. Diagnostic work-up revealed early-stage diabetes and hypophosphatemia, both potentially contributing to the SFN.



Conclusions

SFN manifests through sensory disturbances such as paresthesias, dysesthesias or neuropathic pain (burning sensations), and protopathic sensory deficits, often accompanied by dysautonomic symptoms. The possible etiologies of SFN are diverse: idiopathic, toxic, metabolic, immunological, infectious, and hereditary.

Diagnostic approaches are often delayed due to symptom overlap with other conditions. Skin biopsy to assess intraepidermal nerve fiber density, quantitative sensory testing (QST), and evaluations of the autonomic nervous system (e.g., laser-evoked potentials, Sudoscan®) are essential tools.

Certain syndromes, such as erythromelalgia (EM) or burning mouth syndrome, are included within the spectrum of SFN. In a recent retrospective study (Monfort et al., JDP 2024), SFN was diagnosed in 43% of a series of 60 EM cases. Secondary EM should prompt a search for an underlying NPF, to allow for early diagnosis and treatment strategies targeting both neuropathic and vascular mechanisms.

Abstract N°: ID-474

Topic: Inflammatory skin diseases

Epidemiological studies of psoriasis vulgaris

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Introduction

Psoriasis vulgaris is a chronic, non-contagious inflammatory skin disease
that affects approximately 1.5% of the Moroccan population. This condition has a significant

impact on patients' quality of life. The objective of this study is to describe the epidemiolog-
ical, clinical, therapeutic, and evolutionary characteristics of patients hospitalized for psoriasis

vulgaris at Mohammed VI University Hospital in Oujda.

Materials and Methods

This is a retrospective descriptive study conducted over a period of 10 years and 1 month, from November 2014 to December 2024. All patients hospitalized for psoriasis vulgaris were included. Epidemiological, clinical, paraclinical, therapeutic, and outcome data were collected using a standardized data collection form

Results

A total of 79 patients were included, representing 3.7% of hospitalizations in the dermatology department, with an average annual incidence of 7 cases. The mean age was 40.2 ± 19.1 years (range: 1 month to 72 years), and the male-to-female ratio was 1.13. The majority of patients had a low socioeconomic status (73.4%), and 46% reported a family history of psoriasis. Clinically, pruritus was observed in 77.2% of cases. Pustular lesions were noted in 10% of patients, and palmoplantar keratoderma in 23% of cases. Nail involvement was frequent (53%), with lesions such as pachyonychia, onycholysis, and pinpoint pitting. Arthralgia was present in 51.9% of patients, predominantly inflammatory in nature, and scalp involvement was observed in 73% of cases.

Conclusions

Psoriasis vulgaris, as observed in our hospitalized series, often presents in severe forms, with systemic involvement and a significant psychosocial impact. A multidisciplinary approach is essential to improve both the functional prognosis and the quality of life of patients.

Abstract N°: ID-475

Topic: Inflammatory skin diseases

Profile of comorbidities associated with psoriasis

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Introduction

Psoriasis is a chronic inflammatory skin disease affecting approximately 2–3% of the global population. Today recognized as a systemic condition, it is frequently associated with metabolic, cardiovascular, musculoskeletal, and psychiatric comorbidities. These comorbidities increase the disease burden, impair quality of life, and may reduce patients' life expectancy.

The aim of this study is to assess the frequency and nature of comorbidities associated with psoriasis in patients followed in our department.

Materials and Methods

This is a retrospective, descriptive, single-center study conducted in the dermatology department of CHU Mohammed VI in Oujda, over a period from November 2014 to July 2025. A total of 110 patients hospitalized for psoriasis, encompassing all clinical forms, were included.

Results

A total of 110 patients with psoriasis of all types were included. The mean age was 39.21 ± 19 years, with a slight male predominance (52% men vs. 48% women).

From a rheumatologic perspective, psoriatic arthritis was observed in 38 patients (34.5%), while 3 patients (2.7%) had nonspecific rheumatism. Psychiatric disorders were also noted, including 5 cases of depression (4.5%) and 4 cases of anxiety (3.6%), reflecting the psychological impact of psoriasis.

Other comorbidities included chronic inflammatory bowel disease (2 cases, 1.8%), hypothyroidism (5 cases, 4.5%), hyperthyroidism (1 case), epilepsy (2 cases, 1.8%), Parkinson's disease (1 case), vitiligo (1 case, 0.9%), ocular involvement such as blepharitis (2 cases), and chronic kidney disease (2 cases, 1.8%). Regarding lifestyle factors, 27 patients (24.5%) were smokers and 18 (16.4%) consumed alcohol. Notably, 45 patients (40.9%) had no significant medical history.

In our study of 110 patients with psoriasis, we observed a significant prevalence of cardiovascular and metabolic comorbidities. Metabolic syndrome was identified in 20.9% of patients, obesity in 29.1%, type 2 diabetes in 12.7%, dyslipidemia in 20.9%, and hypertension in 9.1%. Additionally, cardiovascular complications were reported, including myocardial infarction in 3.6% of cases, pulmonary embolism, deep vein thrombosis, and one case of atrial fibrillation.

Conclusions

Our study confirms that psoriasis is a systemic disease frequently associated with metabolic, cardiovascular, rheumatologic, and psychiatric comorbidities. These associations underscore the need for systematic screening and a multidisciplinary approach to improve patients' quality of life and prognosis.

Abstract N°: ID-479

Topic: Inflammatory skin diseases

Psoriasis Vulgaris in Focus: Emotional, Physical, and Social Impacts on Patients

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[1]CHU Mohammed 6 oujda, dermatology, oujda, Morocco

Introduction

Psoriasis vulgaris is a chronic, non-contagious inflammatory skin disease that affects approximately 1.5% of the Moroccan population. This condition has a significant impact on patients' quality of life. The aim of our study was to describe the epidemiological, clinical, therapeutic, and evolutionary characteristics of patients hospitalized for psoriasis vulgaris at Mohammed VI University Hospital in Oujda, with a particular focus on the impact of the disease on quality of life.

Materials and Methods

This is a retrospective, descriptive study conducted over a period of 10 years and 1 month, from November 2014 to December 2024. All patients hospitalized for psoriasis vulgaris were included.
Epidemiological, clinical, paraclinical, therapeutic, and outcome data were collected using a standardized data collection form.
Quality of life was assessed using the Dermatology Life Quality Index (DLQI) for adults and the Children's Dermatology Life Quality Index (CDLQI) for pediatric patients. In addition, the Skindex questionnaire was used to evaluate the emotional, symptomatic, and functional impact of psoriasis

Results

The mean DLQI score in our study was 14.7 7.45, ranging from 0 to 30. The most represented category was thatof patients experiencing a significant impact on quality of life (DLQI 11-20), which included 31 cases, representing 44.9% of the sample.
For pediatric patients, the mean CDLQI score was 14 $ 3, with a range from 6 to 18, indicating a considerable impact of psoriasis on children's quality of life.
The Skindex scores further detailed the impact of the disease:
* Emotions: mean 42 ÷ 4.5% (range 34-52%)
* Symptoms: mean 34 ÷ 6.5% (range 42-68%)
* Functioning: mean 28 + 9.25% (range 18-55%)
These results demonstrate that psoriasis vulgaris significantly affects multiple dimensions of patients' daily lives, including emotional well-being, physical symptoms, and functional abilities.

Conclusions

Psoriasis vulgaris has a profound effect on patients' quality of life, affecting both adults and children. The DLQI, CDLQI, and Skindex scores indicate that a large proportion of patients experience a significant emotional, symptomatic, and functional burden. These findings highlight the need for comprehensive, multidisciplinary care approches that address not only the physical symptoms of psoriasis but also its psychosocial and quality-of-life impacts.

Abstract N°: ID-524

Topic: Inflammatory skin diseases

A Case of Wells Syndrome With a Rapid Response to Omalizumab Therapy

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Introduction
Wells syndrome (eosinophilic cellulitis) is a rare inflammatory dermatosis characterized by recurrent erythematous, pruritic and cellulitis-like skin lesions accompanied by eosinophilic infiltration in the dermis. The etiology and optimal management of Wells syndrome remain unclear and therapeutic responses are often variable. Here in, we report a case of refractory Wells syndrome showing a rapid and complete response to omalizumab therapy.

Materials and Methods
A 21-year-old female patient with a 5-year history of recurrent pruritic papular lesions on the back and lower extremities, accompanied by intermittent fever, fatigue and arthralgia, was evaluated. The patient had previously received systemic antibiotics and corticosteroids without clinical improvement. Dermatological examination, laboratory investigations, and histopathological evaluation of punch biopsy specimens were performed. Based on clinical and histopathological findings, a diagnosis of Wells syndrome was established. After obtaining off-label approval, omalizumab therapy was initiated, and the patient was followed clinically.

Results

Physical examination revealed pruritic, annular hyperpigmented patches with infiltrated papules and plaques on the back and bilateral lower extremities. Histopathological examination demonstrated superficial and deep perivascular inflammatory infiltrates rich in eosinophils, without findings consistent with granuloma annulare or sarcoidosis. The findings were considered compatible with Wells syndrome in correlation with clinical features.

The patient was treated with subcutaneous omalizumab at a dose of 300 mg every 4 weeks. After 4 months of therapy, complete resolution of cutaneous lesions and systemic symptoms was observed. Treatment was well tolerated and no adverse effects were recorded during follow-up.

Conclusions
This case highlights omalizumab as a potentially effective therapeutic option in refractory Wells syndrome. The rapid and complete clinical response observed in our patient suggests that targeting IgE-mediated pathways may play a role in the management of eosinophilic dermatoses. Further studies are needed to clarify the efficacy and safety of omalizumab in Wells syndrome.

Abstract N°: ID-551

Topic: Inflammatory skin diseases

Evaluation of systemic and biologic therapies in adult erythrodermic pityriasis rubra pilaris: a 10-year single-centre study in Russia

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Introduction

Pityriasis rubra pilaris (PRP) is a rare papulosquamous disorder frequently characterized by erythroderma. Due to limited data on the etiopathogenesis of PRP, treatment of this disease is challenging. Systemic retinoids are regarded as the first-line therapy, but they are not always sufficiently effective. The similarity between PRP and psoriasis pathogenic mechanisms has led to the consideration of genetically engineered biological agents (GEBAs) as an adjunctive treatment for PRP.

Materials and Methods

The study was conducted at the Department of Dermatology and Venereology, Russia, from May 2014 to May 2024. It included 21 patients over the age of 18 with the erythrodermic form of PRP. Patients were selected from archive records based on the following criteria: age 18-80 years and presence of the erythrodermic form of PRP (Psoriasis Area and Severity Index (PASI) ≥20). The Dermatology Life Quality Index (DLQI) was evaluated at baseline and monitored monthly during the treatment period. Twenty-one consecutive adults with erythrodermic PRP were treated with systemic therapies and followed prospectively during routine clinical care. The treatment distribution was as follows: 38.1% (n=8) received acitretin, 14.3% (n=3) isotretinoin, 38.1% (n=8) methotrexate, 28.6% (n=6) prednisolone, 4.8% (n=1) dexamethasone, 19% (n=4) netakimab, 4.8% (n=1) ustekinumab, and 4.8% (n=1) phototherapy (PUVA, UVB-311nm). The average PASI score before treatment was 28 ± 8.6, and the average DLQI was 21 ± 2.1.

Results

Following acitretin therapy, patients experienced significant regression of lesions, with a corresponding decrease in PASI to an average of 5 ± 3.2 points (achieving PASI75) and in DLQI to an average of 3.7 ± 1.9 points, indicating a positive therapeutic effect. One patient (4.8%) underwent phototherapy (PUVA, UVB-311nm) as monotherapy without achieving a clinical effect. However, when phototherapy was combined with other treatments, it demonstrated stabilization of the skin process and improved disease dynamics. Specifically, combination therapy with acitretin and phototherapy (RePUVA) achieved mean scores of 7.2 ± 4.6 (PASI), representing a decrease in PASI by ≥75%, and 5 ± 1 (DLQI), demonstrating enhanced efficacy. The effectiveness of methotrexate and phototherapy as

monotherapy for PRP remains controversial. In cases of relapse or resistance to initial therapy, GEBAs were used and found to be at least as effective as acitretin. Remission (achieving PASI 90) following successful treatment with netakimab and ustekinumab was maintained for up to 18 months. Follow-up continues to assess the long-term outcomes of biological therapy for PRP.

Conclusions

The data confirm the rationale for the first-line use of systemic retinoids in PRP. In this small cohort, acitretin appeared to provide greater overall clinical improvement than isotretinoin. Genetically engineered biological therapy may be considered an effective adjunct for severe and treatment-resistant PRP, contributing to sustained remission and improved quality of life. However, the interpretation of these findings is limited by the small sample size, single-centre retrospective design, absence of a control group, and the purely descriptive nature of the analysis.

Abstract N°: ID-574

Topic: Inflammatory skin diseases

Revisiting Palmoplantar Inflammatory Dermatoses

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Introduction
Palmoplantar inflammatory dermatoses—chronic hand eczema (CHE), hyperkeratotic hand eczema (HHE), palmoplantar pustulosis (PPP), palmar psoriasis, and pompholyx—often show overlapping features, leading to diagnostic uncertainty and treatment selection. Because classification is largely morphology-based, biologically distinct entities may be grouped under broad labels such as “CHE.” Since 2020, a single referral center has conducted a series of studies using consistent histopathological criteria and immunohistochemical (IHC) methods to clarify whether key palmoplantar conditions align with the eczematous axis or a psoriasis-related spectrum. Here, we synthesize four investigations and propose a pathophysiology-oriented spectrum model integrating keratinocyte differentiation, inflammatory signatures, and real-world systemic treatment outcomes.

Materials and Methods
This narrative review consolidates four studies from one tertiary center using harmonized diagnostic frameworks. Palmar psoriasis, CHE/HHE, PPP, and pompholyx were assessed by routine histopathology and targeted IHC. Differentiation markers included basal keratins (K5/K14), palmoplantar keratin (K9), and involucrin, and psoriasis-associated mediators included β-defensin 2 and IL-36γ. Analyses compared marker distribution and intensity across diagnostic groups alongside histologic patterns (e.g., psoriasiform hyperplasia, granular layer changes, and parakeratosis). A retrospective outcomes study compared systemic therapy in refractory CHE, evaluating oral alitretinoin versus cyclosporine using 24-week response and drug survival.

Results

Across the included studies, HHE repeatedly exhibited psoriasis-like rather than eczematous biology. Histologically, HHE shared psoriasiform epidermal hyperplasia, a diminished or absent granular layer, and confluent parakeratosis with palmar psoriasis. Immunohistochemistry showed increased β-defensin 2 and IL-36γ expression in HHE, comparable to palmar psoriasis and higher than CHE, supporting a psoriasis-spectrum interpretation. Differentiation-marker profiling also demonstrated suprabasal extension of K5/K14 with reduced K9 and premature involucrin expression in HHE and palmar psoriasis, indicating disrupted palmoplantar differentiation and early terminal differentiation.
Using a similar IHC framework, PPP and pompholyx were distinguished despite clinically similar vesiculopustular presentations. PPP showed keratinocyte differentiation abnormalities consistent with a psoriasis-adjacent profile, including K5 extension beyond the basal layer, reduced K9 around pustules, and involucrin extension into basal layers. In contrast, pompholyx largely preserved palmoplantar differentiation, with relatively maintained K9 expression and a more physiologic involucrin pattern.
In a retrospective cohort of refractory CHE, oral alitretinoin achieved a higher 24-week responder rate than cyclosporine, while drug survival did not significantly differ. Together with the IHC findings, this underscores biological heterogeneity within CHE and suggests that hyperkeratotic phenotypes overlapping with psoriasis-like differentiation may show distinct systemic treatment responsiveness.

Conclusions
Collectively, these four studies support reframing palmoplantar inflammatory dermatoses as a continuous spectrum

from eczema-dominant disorders to psoriasis-adjacent and psoriasis-spectrum disease. HHE consistently demonstrates psoriasis-like inflammatory signaling and keratinocyte differentiation disruption, arguing against its placement as a simple subtype of CHE. PPP similarly aligns with psoriasis-adjacent differentiation abnormalities while retaining distinctive clinicopathological features, whereas pompholyx and typical CHE more closely follow an eczematous differentiation pattern. Integrating IHC signatures with real-world systemic treatment outcomes provides a biologically grounded framework that may improve diagnostic precision and guide individualized systemic treatment selection in palmoplantar disease.

Abstract N°: ID-576

Topic: Inflammatory skin diseases

Undiagnosed Wells syndrome presenting with relapsing-remitting urticarial rash for 28 years

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Introduction
A 40-year-old male was transferred to the Internal Medicine Department with a four-day history of fever up to 39^{o}C and a rash, predominantly distributed on the back. This exacerbation was present for the last 4-months, but the patient had similar episodes of unexplained fever and rash from the age of twelve. No other systemic symptoms were reported.

Materials and Methods
During Dermatological consultation, the clinical examination was notable for red urticarial wheals up to 8 cm in diameter with partial central clearing. Within 72 hours the lesions had been spreading centrifugally with central involution. This evolution pattern of the exanthem dominated also the previous episodes, as confirmed by medical history. Facial involvement was present at admission, but had subsided 2 days later.

The patient did not receive any systemic medications and reported no allergies. His medical history was notable for this particular rash for 28 years, without however a consistent temporal or duration pattern. A burning sensation was reported to herald the appearance of the rash and involved the scalp before spreading to the rest of the trunk. The only identifiable not-specific eliciting factor was life-stress periods. Pruritus was rare to absent. The temporal association of fever with the appearance of rash was inconsistent, as it was reported to appear before, during or even after it. Systemic corticosteroids usually led to remission whereas antihistamines were mostly ineffective.

Laboratory findings showed ANA positivity at 1:160. Stool parasitology, viral testing (HIV, CMV, EBV, Hepatitis B, Hepatitis C, HSV, VZV, Rubella virus), and Familial Mediterranean Fever (FMF) screening were negative. Serum protein electrophoresis and immunofixation were unremarkable. The absolute eosinophil count was within normal range (0,22x10^{3}/μL), while IgE is elevated (204 U/ml with normal value <165 U/ml). Normal audiometry results excluded Muckle-Wells syndrome.

