Abstract N°: ID-140

Topic: Oral mucosa and other skin-adjacent mucous membranes

Dental Sinus: Cutaneous Clues to a Root Cause

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Introduction
Dental sinuses commonly occur in the setting of a chronic periapical abscess in a carious tooth. They usually occur intraorally, however may rarely present extraorally, through the facial skin.

Materials and Methods
A 78-year-old female presented with a 4-month history of a dimpled cystic lesion along the right mandible. This lesion developed after the patient sustained a mechanical fall face forward. The lesion was not tender, however cosmetically unpleasant. A diagnosis of an abscess was done in the community; however oral antibiotics were ineffective. The lesion was investigated further with magnetic resonance imaging.

Results
The magnetic resonance imaging showed enhancement of the small superficial nodule corresponding to the skin findings, which connected to the right lower second premolar tooth via a subcutaneous sinus tract. There was also periapical enhancement in relation to the right lower second premolar tooth suggestive of underlying dental caries. An urgent dental review was set up, and the patient underwent a dental extraction of the diseased tooth. Within a few days post extraction, the skin lesion began resolving.

Conclusions
Dental sinuses consist of a sinuous channel or cord-like tissue which extends from a dental infection site to the face or neck. Enzymes such as hyaluronidase and collagenase area released from pathogenic microorganisms, which lead to breakdown of the surrounding tissue, allowing for progression through the fascial planes. These lesions are frequently misdiagnosed due their resemblance with other conditions such as granulomatous diseases, non melanoma skin cancers, furuncles, hidradenitis suppurativa, actinomycosis and tuberculosis cutis ororficialis. Furthermore, they are usually not associated with overt dental symptoms. The commonest underlying cause for dental sinuses is chronic periapical infections, and the location of the dental sinus typically correlates with the affected tooth. Other aetiologies include complications of dental implants, trauma and osteomyelitis. Management includes referral to a dental surgeon to eliminate the source of the periapical abscess, usually via extraction of the affected tooth. Once the infection source is treated, the sinus tract usually resolves spontaneously, and no further interventions are required.

Through our case, we aim to raise awareness about this uncommon condition. Dental causes should be considered when patients present with lesions in the orofacial region.

Abstract N°: ID-856

Topic: Oral mucosa and other skin-adjacent mucous membranes

Late-onset vulvar steatocystoma multiplex: a rare and challenging localization

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Introduction

Steatocystoma is a benign cystic disorder arising from the pilosebaceous unit. It may present as a solitary lesion (steatocystoma simplex) or as multiple lesions known as steatocystoma multiplex. Clinically, it manifests as smooth, mobile, subcutaneous nodules, typically affecting sebaceous gland–rich areas such as the chest, axillae, and inguinal region. Vulvar involvement is exceptionally rare.

Materials and Methods

We report the case of a 43 years old woman with no significant personal or family history, who presented with asymptomatic vulvar nodules evolving for one year. The lesions were bilaterally located on the labia majora, slowly progressive, non-inflammatory, and painless. Clinical examination revealed multiple well-circumscribed, mobile subcutaneous nodules covered by normal-appearing skin.

Histopathological examination showed dermal cystic structures with multiple invaginations, lined by stratified squamous epithelium lacking a granular layer. Sebaceous glands were present within the cyst wall, with eosinophilic material in the cornified layer, confirming the diagnosis of steatocystoma multiplex.

Based on clinical and histological findings, a diagnosis of localized vulvar steatocystoma multiplex was established. Surgical excision was performed.

Multiple steatocystomas on the labia majora

Results

Steatocystoma multiplex usually appears during adolescence or early adulthood, often associated with increased sebaceous activity, while vulvar localization remains extremely uncommon. To date, only a few cases of vulvar steatocystoma multiplex have been reported in the literature, most occurring either in familial forms or in older patients.

Our case is distinguished by its late onset, sporadic nature, and strictly localized vulvar involvement, emphasizing the diagnostic challenge posed by this rare presentation. Differential diagnoses include multiple epidermoid cysts, eruptive vellus hair cysts, neurofibromatosis, lipomas, and xanthomatosis, making histopathological confirmation essential.

Conclusions

Vulvar steatocystoma multiplex is an exceptional entity, particularly when presenting as a late-onset, localized, sporadic form. This case highlights the importance of considering steatocystoma multiplex in the differential diagnosis of chronic, asymptomatic vulvar nodules and underlines the key role of histopathology in establishing the diagnosis. Reporting such rare localizations contributes to better recognition and management of this uncommon condition.

