

62° CONGRESSO
NAZIONALE ADOI **2026**

17/19
SETTEMBRE
2026

FIRENZE

**PALAZZO
DEI CONGRESSI**
Piazza Adua, 1

**PRESIDENTE
DEL CONGRESSO**
*Prof.ssa
Marzia Caproni*



SCANNERIZZA IL QR CODE, VISITA IL
SITO DEL CONGRESSO E RIMANI AGGIORNATO
congressonazionaleadoi.it



PRESIDENTE E COMITATI

PRESIDENTE E REFERENTE SCIENTIFICO DEL CONGRESSO

Marzia Caproni

*Direttore SOS Immunopatologia cutanea e malattie rare dermatologiche,
Dipartimento di Scienze della Salute, Sezione di Dermatologia, Presidio Palagi
Azienda Usl Toscana Centro, Firenze*

COMITATO SCIENTIFICO DEL CONGRESSO

Davide Melandri

Cesare Massone

Leonardo Bianchi

Carlo Cota

Aldo Cuccia

Luca Fania

Angela Giuliani

Laura Miccio

Eugenio Provenzano

Davide Strippoli

COMITATO SCIENTIFICO LOCALE SENIOR

Emiliano Antiga

Emanuele Cipollini

Vincenzo De Giorgi

Nicola Pimpinelli

Francesca Prignano

Camilla Salvini

COMITATO SCIENTIFICO LOCALE JUNIOR

Diletta Bonciani

Alberto Corrà

Vieri Grandi

Elena Biancamaria Mariotti

Roberto Maglie

Nicola Milanese

Luigi Pisano

Lavinia Quintarelli

Valentina Ruffo di Calabria

Alice Verdelli

ORGANI DIRETTIVI ADOI

PRESIDENTE

Davide Melandri

VICEPRESIDENTE

Cesare Massone

CONSIGLIERI

Leonardo Bianchi

Marzia Caproni

Aldo Cuccia

Luca Fania

Angela Giuliani

Eugenio Provenzano

Davide Strippoli

TESORIERE

Maria Teresa Corradin

RESPONSABILE QUALITÀ

Filippo Maria Larussa

SEGRETARIO

Laura Miccio

SEGRETERIA AMMINISTRATIVA

Doris Franco

SEGRETARIO SCIENTIFICO

Carlo Cota

COMITATO SCIENTIFICO

Salvatore Amato

Nicola Arpaia

Emilio Berti

Vincenzo Bettoli

Lucia Brambilla

Andrea Conti

Antonio Cristaudo

Ornella De Pità

Biagio Didona

May El Hachem

Fabrizio Fantini

Gerardo Ferrara

Giovanna Galdo

Dennis Linder

Giovanna Malara

Daniela Marotto

Aldo Morrone

Marcello Pani

Mauro Picardo

Eugenio Provenzano

Francesca Sampogna

Giandomenico Sebastiani

Ignazio Stanganelli

Adriano Vercellone

DELEGATI REGIONALI

Giampiero Mazzocchetti, *Abruzzo*

Angelo Piccirillo, *Basilicata*

Giancarlo Valenti, *Calabria*

Giovanni Sarraco, *Campania*

Carmine D'Acunto, *Emilia-Romagna*

Claudia Colli, *Friuli-Venezia Giulia*

Francesco Ricci, *Lazio*

Gianmaria Viglizzo, *Liguria*

Paola Monari, *Lombardia*

Giorgio Mozzicafreddo, *Marche*

Concetto Paolo Agnusdei, *Molise*

Rossana Tiberio, *Piemonte*

Antonio Miracapillo, *Puglia*

Maria Giovanna Atzori, *Sardegna*

Salvatore Amato, *Sicilia*

Franca Taviti, *Toscana*

Gabriele Perazzolli, *Trentino-Alto Adige*

Marta Tramontana, *Umbria*

Maurizio Norat, *Valle D'Aosta*

Maria Teresa Scaini, *Veneto*

62° CONGRESSO
NAZIONALE ADOI **2026**

17/19
SETTEMBRE
2026

FIRENZE

PALAZZO
DEI CONGRESSI
Piazza Adua, 1

PRESIDENTE
DEL CONGRESSO
Prof.ssa
Marzia Caproni



ORAL COMMUNICATIONS



THE SKIN: A COGNITIVE AND AFFECTIVE STORY

G. Caresana

Dermatologic Surgery, Casa di Cura Piacenza, Italy

Keywords: *Tactile C-Fibres, Affective Touch.*

Introduction. The skin reflects biological, symbolic, and identity-related meanings that are deeply rooted in the history of humanity. The study and reflection on the skin have involved many different disciplines across fields, often very diverse from one another: Medicine, Religion, Philosophy, History, Psychology, Literature, Art, Communication, Sociology, and Law.