A lesional biopsy from the urticarial-like wheals demonstrated the presence of an eosinophilic infiltrate and complete absence of signs of vasculitis.

Results
The constellation of clinical and laboratory findings set the diagnosis of Wells syndrome as all four major diagnostic criteria – typical clinical presentation, absence of an associated systemic disease, a relapsing-remitting course and histological evidence of eosinophilic infiltrates without vasculitis – were fulfilled. From the minor criteria, only stress could be noted as a possible triggering factor. Notably, for the diagnosis of Wells syndrome only two major and one minor criterion are required.

Conclusions
This is a rare presentation of “long” Wells syndrome. Although during the present hospitalization the exanthem subsided by the time the diagnostic results were available, possible future therapeutic interventions were discussed with the patient.

Abstract N°: ID-667

Topic: Inflammatory skin diseases

Cytomegalovirus-induced erythema annulare centrifugum in an immunocompetent adult

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Introduction
Erythema annulare centrifugum (EAC) is a rare inflammatory condition belonging to the group of figurate erythemas. It is characterized by annular, arciform, or polycyclic erythematous plaques that expand centrifugally with central clearing.

Materials and Methods
We report a case of erythema annulare centrifugum revealing cytomegalovirus (CMV) reactivation in an immunocompetent adult patient.

Results
A 66-year-old man, with no significant past medical history and no medication use, was hospitalized for a widespread skin eruption evolving for one month, in the absence of fever and with preserved general condition. Clinical examination revealed pruritic annular erythematous plaques with a pale center and a finely scaly, infiltrated border, involving the trunk, back, and all four limbs, without facial, mucosal, ungueal or hair involvement. Histopathological examination of a skin biopsy showed a dermal lymphocytic inflammatory infiltrate arranged in perivascular “trailing scale" pattern, without leukocytoclastic vasculitis, consistent with erythema annulare centrifugum; direct immunofluorescence was negative. Extensive biological and immunological investigations (complete blood count, renal and liver function tests, serum protein electrophoresis, thyroid function tests, antinuclear antibodies), as well as ophthalmologic and otorhinolaryngologic examinations, upper and lower gastrointestinal endoscopy, and thoraco-abdomino-pelvic computed tomography, revealed no significant abnormalities. Viral serology showed elevated anti-CMV IgG (>500) and IgM (1.71) titers, supporting CMV reactivation. Given the preserved immune status and absence of severity signs, therapeutic abstention regarding CMV, combined with the application of high-potency topical corticosteroids, was adopted, leading to complete resolution of the lesions within three weeks, without recurrence or complications. Erythema annulare centrifugum may be associated with various conditions, including infections, medications, autoimmune diseases, neoplasms, and stress. Cases of EAC following SARS-CoV-2 infection, cancer immunotherapies, and as a paraneoplastic manifestation of lymphomas and bronchopulmonary carcinoma have been reported in the literature. Histologically, the presence of a perivascular inflammatory infiltrate arranged in “coat-sleeve” cuffs is characteristic of EAC. CMV infection in immunocompetent patients is usually asymptomatic and only rarely results in severe organ involvement. Cutaneous manifestations of CMV infection may include a polymorphous exanthem, sometimes with a purpuric component, and Lipschütz-type periorificial ulcerations. The occurrence of EAC during CMV reactivation is unusual and supports the hypothesis of a delayed hypersensitivity reaction secondary to viral infection.

Conclusions
This case highlights erythema annulare centrifugum as a rare cutaneous manifestation revealing cytomegalovirus reactivation in an immunocompetent patient, supporting the need for systematic infectious screening in patients presenting with EAC.

Abstract N°: ID-683

Topic: Inflammatory skin diseases

Genetic liability for psychiatric, psychosocial, and cognitive phenotypes is associated with increased occurrence of rosacea in the Danish Blood Donor Study

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Introduction

Rosacea is a chronic, inflammatory skin disease (prevalence <1%–22%) associated with psychosocial burden and psychiatric diseases. While Genome-wide association studies (GWAS) have advanced rosacea genetics, genetic pathways linking rosacea to psychiatric, psychosocial, and cognitive phenotypes remain unclear. Using Polygenic risk scores (PRSs), we examined associations between genetic liability across these phenotypes and rosacea, assessed mediation via expressed personality and examined links with self-reported mental and physical well-being. To our knowledge, this is the first mental health PRS study in rosacea.

Materials and Methods

This cross-sectional study was conducted within the Danish Blood Donor Study (DBDS) cohort. Rosacea cases were identified based on questionnaire-data, and controls were reclassified based on rosacea-specific topical treatment and/or a relevant ICD-10 code. We included 3,303 cases and 24,853 controls (N=28,156).

PRSs for psychiatric, psychosocial, and cognitive phenotypes were the main exposures. Outcomes were rosacea status and health-related quality of life based on the Short Form-12 health survey (SF-12) mental component summary (MCS) and physical component summary scores (PCS). Logistic regression was used to test PRS-rosacea associations, with additional models adjusting for Big Five personality traits (openness, conscientiousness, extraversion, agreeableness and neuroticism) PRSs and rosacea PRS. Mediation analyses (1,436 cases and 10,368 controls) evaluated self-reported Big Five personality traits as potential mediators. For SF-12, PRSs were analysed by quintiles (top vs bottom; middle excluded). We classified four groups (control-low PRS, control-high PRS, rosacea-low PRS, rosacea-high PRS). Mean MCS/PCS (mean 50 (SD 10); higher = better) were compared across groups using linear regression. All analyses were adjusted for age, sex, and the first ten principal components (PC1-PC10).

Results

The study showed that high PRS for attention-deficit/hyperactive disorder (ADHD) (OR = 1.07, 95% CI:1.03-1.11, p<0.001), bipolar disorder (BD) (OR = 1.06, 95% CI:1.02–1.09, p=0.004), anxiety (OR = 1.04, 95% CI: 1.001–1.07, p=0.0473), loneliness (OR = 1.07, 95% CI: 1.04–1.11, p<0.001), major depressive disorder (MDD) (OR = 1.07, 95% CI:1.03–1.10, p<0.001), neuroticism (OR = 1.11, 95% CI:1.07–1.15, p<0.001), and schizophrenia (SCZ) (OR = 1.07, 95% CI:1.04–1.11, p<0.001) were associated with rosacea (Figure 1). As a validation step, an external rosacea PRS was associated with questionnaire-defined rosacea. Adjustment for neuroticism PRS attenuated associations for anxiety, MDD, and loneliness. Genetic correlation analyses indicated stronger correlations between neuroticism and MDD (0.46) and loneliness (0.51), with weaker correlation for anxiety (0.24). Mediation analyses suggested partial mediation via self-reported neuroticism for associations involving MDD PRS (19.2%), loneliness PRS (21.8%), and neuroticism PRS (16.2%), with smaller indirect effects for ADHD PRS and SCZ PRS (7.7% and 4.6%). A small proportion (-0.9%–5.2%) were mediated via the other four personality traits. Among 11,022 individuals, mean MCS differed across the four PRS groups. Across PRSs, mean MCS and PCS were highest in the control-low PRS group (MCS 51.58–52.67; PCS 54.9 –55.69) and lowest in the rosacea-high PRS group (MCS 48.35–50.02; PCS 54.37–54.97).

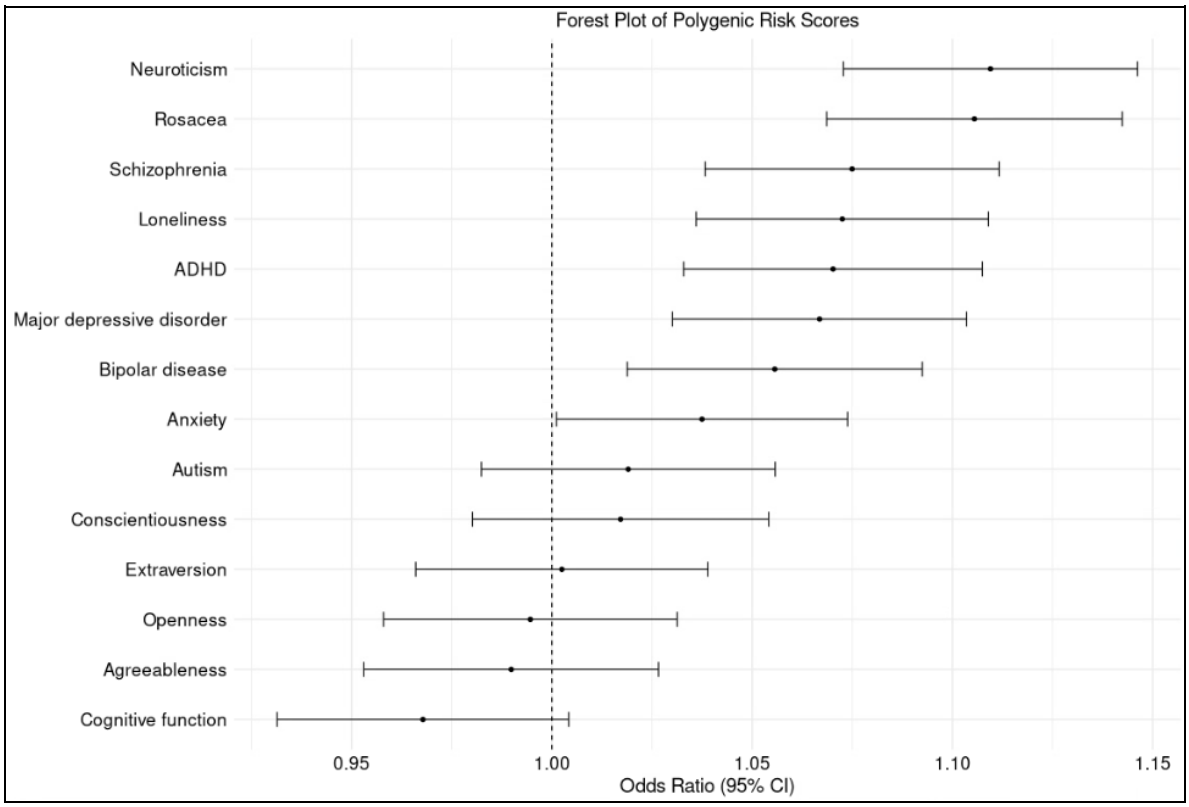

Figure 1: Forest plot of associations between mental health polygenic risk scores (PRSs) and rosacea, adjusted for age, sex and the first ten principal components (PC1-PC10).

Conclusions

In conclusion, several PRSs for psychiatric, psychosocial, and cognitive phenotypes were associated with rosacea, indicating that polygenic liability to these phenotypes is associated with rosacea. A subset of associations was partly mediated by expressed neuroticism. A great part of the associations attenuated when adjusting for neuroticism PRS, indicating substantial genetic correlation. Finally, across PRSs, the rosacea-high PRS group reported the lowest mean MCS and PCS scores, whereas the control-low PRS group reported the highest.

Abstract N°: ID-709

Topic: Inflammatory skin diseases

Generalized Granuloma Annulare Successfully Treated With Upadacitinib in an Elderly Patient

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Introduction
Granuloma annulare (GA) is a relatively common, non-infectious, inflammatory granulomatous dermatosis. Its etiology remains unknown, and both topical and systemic therapies are often unsatisfactory, particularly in generalized GA. We report a case of generalized GA in an elderly patient successfully treated with oral upadacitinib.

Materials and Methods
An 83-year-old woman presented with an 8-month history of erythematous annular plaques. The well-demarcated, non-scaly lesions were accompanied by tingling sensations and involved the trunk and lower extremities, predominantly the legs. The lesions caused significant psychological distress. Her medical history included osteoarthritis, dyslipidemia, and interstitial lung disease. Laboratory findings were unremarkable except for a positive interferon-gamma release assay. Skin biopsy from the left chest revealed lymphohistiocytic aggregation in the upper reticular dermis without epidermal changes and increased dermal mucin deposition, consistent with GA. Oral acitretin (10 mg/day) was initiated and led to gradual improvement; however, new lesions developed during treatment, leading to discontinuation at week 26. Cyclosporine (50 mg/day) was subsequently initiated but discontinued due to intolerable alopecia. Oral upadacitinib (15 mg/day) was then started.

Results
Clinical improvement began after 3 weeks, with marked improvement by week 16, characterized by significant lesion flattening with residual post-inflammatory hyperpigmentation. The dose was tapered over 4 weeks and discontinued at week 20. No recurrence was observed during the 1-year follow-up period.

Conclusions
Generalized GA often follows a chronic, treatment-refractory course, and effective systemic options remain limited. Recent studies have demonstrated upregulation of Th1/Th2 pathways and activation of JAK–STAT signaling in the pathogenesis of GA, supporting JAK inhibition as a plausible therapeutic strategy. Prior case reports have described favorable responses to several targeted agents, including tofacitinib, baricitinib, upadacitinib, abrocitinib, and deucravacitinib, with generally good tolerability and no relapse during reported follow-up. Our patient presented with classic generalized GA without predisposing factors and was refractory to conventional therapies. Upadacitinib led to complete clearance without adverse events or recurrence during follow-up. Importantly, this case highlights the safety and efficacy of JAK inhibition, even in elderly patients with increased comorbidity risk. Further studies are needed to clarify long-term efficacy, safety, and relapse patterns of JAK inhibitors in generalized GA across different age groups.

Abstract N°: ID-736

Topic: Inflammatory skin diseases

Nail Involvement in Isolated Cutaneous Langerhans Cell Histiocytosis: A Pediatric Case Report

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Introduction
Langerhans cell histiocytosis (LCH) is a rare proliferative disorder characterized by the infiltration of tissues by atypical Langerhans cells. Cutaneous involvement occurs in 30% to 60% of cases, but nail involvement remains exceptional and is largely underestimated due to its polymorphic presentation and the scarcity of reports in the literature.

Materials and Methods
We report the case of a 4-year-old child, born to consanguineous parents (third-degree cousins), with no notable medical history, presenting with diffuse disseminated papulosquamous lesions, erosive plantar keratoderma, and crusted alopecia of the scalp.

Results
Examination of the nails revealed marked involvement, with anonychia of the left great toe, onychorrhexis with purpuric striae on the other toenails, paronychia of all the fingernails on the right hand associated with peri- and subungual crusts and pustules, as well as onycholysis and multifocal nail dystrophy.
A skin biopsy showed a dermal infiltration of atypical Langerhans cells, confirmed by positive immunohistochemical staining for CD1a. Systemic involvement was ruled out through blood tests and imaging, including standard radiographs, thoracoabdominal-pelvic CT scan, and cerebral and spinal MRI. The patient was started on methotrexate at a dose of 0.3 mg/kg/day.

Conclusions
Nail involvement in Langerhans cell histiocytosis (LCH) is particularly rare and often underdiagnosed, as it can be mistaken for dystrophic changes secondary to mechanical trauma or fungal infections. Reported manifestations include longitudinal striations, subungual hyperkeratosis, hemorrhagic pustules, onycholysis, chronic paronychia, and, in rare cases, complete nail plate loss. While some studies suggest that nail involvement may be associated with multisystem disease and a poorer prognosis, others report favorable outcomes with chemotherapy. This case of isolated cutaneous LCH with significant nail involvement underscores the importance of a thorough nail examination in the diagnostic process. Given the uncertainty regarding its prognostic implications, close monitoring remains essential to assess the risk of systemic progression and to guide long-term management.

Abstract N°: ID-768

Topic: Inflammatory skin diseases

Extensive Perforating Granuloma Annulare Mimicking Autoimmune Dermatoses: A Case Report

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Introduction

Perforating granuloma annulare represents a rare histopathological variant of granuloma annulare, characterized by transepidermal elimination of altered collagen. Extensive or generalized forms are exceptionally uncommon, with available data limited almost exclusively to isolated case reports and small case series. Owing to its clinical polymorphism and histopathological resemblance to other inflammatory or autoimmune dermatoses, perforating granuloma annulare may pose significant diagnostic challenges, often resulting in delayed diagnosis and exposure to prolonged, non-targeted immunosuppressive therapies.

Materials and Methods

We describe the case of a 52-year-old woman without known immunodeficiency who presented with a progressive, widespread cutaneous eruption. The disease onset occurred in 2023 with nodular lesions involving the face, scalp, and upper extremities, followed by gradual centrifugal spread to the trunk and lower limbs, including the lower legs. Given the extensive distribution and progressive evolution, an immune-mediated dermatosis was initially suspected. The patient underwent multiple treatment regimens, including systemic corticosteroids, hydroxychloroquine, and azathioprine, based on an initial histopathological interpretation suggestive of discoid lupus erythematosus. Comprehensive laboratory evaluation repeatedly excluded autoimmune, inflammatory, infectious, and endocrine disorders. In the setting of persistent disease activity and clinicopathological inconsistency, repeat skin biopsies were obtained.

Results

Histopathological examination of two independent biopsy specimens demonstrated palisading granulomatous inflammation with central collagen degeneration and transepidermal elimination of necrobiotic material, confirming the diagnosis of extensive perforating granuloma annulare. Despite prolonged exposure to systemic immunosuppression, the disease exhibited a progressive course with only minimal and transient clinical improvement. Following diagnostic reassessment, therapeutic management was revised, and systemic treatment with methotrexate in combination with acitretin was initiated. Clinical response is currently being monitored.

Conclusions

This case highlights an unusual, extensive presentation of perforating granuloma annulare in an immunocompetent patient, contributing to the limited body of literature on generalized disease. Awareness of this rare entity is essential to avoid diagnostic delay and unnecessary immunosuppressive treatment. Repeated clinicopathological correlation should be considered in patients with progressive, treatment-resistant granulomatous dermatoses to ensure accurate diagnosis and appropriate therapeutic strategies.

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Topic: Inflammatory skin diseases

SERUM TUMOR NECROSIS FACTOR ALPHA AND INTERLEUKIN-6 IN HIDRADENITIS SUPPURATIVA PATIENTS

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Introduction

Hidradenitis suppurativa (HS), or acne inversa, is a long-standing, progressive, and disabling inflammatory disease of the skin marked by repeated flare-ups of intensely painful, deeply-seated nodules, abscesses and draining fistulae. The key pathological mechanism in HS is follicular occlusion followed by a pronounced inflammatory response. Central to this inflammatory cascade is the overexpression of proinflammatory mediators, including tumor necrosis factor- alpha (TNF-α) and interleukin-6 (IL-6).