Abstract N°: ID-888

Topic: Oral mucosa and other skin-adjacent mucous membranes

Mycoplasma-induced rash and mucositis (MIRM): A Distinct Mucocutaneous Entity in Children?

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Introduction

Mycoplasma-induced rash and mucositis (MIRM) is a recent clinical entity described as a cutaneo-mucosal syndrome associated with Mycoplasma pneumoniae infection. It is increasingly recognized as distinct from erythema multiforme major and Stevens–Johnson syndrome, particularly in pediatric populations.

Materials and Methods

Herein, we report the case of a child with Mycoplasma-induced rash and mucositis (MIRM).

Results

A previously healthy and non-medicated six year-old male, presented to our consultation in February for acute onset of severe oral and ocular mucositis following respiratory prodromes. Physical examination showed erosive hemorrhagic cheilitis associated with conjunctival hyperemia and hemorrhagic genital erosions, along with sparse atypical targetoid skin lesions with central necrotic-hemorrhagic bullae involving the face, trunk, back, and limbs, without true acral predominance and affecting less than 10% of the body surface area. Nickolsky sign was negative. Other clinical signs included fever, myalgia, dry cough and wheezing rales. Laboratory investigations revealed a biological inflammatory syndrome, while chest radiography showed bilateral interstitial pulmonary infiltrates. Histopathological examination of a skin biopsy showed Thinned epidermis, ulcerated and focally detached with subepidermal clefting; suprabasal keratinocyte necrosis with exocytosis of neutrophils and eosinophils; edematous superficial dermis containing a few capillaries with ectatic walls, and showing a polymorphous inflammatory infiltrate predominantly perivascular. Mycoplasma pneumoniae serology came back positive with high levels of immunoglobulin M antibodies. The patient was managed with Azithromycin at a dose of 1g per day for three days associated with oral corticosteroids at a dose of 0.5mg/kg/j for five days. Cutaneous lesions healed first, followed by mucosal improvement after two weeks with no observed residual sequelae. The patient experienced a second, milder episode the following winter in December, subsequent to a new Mycoplasma pneumoniae infection confirmed by serology.

Conclusions

Mycoplasma pneumoniae is responsible for mucocutaneous manifestations in approximately 25% of cases. MIRM represents an overlapping syndrome between Mycoplasma pneumoniae associated erythema multiforme major and Stevens–Johnson syndrome. It predominantly affects pediatric male patients, with a higher incidence during winter. Clinically, MIRM is characterized by severe involvement of at least two mucosal sites, associated with atypical targetoid lesions with a bullous component and a less pronounced acral predominance. Histopathologically, findings may mimic toxic epidermal necrolysis. The diagnosis relies on the combination of these clinical and paraclinical features, in the absence of drug exposure or recent Herpes Simplex Virus infection. General condition is usually preserved, and outcomes are favorable with systemic corticosteroids combined with macrolide therapy, with minimal or no long-term sequelae. This case underlines the distinct clinical profile of MIRM, allowing accurate diagnosis and appropriate management with favorable outcomes, especially in the pediatric population.

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Topic: Oral mucosa and other skin-adjacent mucous membranes

Intralesional Hyaluronidase and Triamcinolone for the Treatment of Lip and Oral Mucosal Scarring: A Case Report

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Introduction

Hyaluronidase is an enzyme with multiple medical applications, including use as a drug adjuvant, management of filler-related complications, improvement of scar appearance and even mobility of the perioral skin in patients with systemic sclerosis. This report presents the use of intralesional hyaluronidase combined with triamcinolone for the treatment of lip and oral mucosal scarring.

Results

An 18-year-old female presented to the outpatient department with complaints of lip scarring and cosmetic deformity and was referred by an oral surgeon.

Three months prior to the presentation she developed ulcers of the upper and lower lips. Symptomatic therapy with topical gels and antiseptic mouth rinses was administered by primary care physician. A month later, new ulcers appeared on the right buccal mucosa. Laboratory results were normal at the time, except for low ferritin and vitamin D levels. Subsequent treatment with dexamethasone mouth rinse was ineffective. Lesions healed with subsequent scar formation.