Materials and Methods. The skin is the organ that connects us with the environment in which we live and with our fellow human beings. The sensory aspect of the skin—touch—is a function that operates constantly and automatically, so much so that we are often not even aware of it.

Results. Touch is a bidirectional function: on the one hand, through discriminative (epicritic) tactile sensitivity, mechanoreceptors, thermoreceptors, and baroreceptors, it allows us to actively explore the world around us and obtain information from the external environment; on the other hand, it enables us to establish contact and affective interactions through a silent dialogue and a universal language—af-

fective touch—shared by all humankind.

Conclusions. While in the nineteenth century medical studies were mainly focused on the discriminative tactile function of the skin, the twentieth century saw the emergence of a growing interest in tactile function also in its relational and affective aspects, through clinical, behavioral, and neuroendocrine studies. This development has continued up to the most recent neurophysiological findings of the twenty-first century, culminating in the awarding of the Nobel Prize in Physiology or Medicine in 2021.

References

1. Paterlini M, La pelle che pensa. Codice Edizioni, 2025.
2. Field TM, Scafidi FA, Schamberg SM. Massage of Preterm Newborn to Improve Growth and Development. *Pediatric Nursing* 1;1987: 285-289.
3. McKemy DD, Neuhausser W, Julius D. Identification of a Cold Receptor Reveals a General Role for TRP Channels in Thermosensation. *Nature* 416;2002:52-58



LINE-FIELD CONFOCAL OPTICAL COHERENCE TOMOGRAPHY CORRELATES OF DERMOSCPIC GLOBULES

G. Cortonesi, V. Cioppa, L. Tognetti, P. Rubegni, E. Cinotti

UOC Dermatologia, AOU Senese, Siena University, Italy

Keywords: Globules, Non-Invasive.

A subset of melanocytic lesions is characterized by the presence of round to oval globules, which can be distributed throughout the lesion. The presence of regularly distributed globules at the periphery of a lesion indicates horizontal growth in a nevus. However, peripheral globules may also be found in melanomas, particularly when irregularly distributed at the lesion's edge. Reflectance confocal microscopy (RCM) has been used to correlate these features with histopathology. Under RCM, peripheral globules appear as junctional clusters of melanocytes protruding into dermal papillae or as widened interpapillary spaces at the lesion's edge. Other non-invasive imaging techniques, such as super-high magnification ($\times 400$) dermoscopy and fluorescence advanced videodermoscopy, have also demonstrated correlations between dermoscopic and histopathological findings. These methods reveal round melanocytic aggregates associated with globules. A novel optical technique, line-field confocal optical coherence tomography (LC-OCT), has been developed to provide high-resolution, deep-penetration, in vivo imaging for various inflammatory, infectious, and neoplastic dermatological conditions. LC-OCT incorporates an integrat-