Materials and Methods

This study was carried out at the Dermatology Outpatient Clinic, Faculty of Medicine, Alexandria University. Atotal of 30 individuals were enrolled, including 20 patients diagnosed as HS and 10 apparently healthy volunteers serving as control group. Both males and females werer included in the study. Ethical approval was obtained from the institutional board and a written informed consent was secured from each participant prior to participation.
Detailed history taking, clinical examination and evalution of HS severity using the International Hidradenitis Severity Scoring System (IHS4) were performed. Venous blood samples were collected from all participants and serum level of TNF-α and IL-6 were measured using standardized sandwich enzyme-linked immunosorbent assay (ELISA) technique.

Results

Among HS patients, the IHS4 score ranged from 3 to 44 with a mean of 9.10 ± 11.72. Serum TNF-α level were significantly higher in HS patients compared to healthy control group ($P<0.001$). In contrast, serum IL-6 levels have no significant difference from control group ($P=0.328$).
Moreover, there were no significant correlation between serum levels of TNF-α or IL-6 and disease severity as assessed by IHS4 score.

Conclusions

Patients with HS exhibit elevated systemic TNF-α, denoting increased inflammatory activity, while IL-6 levels were similar to those of healthy control group.
Neither TNF-α nor IL-6 correlated significanltly with disease severity.
The elevated serum TNF-α in HS patients the effectiveness of anti TNF-α medications in such cases.

Abstract N°: ID-863

Topic: Inflammatory skin diseases

Pyoderma Gangrenosum in a patient with polycythemia vera and bladder urothelial carcinoma

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Introduction

Pyoderma gangrenosum (PG) is a rare neutrophilic dermatosis characterized by rapidly enlarging ulcers with purple, undermined borders, often linked to systemic conditions like inflammatory bowel disease or arthritis, and is diagnosed clinically by excluding other causes. Certain medications—most commonly isotretinoin, proton pump inhibitors, and propylthiouracil—may be associated with PG. However, there are limited data regarding an association between hydroxyurea and PG. PG may also occur in association with certain hematologic malignancies, most often acute lymphoblastic leukemia and myelodysplastic syndrome, but it can also be seen in polycythemia vera. Other solid tumors, most frequently breast and gastrointestinal tract tumors, may also be associated with PG.

Results

A 70-year-old man presented with a three-month history of ulcerative skin lesions with undermined borders and necrotic bases affecting the gluteal region, lower extremities, and hands. The lesions were associated with hoarseness and arthralgia. The patient had a history of polycythemia vera, treated with hydroxyurea and intermittent phlebotomies since 2017. Since 2019, he had undergone four surgical resections of high-grade urothelial carcinoma of the urinary bladder, without evidence of dissemination. At the time of presentation, a recurrent bladder lesion was identified, and surgical excision was planned. Laboratory evaluation demonstrated leukocytosis (white blood cell count 51 × 10^9/L), thrombocytosis (platelet count 569 × 10^9/L), and elevated serum IgA levels (4.35 g/L), while complement components C3 and C4 were within normal limits. Circulating immune complexes, antinuclear antibodies, extractable nuclear antigens (ENA), anticardiolipid antibodies (ACA), and perinuclear and cytoplasmic antineutrophil cytoplasmic antibodies (p- and c-ANCA) were negative. Computed tomography (CT) of the chests, abdomen, and pelvis revealed early emphysematous changes in the lungs and infiltration of the posterior wall of the urinary bladder. To make a diagnosis of PG, the patient underwent differential diagnostic evaluation for Wegener's granulomatosis, including endoscopic examination and biopsy of the nasal mucosa, which demonstrated chronic nonspecific inflammation. In addition, to exclude hydroxyurea as a potential cause of PG, therapy was discontinued for 15 days in consultation with a hematologist, without significant clinical improvement. The diagnosis of PG was established by exclusion of other causes and confirmed by biopsy of the skin ulcer margin. Histopathological examination revealed a dense neutrophilic infiltrate in the dermis immediately beneath the ulceration, with focal areas of collagen necrosis, findings consistent with pyoderma gangrenosum. Following histopathological evaluation, systemic corticosteroid therapy was initiated upon admission (methylprednisolon and prednisone at a total dose 0.75 mg/kg) with gradual dose tapering. After histopathological confirmation, dapsone was added at a dose of 50 mg daily, resulting in a satisfactory therapeutic response with initial regression of the skin lesions.

Conclusions

Pyoderma gangrenosum is a rare neutrophilic dermatosis that may occur in association with systemic diseases, certain medications, and malignancies. Therefore, careful evaluation for potential comorbidities and early initiation of appropriate therapy are essential.

Abstract N°: ID-940

Topic: Inflammatory skin diseases

Idiopathic Generalized Granuloma Annulare in an Adolescent: A Case Report

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Introduction

Granuloma annulare is a benign inflammatory skin condition that, in most cases, has no clearly identified cause. The localized form is the most common presentation, whereas the generalized variant is less frequent and can sometimes be difficult to diagnose, especially in children and adolescents.
When lesions are widespread, they may resemble other inflammatory or granulomatous skin disorders, making histological confirmation and a careful etiological evaluation necessary.
We present the case of an adolescent evaluated in our department for diffuse cutaneous lesions, in whom the diagnosis of idiopathic generalized granuloma annulare was confirmed.

Materials and Methods

A 16-year-old boy with no significant medical history was seen in our department for skin lesions that had been gradually developing over the past three years.
On dermatological examination, multiple erythematous-violaceous lesions were observed. These lesions were non-itchy and painless, and had merged to form plaques located on the thighs, around the umbilical area, and on the trunk.
There was no involvement of the mucous membranes or nails, and the patient reported no other associated symptoms.
In view of the chronic evolution and clinical appearance, a skin biopsy was performed. Histopathological examination, supported by immunohistochemical analysis, confirmed the diagnosis of granuloma annulare, revealing a palisading granulomatous infiltrate with areas of collagen degeneration.
Routine laboratory tests were completely normal, and no underlying systemic, metabolic, or immunological disorder was identified, supporting the idiopathic nature of the disease.
The patient was treated with topical corticosteroids and phototherapy, leading to a progressive and marked improvement of the skin lesions.

Results

Granuloma annulare is a benign inflammatory skin condition whose exact cause remains unclear. In most cases, especially in children and adolescents, it occurs without any identifiable trigger and is considered idiopathic.

While granuloma annulare is relatively common overall, the generalized form is much less frequent. It represents approximately 8–15% of cases worldwide and is characterized by multiple, widespread lesions mainly affecting the trunk and limbs. This form tends to be more persistent and chronic than the localized variant.

Because of its diffuse presentation, generalized granuloma annulare can be difficult to diagnose and may resemble other skin diseases such as cutaneous sarcoidosis, lichen planus, or drug-induced eruptions. For this reason, histological confirmation is essential. The typical finding of a palisading granulomatous infiltrate with areas of collagen degeneration strongly supports the diagnosis.

Although several associations have been described, including diabetes, thyroid disorders, and dyslipidemia, most cases remain idiopathic. In our patient, an extensive evaluation did not reveal any underlying condition.

There is no standardized treatment for generalized granuloma annulare. Therapeutic options include topical

corticosteroids, calcineurin inhibitors, phototherapy, and, in resistant cases, systemic treatments. In this case, the combination of topical therapy and phototherapy led to significant clinical improvement.

Conclusions

This case illustrates an unusual presentation of extensive generalized granuloma annulare in an adolescent, a population in which the generalized form is rarely reported. The wide distribution and long evolution of the lesions initially raised diagnostic difficulties and required histological confirmation. A thorough etiological work-up was normal, confirming the idiopathic nature of the disease. Despite the impressive clinical presentation, the patient responded well to conservative therapy, highlighting the benign prognosis of this condition. This report emphasizes the importance of recognizing generalized granuloma annulare in young patients to ensure accurate diagnosis, appropriate management, and proper reassurance.

Abstract N°: ID-954

Topic: Inflammatory skin diseases

Neutrophilic Urticarial Dermatosis in a Lupus Patient: A Case Report

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Introduction
Neutrophilic urticarial dermatosis (NUD) represents a distinct, non-vasculitic neutrophilic dermatosis characterized by persistent urticarial plaques. While its pathogenesis remains incompletely elucidated, NUD is frequently reported in association with systemic autoinflammatory disorders. A significant clinical correlation exists between NUD and systemic lupus erythematosus (SLE), suggesting a potential shared immunopathogenic pathway. We report a case of NUD occurring in a patient with established SLE, underscoring the importance of recognizing this cutaneous manifestation within the spectrum of lupus.

Materials and Methods
NA

Results
A 38-year-old woman with a documented history of SLE was referred for evaluation of rapidly progressive cutaneous lesions present for less than 24 hours. Dermatological examination revealed multiple firm, fixed, erythematous plaques on the upper trunk and face, notable for their lack of pruritus or significant edema. A skin biopsy was performed. Histopathological analysis demonstrated minimal vacuolar interface dermatitis accompanied by a dense, predominantly neutrophilic infiltrate. This infiltrate was arranged in a superficial and deep perivascular as well as an interstitial distribution, featuring marked leukocytoclasis. Critically, there was no fibrinoid necrosis of vascular walls, no dermal edema, and no evidence of epidermal involvement. Laboratory studies revealed an associated biological inflammatory syndrome. Based on these clinicopathological findings, a definitive diagnosis of SLE-associated NUD was established.

Conclusions
Our case exemplifies the specific association between NUD and SLE. The diagnosis rests on stringent clinicopathological correlation to exclude key differentials: urticarial vasculitis, bullous SLE, and Sweet's syndrome. Pathophysiology likely involves dysregulation of the innate immune system, with aberrant neutrophil activation and recruitment playing a central role. This is supported by the frequent co-occurrence of NUD with other autoinflammatory diseases and the recognition of other neutrophilic variants of cutaneous lupus. NUD can precede the formal diagnosis of SLE or emerge during its course, and its systemic symptoms can mimic a generalized lupus flare, potentially leading to diagnostic delay. Beyond SLE, NUD has been reported in association with other immune dysregulatory states. First-line management typically involves agents that inhibit neutrophil migration and function, such as colchicine, dapsone, or, in refractory cases, interleukin-1 inhibitors. Although rare, NUD is a clinically significant manifestation that warrants recognition to ensure accurate diagnosis and appropriate therapy in patients with SLE.

Abstract N°: ID-956

Topic: Inflammatory skin diseases

Psoriasiform lesions arising over generalized morphea in a patient treated with abatacept

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Introduction
Morphea is a chronic inflammatory dermatosis characterized by cutaneous fibrosis and is frequently associated with autoimmune diseases, including rheumatoid arthritis. Abatacept, a selective T-cell co-stimulation modulator used in rheumatoid arthritis, is rarely associated with cutaneous adverse events, particularly psoriasiform eruptions.

Materials and Methods
We report the case of a 71-year-old woman with long-standing rheumatoid arthritis who developed generalized morphea with a recalcitrant course despite multiple treatments, including topical corticosteroids, phototherapy, methotrexate and intravenous immunoglobulin. Given the extent and refractoriness of the disease, monthly abatacept therapy was initiated. Clinical, histopathological and therapeutic data were reviewed.

Results
Treatment with abatacept led to progressive improvement and stabilization of generalized morphea. However, after six months of therapy, non-pruritic erythematous-squamous plaques developed exclusively over areas previously affected by morphea. Clinical and histological findings were consistent with psoriasiform lesions. Topical treatment with calcitriol resulted in improvement of the secondary eruption, while abatacept was maintained and the underlying morphea remained stable.

Conclusions
The coexistence of morphea and psoriasiform lesions is rare and may reflect complex interactions between distinct immunological pathways, particularly Th2-predominant mechanisms in morphea and Th1/Th17 activation in psoriasis. In this context, abatacept may act as a trigger for a paradoxical immunological reaction. The strict localization of psoriasiform lesions to pre-existing morphea plaques further suggests a possible role of Wolf's isotopic phenomenon. This case highlights the importance of recognizing paradoxical cutaneous reactions in patients treated with biologic therapies.

Abstract N°: ID-957

Topic: Inflammatory skin diseases

The Ketogenic Diet as an Emerging Trigger for Prurigo Pigmentosa: A Case Report

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Introduction
Prurigo pigmentosa (PP) is a rare inflammatory dermatosis characterized by pruritic, erythematous papules that resolve with reticulated hyperpigmentation. Its pathogenesis is closely linked to ketotic states. With the widespread adoption of the ketogenic diet for weight management, nutritional ketosis has become an increasingly recognized trigger. We report a case of PP arising in this context, highlighting this emerging clinical association.

Materials and Methods
NA

Results
A 35-year-old man with no significant past medical history presented with a two-month history of a pruritic rash on his back, characterized by recurrent flares and remissions. Physical examination revealed a symmetrical eruption of erythematous papules and plaques overlying a reticulated hyperpigmented patch on the back. Urinalysis demonstrated significant ketonuria (+++) without glycosuria, ruling out diabetic ketoacidosis. Patch testing was negative, excluding allergic contact dermatitis. Histopathological examination of a skin biopsy showed focal epidermal spongiosis and a superficial perivascular polymorphous infiltrate composed of lymphocytes, neutrophils, and eosinophils. The diagnosis of prurigo pigmentosa was established based on the integration of the characteristic clinical presentation, supportive histopathology, exclusion of alternative diagnoses, and the pivotal finding of ketonuria in a non-diabetic patient.

Conclusions
Our case illustrates the evolving demographic and etiological profile of PP, presenting in a male patient with ketonuria in the absence of diabetes. The isolated ketonuria strongly implicates nutritional ketosis, likely from a ketogenic diet, as the direct pathogenic trigger. The rising global incidence of PP parallels the widespread adoption of low-carbohydrate diets, rendering it a significant clinical and public health consideration. Early diagnosis is crucial to alleviate symptoms, prevent post-inflammatory hyperpigmentation, and guide effective management through dietary modification. This report underscores the necessity of systematically inquiring about dietary habits and assessing for ketonuria in patients with suggestive eruptions. Furthermore, it highlights the critical need to elucidate the precise pathophysiological mechanisms by which ketone bodies or the associated metabolic state incite the characteristic spongiotic and inflammatory response seen in PP. Thus, this report reinforces the association between self-induced nutritional ketosis and the development of prurigo pigmentosa. Increased awareness of this link is essential for prompt diagnosis and appropriate dietary counseling in affected individuals.

Abstract N°: ID-960

Topic: Inflammatory skin diseases

Refractory Painful Plantar Erythema as a Rare Initial Manifestation of Lichen Planus

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Introduction

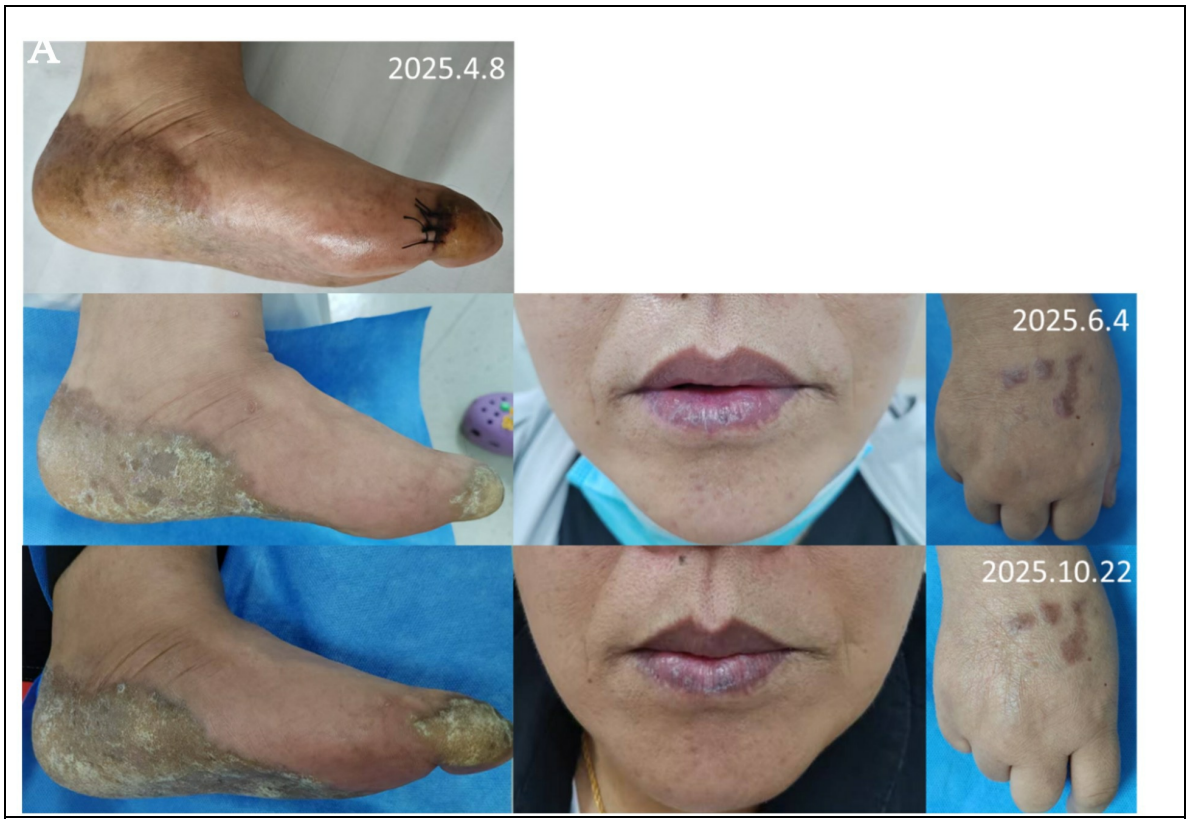
Lichen planus (LP) is a chronic immune-mediated inflammatory disorder with characteristic cutaneous features. Atypical initial presentations, particularly those dominated by pain and confined to weight-bearing sites, are rare and may result in delayed diagnosis. We present an unusual case of LP initially manifesting as isolated painful plantar erythema, highlighting diagnostic challenges and therapeutic response to apremilast.