Clinical examination revealed lip incompetence and cicatricial changes of both lips with marked restriction of mouth opening. Intraoral examination was not possible due to limited oral aperture. Palpation demonstrated significant induration of the upper and lower lip mucosa. The patient reported a subjective sensation of tissue tightness consistent with fibrotic involvement. Extensive investigations excluded possible underlying infectious, autoimmune or paraneoplastic etiologies. Histopathological examination of a mucosal biopsy revealed tissue fibrosis. The underlying cause remained unclear, although artefact excoriation of the ulcers was considered a possible cause. Intralesional injections of hyaluronidase (500 U) combined with triamcinolone acetate (20 mg) were initiated. Improvement in tissue tension and mouth opening was noted the day after the first injection. Treatments were continued every 2–3 weeks over a nine-month period, with progressive improvement in oral aperture and tissue elasticity and without evidence of tissue atrophy. Acneiform eruptions in the U-zone developed during treatment, possibly related to triamcinolone. No new ulcers or scarring developed during follow-up. The patient is currently scheduled for surgical intervention to further improve oral commissure mobility.

Conclusions

An 18-year-old female presented with progressive lip scarring and functional impairment following recurrent oral and labial ulceration. Although the underlying cause of the scarring remains unclear, intralesional injections of hyaluronidase combined with triamcinolone helped to reduce induration and increase mucosal tissue elasticity and lip mobility.

Abstract N°: ID-966

Topic: Oral mucosa and other skin-adjacent mucous membranes

Mycoplasma Induced Rash and Mucositis sine Rash: Expanding the spectrum of Mycoplasma Associated Mucocutaneous Disease

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Introduction

Mycoplasma-induced rash and mucositis (MIRM) is an immune-mediated mucocutaneous eruption associated with *Mycoplasma pneumoniae* infection. It is classically characterized by pneumonia, mucositis involving at least two mucosal sites, and variable cutaneous involvement. **MIRM sine rash** represents a distinct and under-recognized subtype, presenting with isolated mucositis in the absence of skin lesions. Awareness of this entity is essential, as it may clinically mimic Stevens–Johnson syndrome/toxic epidermal necrolysis (SJS/TEN) but follows a more benign course.
We report a single case of MIRM sine rash in a previously healthy adult male. Clinical features, laboratory findings, imaging studies, treatment approach, and outcome were analyzed.

Materials and Methods

A 29-year-old man presented with one week of fever and cough, followed by three days of painful oral and ocular lesions associated with odynophagia and dysuria. He had not taken any medications apart from antipyretics. Examination revealed extensive erosions and ulcers involving the lips, buccal mucosa, hard palate, glans penis, and nasal mucosa. Marked bilateral conjunctival injection was noted, with corneal epithelial defect on the right eye. No vesicular, targetoid, or other cutaneous lesions were present. Respiratory examination revealed scattered crepitations. Laboratory evaluation showed neutrophilic leukocytosis, elevated C-reactive protein, and mild transaminitis. Peripheral blood smear showed no hemolysis. Serum *Mycoplasma pneumoniae* IgM antibodies were positive, and chest radiography demonstrated a right lower-lobe infiltrate. A diagnosis of MIRM sine rash was made.
The patient was treated with intravenous clarithromycin for seven days and oral prednisolone (1 mg/kg/day), tapered over four weeks due to severe ocular involvement, along with topical oral and ophthalmic corticosteroids and supportive care.

Results

Complete resolution of all mucosal lesions including ocular lesions without sequale was achieved.

Conclusions

MIRM sine rash is a rare but important differential diagnosis in acute multisite mucositis without skin involvement. Compared with SJS/TEN, it predominantly affects younger patients, follows a respiratory prodrome, and has a favorable prognosis with appropriate antimicrobial and supportive therapy. Early recognition of this entity is crucial to avoid misdiagnosis and unnecessary aggressive management, and to ensure timely, targeted treatment.

Abstract N°: ID-981

Topic: Oral mucosa and other skin-adjacent mucous membranes

Orofacial Microcystic Lymphangioma: Dermoscopic Diagnosis and Therapeutic Approach

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Introduction

Microcystic lymphangioma is a rare and benign congenital malformation. Its origin remains uncertain: it may result either from sequestration of primitive lymphatic hyperplasia or from congenital obstruction.
Two theories explain lymphatic development: derivation from the venous plexus or formation from five primitive venous sacs, including the jugular sac. We report a case of lingual lymphangioma treated with sirolimus.

