Oral Communications

COMPLEX CUTANEOUS LEISHMANIASIS: A REPORT OF TWO CASES FROM THE DERMATOLOGY UNIT OF THE UNIVERSITY OF BOLOGNA, SANT'ORSOLA-MALPIGHI HOSPITAL

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Introduction. Cutaneous Leishmaniasis (CL) is an increasingly complex challenge in the Mediterranean basin. Driven by climate change and migratory flows, CL is now an evolving pathology no longer restricted to rural areas. Despite its prevalence, it remains a neglected disease. Its clinical heterogeneity—from papules to ulcerated nodules or erysipeloid plaques—often leads to diagnostic delays, especially without clear exposure history. This study uses two complex cases to emphasize CL's role in differential diagnosis of atypical chronic skin lesions and the need for multidisciplinary management.

Materials and Methods. Two cases from IRCCS Policlinico Sant'Orsola-Malpighi (Bologna) are reported. Case 1: 55-year-old male, seen in January 2026 for a large erythematous-ulcerative-crusted swelling of the left upper eyelid, initially misdiagnosed as epithelioma. Case 2: 70-year-old male, presented in December 2022 with a large plaque on the forehead and scalp, initially interpreted as rosacea. In both immunocompetent patients, diagnosis was confirmed via histology and PCR after multiple therapy failures.

Results. A multidisciplinary protocol was established between Dermatology Unit and Infectious Diseases Department. Case 1: After initial failure of weekly intralesional (IL) injections of meglumine antimoniate and IV liposomal amphotericin B, the regimen was intensified by adding oral miltefosine and oral allopurinol. Resolution was achieved in 4 months with restored eyelid function, though plastic surgery was required for sequelae. Management was influenced by a schizoaffective disorder. Case 2: The patient faced long-term recurrences. After initial remission with IL injections of meglumine antimoniate, cryotherapy and oral miltefosine (later integrated with hydroxychloroquine), histologically confirmed relapses occurred in 2024 and 2025. This required an intensive protocol with IV pentamidine for one year, oral miltefosine for one month, and IL injections of meglumine antimoniate, reaching complete remission after 5 months.

Conclusions. CL misdiagnosis highlights a gap in early recognition, even in endemic areas. For critical sites or recurrent forms, no uniform therapy exists and treatment must be tailored to the individual . Success depends on early PCR diagnosis and specialist collaboration. A combined approach and prolonged follow-up are essential for parasite eradication and managing aesthetic-functional sequelae, minimizing recurrence risk.

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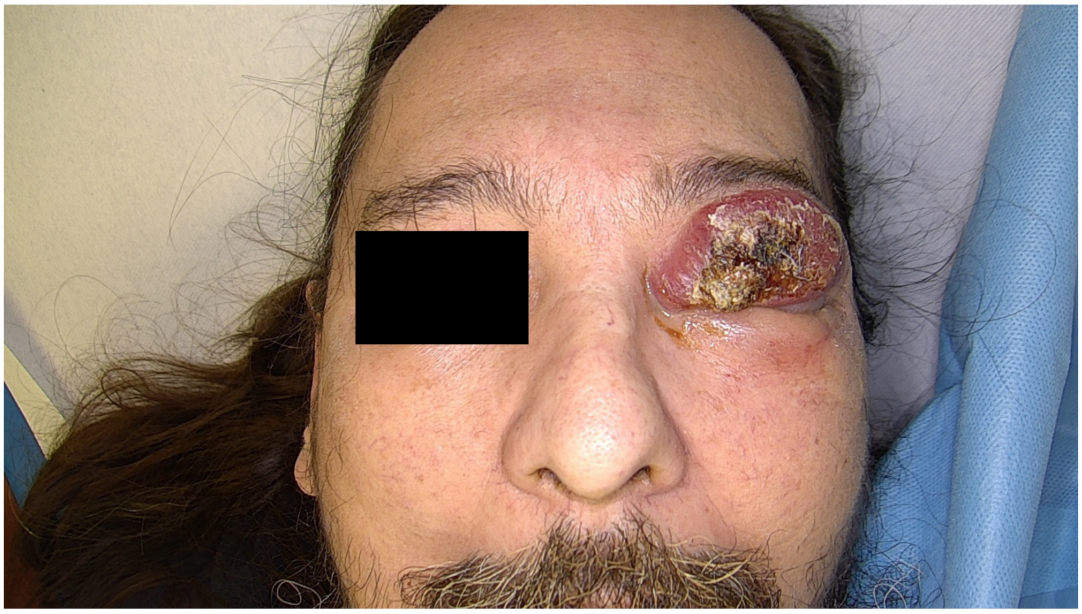
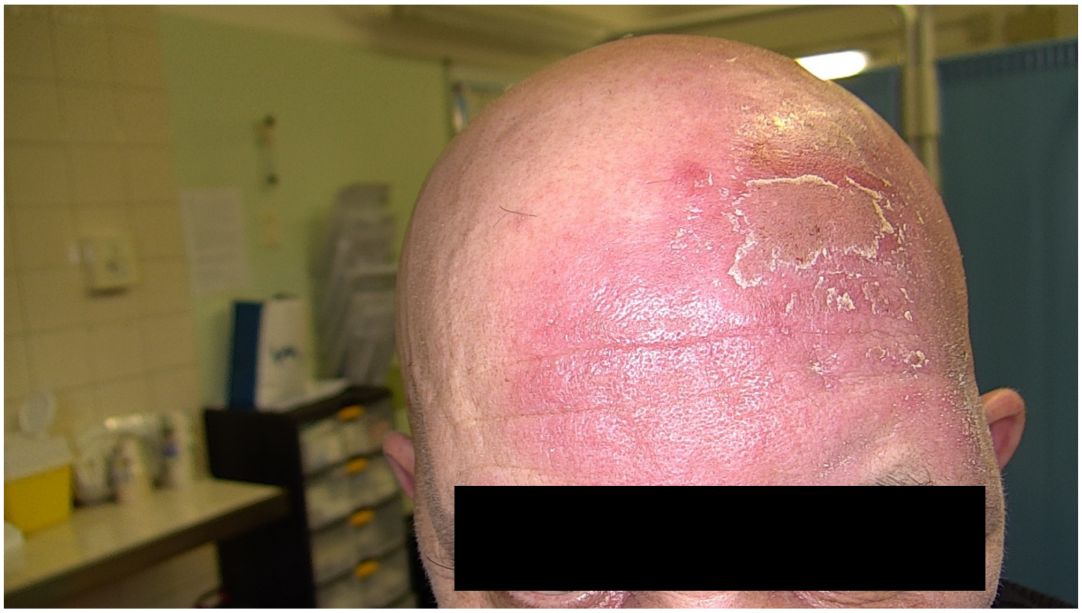


Case 1



Case 2