Materials and Methods

Clinical features, laboratory findings, histopathological characteristics, and treatment responses were analyzed in a patient with chronic unilateral plantar erythema and pain. Diagnostic evaluation included autoantibody testing and histopathological examination of a plantar skin biopsy. Therapeutic outcomes were assessed through longitudinal clinical follow-up.

Results

The patient presented with a prolonged course of progressive plantar pain accompanied by erythema and swelling, initially misdiagnosed as soft tissue infection and treated with systemic antibiotics without sustained benefit. Recurrent symptoms and subsequent development of well-demarcated hyperpigmented plantar macules prompted further investigation(Fig1.A). Autoantibody testing was positive, and histopathology revealed classic features of LP, confirming the diagnosis. Systemic therapy with hydroxychloroquine provided inadequate disease control, and the disease progressed with the appearance of typical LP lesions at additional cutaneous sites(Fig1.B). Following escalation to apremilast, the patient experienced improvement (Fig1.C), including substantial resolution of plantar pain and regression of cutaneous lesions during follow-up.



A, Seven months after the onset of recurrent pain, well-demarcated hyperpigmented macules with a dark brown hue gradually developed on the foot; B, Two months after initiating hydroxychloroquine therapy, the patient gradually developed typical lichen planus lesions on the foot (left), lower lip (middle), and dorsum of the hand (right); C, After four months of apremilast treatment, the cutaneous lesions of foot (left), lower lip (middle), dorsum of the hand (right)showed marked improvement, and the pain symptoms resolved completely.

Conclusions

Isolated painful plantar erythema represents a rare and diagnostically challenging initial manifestation of lichen planus. Early histopathological evaluation is essential to avoid misdiagnosis and inappropriate treatment. In refractory cutaneous LP, apremilast may serve as an effective therapeutic option and warrants further clinical investigation.

Abstract N°: ID-977

Topic: Inflammatory skin diseases

Cutaneous sarcoidosis as a marker of systemic disease

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Introduction

Sarcoidosis is a multisystem granulomatous disease of unknown etiology, characterized histologically by non-caseating epithelioid granulomas. Cutaneous involvement may represent the first clinical manifestation and can precede or accompany systemic disease. Due to its clinical polymorphism, cutaneous sarcoidosis remains a diagnostic challenge. The aim of this report is to describe a case of extensive cutaneous sarcoidosis associated with pulmonary involvement, emphasizing the diagnostic approach, differential diagnosis, and therapeutic decision-making.

Materials and Methods

We report the case of a 52-year-old female, non-smoker, who presented with a three-month history of painful, indurated erythematous-violaceous papules, plaques, and papulovesicular lesions disseminated on the lower limbs, upper limbs, trunk, and face, associated with fatigue, exertional dyspnea, arthralgia, and chest discomfort. Clinical dermatological examination, diascopy, dermoscopy, laboratory tests, and incisional skin biopsy were performed. A systemic evaluation included chest radiography, high-resolution computed tomography, pulmonary function tests, abdominal ultrasound, electrocardiography, echocardiography, and ophthalmologic assessment. Infectious and non-infectious granulomatous disorders were considered in the differential diagnosis.

Results

Histopathological examination revealed non-caseating epithelioid granulomas with minimal lymphocytic infiltrate (“naked granulomas”), consistent with cutaneous sarcoidosis. Laboratory investigations showed an inflammatory syndrome. Chest imaging demonstrated mediastinal lymphadenopathy with calcifications, while pulmonary function tests revealed moderately reduced diffusing capacity with preserved spirometric values. No significant cardiac, ocular, or abdominal involvement was detected. Based on the clinical, histological, and imaging findings, a diagnosis of sarcoidosis with extensive cutaneous and pulmonary involvement was established. Given the rapid progression, extensive skin involvement, pulmonary disease, and lack of response to topical therapy, systemic treatment with oral corticosteroids combined with methotrexate was initiated. The patient improved with remission of the lesions and systemic symptoms.

Conclusions

Cutaneous sarcoidosis may be the presenting sign of systemic disease and should prompt a thorough multidisciplinary evaluation. Clinicopathological correlation and comprehensive systemic assessment are essential for accurate diagnosis and appropriate management. Systemic therapy is warranted in patients with extensive cutaneous involvement and associated organ disease in order to control disease activity and prevent long-term complications.

Abstract N°: ID-984

Topic: Inflammatory skin diseases

A Rare Polymorphic Urticarial and Bullous Presentation of Wells Syndrome : Diagnostic and Therapeutic Challenges

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Introduction

Wells syndrome (eosinophilic cellulitis) is a rare inflammatory dermatosis characterized by marked clinical polymorphism. Persistent urticarial and vesiculobullous forms, which are exceptional, may mimic chronic urticaria or autoimmune bullous dermatoses, leading to diagnostic and therapeutic challenges. Diagnosis relies on histopathological examination, which may sometimes be non-specific. The aim is to describe a polymorphic urticarial and bullous form of Wells syndrome and to discuss diagnostic pitfalls and therapeutic management.

Materials and Methods

We report the case of a 19-year-old female patient with a history of penicillin-induced acute generalized exanthematous pustulosis (AGEPShe was admitted for a polymorphic eruption consisting of vesiculobullous lesions arising on urticarial inflammatory plaques, associated with pseudo-cellulitic edema, involving the skin folds and the left thigh.

A skin biopsy with histopathological examination revealed a dense dermal eosinophilic infiltrate with characteristic flame figures, consistent with Wells syndrome. The complete blood count showed marked peripheral eosinophilia (3,400/mm^3). Based on the presence of two major and two minor criteria, the diagnosis of Wells syndrome was established.

Systemic corticosteroid therapy with prednisone at 0.5 mg/kg/day was initiated, resulting in rapid clinical improvement. After six months of remission, corticosteroid tapering revealed steroid dependence. In view of this course, a steroid-sparing regimen combining colchicine (1 mg/day) and dapsone (100 mg/day) was introduced.

Results

The present case illustrates a rare and polymorphic form of Wells syndrome, combining persistent urticarial lesions, pseudo-cellulitic edema, and vesiculobullous lesions, atypical manifestations that are well described but uncommon in the literature. These clinical presentations may mimic chronic urticaria or autoimmune bullous diseases, resulting in diagnostic delays, particularly in young patients or those with an allergic background.

The clinical polymorphism of Wells syndrome explains the wide range of initial differential diagnoses. In vesiculobullous forms, the exclusion of autoimmune bullous dermatoses by direct immunofluorescence is essential. Diagnosis primarily relies on histopathological examination, showing a dermal eosinophilic infiltrate with or without flame figures, which are neither constant nor specific. The diagnostic criteria proposed in 2013 allow the inclusion of these atypical forms after

exclusion of alternative etiologies.

From a therapeutic perspective, systemic corticosteroids remain the first-line treatment and are usually associated with a rapid response. However, polymorphic and recurrent forms are frequently complicated by steroid dependence, as observed in our patient. Several studies have reported the benefit of steroid-sparing agents, including colchicine, dapsone, methotrexate, azathioprine, and ciclosporin, with variable outcomes. Isolated cases have also described the efficacy of eosinophil-targeted therapies, such as omalizumab or anti–IL-5 biologics, in severe or refractory forms.

Conclusions

Urticarial and vesiculobullous forms of Wells syndrome represent rare and polymorphic presentations associated with significant diagnostic challenges. Diagnosis requires a rigorous clinico-histological approach integrating current diagnostic criteria. Therapeutic management should be individualized, particularly in recurrent or steroid-dependent forms.

Abstract N°: ID-1008

Topic: Inflammatory skin diseases

Atypical bullous erythema multiforme following topical henna exposure: a case report

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Introduction

Erythema multiforme is an acute inflammatory dermatosis, most often of infectious origin, characterized by typical target lesions. The bullous form, which is rarer, may be associated with blister formation and epidermal detachment, constituting a diagnostic pitfall with severe cutaneous adverse reactions, particularly Stevens–Johnson syndrome. Distinguishing between these entities is essential due to differences in etiology, prognosis, and management. We report a case of extensive bullous erythema multiforme without identified drug-related or infectious etiology.

Materials and Methods

A 74-year-old woman with no significant medical history was admitted for evaluation of an acute bullous dermatosis evolving for one week, marked by the sudden onset of blisters on an erythematous background involving the forearms, trunk, and lower limbs, secondarily complicated by epidermal detachment. No recent drug intake or intercurrent infection was reported, except for a topical henna application a few days before lesion onset, in a context of low-grade fever.

Dermatological examination revealed multiple clear blisters, both flaccid and tense, on an inflammatory erythematous background, with epidermal detachment estimated at 14% of the body surface area and a positive Nikolsky sign. Symmetrical typical target lesions surmounted by blisters were observed on the forearms. Lesions predominantly involved intertriginous areas. Mucous membranes were spared.

Histopathological examination showed a subepidermal bullous dermatosis with keratinocyte necrosis and lichenoid interface dermatitis, without diffuse epidermal necrosis. Direct and indirect immunofluorescence studies were negative. The clinical course under conservative management was favorable, with progressive improvement.

Results

Bullous erythema multiforme (BEM) is considered a severe form of erythema multiforme, within the spectrum of erythema multiforme major. It is characterized by blister formation on typical target lesions and differs from severe drug-induced dermatoses, particularly Stevens–Johnson syndrome, in terms of etiology, histopathology, and generally favorable prognosis.

In this case, certain features differed from the classic presentation, notably the involvement of intertriginous areas and the extent of epidermal detachment. However, extensive forms of BEM with atypical distribution have been reported when lesion morphology remains suggestive.

Histopathology confirmed the diagnosis, showing a subepidermal blister associated with interface dermatitis and keratinocyte necrosis, without diffuse epidermal necrosis. Negative immunofluorescence allowed exclusion of an autoimmune bullous disease.

Topical henna application represents a notable exposure in this case. Although no direct causal relationship between henna and erythema multiforme has been established, some henna preparations containing chemical additives may act as non-specific triggering factors for immune-mediated cutaneous reactions. Natural henna (*Lawsonia inermis*) is generally considered weakly sensitizing; however, commercially available preparations may contain immunogenic

additives or dyes capable of inducing immune-mediated skin reactions. This observation highlights the importance of a detailed assessment of topical exposures in acute bullous dermatoses of unclear etiology.
The favorable outcome under conservative management is consistent with data from the literature and further supports the diagnosis of bullous erythema multiforme.

Conclusions

Bullous erythema multiforme remains a rare entity with a potentially misleading clinical presentation. A rigorous clinico-pathological approach is essential to establish the diagnosis and guide appropriate management.

Abstract N°: ID-1023

Topic: Inflammatory skin diseases

Comprehensive Dermatological and Ophthalmological Evaluation of a High-Tolerance Sunscreen: Clinical Benefits in Rosacea Patients with Sensitive Skin Across light to dark Phototypes in a Brazilian Study

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Introduction
Rosacea patients frequently require consistent photoprotection to prevent symptom exacerbation triggered by ultraviolet exposure, heat and visible light. However, sunscreen use remains challenging in this population due to frequent cutaneous intolerance, sensory discomfort and ocular irritation, particularly in individuals with sensitive skin, which may compromise adherence. Moreover, rosacea is clinically assessed mainly in lighter phototypes, while in darker phototypes the condition is less visible and requires complementary evaluation through sensitivity-related and functional parameters. The objective of this study was to assess the dermatological and ophthalmological tolerance and clinical and functional efficacy of a sunscreen specifically formulated for sensitive skin, including subjects presenting rosacea, under real-use conditions, in women and men representing all skin phototypes.

Materials and Methods
This clinical study was conducted in Brazil during the autumn season and was subject to dermatological and ophthalmological control. Of 36 enrolled adults, 31 completed the study and were analyzed. Women and men aged 18–65 years presenting sensitive skin, including subjects with mild to moderate rosacea, were included. All skin phototypes (I–VI) and all skin types were represented. The investigational sunscreen was applied to the face, neck and periocular area at least twice daily in the morning and during the daytime, for 28 days. Clinical evaluation included objective assessment of rosacea-related signs using the Investigator Global Assessment of Rosacea Severity Score (IGA-RSS) and instrumental colorimetric facial redness analysis from photos taken at each visit. Ocular tolerance was evaluated by an ophthalmologist. Functional outcomes relevant to all phototypes were evaluated using the Sensitive Scale-10 (SS-10), flushing (frequency, intensity and duration), and quality-of-life [Rosacea Quality of Life (RosaQoL) and Burden of Sensitive Skin (BoSS)] questionnaires. Post-treatment values were compared with baseline (Wilcoxon signed-rank test).

Results
The investigational sunscreen was very well tolerated dermatologically and ophthalmologically, with no adverse events reported. A clinically meaningful reduction in rosacea severity was observed, with a statistically significant decrease in IGA-RSS of −30.4% at D14 and −46.4% at D28 compared with baseline. Full facial acquisitions confirmed a significant reduction of redness at D28 by clinical grading (−24.1%). A marked and statistically significant improvement in sensitive skin symptoms was observed. Considering the total SS-10 score, a significant improvement was recorded at all evaluation time points (D0, D14 and D28), with a mean reduction of −86.6% at D28 compared with baseline. Significant improvements were also observed for individual functional symptoms, including general discomfort, hot flushes, itching, pain and redness, demonstrating a rapid onset of action and sustained efficacy over time. Rosacea trigger-related symptoms improved significantly, with reductions in flushing frequency, intensity and duration across the study period. Quality-of-life outcomes improved significantly, with reduced BoSS and RosaQoL scores reflecting a decreased sensitive-skin discomfort and a better overall quality of life. Subjective questionnaires further confirmed high levels of perceived efficacy, comfort and soothing effect.

Conclusions

This study demonstrated that this sunscreen provides clinically and functionally significant benefits, and is very well tolerated by sensitive skin, regardless of phototype or gender. These results support the use of this sunscreen as a regular photoprotective solution for sensitive and rosacea-prone skin.

Abstract N°: ID-1036

Topic: Inflammatory skin diseases

It's not just lupus: diagnostic complexity in evolving inflammatory dermatoses

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Introduction
Chronic inflammatory dermatoses may evolve over time, with overlapping morphologic features that obscure diagnosis and complicate management. Coexistence of discoid lupus erythematosus (DLE) and psoriasis is uncommon and presents therapeutic challenges, particularly when compounded by infection risk. We report a complex case highlighting diagnostic reassessment, histopathologic discordance, and management constraints in evolving inflammatory skin disease.

Materials and Methods
A 45-year-old woman (Fitzpatrick skin type VI) with longstanding facial dermatosis diagnosed as DLE was followed longitudinally for 8 years. Clinical progression, histopathology (including direct immunofluorescence), autoimmune serology, and infection screening were reviewed. Repeat biopsies were performed from representative facial and body sites following disease evolution.

Results

The patient had facial and neck involvement since 2009 and was treated for biopsy-proven DLE from 2018 with hydroxychloroquine and topical corticosteroids. She subsequently developed immune thrombocytopenic purpura requiring systemic therapy but did not meet criteria for systemic lupus. After seven years of relative stability, she presented with abrupt onset of widespread, severely pruritic psoriasiform plaques involving approximately 15% body surface area, in addition to chronic facial disease. Examination demonstrated three distinct patterns: scarring facial plaques with "lonely hairs," atrophic neck changes, and well-demarcated extensor plaques.

Right cheek biopsy showed a lichenoid interface reaction with epidermal atrophy, basal vacuolar change, pigment incontinence, and severe solar elastosis, consistent with "burnt-out" cutaneous lupus. Unexpectedly, features of colloid milium were also identified. Retrospective history revealed possible intermittent use of a topical skin-lightening agent applied to facial hyperpigmented areas approximately 5 years earlier, raising consideration of secondary colloid milium on a background of chronic inflammation and actinic damage. Left knee biopsy demonstrated classic psoriatic histopathology, confirming a second concurrent inflammatory dermatosis.

Routine infection screening prior to potential systemic escalation revealed a strongly positive interferon-gamma release assay, consistent with latent tuberculosis, further constraining immunomodulatory options. Autoimmune serology was otherwise unremarkable. Management required optimisation of site-specific topical therapy and continuation of hydroxychloroquine, with multidisciplinary input from dermatology, infectious diseases, and rheumatology to balance disease control against risks of tuberculosis reactivation and lupus or psoriasis exacerbation.

Conclusions
This case illustrates how chronic inflammatory dermatoses may evolve into overlapping disease phenotypes,

necessitating diagnostic reassessment despite years of apparent stability. Discoid lupus can mimic psoriasiform disease, while true psoriasis may arise concurrently. Morphologic change or treatment-refractory disease should prompt repeat biopsy of representative sites. Secondary colloid milium may complicate chronic facial lupus, potentially influenced by ultraviolet exposure and topical agents. Comprehensive infection screening is essential before systemic escalation, particularly in patients with migration or exposure risk. Multidisciplinary care and stepwise therapeutic strategies are critical in managing complex overlap disease.

Abstract N°: ID-1056

Topic: Inflammatory skin diseases

Pyoderma gangrenosum: a diagnostic and therapeutic challenge

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Introduction
Pyoderma gangrenosum (PG) is a rare neutrophilic dermatosis characterized by the rapid onset of painful, ulcerative skin lesions with violaceous borders. It represents a diagnostic and therapeutic challenge due to its clinical variability and association with systemic diseases. This case highlights the importance of early recognition and multidisciplinary management of PG.

Materials and Methods
We report a clinical case of PG with extensive lower limb involvement.

Results
An 84-year-old woman with a medical history of rheumatoid arthritis treated with tocilizumab, presented to the dermatology department due to the appearance of bullous lesions on the right lower limb. These lesions rapidly evolved into a painful ulcer. On physical examination, a 15 cm ulcer with violaceous borders was observed, extending circumferentially from the lateral malleolus to the mid-calf of the right leg. A skin biopsy was performed, which supported the diagnosis of PG. Systemic treatment was initiated with prednisone, azathioprine and etanercept. In addition, negative pressure wound therapy (NPWT) was used to minimize the risk of infection and accelerate epithelialization.