Materials and Methods

A 26-year-old woman with no significant medical history presented with white vesicules evolving since the age of 4 years. These lesions progressively fill with blood, may rupture spontaneously with a mild burning sensation, and subsequently recur. Initially localized on the dorsal and ventral surfaces of the tongue, the lesions later extended to the chin.

The patient reported no difficulty with speech, swallowing, or breathing.

Dermoscopy revealed dilated translucent lacunae separated by pale septa, with the characteristic “frog spawn” appearance.

Biopsy of a lesion confirmed microcystic lymphangioma, and facial MRI demonstrated involvement of the floor of the mouth with intermuscular extension and petechial subcutaneous infiltration of the mentonian region. Management consisted of electrocoagulation of the chin lesions combined with sirolimus therapy (1.6 mg/m^2/day).

Results

Lymphangiomas are benign congenital malformations of the lymphatic system, first described by Virchow in 1854. They usually appear before the age of 2 years, with 50% detected at birth. In our case, onset at 4 years represents an atypical presentation. Their pathogenesis remains uncertain and may involve incomplete development of the lymphatic system or abnormal aggregation of lymphatic tissue.

Histologically, lymphangiomas are composed of mucosal and submucosal lymphatic spaces and are classified as microcystic (<2 cm^3), macrocystic (>2 cm^3), or mixed.

Complete surgical excision remains the treatment of choice; however, alternative modalities such as cryotherapy, electrocoagulation, sclerotherapy, corticosteroids, or embolization have been used. Recurrence rates are high, particularly for extensive microcystic lymphangiomas that are difficult to excise surgically, especially when involving the tongue.

Because pathogenesis often involves activating mutations of **PIK3CA**, inhibitors of the **PI3K/AKT/mTOR pathway** have been introduced, demonstrating notable efficacy in pediatric pure lymphatic malformations.

Conclusions

Lymphangiomas are relatively rare malformations, occurring more frequently in children than in adults, with a predilection for the head and neck region. Early diagnosis allows prompt management, thereby reducing the risk of subsequent complications.

Abstract N°: ID-1094

Topic: Oral mucosa and other skin-adjacent mucous membranes

Dermoscopy-guided Diagnosis of Staphylococcal Lip Infection in an Immunocompromised Child: A Diagnostic Pitfall

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Introduction

In immunocompromised children, acute lip swelling following hematopoietic stem cell transplantation is commonly attributed to toxic mucositis or herpetic reactivation. However, several reports describe severe bacterial lip infections—especially staphylococcal—that may clinically mimic mucositis or angioedema, leading to diagnostic delay. We report a case of edematous staphylococcal cheilitis in which dermoscopy played a pivotal diagnostic role.

Materials and Methods

N/A

Results

A pediatric patient with major beta-thalassemia underwent matched-sibling hematopoietic stem cell transplantation after a conditioning regimen combining thiotepa, fludarabine, and busulfan. On day +2 post-transplant, she developed cheilitis initially attributed to conditioning-related mucositis. This occurred in a context of febrile neutropenia treated with empiric intravenous antibiotics, including Vancomycin, without clinical improvement.

Within 24 hours, the patient developed sudden, painful, acute edema of the upper lip, centered by a small ulceration covered with a hemorrhagic crust. A careful history revealed a pre-existing excoriated lesion on the right ear, raising suspicion of a distant cutaneous entry point.

Dermoscopy revealed a central ulceration with hemorrhagic crust, bordered by yellowish honey-colored crusts, a pattern highly suggestive of bacterial infection rather than viral involvement. A local swab was performed, and topical antibacterial therapy with Mupirocin was added to systemic treatment, resulting in rapid and marked improvement within 48 hours. Bacterial culture identified methicillin-resistant *Staphylococcus aureus*. Serology for herpes simplex virus was negative.