ed video dermoscope, allowing real-time correlation between dermoscopy and LC-OCT findings. To date, globules have been associated with melanocytic nests in the dermis or at the dermoepidermal junction under LC-OCT. In this letter, we describe how LC-OCT can aid in evaluating globules in different pigmented skin lesions, providing histological correlation and potentially reducing unnecessary surgical excisions. Through LC-OCT, we were able to observe vertical, histology-like, three-dimensional images of the histological correlates of globules. Globules are well-demarcated, round to oval structures, aggregated in clusters or located at the periphery of melanocytic lesions. Notably, clinically and dermoscopically indistinguishable globules were revealed to be either pigmented keratinocyte aggregates or melanocytic nests on LC-OCT, allowing differentiation between epithelial and melanocytic lesions. In conclusion, this study confirms the utility of LC-OCT in identifying specific globular patterns, providing additional information beyond clinical and dermoscopic evaluation, and potentially reducing unnecessary excisions of benign skin lesions. Further studies with larger sample sizes are needed to validate our findings.



PERIOCCULAR “ULCUS RODENS-LIKE” SQUAMOUS CELL CARCINOMA TREATED WITH CEMIPIMAB: A CASE REPORT

A. Zordan¹, M. Fino¹, N. Di Meo¹, I. Zalaudek¹, C. Defferrari², S. Sola³, C. Massone⁴

¹Department of Dermatology and Venereology, University of Trieste, Maggiore Hospital, Trieste, Italy; ²Department of Oncology, Galliera Hospital, Genoa, Italy; ³Department of Pathology, Galliera Hospital, Genoa, Italy; ⁴Department of Dermatology, Galliera Hospital, Genoa, Italy

Keywords: Cutaneous-Squamous-Cell-Carcinoma, Cemiplimab.

Cutaneous squamous cell carcinoma (cSCC) is the second most common cutaneous malignancy of the periocular region after basal cell carcinoma (respectively, 10% and 90%). Periocular cSCCs show great clinical variability and currently only few cases of periocular ulcerated cutaneous SCC, mimicking ulcerated basal cell carcinoma *ulcus rodens*-type have been described. We hereby present the case of a 66-year-old woman with a 38x20 mm ulcerated lesion affecting the left medial canthus, the left nasal ala and the upper and lower left eyelids, that she stated to be present for at least 12 months before our first evaluation. Although initially asymptomatic, the patient complained about pruritus, a burning sensation and photophobia as the ulcer enlarged. The neoplasm was initially clinically diagnosed as an *ulcus rodens* basal cell carcinoma; however, histopathology and immunohistochemistry from incisional biopsy were diagnostic for an ulcerated and poorly keratinizing cSCC. A contrast-enhanced CT scan of the facial skeleton and neck was

performed, highlighting tumoral extension to the extraconal adipose tissue and possible invasion of the left nasolacrimal duct, while excluding head and neck lymph node involvement. The patient refused a radical orbital exenteration surgery and radiotherapy was not feasible, hence treatment with endovenous cemiplimab for locally advanced SCC (lacSCC) was initiated. During the treatment a progressive shrinking of the lesion occurred, with a 10x5 mm residual lesion at the ninth month of follow-up, without concomitant adverse events. LacSCC, defined as cSSC not feasible of curative surgery or radiotherapy, can show different clinical presentations, and correct histopathological diagnosis is essential to establish the most adequate therapeutic approach for the patient. In the presented case, cemiplimab, an anti PD-1 monoclonal antibody approved as systemic treatment for lacSCC, allowed great therapeutic response and disease control in a challenging case of lacSCC presenting in a critical anatomic site and clinically simulating basal cell carcinoma.



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

M. Ferrante^{1,2}, M. La Placa^{1,2}, V. Gaspari¹

¹ Dermatology Unit, IRCCS Azienda Ospedaliero, Universitaria di Bologna, Policlinico S. Orsola-Malpighi, Bologna, Italy; ² Department of Medical and Surgical Sciences, Alma Mater Studiorum, University of Bologna, Italy

Keywords: Cutaneous Leishmaniasis, Treatments.