Conclusions
PG requires a high index of suspicion and early intervention. A combined therapeutic approach involving systemic immunosuppressants and tailored wound care, such as NPWT, can optimize outcomes, especially in elderly patients with comorbid disorders.

Abstract N°: ID-1061

Topic: Inflammatory skin diseases

Diabetic Buschke Scleredema: A Case Report

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Introduction
Buschke scleredema is a rare connective tissue disorder characterized by indurated skin thickening, predominantly involving the neck, shoulders, and upper trunk. It differs from systemic sclerosis by the absence of acral sclerosis, Raynaud phenomenon, and visceral involvement. Three clinical forms are classically described: post-infectious, diabetes-associated, and paraneoplastic forms. We report a case of diabetes-associated Buschke scleredema.

Materials and Methods
We report the case of a 64-year-old woman with a history of arterial hypertension for 8 years under treatment and type 2 diabetes mellitus for 10 years treated with insulin, with poor glycemic control (HbA1c 8.8%) and a body mass index of 37.6. She presented with a progressive induration of the skin of the neck, upper trunk, and upper limbs evolving over 5 months.
Clinical examination revealed thickened, hard, and tense skin, difficult to pinch, involving the neck, upper trunk, and upper limbs, with sparing of the extremities. There was no Raynaud phenomenon or mucosal involvement.
Skin biopsy showed a dense dermis composed of thick collagen bundles, fragmented elastic fibers on orcein staining, a mild interstitial and perisudoral lymphoplasmacytic mononuclear inflammatory infiltrate without deep fibrosis, and mucin deposition, consistent with scleredema.
Biological and immunological investigations were unremarkable. Serum protein electrophoresis showed no monoclonal gammopathy, and chest–abdomen–pelvis scan revealed no associated visceral involvement.
The diagnosis of Buschke scleredema was established. Treatment with systemic corticosteroids and methotrexate was initiated, resulting in slight improvement of skin induration.

Results
Buschke scleredema is a rare and often underdiagnosed entity that may pose a differential diagnostic challenge with localized scleroderma, systemic sclerosis, or eosinophilic fasciitis. It is characterized by induration and sclerotic edema of the skin in a cape-like distribution, mainly affecting the neck, shoulders, and trunk, while sparing the extremities.
According to Grattan's classification, three main types are distinguished: type 1, occurring after an acute infection and usually regressing within a few months; type 2, associated with monoclonal gammopathy and a chronic course; and type 3, associated with diabetes, typically in obese patients, as observed in our case. In types 2 and 3, extracutaneous involvement may be present.
Histopathology, showing dermal thickening with mucin deposition, is a key diagnostic feature. Management is not standardized and is based on treating the underlying cause when identified, along with various therapeutic options with variable efficacy. Glycemic control generally does not lead to improvement of scleredema.

Conclusions
Through this case, we emphasize the importance of considering Buschke scleredema in the presence of diffuse, non-sclerodermiform skin induration in order to avoid diagnostic errors and ensure appropriate management.

Abstract N°: ID-1071

Topic: Inflammatory skin diseases

Pyoderma Gangrenosum - Two Difficult Clinical Cases

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Introduction

Pyoderma gangrenosum is a rare neutrophilic inflammatory dermatosis characterized by rapidly enlarging, painful cutaneous ulcers. The diagnosis is primarily clinical and requires the exclusion of other etiologies of skin ulceration. Owing to its unpredictable prognosis, pyoderma gangrenosum constitutes a significant diagnostic and therapeutic challenge, necessitating an individualized management approach.

Materials and Methods

We report two cases of female patients of similar age diagnosed with pyoderma gangrenosum, both presenting with lesions localized to the breast region. In the first patient, the disease exhibited a multifocal course, involving the area beneath the right breast, the left breast, the right upper extremity, and the left foot. The lesions demonstrated peripheral progression and were associated with significant pain. Histopathological examination revealed a nonspecific inflammatory infiltrate. Additionally, the biopsy specimen obtained from the arm suggested features consistent with hidradenitis suppurativa. Despite treatment with cyclosporine A and systemic glucocorticoids, a heterogeneous therapeutic response was observed, with complete resolution of the breast lesion and persistence of an active, treatment-refractory ulcer on the arm. Subsequent biological therapy with secukinumab failed to induce sustained clinical improvement and was associated with disease progression, leading to treatment discontinuation and a change in therapeutic strategy to adalimumab.

The second patient developed pyoderma gangrenosum of the right breast following a surgical procedure. The disease followed a chronic and progressive course and was refractory to topical therapy, hyperbaric oxygen therapy, and systemic immunosuppression. Prolonged treatment with cyclosporine A and systemic glucocorticoids resulted in significant systemic adverse effects, including heart failure, which substantially limited further therapeutic options. After exclusion of contraindications, biological therapy with adalimumab was initiated.

Results

In the first case, treatment with cyclosporine A and systemic glucocorticoids led to complete healing of the ulcer on the left breast, whereas the lesion on the right arm remained active, painful, and resistant to the same treatment. Due to disease progression under previous therapy including secukinumab, adalimumab was introduced as the subsequent line of therapy.

In the second case, despite long-standing disease activity and failure of prior treatments including cyclosporine A and systemic glucocorticoids, initiation of adalimumab resulted in gradual clinical improvement, manifested by a reduction in inflammatory infiltration at the ulcer margins, partial re-epithelialization of the ulcer base, and alleviation of pain. The overall response remains still incomplete, however progressive improvement is observed with each month of therapy.

Conclusions

These cases underscore the marked clinical heterogeneity of pyoderma gangrenosum and the substantial variability in treatment response, both between individual patients and among different lesions in the same patient. Pyoderma gangrenosum remains a considerable therapeutic challenge, highlighting the need for individualized treatment strategies and careful selection of systemic and biological therapies, particularly in refractory disease.

Abstract N°: ID-1080

Topic: Inflammatory skin diseases

Linear Blaschkoid lichen planus mimicking herpes zoster: a diagnostic pitfall in primary care - a case report.

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Introduction

Linear dermatoses following Blaschko's lines may represent a diagnostic challenge and may be misdiagnosed as other dermatological conditions or infections, particularly in primary care.

The aim of this case report is to highlight linear lichen planus as an important differential diagnosis of unilateral linear rashes which, in this case, was initially misdiagnosed and treated as a herpes zoster.

Materials and Methods

This is a case report of a female patient in her mid -70s who presented to general practice with a sudden onset of a unilateral linear erythematous-violaceous rash on her left buttock. The rash was associated with mild pruritus but no pain. A diagnosis of herpes zoster was made and oral antiviral treatment was initiated. Despite treatment, the rash progressed over several weeks to involve the arm, chest, and leg on the same side of the body. The patient was reviewed on two further occasions and received additional courses of low-dose oral antivirals without improvement. She reported no systemic symptoms and no neuropathic pain, which would be typical for herpes zoster.

On further review, the linear distribution of the rash was noted to follow Blaschko's lines, rather than a dermatomal pattern.

Linear lichen planus was suspected and a skin biopsy was arranged in primary care. Histopathological examination demonstrated features, consistent with lichen planus, confirming the diagnosis.

Results

Establishing the correct diagnosis allowed appropriate management and provided reassurance regarding non-infectivity, which was particularly important for the patient, who wished to safely have contact with her newborn granddaughter.

Conclusions

This case illustrates the importance of recognising a Blaschkoid pattern in contrast to a dermatomal distribution. Awareness of this diagnostic pitfall may aid earlier consideration of inflammatory dermatoses such as linear lichen planus, reducing delayed diagnosis and unnecessary treatment in primary care.

Abstract N°: ID-1141

Topic: Inflammatory skin diseases

Beyond GVHD: cutaneous malignancies and chronic inflammatory skin manifestations in post-transplant patients: a systematic review

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Introduction

Skin complications are common and clinically diverse in patients after solid organ and hematopoietic stem cell transplantation. Many dermatologic manifestations share overlapping features, which can delay accurate diagnosis and complicate patient management. The spectrum of skin conditions in these patients is broad and individual disorders may differ in clinical presentation, required management, prognosis and associated morbidity. Therefore, familiarity with this wide range of dermatologic entities is essential for optimal care. Among these, chronic graft-versus-host disease (cGVHD) and non-melanoma skin cancers, including squamous cell carcinoma (SCC) and basal cell carcinoma (BCC), are particularly relevant long-term complications. This study aimed to comprehensively summarize the occurrence, clinical characteristics and risk factors of dermatologic manifestations in post-transplant patients.

Materials and Methods

The authors conducted research in PubMed, EMBASE and Cochrane databases on cutaneous lesions in post-transplant patients. Searching was as comprehensive as possible and included MeSH and EMTREE terms covering publications from January 2021 to December 2025, conducted according to the PRISMA guidelines. A search was managed using the key terms: ‘organ transplantation’ or ‘hematopoietic stem cell transplantation’ with terms corresponding to ‘skin disease’ and ‘cutaneous manifestations’. Additional search terms were used to identify post-transplant dermatological conditions, including ‘post-transplant’ or ‘post-transplantation’ combined with ‘cutaneous’ or ‘dermatologic’. After screening, 12 studies met the inclusion criteria and were analysed.

Results

8 of 12 studies addressed cutaneous malignancies after solid organ transplantation, while four focused on cutaneous manifestations of cGVHD. The majority were observational in design, including retrospective and prospective cohort studies and systematic reviews. Reported outcomes primarily concerned the incidence and distribution of skin cancers in transplant recipients, as well as the assessment of factors associated with the development of cutaneous malignancies and cGVHD in transplant recipients. Based on our analysis of the included studies, we found that non-melanoma skin cancers accounted for over 90% of post-transplant skin malignancies, with basal cell carcinoma more frequent than squamous cell carcinoma. Squamous cell carcinoma occurred 65-250 times more often than in the general population and showed a more aggressive course. Skin cancers typically developed years after transplantation, with median latency exceeding 8 years in kidney and 15 years in heart transplant recipients. In cGVHD, skin involvement was frequently heterogeneous, including severe ulcerative disease, often affecting sclerotic skin, associated with infections and significant morbidity. Several well-established risk factors influence the development of cGVHD, including HLA mismatch between donor and recipient, total body irradiation, vitamin D deficiency and older patient age. Studies

such as CATCH protocol highlight the importance of accurate characterisation of cutaneous cGVHD, as well as the identification of clinical and biological biomarkers predictive of disease onset.

Conclusions

Skin changes in transplant recipients represent a complex clinical challenge beyond GVHD alone. Early recognition of high-risk patients and systematic dermatological monitoring are essential to guide immunosuppressive therapy, cancer prevention and overall patient care. Interdisciplinary collaboration among dermatologists, transplant specialists and hematologists is crucial for improving outcomes and standardizing care.

Abstract N°: ID-1183

Topic: Inflammatory skin diseases

Subacute cutaneous lupus erythematosus associated with vitiligo and leukotrichia: a diagnostic and clinical overlap

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Introduction

Subacute cutaneous lupus erythematosus (SCLE) is an autoimmune dermatosis characterized by annular or papulosquamous lesions and a strong association with anti-SSA/Ro and anti-SSB/La antibodies. SCLE frequently coexists with other autoimmune disorders; however, its association with vitiligo, particularly in the presence of leukotrichia, is rarely reported. The coexistence of these conditions may reflect shared autoimmune mechanisms targeting melanocytes and cutaneous structures.

Materials and Methods

We report the case of a 43-year-old male with a personal and family history of vitiligo, presenting with generalized annular erythematous-infiltrative lesions with erosions involving the trunk, extremities, and scalp. Concomitant widespread depigmented macules affecting the body and scalp were observed, with prominent leukotrichia within the scalp. Laboratory evaluation revealed leukopenia and elevated inflammatory markers. Immunological testing demonstrated positive ANA and high titers of anti-SSA (+++), Ro-52 (+++), and anti-SSB (+++) antibodies, while pemphigus/pemphigoid antibodies were negative. Histopathological examination supported the diagnosis in correlation with the clinical and immunological findings.

Results

Based on the clinicopathological and immunological correlation, a diagnosis of SCLE was established. Concomitant generalized vitiligo with leukotrichia was confirmed. Systemic glucocorticosteroid therapy resulted in marked clinical improvement of inflammatory lesions, supporting the autoimmune inflammatory nature of the disease. The clinical presentation is illustrated in the figures.

Conclusions

The coexistence of SCLE and generalized vitiligo with leukotrichia represents a rare clinical overlap and highlights shared autoimmune pathways. The presence of anti-SSA and anti-SSB antibodies constitutes a key diagnostic marker and supports accurate disease classification. This case underscores the importance of comprehensive clinical and immunological evaluation in patients presenting with inflammatory and pigmentary skin disorders. Recognition of such overlap syndromes is essential for appropriate diagnosis, therapeutic decision-making, and optimization of patient management.

Abstract N°: ID-1191

Topic: Inflammatory skin diseases

Beyond the Classic Pattern: Atypical Grover's Disease

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Introduction
Grover's disease is an uncommon transient acantholytic dermatosis characterized by pruritic papules or vesiculo-papules, mainly affecting elderly Caucasian men. The eruption most commonly involves the upper trunk and back, and it has been associated with sun-exposure, sweating, fever, malignancy, or the initiation of several drugs. Diagnosis is based on both clinical and histopathological findings, such as suprabasal acantholysis and elongation of rete ridges. Currently, there are no evidence-based treatment guidelines for Grover's disease, but fortunately, the evolution is benign.

Materials and Methods
A 52-year-old woman presented to our clinic with a 10-month history of well-demarcated plaques, consisting of agglomerated multiple, skin-colored to light brown-pigmented flat papules on the forehead, cheek and mandibular areas. She experienced significant pruritus and aesthetic discomfort. The complaints appeared after sun exposure and intensified significantly after a holiday to North Africa. She additionally reported undergoing cosmetic procedures such as botulinum toxin injections. Familiar history was negative for a similar skin condition. Initial treatment with mild-potency corticosteroids, calcineurin inhibitors, and emollients for 6 weeks showed no clinical improvement. Histopathological evaluation of a 5 mm skin punch biopsy using hematoxylin–eosin staining revealed: multiple discrete foci composed of acantholytic and dyskeratotic cells and a slightly thickened epidermis covered with parakeratotic columns.

Results
Based on clinical and pathological aspects, we set the diagnosis of atypical Grover disease. Systemic therapy was initiated with Acitretin 20 mg per day for two months, with strict sun protection. Treatment resulted in complete remission, with mild residual hyperpigmentation.

Conclusions
In this case report, we present an atypical presentation of Grover's disease, on the face, of a middle-aged woman, resistant to topical treatments but rapidly responding to low-dose oral Acitretin. While sun exposure is a described trigger, it remains to be clarified the potential role of invasive cosmetic procedures, and if these may shift the epidemiology of the disease towards female, younger groups.

Abstract N°: ID-1198

Topic: Inflammatory skin diseases

TCA versus fractional CO2 laser combined with topical steroids in the managment of alopecia areata

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Introduction
Alopecia areata is a chronic inflammatory disorder resulting in non-cicatricial hair loss. It can affect hair over scalp, beard, and eyebrows/eyelashes and can be generalized. The etiology is unknown, but it is regarded as an autoimmune disorder with genetic predisposition. This often leads to unpredictable hair loss. Despite the availability of different modes of treatment of alopecia areata, some cases are resistant to treatment.

The aim of the study is to compare the efficacy of fractional laser with topical clobetasol propionate versus Trichloro Acetic Acid 35% in patients with alopecia Areata.

Materials and Methods
this was a prospective comparative study was conducted on 40 patients with Alopecia Areata presented to dermatology department at Beni-Suef University hospital. For each patient, one patch was treated one with topical TCA 35% and the other with fractional laser followed by Clobetasol propionate 0.05%. four sessions were done 2 weeks apart. Results were evaluated using trichoscopy.

Results
There was non-statistically significant difference between both treatment protocols regarding the outcome; Scalp Hair Loss score (p-value >0.05).

Conclusions
In conclusion, the current study showed that both Trichloroacetic Acid 35% and fractional laser with topical steroid treatment modalities were safe and effective modalities for the treatment of alopecia areata.

Abstract N°: ID-1203

Topic: Inflammatory skin diseases

Targeting the Invisible Enemy: Subclinical Inflammation as the Missing Link in Recurrent Acne and Pigmentation

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Introduction

Recurrent acne and pigmentary disorders such as post-inflammatory hyperpigmentation and melasma remain a major therapeutic challenge in routine dermatologic practice. Despite apparent clinical clearance, relapse is frequent, leading to prolonged treatment courses and patient dissatisfaction. Growing evidence suggests that visible lesion resolution does not equate to complete disease control. Persistent low-grade or subclinical inflammation—undetectable on routine clinical examination—may continue to activate sebocytes, keratinocytes, immune cells, and melanocytes. This ongoing inflammatory milieu may represent the underlying cause of disease recurrence. This study explores the role of subclinical inflammation as a shared pathogenic pathway in recurrent acne and pigmentation and evaluates the clinical relevance of maintenance-based, low-dose therapeutic strategies.

Materials and Methods

A narrative review of published literature was conducted focusing on histological, molecular, and clinical evidence of subclinical inflammation in acne vulgaris and pigmentary disorders. Studies evaluating inflammatory mediators, barrier dysfunction, cytokine expression, and relapse patterns following treatment discontinuation were analyzed. In addition, real-world clinical observations from outpatient dermatology practice were incorporated to assess recurrence patterns in patients treated with short-term aggressive therapy versus those maintained on low-dose, long-term regimens emphasizing anti-inflammatory control and barrier repair. Therapeutic approaches reviewed included topical retinoids, anti-inflammatory agents, pigment-modulating actives, barrier-repair formulations, and structured maintenance protocols.

Results

Evidence consistently demonstrated the presence of inflammatory infiltrates and cytokine activity in clinically normal-appearing skin following apparent disease clearance. In acne, micro-inflammation was shown to precede comedone formation, while persistent inflammatory mediators contributed to sebaceous hyperactivity and lesion recurrence. In pigmentary disorders, subclinical inflammation stimulated melanocyte activation and impaired pigment resolution, increasing the risk of relapse. Patients managed with abrupt treatment cessation showed higher recurrence rates compared to those receiving structured maintenance therapy. Low-dose, long-term regimens targeting inflammation and barrier integrity resulted in improved disease stability, reduced relapse frequency, and better treatment tolerability. Barrier repair was found to play a critical anti-inflammatory role, enhancing treatment outcomes in both acne and pigmentation.