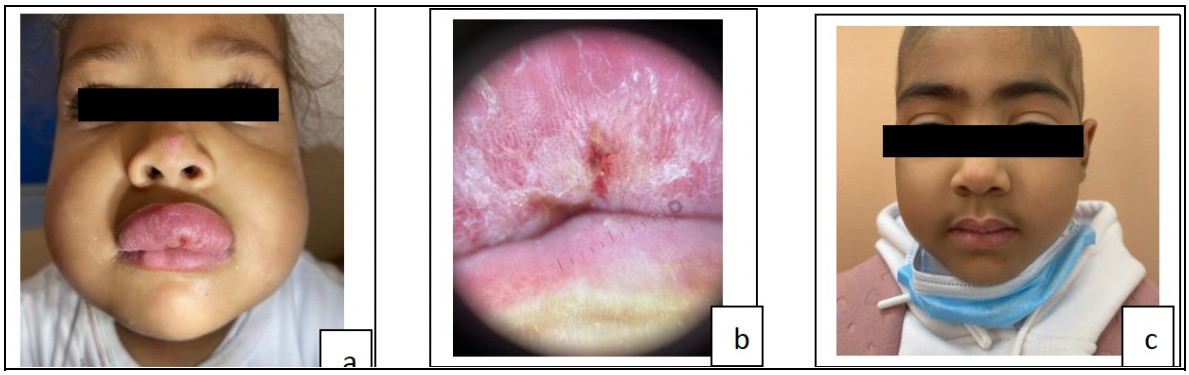

Fig. A: Painful cheilitis with a central erosion. Fig. B: Dermoscopy showing a central erosion covered by a hemorrhagic crust with slightly honey-colored borders. Fig. C: Evolution after treatment: marked improvement within 4 days.

Conclusions

Staphylococcal cheilitis in immunocompromised children may present with striking and misleading clinical features, sometimes resembling acute angioedema, toxic mucositis, or herpetic infection. Published cases highlight the frequent diagnostic confusion, occasionally leading to inappropriate use of antiviral therapy or topical/systemic corticosteroids that may worsen the condition. A targeted history—particularly the search for a distant cutaneous entry point—remains essential, and imaging may be required in severe presentations to rule out locoregional extension or deep collections. To our knowledge, dermoscopy has not been previously reported as a diagnostic aid in this setting. In our case, dermoscopy provided immediate orientation by revealing bacterial-type crusting, thereby supporting early suspicion of staphylococcal infection and enabling timely, effective antistaphylococcal therapy. This observation underscores the potential value of dermoscopy as a rapid, non-invasive tool to avoid diagnostic pitfalls and improve management in vulnerable pediatric patients.

Abstract N°: ID-1282

Topic: Oral mucosa and other skin-adjacent mucous membranes

Labial botriomycoma in a term pregnant woman: A case report

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Introduction
Botriomycoma, also known as pyogenic granuloma (PG), is a benign, non-neoplastic mucocutaneous lesion. Despite its name, it is neither pyogenic nor infectious. PG commonly arises after minor trauma or chronic irritation and can affect the skin or oral mucosa. In pregnant women, it is often referred to as a “pregnancy tumor” due to hormonal influences. Involvement of the labial mucosa, particularly the upper lip, is rare, which can make diagnosis and management challenging.

Materials and Methods
We report the case of a 35-year-old woman at term who presented with a 4-month history of a progressively enlarging lesion on her upper lip. The lesion developed after minor trauma during a meal caused by a spoon. In an attempt to control bleeding, the patient had tied a thread around the base of the mass.

On clinical examination, the lesion appeared as a red, exophytic mass measuring 3 × 3 cm, bleeding on contact, with areas of necrosis, and a thread encircling its base. No other systemic abnormalities were noted.

The lesion was excised using electrocoagulation. Histopathological analysis confirmed the diagnosis of botriomycoma/pyogenic granuloma, revealing granulation tissue with marked vascular proliferation and chronic inflammatory infiltrate. The patient recovered uneventfully, with no recurrence observed during follow-up.

Results
Pyogenic granuloma is considered a reactive lesion resulting from minor trauma or chronic irritation. In pregnant women, hormonal factors can enhance vascular proliferation, contributing to lesion growth.

In this case, several features were noteworthy: the uncommon upper labial location, the traumatic origin (spoon injury), rapid growth with bleeding and necrosis, and patient-induced constriction at the base with a thread, which complicated the clinical presentation.

The differential diagnosis includes hemangioma, peripheral giant cell granuloma, malignant tumors, and inflammatory hyperplasia. Histopathological confirmation is essential, and surgical excision remains the preferred treatment, offering both diagnostic certainty and resolution, with a low recurrence rate of approximately 3%.

Conclusions
This case emphasizes the rare occurrence of labial botriomycoma during pregnancy, highlights the role of trauma and hormonal factors in its development, and underscores the importance of histopathology for accurate diagnosis. Surgical excision or electrocoagulation provides effective treatment with favorable aesthetic outcomes.