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-crusting 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.

References

1. de Vries HJC, Schallig HD. Cutaneous Leishmaniasis: A 2022 Updated Narrative Review into Diagnosis and Management Developments. *Am J Clin Dermatol.* 2022 Nov;23(6):823-840. doi: 10.1007/s40257-022-00726-8. Epub 2022 Sep 14.
2. Blum J, Buffet P, Visser L, Harms G, Bailey MS, Caumes E, Clerinx J, van Thiel PP, Morizot G, Hatz C, Dorlo TP, Lockwood DN. LeishMan recommendations for treatment of cutaneous and mucosal leishmaniasis in travelers, 2014. *J Travel Med.* 2014 Mar-Apr;21(2):116-29. doi: 10.1111/jtm.12089.
3. Todeschini R, Musti MA, Pandolfi P, Troncatti M, Baldini M, Resi D, Natalini S, Bergamini F, Galletti G, Santi A, Rossi A, Rugna G, Granozzi B, Attard L, Gaspari V, Liguori G, Ortalli M, Varani S. Re-emergence of human leishmaniasis in northern Italy, 2004 to 2022: a retrospective analysis. *Euro Surveill.* 2024 Jan;29(4):2300190. doi: 10.2807/1560-7917.ES.2024.29.4.2300190.



Case 1



Case 2



DRUG ECONOMIC ANALYSIS OF THE DOSE SPACING OF BIOLOGICAL DRUGS IN ATOPIC DERMATITIS AND PSORIASIS

A. Filoni¹, L. Pietroleonardo¹, P. Stasi², M. Spagnolo², F. Scicchitano², S. Pelle³, M. Congedo¹

¹UOSVD Dermatology and Allergology, Hospital Vito Fazzi, Lecce, Italy; ²Servizio Farmaceutico Distrettuale, Asl Lecce, Italy; ³Dermatology Outpatient Unit, Asl Lecce, Italy

Keywords: Psoriasis, Atopic Dermatitis.

Introduction. Biologic therapies for psoriasis and atopic dermatitis represent a substantial share of expenditure for the Italian National Health Service (NHS), with annual per-patient costs in psoriasis exceeding €10,000–15,000 and accounting for up to 13.7% of public pharmaceutical spending. Real-world evidence confirms a significant increase in direct healthcare costs compared with conventional therapies; however, these treatments are associated with improved clinical outcomes and quality of life, with incremental cost-effectiveness ratios (ICERs) generally considered acceptable. In the Italian setting, access to these therapies is influenced by regional cost-containment policies (AIFA registries, authorized prescribing centers, and eligibility criteria), leading to geographical variability in prescribing patterns and actual availability of biologic agents. These limitations are particularly relevant in atopic dermatitis as well, where the high cost of newly available biologics affects regional uptake, resulting in disparities in access and potential inequities in patient care.

Materials and Methods. We performed a comparison between the dosing regimen approved in the Summary of Product Characteristics (SmPC) and spacing strategies.

Results and Conclusions. We conducted an economic and financial impact analysis (Budget Impact Analysis) of high-cost immunomodulatory drugs used for the treatment of the diseases under investigation. The analysis aimed to evaluate and compare the annual economic impact associated with the treatment of moderate-to-severe psoriasis and atopic dermatitis. Specifically, the comparison was performed between the dosing regimen approved in the Summary of Product Characteristics (SmPC) and spacing strategies (extension of the dosing interval) applicable in clinical practice to improve the economic sustainability of the Regional Health Service. Assuming that 50% of treated patients are eligible for a spacing strategy, an estimated annual cost saving of nearly 20% could be achieved.

References

1. Di Altobrando A. et al. Deferred time of delivery of biologic therapies in patients with stabilized psoriasis leads to a 'perceived satisfaction': a multicentric study. *J Dermatolog Treat.* 2022 Feb;33(1):415-419. doi: 10.1080/09546634.2020.1759769. Epub 2020 Apr 29. PMID: 32314934.