Conclusions

Subclinical inflammation represents an “invisible enemy” driving the recurrence of acne and pigmentary disorders despite apparent clinical clearance. Recognizing these conditions as chronic inflammatory processes necessitates a shift from episodic lesion-based treatment to continuous, maintenance-focused management. Targeting residual inflammation through low-dose, long-term therapy and barrier-centric approaches offers a rational, patient-friendly strategy to reduce relapse and improve long-term outcomes. Addressing subclinical inflammation may redefine therapeutic success in acne and pigmentation, moving from short-term clearance to sustained remission.

Abstract N°: ID-1240

Topic: Inflammatory skin diseases

Breast-localized Sweet syndrome mimicking breast cancer: a rare diagnostic challenge

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Introduction

Sweet syndrome is a rare neutrophilic inflammatory dermatosis classically characterized by painful erythematous skin lesions associated with systemic symptoms. Although it typically presents as a superficial disease, deep and atypical forms have been described and represent a real diagnostic challenge.

Breast involvement in Sweet syndrome remains exceptionally rare in the literature and constitutes a major diagnostic pitfall. We report a case initially misinterpreted as breast malignancy.

Materials and Methods

N/A

Results

Case presentation

We report the case of a 45-year-old woman with no significant medical history who presented with painful mastitis evolving over several weeks. Clinical examination revealed a suppurative breast collection associated with erythema and marked breast tenderness, without palpable lymphadenopathy. In addition, desquamating erythematous plaques, aseptic knee arthritis, and fever were observed.

Breast imaging (mammography, ultrasound, CT scan, and MRI) revealed a suspicious hypoechoic lesion classified as BIRADS IV, initially suggesting a neoplastic process. To exclude malignancy, a percutaneous biopsy was performed. Histopathological examination demonstrated cystic neutrophilic granulomatous mastitis, leading to the diagnosis of deep Sweet syndrome with breast involvement.

The patient was treated with systemic corticosteroids (1 mg/kg/day), resulting in rapid clinical improvement and marked regression of the breast mass.

Conclusions

Sweet syndrome is a rare neutrophilic dermatosis classically characterized by painful superficial cutaneous lesions, fever, arthralgia, and peripheral leukocytosis. It mainly affects middle-aged adults, with a female predominance, and may be idiopathic or associated with various comorbidities. While the typical presentation and rapid response to corticosteroids facilitate diagnosis, deep and atypical variants remain challenging as they may mimic neoplastic processes.

In our case, we describe an atypical presentation with deep breast involvement presenting as suppurative mastitis associated with aseptic arthritis. Breast cancer was initially suspected due to suspicious radiological abnormalities

classified as BIRADS IV. The diagnosis was confirmed by percutaneous biopsy demonstrating neutrophilic granulomatous mastitis and by the rapid response to systemic corticosteroid therapy.

Approximately 10–20 cases of deep Sweet syndrome or cellulitis-like Sweet syndrome have been reported. To our knowledge, isolated breast involvement has not been specifically described. Aseptic arthritis has also been reported in association with Sweet syndrome and may contribute to diagnostic delay due to its similarity to malignant conditions. These findings highlight the importance of a rigorous multidisciplinary diagnostic approach to avoid unnecessary invasive investigations and allow prompt treatment.

This rare case of breast-localized Sweet syndrome mimicking breast cancer highlights the need to include neutrophilic dermatoses in the differential diagnosis of inflammatory breast lesions. Early recognition of this atypical presentation may limit unnecessary invasive investigations and optimize therapeutic management.

Abstract N°: ID-1255

Topic: Inflammatory skin diseases

Successful Treatment of Pyoderma Gangrenosum Associated with Ankylosing Spondylitis and SAPHO Syndrome with Upadacitinib: A Case Report

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Introduction

Pyoderma gangrenosum is a chronic neutrophilic dermatosis characterized by painful, rapidly progressive cutaneous ulcerations which is associated with systemic inflammatory diseases (most commonly inflammatory bowel disease, arthritis, monoclonal gammopathies, and other hematologic disorders). Increasing evidence suggests that dysregulation of both innate and adaptive immune responses—particularly involving the Th1/Th17 axis and the JAK/STAT signaling pathway—play a key role in pathogenesis. Management of pyoderma gangrenosum can be challenging, especially in patients with multiple comorbidities and refractory disease. Recently, JAK inhibitors, including the selective JAK1 inhibitor upadacitinib, have emerged as promising therapeutic options by targeting multiple proinflammatory cytokine pathways. This report aims to evaluate the clinical response of refractory pyoderma gangrenosum associated with ankylosing spondylitis and SAPHO syndrome to treatment with upadacitinib and describe the
long-term safety and durability of clinical remission.

Materials and Methods

We report a single-case of pyoderma gangrenosum ocurring in a patient with ankylosing spondylitis and SAPHO syndrome.

Clinical, laboratory, histopathological and treatment data were retrospectively collected from medical records. Therapeutic response to upadacitinib was evaluated through serial clinical examinations assessing the ulcer size and pain intensity, and routine laboratory monitoring during long-term follow-up.

Results

A 39-year-old woman with a history of ankylosing spondylitis and SAPHO syndrome, as well as celiac disease, hypothyroidism and hypertension, was initially evaluated in 2021 for recurrent sternoclavicular synovitis, diffuse truncal acne, and elevated erythrocyte sedimentation rate, leading to a diagnosis of SAPHO syndrome.
She had previously received multiple systemic therapies, including sulfasalazine, systemic corticosteroids, certolizumab pegol, and secukinumab, with inadequate disease control.
In October 2024, the patient developed a small, painful, erythematous swelling on the posterior aspect of the right lower leg, which rapidly enlarged and progressed into an exudative ulcerative lesion within approximately one month. Despite having received multiple courses of systemic antibiotics and topical therapies prior to histopathological confirmation, the size of the ulcer continued to increase. Subsequent histopathological examination of a skin biopsy was consistent with pyoderma gangrenosum.
Upadacitinib 15 mg/day was initiated. During approximately 18 months of follow-up, the patient achieved complete clinical remission of pyoderma gangrenosum,without any recurrence or treatment-related adverse events.

Conclusions

This case highlights the potential effectiveness of selective JAK1 inhibition with upadacitinib in the management of pyoderma gangrenosum associated with ankylosing spondylitis and SAPHO syndrome. In a patient with multiple inflammatory comorbidities, upadacitinib was associated with sustained clinical improvement and long-term disease control. These findings support the emerging role of upadacitinib as an effective and well-tolerated therapeutic option in pyoderma gangrenosum and underscore the need for further studies to better define their long-term efficacy and safety in this setting.

Abstract N°: ID-1280

Topic: Inflammatory skin diseases

Sweet syndrome with an essentially clinical diagnosis: A case report

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Introduction

Sweet syndrome, also known as acute febrile neutrophilic dermatosis, is a rare inflammatory disorder belonging to the spectrum of neutrophilic dermatoses. It classically associates an acute cutaneous eruption, fever, and biological inflammatory abnormalities. Although histopathology is usually a key element for diagnosis, some forms may present diagnostic challenges when histological findings are atypical or non-contributory. We report a case of Sweet syndrome in which the diagnosis was established mainly on clinical and evolutionary grounds.

Materials and Methods

We report the case of a 32-year-old woman with no significant past medical history.

The disease began one week prior to consultation with a flu-like syndrome characterized by fever, arthralgia, and pharyngitis, for which the patient was treated with an antistaphylococcal antibiotic .

Two days later, she developed an acute cutaneous eruption involving the face as well as the upper and lower limbs, followed by the onset of edema of the left upper limb, associated with persistent arthralgia.

Dermatological examination revealed:

- **Facial lesions**: edematous inflammatory papules arranged in a rosette pattern, with a central crust;
- **Limb involvement**: diffuse excoriated macules.

Given this atypical clinical presentation, a skin biopsy was performed. Histopathological examination showed a dyskeratotic bullous dermatosis, which was not consistent with the diagnosis of Sweet syndrome.

However, the clinical course was marked by complete spontaneous remission of cutaneous lesions and systemic symptoms within a few weeks, without any specific treatment. No recurrence was observed after 13 months of follow-up, allowing the diagnosis of Sweet syndrome to be retained based on clinical and evolutionary arguments.

Results

The diagnosis of Sweet syndrome is classically based on a combination of clinical, biological, and histological findings, according to the Su and Liu criteria modified by Von den Driesch. Nevertheless, atypical or evolving forms may present histological discrepancies, particularly at early or late stages of the disease.

In our case, the typical clinical presentation (abrupt onset, infectious context, edematous inflammatory papular lesions, arthralgia) and the favorable spontaneous outcome without recurrence were major elements supporting the diagnosis, despite non-specific histological findings. This observation highlights that Sweet syndrome remains primarily a clinical diagnosis, and histopathological findings should always be interpreted in light of the clinical and evolutionary context.

Conclusions

Sweet syndrome should be considered in the presence of any acute inflammatory cutaneous eruption associated with systemic symptoms. This case emphasizes the importance of clinico-evolutionary assessment in establishing the diagnosis, particularly when histological findings are atypical or non-contributory, and highlights the existence of spontaneously resolving forms.

Abstract N°: ID-1301

Topic: Inflammatory skin diseases

Comparative Efficacy of 10% Azelaic Acid Versus 1% Metronidazole in the Treatment of Mild to Moderate Rosacea: A Randomized Controlled Study in Vietnamese Patients

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Introduction
Rosacea is a chronic inflammatory dermatitis frequnetly managed with a combinaton of topical and systemic therapies. Evidence direcly comparing azelaic acid and metronidazole, particularly in Asian populations, remains limited. This study aimed to compare the efficacy and tolerability of 10% Azelaic Acid and 1% Metronidazole, both combined with oral Doxycycline 100mg, in the treatment of mild to moderate rosacea in Vietnamese patients.

Materials and Methods
In this randomized controlled trial, 60 patients with mild to moderate rosacea were allocated 1:1 to receive either 10% Azelaic Acid gel or 1% Metronidazole gel, applied twice daily, in conjunction with oral Doxycycline 100mg once daily for 12 weeks. Efficacy outcomes included changes in the Composite Erythema Assessment Score (CEAS), Investigator Global Assessment (IGA), and Global Facial Severity Score (GFSS). Safety and local tolerability (itching, stinging) were also recorded

Results
In the Azelaic Acid group, the mean CEAS score decreased from 9.1±3.0 at baseline to 0.3±0.4 at 12 weeks, while in the metronidazole group, the mean CEAS score decreased from 9.1±3.4 to 1.6±0.5. The mean IGA scores improved from 2.2±0.7 to 0.07±0.3 in the Azelaic group and from 2.1 ± 0.7 to 0.1 ± 0.3 in the metronidazole group. All patients in both groups achieved a GFSS score of 0 after 12 weeks. Mild local adverse effects were more frequent with azelaic acid, with itching reported in 81.2% versus 57.1% and stinging in 60% versus 55.6% of patients, respectively

Conclusions
Both 10% azelaic acid and 1% metronidazole, in combination with doxycycline 100 mg, are effective for mild to moderate rosacea. Azelaic acid demonstrates slightly superior clinical efficacy but is associated with a higher incidence of mild, transient local irritation.

Abstract N°: ID-1320

Topic: Inflammatory skin diseases

Pityriasis Lichenoides Chronica treated with Doxycycline: A Case Report

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Introduction

Pityriasis lichenoides is an uncommon cutaneous rash of uncertain aetiology. There are two types of this condition: the acute form, Pityriasis lichenoides et varioformis acuta (PLEVA), and the chronic form, Pityriasis lichenoides chronica (PLC). The distinction between the above is based on clinical morphology and histology, and there may be considerable overlap between the two entities.

Materials and Methods

Here we describe a case of PLC. A 34-year-old-female patient presented at our surgery in winter with erythematous, scaly macules and papules localized in the trunk and the proximal extremities for about fifteen days. She had no recent history of acute infection or vaccination and was not receiving any pharmacological treatment. She was afebrile and in good clinical condition.

Results

A treatment with topical steroids and oral methylprednisolone was started, without achieving a complete response. After four weeks of therapy, most of the papules flattened and left pigmented macules. Additionally, new lesions continued to appear. A histological examination was performed, which favored PLC. After the addition of oral doxycycline for 1 month, the skin lesions subsided without recurrence.

Conclusions

This case highlights the importance of considering PLC in the differential diagnosis of persistent papular eruptions. Histopathological examination was pivotal in confirming the diagnosis.

Abstract N°: ID-1367

Topic: Inflammatory skin diseases

Biologics in neutrophilic dermatoses: bridging unmet needs toward precision dermatology

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Introduction
Neutrophilic dermatoses represent a rare and clinically heterogeneous group of inflammatory skin disorders unified by a common pathogenic mechanism—sterile neutrophilic infiltration. Despite increasing research interest, their management remains largely empirical: standardized protocols are lacking, and patients with severe or refractory forms often remain without effective treatment. With the rapid expansion of biologic therapies, neutrophilic dermatoses are emerging as a model for the implementation of precision dermatology. The aim of this review was to synthesize current data on the use of biologic agents and to assess their potential as the foundation for targeted therapeutic strategies.

Materials and Methods
A structured literature search was conducted in PubMed, Scopus, ScienceDirect, and Elsevier databases for the period 2019–2024. Eligible publications included original research, systematic reviews, clinical case reports, and expert recommendations.

Results
The most investigated biologic approaches include anti–IL-1, anti–IL-17, anti–TNF agents, and JAK inhibitors. Anakinra, secukinumab, adalimumab, and tofacitinib have demonstrated clinical benefit in pyoderma gangrenosum, Sweet's syndrome, and other neutrophilic dermatoses refractory to conventional therapies. However, the evidence base remains limited to case reports and small series. Ongoing research into predictive biomarkers highlights the potential for personalized treatment selection. Nevertheless, a substantial proportion of patients still fail to achieve sustained remission, underscoring persistent therapeutic gaps.

Conclusions
Biologic therapy is shaping a new paradigm in the management of neutrophilic dermatoses, offering hope for patients with severe and treatment-resistant disease. Further progress requires multicenter studies, international patient registries, and integration of biomarkers into clinical practice. Addressing the unmet therapeutic needs in this group of disorders demands collaborative efforts within the dermatology community and represents a priority area for future research and guideline development.

Abstract N°: ID-1376

Topic: Inflammatory skin diseases

Generalized lichen planus with multiple mucosal sites: a clinicodermoscopic case confirmed by histology

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Introduction
Generalized lichen planus (LP) is an immune-mediated inflammatory dermatosis that may involve skin and multiple mucosal sites. Because lichenoid drug eruption (LDE) can closely mimic LP, a structured diagnostic approach combining dermoscopy and histopathology is useful. We report a generalized mucocutaneous LP with multi-site mucosal involvement and highlight practical diagnostic clues.

Materials and Methods
A 49-year-old woman presented with a 5-month history of a progressive, intensely pruritic eruption starting on the dorsum of the foot and extending to the trunk and limbs, with concomitant oral and anogenital symptoms. Examination revealed widespread flat-topped polygonal violaceous papules and polycyclic plaques with fine grey-whitish lines, sparing the face and palms/soles. Linear lesions consistent with the Koebner phenomenon were noted. Dermoscopy of cutaneous lesions showed linear Wickham striae with keratin plugs. Mucosal involvement included violaceous lip plaques with whitish reticulations and non-erosive whitish linear plaques/striae on vulvar and perianal mucosa. Skin biopsy confirmed lichen planus, and direct immunofluorescence was negative. Viral hepatitis and HIV serologies were negative. The patient was treated with oral corticosteroids (0.5 mg/kg/day) and potent topical corticosteroids for mucosal sites, with marked clinical improvement within a few weeks.

Results
This case is instructive for daily practice. First, generalized LP warrants systematic screening of multiple mucosal sites, as anogenital and oral lesions may be overlooked yet drive morbidity. Second, dermoscopy provides immediate bedside support by demonstrating Wickham striae and keratin plugs, strengthening suspicion and guiding timely biopsy. Third, differentiating LP from LDE has therapeutic implications: LDE requires meticulous drug review and withdrawal, whereas idiopathic LP often needs anti-inflammatory therapy; in our patient, the combination of classic clinicodermoscopic pattern, histologic confirmation, and negative DIF supported LP. Finally, documenting treatment response reinforces the benefit of early recognition and comprehensive mucosal management.

Conclusions
Generalized LP may present with extensive multi-site mucocutaneous involvement. Clinicodermoscopic features combined with histology (and DIF when appropriate) secure diagnosis and facilitate effective treatment, improving outcomes.

Abstract N°: ID-1380

Topic: Inflammatory skin diseases

The "Setting Sun" Sign at the Medial Canthus: Adult-Onset Xanthogranuloma

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Introduction

Xanthogranuloma is a benign non-Langerhans cell histiocytosis characterized by a dermal accumulation of lipid-laden histiocytes. While it predominantly affects infants and young children, adult-onset xanthogranuloma is rare and may present in atypical anatomical locations. The pathophysiology is thought to involve a reactive histiocytic proliferation secondary to an unknown inflammatory or immune trigger, leading to lipid accumulation within macrophages.
We report a rare case of adult-Onset Xanthogranuloma in an unusual site, offering the chance to explore the clinical and therapeutic challenges related to this entity.

Results

We report the case of a 59-year-old man with no significant past medical history who presented with a **2-year history** of an asymptomatic, non-pruritic papular lesion located at the **medial canthus of the right eye**. Clinical examination revealed a **well-circumscribed, firm, yellowish papule**, measuring approximately **0.5 cm in its greatest diameter**, arising on otherwise normal surrounding skin. Dermoscopy showed a **homogeneous yellow background associated with arborizing vessels**, surrounded in some areas by a brownish and erythematous halo, producing the characteristic **"setting sun" appearance**. The combination of clinical and dermoscopic findings was considered **pathognomonic for xanthogranuloma**.

Laser therapy was initially proposed as a minimally invasive treatment option. However, the patient opted for **surgical excision** in order to obtain a rapid and definitive cosmetic outcome.