Abstract N°: ID-1310

Topic: Oral mucosa and other skin-adjacent mucous membranes

A Review of Current Scoring Systems for Oral and Ocular Scarring in Mucous Membrane Pemphigoid and Lichen Planus

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Introduction
Chronic mucosal inflammatory conditions such as mucous membrane pemphigoid (MMP) and lichen planus (LP) can lead to progressive mucosal scarring which can have significant impacts on an individual's quality of life, resulting in physical discomfort, functional impairment, and potential disfigurement. Currently, there are no therapies that reverse established scarring, and prevention relies on early detection and effective control of inflammation. Subepithelial fibrosis may also progress despite minimal or absent clinical disease activity, increasing the risk of delayed recognition and referral. Accurate identification and longitudinal monitoring of mucosal scarring is therefore critical. Multiple disease activity and severity scoring systems have been developed for MMP and LP; however, their ability to capture scarring, particularly across disciplines, remains poor.

Materials and Methods
A narrative literature review was conducted, using Medline (Ovid), to identify and evaluate published disease activity, severity and scarring measures used in MMP and LP, with a focus on tools assessing oral and ocular mucosal involvement.

Results
Numerous multisite and site-specific scoring systems have been described for MMP and LP. Commonly used multisite tools, including the Mucous Membrane Pemphigoid Disease Activity Index (MMPDAI) and the Autoimmune Bullous Skin Disorder Intensity Score (ABSIS). However, these have not been formally validated for MMP and provide limited scope in scarring assessment, relying on binary measures without the ability to characterise severity or monitor change over time. Site-specific scoring systems such as the Oral Disease Severity Score (ODSS) are validated for assessing oral disease activity in MMP and LP but do not capture scarring complications. Ocular scarring tools, including the Cicatrizing Conjunctivitis Assessment Tool, are validated but are technically complex. Most single mucosal site assessments require specialist expertise and/or equipment, limiting their utility and uptake across different specialties.

Conclusions
Current disease assessment tools for MMP and LP inadequately capture mucosal scarring and are largely discipline-specific, limiting interdisciplinary use and early identification of progressive fibrosis. There is an unmet need for a simple, validated, and clinically practical scarring assessment tool that can be applied across specialties to facilitate early detection, timely referral, and longitudinal monitoring of mucosal scarring.

Abstract N°: ID-1312

Topic: Oral mucosa and other skin-adjacent mucous membranes

The role of candidal infection in the clinical course of focal alopecia

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Introduction

Alopecia areata (AA) is a chronic autoimmune disorder characterized by patchy hair loss. In recent years, the role of opportunistic microorganisms, including Candida fungi, in the development of chronic dermatoses has been actively studied. However, their impact on the pathogenesis of alopecia areata remains insufficiently understood.

Objective: To assess the frequency of Candida fungi detection in biological substrates of patients with alopecia areata, considering clinical forms of the disease.

Materials and Methods

The study included 112 patients with alopecia areata aged 1 to 52 years, of whom 67 (59.8%) were women and 45 (40.2%) were men. All patients underwent clinical, mycological, and statistical investigations. Mycological studies were conducted using culture-based analysis of biological substrates, including oral mucosa swabs, intestinal samples, and skin scales.

Results

Clinical and mycological investigations revealed Candida fungi in 86.6% (97 out of 112) of patients with alopecia areata. According to clinical forms:

- Intestinal candidiasis was detected in 59.8% of cases.
- Oral mucosal candidiasis in 19.6%.
- Candida colonization (asymptomatic carriage) was found in 23.7% of cases.

Fungal lesions were most frequently observed in patients with the progressive stage of alopecia areata (57.5%). Species identification showed that among yeast-like fungi, *Candida krusei* was the most prevalent (64 cases, 65.9%), followed by *Candida albicans* (18 cases, 18.5%).

Regarding clinical forms of alopecia areata, *Candida* fungi were most commonly isolated in patients with patchy alopecia (49 cases, 50.5%), while in patients with subtotal and total alopecia, the detection rates were 19.6% and 18.5%, respectively. In patients with universal alopecia, the rate was 10.3%.

Conclusions

The results of mycological investigations indicate the development of fungal infections, particularly intestinal candidiasis with sensitization, in patients with alopecia areata. These findings highlight the need for systemic antifungal therapy in the management of such cases.