2. Van der Schoot LS et al. Regaining adequate treatment responses in patients with psoriasis who discontinued dose reduction of adalimumab, etanercept or ustekinumab. *Br J Dermatol.* 2022 Dec;187(6):1028-1030. doi: 10.1111/bjd.21797. Epub 2022 Aug 20. PMID: 35895852; PMCID: PMC10087531.

3. Van Bezooijen JS et al. Prolongation of Biologic Dosing Intervals in Patients With Stable Psoriasis: A Feasibility Study. *Ther Drug Monit.* 2017 Aug;39(4):379-386. doi: 10.1097/FTD.0000000000000420. PMID: 28570371.

4. Blauvelt A et al. Extension of ustekinumab maintenance dosing interval in moderate-to-severe psoriasis: results of a phase IIb, randomized, double-blinded, active-controlled, multicentre study (PSTELLAR). *Br J Dermatol.* 2017 Dec;177(6):1552-1561. doi: 10.1111/bjd.15722. Epub 2017 Nov 16. PMID: 28600818.

5. Reich K et al. Secukinumab dosing optimization in patients with moderate-to-severe plaque psoriasis: results from the randomized, open-label OPTIMISE study. *Br J Dermatol.* 2020 Feb;182(2):304-315. doi: 10.1111/bjd.18143. Epub 2019 Sep 8. PMID: 31102257.

6. Mastorino L. et al. Dose modulation strategies in patients with psoriasis: real-world comparison between secukinumab and brodalumab for up to 1 year after dose spacing. *Clin Exp Dermatol.* 2025 Oct 27;50(11):2172-2178. doi: 10.1093/ced/llaf250. PMID: 40499920.

7. Lebwohl M et al. Phase 3 Studies Comparing Brodalumab with Ustekinumab in Psoriasis. *N Engl J Med.* 2015 Oct;373(14):1318-28. doi: 10.1056/NEJMoa1503824. PMID: 26422722.

8. Lebwohl M. et al. Recapture Rate of Brodalumab in Patients With a Lapse in Treatment. *J Drugs Dermatol.* 2020 Apr 1;19(4):384-387. doi: 10.36849/JDD.2020.5026. PMID: 32272515.

9. Wang C et al. Extension of Secukinumab and Ixekizumab Dose for Moderate-To-Severe Psoriasis in Low Disease Activity Intervals. *Exp Dermatol.* 2025 May;34(5):e70122. doi: 10.1111/exd.70122. PMID: 40369849.

10. Eyerich K et al. Noninferiority of 16-Week vs 8-Week Guselkumab Dosing in Super Responders for Maintaining Control of Psoriasis: The GUIDE Randomized Clinical Trial. *Dermatol.* 2024 Nov 1;160(11):1257. doi: 10.1001/jamadermatol.2024.4370. PMID: 39083288; PMCID: PMC11292573.

11. Warren RB et al. Time to relapse after tildrakizumab withdrawal in patients with moderate-to-severe psoriasis who were responders at week 28: post hoc analysis through 64 weeks from reSURFACE 1 trial. *J Eur Acad Dermatol Venereol.* 2021 Apr;35(4):919-927. doi: 10.1111/jdv.16964. Epub 2020 Nov 5. PMID: 32979235.