Conclusions

This case highlights the importance of recognizing **adult-onset xanthogranuloma**, particularly in atypical periocular locations. Dermoscopy is a valuable non-invasive tool that can strongly support the diagnosis and help avoid unnecessary investigations. Although xanthogranuloma is a benign condition, treatment decisions should be individualized, taking into account lesion location, cosmetic concerns, and patient preference.

Abstract N°: ID-1408

Topic: Inflammatory skin diseases

c-MET–MAPK signaling drives macrophage migration in *Mycobacterium marinum* skin infection

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Introduction
Skin infections caused by *Mycobacterium marinum* are increasingly prevalent and challenging to treat. While bacterial components can trigger macrophage migration, it remains unclear whether viable bacteria activate distinct and more potent signaling programs compared to inactivated bacteria—a key question for understanding infection-specific immune modulation. To discriminate between immune responses to bacterial components and signals specific to bacterial viability, we compared macrophage responses to live versus heat-killed *M. marinum*. This study aimed to identify viability-dependent pathways underlying early granuloma formation and disease progression.

Materials and Methods
Primary mouse bone marrow-derived macrophages (BMDMs) were stimulated with live or heat-killed *M. marinum* at an MOI of 5. Transcriptomic profiling via RNA-seq identified differentially expressed genes, followed by GO and KEGG pathway enrichment analyses. Macrophage migration was evaluated using Transwell and wound-healing assays. ERK and p38 activation was assessed by Western blot. The role of c-MET was examined using inhibitor PHA-665752 and siRNA-mediated knockdown. Clinical relevance was supported by proteomic analysis of patient skin lesions.

Results
RNA-seq revealed that live, but not heat-killed, *M. marinum* significantly upregulated migration-related genes, including c-MET, and enriched MAPK signaling pathways ($p < 0.01$). Live infection enhanced macrophage migration, accompanied by increased phosphorylation of ERK and p38. Pharmacological inhibition or genetic knockdown of c-MET reduced migration and suppressed ERK/p38 activation. Clinical proteomic analysis further demonstrated upregulation of c-MET-associated proteins, with differentially expressed proteins implicated in MAPK signaling, cytoskeletal reorganization, and migration control.

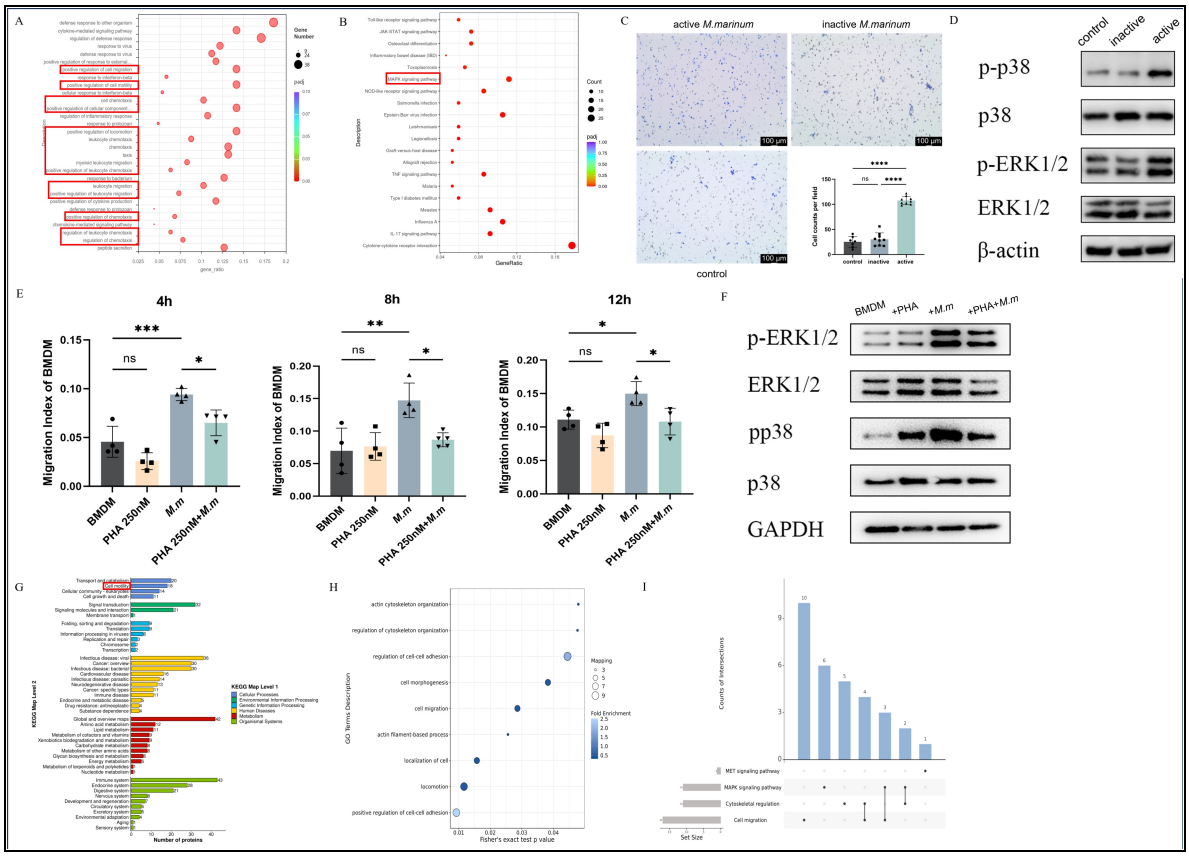

Figure. Activation of c-Met–MAPK Axis Drives Macrophage Migration in Mycobacterium marinum Infection. A. GO enrichment analysis reveals that upregulated genes are significantly enriched in biological processes such as "positive regulation of cell migration", "positive regulation of cell motility", and "cell chemotaxis". B. KEGG pathway enrichment analysis identified significant enrichment in the Cytokine-cytokine receptor interaction pathway and the MAPK signaling pathway. C. Transwell assay demonstrates a significant increase in the number of BMDMs migrating towards the supernatant of active M. marinum-infected cells. D. Western blot analysis indicates that active M. marinum infection significantly induces the phosphorylation of p38 and ERK. E-F. BMDMs were pretreated with the c-Met selective inhibitor PHA-665752 (250 nM; Selleck, USA) 1 hour prior to M. marinum infection. Images taken at 4, 8, and 12 hours post-infection show that Met inhibition significantly attenuates the migratory capacity of infected cells (E), accompanied by a marked downregulation of pp38 and pERK phosphorylation levels (F). G-I. KEGG pathway enrichment analysis of differentially expressed proteins between lesional and paired normal tissue from M. marinum-infected patients shows that 63 proteins are significantly enriched in pathways related to cellular processes (G). GO enrichment analysis reveals significant enrichment of biological processes associated with cell migration (H). Pleiotropy analysis of upregulated genes shows that multiple genes are concurrently involved in processes such as the MAPK signaling pathway, cytoskeleton regulation, and the control of cell migration (I).

Conclusions

Our findings demonstrate that live *M. marinum* specifically enhances macrophage migration through activation of the c-MET–MAPK signaling axis, identifying a viability-dependent pathway that regulates macrophage recruitment. This provides new insights into granuloma formation and immune microenvironment modulation in cutaneous mycobacterial infection, suggesting c-MET as a potential therapeutic target.

Abstract N°: ID-1417

Topic: Inflammatory skin diseases

When Pustules Deceive: Clinicopathological Correlation in Subcorneal Pustular Dermatosis Highlighting Diagnostic Pitfalls in Pustular Dermatoses

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Introduction

Subcorneal pustular dermatosis (SCPD) is a rare chronic neutrophilic dermatosis characterized by sterile superficial pustules predominantly involving flexural and truncal regions. Owing to its significant clinical overlap with immunobullous and pustular dermatoses, accurate diagnosis requires careful clinicopathological correlation. Although traditionally described as a cutaneous-limited disorder, neutrophilic dermatoses are increasingly recognized within a broader spectrum of systemic inflammatory dysregulation. Early recognition is essential to prevent diagnostic delay, inappropriate therapy, and prolonged disease morbidity.

Materials and Methods

We report the case of a 48-year-old female with known type 2 diabetes mellitus who presented with acute onset multiple superficial pustular lesions over the trunk and upper limbs of three days duration. There was no history of hypertension, tuberculosis, or thyroid disease. Dermatological examination revealed multiple flaccid pustules on an erythematous base arranged in annular and serpiginous patterns involving trunk and proximal extremities, with sparing of mucosa, scalp, and nails.Histopathological examination of lesional skin demonstrated a subcorneal pustule predominantly composed of neutrophils with minimal acantholysis and absence of significant epidermal spongiosis or necrosis. Direct immunofluorescence from perilesional skin was negative for intercellular and basement membrane zone immune deposition.Colonoscopic biopsy performed for evaluation of chronic loose stools demonstrated focal active colitis, noted as a concurrent inflammatory finding.Clinicopathological correlation supported a diagnosis of SCPD.

Results

Clinical morphology combined with histopathological findings enabled differentiation from IgA pemphigus, pustular psoriasis, and other immunobullous disorders. Negative immunofluorescence findings further supported exclusion of autoimmune blistering diseases.The patient was initiated on systemic corticosteroids and colchicine, with subsequent clinical improvement.The incidental identification of focal active colitis during evaluation of gastrointestinal symptoms raises the possibility of a shared neutrophil-mediated inflammatory milieu. While not classically described as a direct association with SCPD, this finding may reflect overlapping inflammatory pathways or early systemic inflammatory spectrum disease and warrants longitudinal follow-up.

Conclusions

Subcorneal pustular dermatosis remains an important diagnostic consideration in patients presenting with superficial sterile pustular eruptions. This case highlights the critical role of integrated clinical morphology, histopathology, and

immunofluorescence in establishing diagnostic accuracy. The presence of biopsy-confirmed focal active colitis in this patient underscores the importance of systemic evaluation in neutrophilic dermatoses and may support the concept of shared inflammatory pathways. Early recognition enables targeted therapy, prevents unnecessary immunosuppression, and improves clinical outcomes. Continued clinical observation may further clarify potential systemic inflammatory associations within neutrophilic dermatosis spectrum disorders.

Abstract N°: ID-1418

Topic: Inflammatory skin diseases

Radiation-induced morphea following breast-conserving oncologic treatment: a case report

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Introduction

Radiation-induced morphea (RIM) is a rare complication of radiotherapy, characterized by inflammatory fibrosis that typically develops within the irradiated field, although extension beyond the treatment area has also been described. It is most frequently reported in patients treated for breast carcinoma, with an estimated incidence of approximately 1 in 500 patients receiving radiotherapy. Clinically, RIM usually evolves through two stages: an early inflammatory phase and a subsequent “burn-out” phase marked by progressive sclerosis. The onset may occur months to years following completion of radiotherapy, and predictive risk factors remain poorly defined.

Materials and Methods

We report the case of a 63-year-old woman diagnosed with invasive carcinoma of the left breast, treated with breast-conserving surgery followed by adjuvant radiotherapy. Approximately one year after the completion of radiotherapy, she developed erythema of the left breast, followed by progressive skin induration.

Results

Clinical examination revealed confluent sclerotic plaques involving the entire left breast with a violaceous inflammatory border, associated with pain and discomfort. Histopathological evaluation demonstrated thickened and hyalinized collagen bundles in the dermis, reduced elastic fibers, and focal perivascular lymphocytic infiltration, without evidence of malignant cells. Complete blood count and basic biochemical analyses were within normal limits. Borrelia burgdorferi serology (IgM, IgG) was negative. Breast cancer tumor markers were within reference ranges, and breast ultrasound showed no evidence of tumor recurrence. Following multidisciplinary oncologic consultation, methotrexate (15 mg subcutaneously weekly) and topical tacrolimus 0.1% ointment were initiated. Partial clinical improvement was observed after five months of therapy, with reduction of the erythematous border. However, as induration and sclerosis persisted, the patient was started on hydroxychloroquine 300 mg daily, and clinical response is currently being evaluated.

Conclusions

Proposed pathophysiological mechanisms of RIM include radiotherapy-triggered activation of cancer-educated fibroblasts, which may subsequently stimulate quiescent fibroblasts, promoting inflammation and fibrosis. Considering the differential diagnosis, onset timing may help differentiate RIM from acute radiation dermatitis, which generally appears during or shortly after radiotherapy. Post-irradiation fibrosis should also be considered; however, it predominantly affects deep subcutaneous tissue and fascia, with minimal inflammatory infiltrate. Importantly, mastitis

carcinomatosa and cutaneous metastatic spread must be excluded, making histopathological confirmation mandatory. Prior case series indicated that patients with pre-existing autoimmune conditions are more likely to develop RIM that extends beyond the irradiated area. Although evidence for treatment is limited to case reports and small case series, therapeutic approaches generally mirror those used in idiopathic morphea. RIM does not appear to be associated with cancer prognosis, but it may lead to significant long-term cosmetic morbidity.

Abstract N°: ID-1447

Topic: Inflammatory skin diseases

Cyclines in folliculitis Decalvans : When the Response Exceeds Expectations - A Case Report

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Introduction

Folliculitis decalvans is a rare, chronic inflammatory disease of the hair follicle, first described by Quinquaud in the 19th century. It represents a primary neutrophilic cicatricial alopecia, characterized by recurrent inflammatory flares that progressively lead to irreversible scarring alopecia. The disease has a major impact on patients' quality of life and remains a significant therapeutic challenge due to its chronicity, frequent relapses, and variable response to treatment.

Early diagnosis and prompt management are essential to control inflammation and prevent permanent follicular destruction. Among available treatments, cyclines are commonly used for their combined antibacterial and anti-inflammatory properties, particularly in relation to *Staphylococcus aureus* colonization.

We report a case of severe folliculitis decalvans in an immunocompromised patient, showing a rapid and complete clinical response to oral doxycycline, with full resolution of inflammatory signs and complete hair regrowth.

Materials and Methods

his work is a **single case report**.

Patient and Clinical Evaluation

A 41-year-old male patient was followed in the hematology department for a high-grade B-cell lymphoma, Ann Arbor stage IV. One week after the first cycle of chemotherapy according to the R-CHOP protocol, the patient presented with a sudden and severe exacerbation of scalp lesions.

Clinical examination revealed diffuse erythema of the scalp associated with papulo-pustular lesions, crusts, scaling, and extensive alopecia. Several alopecic plaques were noted, the largest exceeding 5 cm in diameter.

Dermoscopy

Dermoscopy showed:

- Active follicular pustules
- Black dots
- Tufted hairs
- Perifollicular hyperkeratosis
- Hemorrhagic crusts
- Diffuse inflammatory erythematous background

These findings were consistent with a severe form of folliculitis decalvans.

Treatment and Follow-up

Treatment with oral doxycycline at a dose of **100 mg/day** was initiated. The patient was followed clinically and dermoscopically to assess treatment response and disease severity.

Results

The initial presentation was classified as **severe folliculitis decalvans**, corresponding to **stage 4** on the clinical severity scale, with extensive inflammatory alopecia.

The clinical response to doxycycline was rapid and marked:

- Quick regression of pruritus and trichodynia
- Resolution of pustules and crusts
- Persistence of only mild residual erythema

Most notably, **alopecia completely regressed**, with full hair regrowth observed. The clinical severity score improved significantly, from **stage 4 to stage 1**, indicating minimal residual disease activity.

The tolerance of treatment was good, and no adverse effects were reported.

Conclusions

This case highlights a remarkable clinical response of severe folliculitis decalvans to oral doxycycline, with rapid resolution of inflammatory signs and complete hair regrowth, even in an immunocompromised patient. Early diagnosis, prompt initiation of appropriate therapy, and close clinical and dermoscopic follow-up are essential to prevent irreversible scarring alopecia. Cyclines remain an effective therapeutic option in the management of folliculitis decalvans, including severe presentations.

Abstract N°: ID-1467

Topic: Inflammatory skin diseases

Eruptive pruritic papular porokeratosis successfully treated with bimekizumab

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Introduction

Porokeratoses are uncommon acquired disorders of keratinization that are characterized by the presence of a cornoid lamella. Clinically, they present as well-demarcated papules or plaques with a hyperkeratotic border and an atrophic center. These lesions may be isolated or disseminated, which allows for classification into several subtypes.
These include porokeratosis of Mibelli, disseminated superficial porokeratosis, disseminated superficial actinic porokeratosis, linear porokeratosis, porokeratosis ptychotropica, and eruptive disseminated porokeratosis (EDP). EDP includes eruptive pruritic papular porokeratosis (EPPP). Treatment remains challenging, particularly in disseminated forms.

Materials and Methods

We present the case of a 50-year-old man with a three-year history of pruritic, brownish, disseminated papules and plaques. The initial clinical diagnosis was eruptive pruritic papular porokeratosis. However, the histopathology results were inconclusive, initially suggesting psoriasis and subsequently Grover disease. Multiple treatments were attempted, including a combination of topical corticosteroids and calcipotriol, topical cholesterol and lovastatin, methotrexate, acitretin, phototherapy, roflumilast, and adalimumab, but there was no clinical response. A repeat skin biopsy confirmed the initial diagnosis of EPPP.

Results

Treatment with the dual anti-IL-17A/F monoclonal antibody bimekizumab was initiated and resulting in significant clinical improvement after 12 weeks and a marked reduction in pruritus, with flattening of the papular rim and resolution of hyperkeratosis. Residual post-inflammatory hyperpigmented macules remained.

Eruptive pruritic papular porokeratosis is considered a variant of EDP and, according to some authors, both entities may represent the same condition. Although the exact pathogenesis of porokeratosis remains unclear, eruptive and inflammatory forms are thought to represent an immune response against tumorigenic keratinocyte clones. Dysregulation of the mevalonate kinase (MVK) pathway has also been implicated, and recent studies have demonstrated upregulation of the IL-17 axis in cases of MVK alterations. In addition, histopathological findings in EPPP frequently reveal lymphocytic and eosinophilic infiltration, together with high expression of IL-31.

Conclusions

In this context, targeted therapies such as anti-IL-17 agents, JAK inhibitors, or anti-IL-31 agents may play a relevant role in managing these uncommon disorders, which significantly impair quality of life and self-perception. As EDP may be associated with underlying neoplasms or viral infections, appropriate screening is mandatory prior to initiating immunosuppressive therapies.