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Topic: Oral mucosa and other skin-adjacent mucous membranes

Recurrent reactive infectious mucocutaneous eruption (RIME) triggered by different infectious pathogens

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Introduction

Reactive infectious mucocutaneous eruption (RIME) is a newly introduced term for mucocutaneous eruptions linked to respiratory pathogens. Previously referred to as *Mycoplasma pneumoniae*-induced rash and mucositis (MIRM), the identification of a variety of other pathogens causing similar manifestations prompted the widening of the term. RIME is characterized by involvement of typically two or more mucous membranes, with or without cutaneous involvement, following a respiratory prodrome. Recurrent episodes of RIME have been reported, linked to various infectious agents.

Materials and Methods

We report the case of a 34-year-old man who presented with a two-week history of painful oral mucosal sores. The lesions were preceded by fever, cough, and general malaise. His medical history revealed a similar episode of oral ulcerations seven years earlier, also following respiratory and systemic symptoms, which had been diagnosed as MIRM and successfully treated with azithromycin. He reported no recurrences of lesions in the intervening years.

Results

On admission, the patient exhibited confluent ulcerations covered with fibrin deposits on the buccal and palatal mucosa and the tongue. The lesions were painful, accompanied by odynophagia and dysphonia. Other mucocutaneous and systemic findings were unremarkable. Laboratory tests revealed an elevated erythrocyte sedimentation rate (52 mm/h), slightly elevated C-reactive protein (6.1 mg/L) and decreased hemoglobin level of 122 mg/L. Serological screening for HIV, hepatitis B and hepatitis C virus was negative. Given that RIME and/or MIRM were the leading clinical suspicions, a multiplex PCR test of a nasopharyngeal swab was performed, detecting *Chlamydophila pneumoniae* and Adenovirus DNA, while *M. pneumoniae* DNA was absent. Chest X-ray findings were within normal limits. Treatment included intravenous methylprednisolone (~0.9 mg/kg/day), followed by a gradual taper with oral prednisone, azithromycin 500 mg/day for 10 days, and antimicrobial and symptomatic local therapy. The lesions fully resolved within three weeks, with no recurrences reported to date.

Conclusions

The presented case describes a patient with recurrent RIME caused by different microorganisms – initially *Mycoplasma pneumoniae*, followed by *Chlamydophila pneumoniae*/Adenovirus coinfection. In recurrent RIME cases, *M. pneumoniae* is often identified as the causative agent in the first episode. Subsequent episodes of RIME have been linked to various infectious pathogens, including *M. pneumoniae*, SARS-CoV-2, Influenza virus, and others. The recurrence rate ranges from 8-38%, with varying severity across episodes. Therefore, recurrent RIME may be anticipated in patients with a prior

history, and clinicians should consider testing for multiple respiratory pathogens in suspected RIME cases, rather than focusing solely on *M. pneumoniae*.

Abstract N°: ID-1578

Topic: Oral mucosa and other skin-adjacent mucous membranes

Recurrent Geographic Tongue in a Child Triggered by Acidic Foods: A Clinical Case

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Introduction

Geographic tongue, or benign migratory glossitis, is a benign inflammatory disorder characterized by circinate erythematous patches with loss of filiform papillae and dynamic migration. Although common in adults, symptomatic pediatric presentations are less common but may be triggered by irritants such as acidic foods. Recognizing typical features is essential to avoid unnecessary investigations and to distinguish the condition from infectious, or inflammatory mimickers.

Materials and Methods

N/A

Results

A **6-year-old girl** presented with **recurrent, mildly painful, non-removable geographic patches** on the tongue. Episodes occurred **systematically after ingestion of acidic foods**, especially citrus fruits, and resolved spontaneously within **3–4 days**.
The child had **normal growth**, **no vitamin deficiency**, **no personal or family history of psoriasis**, and no signs suggestive of systemic disease.

Clinical examination showed **well-defined erythematous areas with white geographic spiraled borders**. Dermoscopy displayed the same **geographic pattern surrounding areas of ectatic papillae** .

Given the benign and self-limiting nature of the condition, management consisted of **symptomatic care** only, with **prednisone mouth rinses** proposed in case of significant discomfort. No dietary restrictions were required as symptoms remained minimal.