12. Luz M. et al. Real-World Evidence on Dose Spacing of Risankizumab for Psoriasis: A Multicenter Retrospective Cohort Study. *Dermatol Ther (Heidelb)*. 2026 Jan;16(1):653-658. doi: 10.1007/s13555-025-01588-8. Epub 2025 Nov 10. PMID: 41214414; PMCID: PMC12873057.
13. Gisondi P. et al. Is risankizumab as needed administration a good option for patients with plaque psoriasis? *J Eur Acad Dermatol Venereol*. 2022 Sep;36(9):e713-e715. doi: 10.1111/jdv.18182. Epub 2022 May 5. PMID: 35470475.
14. Abbad-Jaime De Aragón C. et al. Bimekizumab as-needed dosing in patients with psoriasis: a case series. *J Dermatolog Treat*. 2025 Dec;36(1):2492197. doi: 10.1080/09546634.2025.2492197. Epub 2025 Apr 21. PMID: 40256854.
15. Vieira J. et al. Successful dupilumab dose spacing in controlled severe atopic dermatitis and predictive factors. *Eur Ann Allergy Clin Immunol*. 2025 Mar 7. doi: 10.23822/EurAnnACI.1764-1489.387. Epub ahead of print. PMID: 40270359.
16. Weidinger S. et al. Predicting success with reduced dosing frequency of tralokinumab in patients with moderate-to-severe atopic dermatitis. *Br J Dermatol*. 2025 Feb 18;192(3):410-419. doi: 10.1093/bjd/ljae439. PMID: 39657020.
17. Tong Z et al. Upadacitinib Dose Reduction Regimen in Elderly Patients with Atopic Dermatitis, Guided by Treat-to-Target Consensus Recommendations. *Am J Clin Dermatol*. 2025 May;26(3):437-447. doi: 10.1007/s40257-025-00923-1. Epub 2025 Feb 12. PMID: 39939577.
18. Schlösser AR et al. Successful Dose Reduction of Janus-kinase Inhibitors in Well-controlled Atopic Dermatitis: A Prospective, Multicentre, Real-world Study. *Acta Derm Venereol*. 2025 Nov 17;105:adv44165. doi: 10.2340/actadv.v105.44165. PMID: 41247178; PMCID: PMC12632132.



METABOLIC DYSREGULATION AND IMMUNE ACTIVATION IN VITILIGO: UNVEILING THE MITOCHONDRIAL AND INFLAMMATORY IMPRINT OF DISEASE PATHOGENESIS

S. Caputo¹, A. Marini¹, S. Scano¹, F. Papaccio¹, R. Marrapodi¹, P. Iacovelli², A. Presaghi³, E. Migliano³, C. Cota⁴, A. Filoni⁵, M. Picardo⁶, B. Bellei¹

¹Laboratory of Cutaneous Physiopathology and Integrated Center of Metabolomics Research, San Gallicano Dermatological Institute, IRCCS, Rome, Italy; ²Clinical Dermatology, Phototherapy Unit, San Gallicano Dermatological Institute, IRCCS, Rome, Italy; ³Department of Plastic and Regenerative Surgery, San Gallicano Dermatological Institute, IRCCS, Rome, Italy; ⁴Genetic Research, Molecular Biology and Dermatopathology Unit, San Gallicano Dermatological Institute, Rome, Italy; ⁵UOSVD Dermatology and Allergology, Hospital Vito Fazzi, Lecce, Italy; ⁶Istituto Dermopatico dell'Immacolata, IDI-IRCCS, Rome, Italy

Keywords: Vitiligo, Metabolic Dysfunction.

Vitiligo pathogenesis involves a complex interplay of genetic susceptibility, oxidative stress, and autoimmune-mediated melanocyte destruction. While impaired adhesion and defective regeneration contribute to the disease, recent evidence highlights the role of early metabolic alterations in triggering pathogenesis. Clinically, patients frequently present systemic metabolic comorbidities, including dyslipidemia, altered glucose homeostasis, and compromised antioxidant capacity. This study evaluated the in vitro metabolic profiles of dermal and epidermal cells isolated from the non-lesional skin of vitiligo patients compared to matched healthy controls. Our findings reveal that vitiligo-derived melanocytes, keratinocytes, and fibroblasts exhibit severe mitochondrial dysfunction, resulting in depleted ATP levels and elevated reactive oxygen species (ROS). To compensate for this energetic deficit, cells implement a metabolic adaptation mimicking hypoglycemia, characterized by upregulated Glut-4 expression, increased glucose uptake, and activation of autophagic pathways. This excessive glucose influx leads to the intracellular accumulation and microenvironmental release of advanced glycation end-products (AGEs), which may act as tissue messengers. However, the resulting cytoplasmic hyperglycemia over activates the mTOR/S6 path-