Abstract N°: ID-1471

Topic: Inflammatory skin diseases

Topical Steroid–Damaged Face: A Comprehensive Clinico-Dermoscopic-Histopathological Assessment

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Introduction

Topical steroid–damaged face (TSDF) is an emerging dermatological concern caused by the prolonged and unsupervised use of unregulated, easily availabe over-the-counter topical corticosteroids on the face, especially in Asia. Clinical features include erythema, papules, pustules, telangiectasias, pigmentary alterations and cutaneous atrophy. Histopathological data on TSDF is limited, resulting in gaps in understanding its tissue-level changes.

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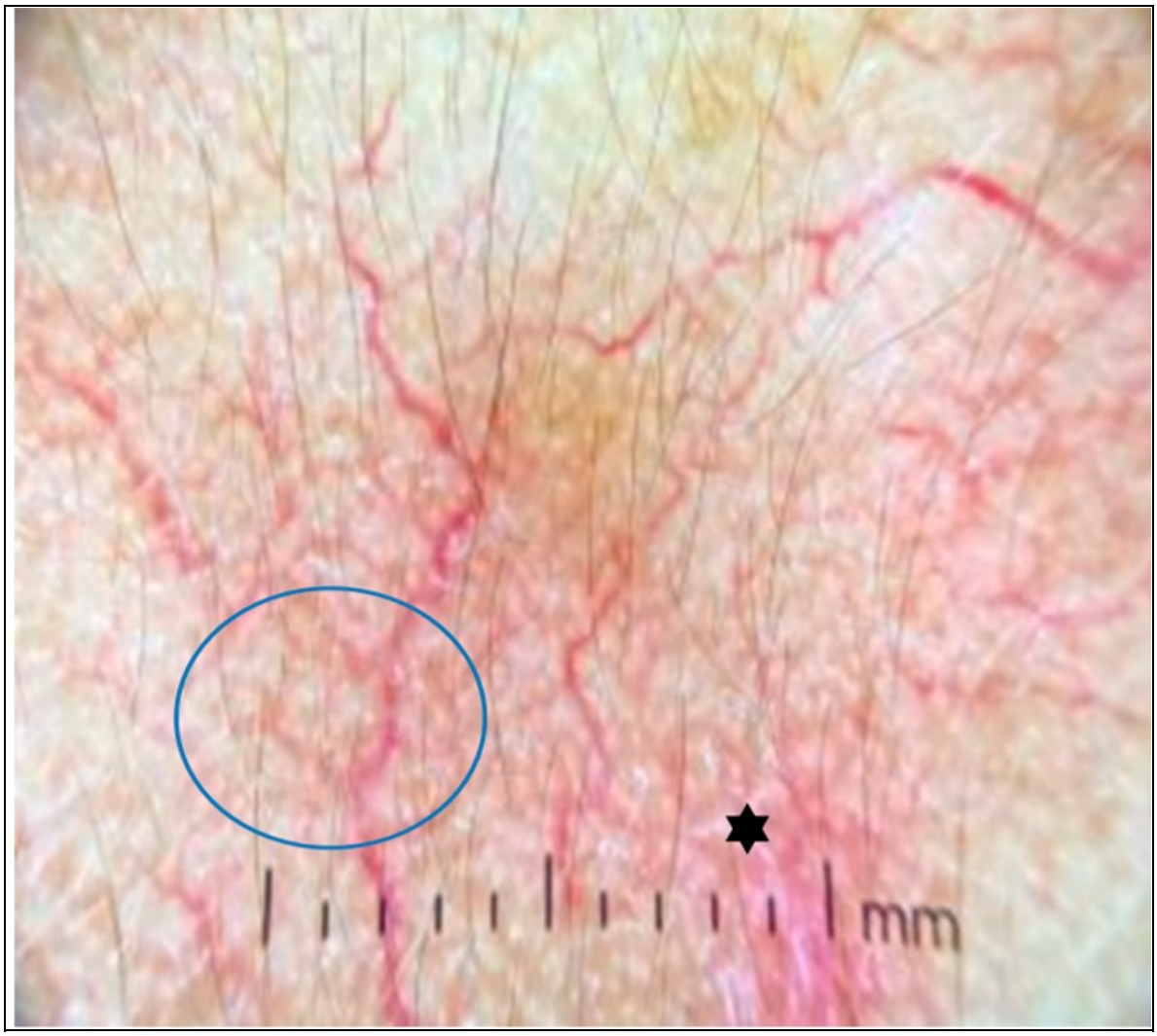
Materials and Methods

A cross-sectional study was conducted on 30 patients clinically diagnosed with TSDF. Case definition included patients presenting with facial redness, itching, burning photosensitivity, erythematous papules and/or atrophy, with a history of topical steroid use for >= 1 month, diagnosed by at least two qualified dermatologists. Detailed clinical evaluation was followed by dermoscopic assessment of a representative site (DL200, 10x), and subsequent histopathological correlation was performed fromtissue samples of the same lesion site.

Results

The mean age of patients was 29.87 **± 9.5 years (range 18-62 years)**, with a marked female predominance (90%). A little more than half the patients were literate (16, 53.3%). The duration of topical steroid application was variable (< 6 months: 36.7%, 6-12 months: 43.4%, > 6 months: 20%). Most participants used the topical product for indications of skin brightening (43.3%)and melasma (26.7%). The potency of the topical steroid used was > Class III in 60% patients. Most patients reported friends/relatives, and non-dermatologist doctors being their source of recommdation for the use of topical steroid, while some bought directly from the pharmacist Clinically, erythema (90%) and telangiectasia (80%) were the most frequent findings. The most common dermoscopic findings were white structureless areas (76.7%), reticular vessels (73.3%), linear branching bessels (66.7%), brown globules (60%), and red background (46.7%). Additional patterns included linear and dotted vessels, pigment network alterations, and follicular changes. Histopathology showed perivascular and perifollicular chronic lymphohistiocytic inflammatory infiltrates (73.3%), vascular dilatation (34.8%), vascular proliferation (30.4%) and epidermal atrophy (30.4%) as the most common changes. Other features included follicular plugging, extravasation of RBCs, dermal atrophy and solar elastosis, highlighted on special stains (Verrhoef von gieson).



Conclusions

Dermoscopy of TSDF shows reticular vessels and white structureless areas, reminiscent of rosacea. Histopathology of TSDF (topical steroid damaged face) also shows chronic inflammation much more frequently than dermal atrophy, re-emphasising the inflammatory pathophysiology of a disorder that occurs due to prolonged use of anti-inflammatory steroidal topicals.

Abstract N°: ID-1516

Topic: Inflammatory skin diseases

Melkersson-Rosenthal Syndrome: A Rare and Underdiagnosed Entity

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Introduction

Melkersson–Rosenthal syndrome (MRS) is a rare form of orofacial granulomatosis classically defined by a clinical triad including recurrent orofacial edema, peripheral facial nerve palsy, and fissured tongue. Its etiopathogenesis remains poorly understood, and diagnosis is often delayed due to the incomplete expression of the triad. Management remains challenging, with no standardized therapeutic guidelines.

Materials and Methods

We report two cases highlighting the clinical heterogeneity and diagnostic challenges of this rare condition.

Results

Case 1:

A 45-year-old woman with no relevant medical history presented with acute inflammatory macrocheilitis of the upper lip. Clinical history revealed previous recurrent episodes of peripheral facial nerve palsy. Physical examination showed residual facial asymmetry related to past facial paralysis, persistent inflammatory macrocheilitis, and a congenital fissured tongue. The association of these findings supported the diagnosis of MRS.

Case 2:

A 33-year-old woman with no relevant medical history presented with a congenital fissured tongue, recurrent orofacial edema with macrocheilitis, and repeated episodes of peripheral facial nerve palsy. The clinical presentation was consistent with a complete form of MRS.

Conclusions

MRS is a rare and underdiagnosed condition, as the complete clinical triad is observed in only a minority of cases. Macrocheilitis, often corresponding to Miescher's cheilitis, is frequently the initial manifestation and the main reason for consultation. Facial nerve palsy is typically recurrent and may lead to functional sequelae, while fissured tongue, although non-specific, represents an important diagnostic clue. Diagnosis is primarily clinical, with histopathological examination showing non-caseating granulomatous inflammation in incomplete or doubtful cases. Therapeutic management is not standardized and mainly relies on systemic or intralesional corticosteroids, with variable efficacy. Early recognition of this syndrome is essential to reduce diagnostic delay and improve patient management.

Abstract N°: ID-1521

Topic: Inflammatory skin diseases

Sweet Syndrome and Henna: A Possible Association

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Introduction

Sweet syndrome is an inflammatory disorder characterized by painful, infiltrated skin lesions associated with systemic inflammation. It can occur either as an idiopathic condition or secondary to various underlying factors, including infections, hematologic malignancies, autoimmune diseases, or exposure to certain medications.

Henna is widely used for cultural and cosmetic purposes and is generally considered safe. However, it can sometimes trigger cutaneous reactions, most commonly allergic in nature. The occurrence of Sweet syndrome following henna application is exceptionally rare.

We report a case of bilateral Sweet syndrome of the hands that developed after the use of traditional henna.

Materials and Methods

A 36-year-old woman with no significant past medical history was admitted to our department for painful, infiltrated skin lesions on both hands, which had been evolving for approximately one month. The lesions appeared three days after she applied traditional henna.

Dermatological examination revealed well-demarcated erythematous-violaceous plaques on the dorsal surfaces of both hands. The lesions were slightly infiltrated, asymmetric, and covered with scaly papulo-nodules. Residual orange discoloration consistent with henna staining was also noted. Examination of the mucous membranes and nails was unremarkable.

A skin biopsy demonstrated features of a neutrophilic dermatosis, consistent with Sweet syndrome. Laboratory investigations revealed neutrophilic leukocytosis, indicating a systemic inflammatory response. The patient showed significant clinical improvement under treatment with colchicine.

Results

Sweet syndrome is an uncommon inflammatory dermatosis, and cases triggered by topical exposures are particularly rare. Although henna is widely used worldwide for cosmetic and cultural purposes, reports linking it to Sweet syndrome are exceedingly scarce. Fewer than ten cases have been documented in the international literature, indicating that this association is highly unusual. Most cases of Sweet syndrome are related to infections, medications, or systemic diseases, while cutaneous exposure-induced forms represent only a very small fraction. The low number of reported cases may reflect under-recognition or under-reporting, especially in regions where henna use is common. Nevertheless, existing data suggest that Sweet syndrome following henna application remains a highly uncommon clinical event, and each new case contributes valuable insight into potential environmental triggers of neutrophilic dermatoses.

Conclusions

This case highlights the importance of considering Sweet syndrome in patients presenting with painful inflammatory skin lesions that do not respond to standard treatments.

Early recognition of this condition allows for prompt and appropriate management, helping to avoid misdiagnosis and unnecessary therapies particularly in cultural contexts where henna use is widespread.

Abstract N°: ID-1536

Topic: Inflammatory skin diseases

Psoriasis Induced After Pentavalent Vaccination: Report of Three Pediatric Cases

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Introduction

Psoriasis is a chronic inflammatory skin disease with genetic and immunological components. In children, its clinical presentation may be atypical, and disease onset can sometimes be triggered by environmental factors, particularly infectious or immunological stimuli. Vaccinations have rarely been reported in the literature as potential triggers of psoriatic flares. We report three cases of infants who developed psoriasis shortly after administration of the pentavalent vaccine (DTP-HepB-Hib).

Materials and Methods

Three infants without personal or family history of psoriasis were evaluated after the appearance of erythematous and scaly skin lesions following pentavalent vaccination. Clinical examination was performed in all cases, and a skin biopsy was carried out when necessary to confirm the diagnosis. Data regarding vaccination timing, clinical presentation, histopathological findings, and therapeutic response were collected and analyzed.

Results

Case 1 involved a 9-month-old female infant who developed well-demarcated erythematous scaly plaques on the trunk and upper limbs ten days after the third dose of the pentavalent vaccine. Clinical features were consistent with guttate psoriasis. Treatment with moderate-potency topical corticosteroids and emollients led to partial improvement within two weeks.

Case 2 concerned a 2-month-old female infant who presented with diffuse erythematous scaly lesions predominantly affecting the scalp and flexural areas seven days after the first vaccine dose. Skin biopsy showed hyperkeratosis with parakeratosis, regular acanthosis, and superficial dermal inflammatory infiltrate, confirming psoriasis. Intensive emollient therapy and topical corticosteroids resulted in significant regression after three weeks.Case 3 was a 2-month-old male infant who developed generalized erythematous scaly plaques covering more than 80% of the body surface 48 hours after pentavalent vaccination.Clinical examination revealed no fever or systemic symptoms. Histopathology confirmed diffuse plaque psoriasis. Rapid clinical improvement was achieved with topical corticosteroids and emollients.

Conclusions

These observations highlight a rare but noteworthy clinical entity: psoriasis potentially triggered by vaccination in infants. Although a direct causal relationship cannot be definitively established, the short delay between vaccination and symptom onset suggests a possible temporal association. Awareness of this potential link is important for early diagnosis and appropriate management. However, vaccination remains essential for public health and should not be discontinued; careful dermatological monitoring is recommended in the event of post-vaccination cutaneous eruptions.

Abstract N°: ID-1591

Topic: Inflammatory skin diseases

Regenerative medicine in the treatment of specific dermatologic disorders: a systematic review of randomized controlled clinical trials

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Introduction
The aim of this study is to systematically review randomized controlled clinical trials (RCTs) studying various types of regenerative medicine methods (such as platelet-rich plasma, stromal vascular fraction, cell therapy, conditioned media, etc.) in treating specific dermatologic diseases. Rejuvenation, scarring, wound healing, and other secondary conditions of skin damage were not investigated in this study.

Materials and Methods
Major databases, including PubMed, Scopus, and Web of Science, were meticulously searched for RCTs up to January 2024, focusing on regenerative medicine interventions for specific dermatologic disorders (such as androgenetic alopecia, vitiligo, alopecia areata, etc.). Key data extracted encompassed participant characteristics and sample sizes, types of regenerative therapy, treatment efficacy, and adverse events.

Results
In this systematic review, 64 studies involving a total of 2888 patients were examined. Women constituted 44.8% of the study population, while men made up 55.2% of the participants, with an average age of 27.64 years. The most frequently studied skin diseases were androgenetic alopecia (AGA) (45.3%) and vitiligo (31.2%). The most common regenerative methods investigated for these diseases were PRP and the transplantation of autologous epidermal melanocyte/keratinocyte cells, respectively. Studies reported up to 68.4% improvement in AGA and up to 71% improvement in vitiligo. Other diseases included in the review were alopecia areata, melasma, lichen sclerosus et atrophicus (LSA), inflammatory acne vulgaris, chronic telogen effluvium, erosive oral lichen planus, and dystrophic epidermolysis bullosa. Regenerative medicine was found to be an effective treatment option in all of these studies, along with other methods. The regenerative medicine techniques investigated in this study comprised the transplantation of autologous epidermal melanocyte/keratinocyte cells, isolated melanocyte transplantation, cell transplantation from hair follicle origins, melanocyte–keratinocyte suspension in PRP, conditioned media injection, a combination of PRP and basic fibroblast growth factor, intravenous injection of mesenchymal stem cells, concentrated growth factor, stromal vascular fraction (SVF), a combination of PRP and SVF, and preserving hair grafts in PRP.

Conclusions
Regenerative medicine holds promise as a treatment for specific dermatologic disorders. To validate our findings, it is recommended to conduct numerous clinical trials focusing on various skin conditions. In our study, we did not explore secondary skin lesions like scars or ulcers. Therefore, assessing the effectiveness of this treatment method for addressing these conditions would necessitate a separate study.

Abstract N°: ID-1594

Topic: Inflammatory skin diseases

Cutaneous Crohn's disease without gastrointestinal manifestations: 5-year follow-up.

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Introduction
Crohn's disease is a multisystemic condition dependent on Th1 pathways. Involvement can extend throughout the gastrointestinal tract. It can affect the skin before or after intestinal involvement.
On the skin, one can observe vulvar and perianal erythema and induration, asymmetric vulvar swelling, perianal erosions, lymphedema of the prepuce, lymphedema and induration of the scrotum, inflammation and lymphedema leading to twisting of the penis along its long axis, referred to as a "saxophone penis," perianal tags and indurated plaques, firm erythematous plaques of the mons pubis and labia majora and minora, intraoral ulcer, draining sinuses, and enlargement of the vermilion lip due to granulomatous inflammation.
In both cutaneous and oral lesions of Crohn's disease, small, nodular, non-caseating, epithelioid granulomas with surrounding lymphocytes are found in the superficial and deep dermis, sometimes extending into the subcutaneous fat. There are a few scattered multinucleated Langhans-type giant cells and a sparse perivascular lymphohistiocytic infiltrate; overlying ulceration may be present. Clinically, "knife-like" fissures are characteristic.

Materials and Methods
Case report.

Results
A 28-year-old female patient presented with linear ulcers on facial sections in the axillas, groin, buttocks, inframammary regions, gluteal fold, and labia majora for 3 months (Figure 1). There were plaques with seropurulent discharge on the genitalia. A biopsy was performed that included normal skin and ulcer (Figure 2), which showed an area of ulceration. The adjacent epidermis has a reparative appearance, with irregular acanthosis, moderate spongiosis, and foci of parakeratosis. The superficial and deep dermis exhibits numerous well-formed granulomas, with frequent multinucleated giant cells, associated with mixed inflammatory infiltrate (lymphocytes, plasma cells, neutrophils, and eosinophils), compatible with granulomatous dermatitis (Figure 3), which reinforces the clinical hypothesis of cutaneous Crohn's disease.
Endoscopy, colonoscopy, and fecal calprotectin were performed over 5 years and were normal.
The patient is being treated with infliximab and methotrexate, showing a good response (Figure 4).

Conclusions
Cutaneous manifestations related to systemic diseases are important tools that aid in the early diagnosis of conditions with high morbidity and mortality. Furthermore, the specific recognition of cutaneous diseases in systemic contexts allows for appropriate and early treatment.