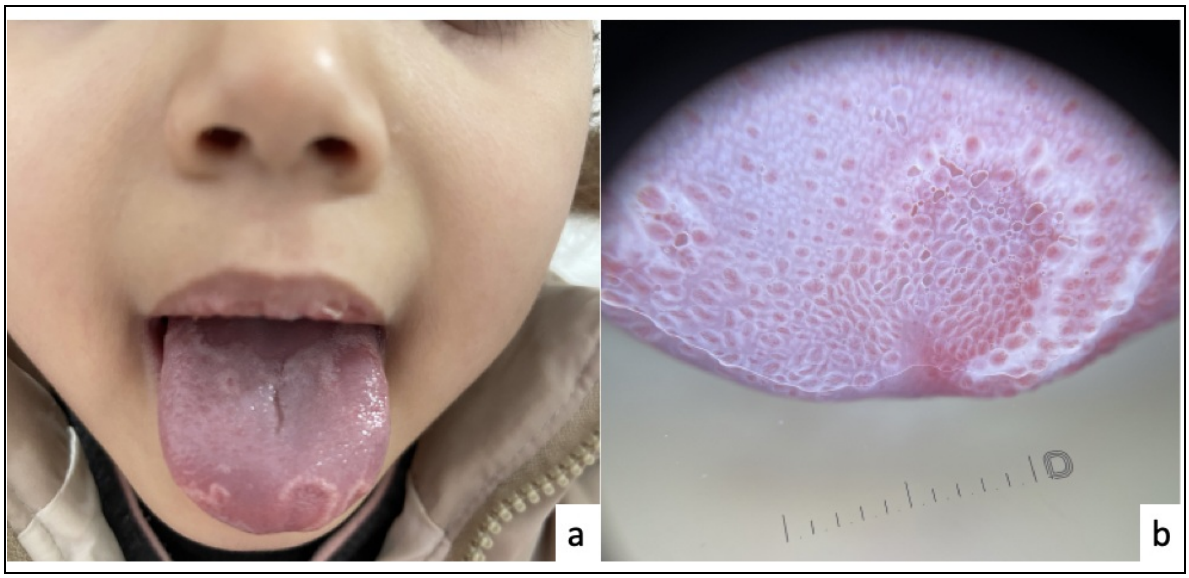

Fig a: Clinical presentation showing erythematous geographic patches on the tongue. (b) Dermoscopic view highlighting peripheral ectatic filiform papillae and a geographic contour

Conclusions

This case illustrates a **benign, recurrent, and environmentally triggered** form of geographic tongue in a child. Clinical recognition of its dynamic, migratory features is key to avoiding unnecessary testing and reassuring families. Symptomatic management is usually sufficient, and the identification of harmless triggers such as acidic foods can help guide counseling.

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Topic: Oral mucosa and other skin-adjacent mucous membranes

Zoon's vulvitis as a differential diagnosis of erosions in mucosal regions

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Introduction

Diagnosing vesiculobullous eruptions and erosions when they affect only mucous membranes and semi-mucous membranes is challenging. Antibodies are often negative or unavailable, and obtaining an appropriate sample for biopsy and immunofluorescence is a challenge due to the absence of the bulla roof.
In this context, in addition to mucosal pemphigoid, acquired epidermolysis bullosa, pemphigus vulgaris, erosive lichen planus, squamous cell carcinoma, intraepithelial neoplasia, and extramammary Paget's disease, Zoon's vulvitis is a differential diagnosis to be considered, even if questioned as a specific nosological etiology.

Materials and Methods

Case report.

Results

A 27-year-old female patient presented with a 3-year history of painful erosion on the labia minora, labia majora, and clitoris, especially the left side (Figure 1).
Given the hypotheses, an incisional biopsy was performed extending from normal skin to the central region of erosion (Figure 2), which showed an extensive ulcerated area covered by a fibrinoleukocytic crust. The adjacent epidermis exhibits attenuation, with loss of the granular and corneal layers. The superficial dermis shows a dense band-like inflammatory infiltrate, composed of numerous plasma cells, lymphocytes, and some neutrophils (Figure 3), reinforcing the clinical hypothesis of Zoon's vulvitis. Antibodies and immunofluorescence were negative.

Conclusions

While most authorities believe this condition occurs in men, its existence as a separate entity in women has been questioned. This is because many of the clinical features in women are indistinguishable from those of erosive lichen planus, mucous membrane pemphigoid, or lupus erythematosus, and the lichenoid features histologically overlap with erosive lichen planus and lichen sclerosus, making this diagnosis more challenging.