way, inducing a negative feedback loop in IGFR/InsR signaling via chronic hyperphosphorylation of IRS1 at Ser612. This modification blunts the insulin response, establishing a state of cellular insulin resistance. Notably, chronic stimulation with insulin and IGF-1 worsens the ATP deficit, further elevating ROS and AGEs. Among the analyzed cell types, keratinocytes demonstrated high sensitivity to glucotoxicity. Their metabolic impairment triggers a robust inflammatory response, marked by the secretion of innate immunity mediators, including CXCL10, IL-6, IL-8, IL-1 α , IL-1 β , and TNF α , which promote THP-1 monocyte differentiation. In turn, THP-1 cells exposed to vitiligo keratinocyte-conditioned medium release high levels of immunostimulatory molecules (IL-1 α , IL-1 β , IL-6, IL-8, CXCL10, CXCL12, CXCL16, PD-L1), amplifying the inflammatory network. This mechanism is critical, as the transition from a diffuse chronic inflammation to a localized form of autoimmunity represents the key turning point of vitiligo onset, likely driven by the loss of an precarious homeostatic equilibrium. Ultimately, the engagement of innate immune cells facilitates adaptative immune response. These data substantiate the link between metabolic dysfunction and vitiligo onset, offering new translational perspectives for early therapeutic intervention.



IS AJCC STAGE IIA MELANOMA A HOMOGENEOUS DISEASE? A 23-YEAR SINGLE-CENTER EXPERIENCE

C. Cescatti¹, C. Trevisiol², P. Del Fiore², G. Madeo³, N. Romagnolo⁴, F. Cassalia², A. Acciardi², S. Mocellin^{2,3}, M. Alaibac⁴

¹Department of Medicine (DIMED), School of Medicine, University of Padova, Italy; ²Soft-Tissue, Peritoneum and Melanoma Surgical Oncology Unit, Veneto Institute of Oncology IOV - IRCCS, Italy; ³Department of Surgery, Oncology and Gastroenterology (DISCOG), University of Padova, Italy; ⁴Dermatology Unit, Department of Medicine, University of Padova, Italy

Keywords: Melanoma Stage Iia, Prognosis.

Introduction. Stage IIA cutaneous melanoma is generally considered an intermediate-risk disease with favorable long-term outcomes. However, patients within this stage represent a clinically heterogeneous population, and their risk of recurrence and melanoma-related death may vary considerably. The aim of this study was to investigate long-term outcomes and identify prognostic factors in patients with AJCC stage IIA melanoma, with particular attention to differences between T2b and T3a tumors.

Materials and Methods. We performed a retrospective analysis of 201 consecutive patients diagnosed with AJCC stage IIA cutaneous melanoma between 2001 and 2024 at a tertiary referral center. Clinicopathological variables included demographic characteristics, Breslow thickness, histological subtype, mitotic activity, Clark level, lymphovascular invasion, regression, and tumor-infiltrating lymphocytes (TILs). Disease-free survival (DFS), melanoma-specific survival (MSS), and overall survival (OS) were estimated using Kaplan-Meier analysis and evaluated through Cox proportional hazards models.

Results. The study population comprised 99 patients with T2b melanoma and 102 with T3a melanoma. After a median follow-up of 144 months, 55 patients developed disease recurrence. Recurrence occurred significantly more frequently among patients with T3a melanoma than among those with T2b disease (35.3% vs 19.2%; $p=0.016$). Patients with T3a melanoma also experienced significantly poorer long-term outcomes, with a 5-year DFS of 67.5% compared with

87.5% in T2b melanoma and a 5-year OS of 74.5% versus 84.6%, respectively. A similar, although not statistically significant, trend was observed for melanoma-specific survival. During follow-up, 84 deaths were recorded, including 40 attributable to melanoma. Multivariable analysis identified Breslow thickness as an independent predictor of recurrence, whereas brisk TILs were independently associated with improved disease-free survival.

Conclusions. Although classified within the same AJCC stage, T2b and T3a melanomas exhibit substantially different clinical outcomes. These findings suggest that stage IIA melanoma encompasses biologically distinct risk groups and highlight the potential contribution of clinicopathological and immune-related factors to a more refined prognostic stratification. Further studies are warranted to refine surveillance strategies and identify patients who may benefit from more personalized follow-up approaches.

References

1. Gershenwald JE, Scolyer RA, Hess KR, et al. Melanoma staging: Evidence-based changes in the American Joint Committee on Cancer eighth edition cancer staging manual. *CA Cancer J Clin.* 2017;67(6):472-492. doi:10.3322/caac.21409;
2. Maher NG, Vergara IA, Long GV, Scolyer RA. Prognostic and predictive biomarkers in melanoma. *Pathology.* 2024;56(2):259-273. doi:10.1016/j.pathol.2023.11.004;
3. Homsí J, Kashani-Sabet M, Messina JL, Daud A. Cutaneous melanoma: prognostic factors. *Cancer Control.* 2005;12(4):223-229. doi:10.1177/107327480501200403



RECURRENCE DEFINES PROGNOSIS IN THICK MELANOMA: A LONG-TERM SINGLE-CENTER EXPERIENCE

S. Apa¹, P. Del Fiore², C. Trevisiol², G. Madeo³, N. Romagnolo⁴, F. Cassalia², A. Acciardi², S. Mocellin^{2,3}, M. Alaibac⁴

¹Department of Medicine (DIMED), School of Medicine, University of Padova, Italy; ²Soft-Tissue, Peritoneum and Melanoma Surgical Oncology Unit, Veneto Institute of Oncology IOV - IRCCS, Italy; ³Department of Surgery, Oncology and Gastroenterology (DISCOG), University of Padova, Italy; ⁴Dermatology Unit, Department of Medicine, University of Padova, Italy

Keywords: Thick Melanoma, Prognosis.

Introduction. Thick cutaneous melanoma remains a high-risk malignancy despite advances in diagnosis and treatment. Although Breslow thickness is a well-established prognostic factor, outcomes among patients with thick melanoma remain heterogeneous. The aim of this study was to evaluate long-term outcomes, recurrence patterns, and prognostic factors in a cohort of patients with thick cutaneous melanoma.

Materials and Methods. We retrospectively analyzed 278 consecutive patients diagnosed with thick cutaneous melanoma (Breslow thickness >4 mm) between 2000 and 2020 at a tertiary referral center. Clinicopathological variables included age, sex, Breslow thickness, mitotic rate, ulceration, primary tumor site, and sentinel lymph node biopsy (SLNB) status. Overall survival (OS) and melanoma-specific survival (MSS) were estimated using Kaplan-Meier analysis and evaluated through Cox proportional hazards models.

Results. After a median follow-up of 95 months, 138 patients (49.6%) developed disease recurrence. The most frequent first recurrence pattern was in-transit or regional cutaneous recurrence (33.3%), followed by distant metastasis (27.5%) and regional nodal recurrence (25.4%). During follow-up, 122 melanoma-specific deaths and 188 deaths from any cause were recorded. Patients who experienced recurrence showed markedly worse outcomes compared with those who remained recurrence-free. Five-year MSS was

49.4% in patients with recurrence and 78.6% in those without recurrence, while five-year OS was 44.2% and 65.0%, respectively. In multivariable analysis, Breslow thickness, ulceration, and SLNB status emerged as independent prognostic factors for both melanoma-specific and overall survival.

Conclusions. Despite advances in melanoma management, thick melanoma remains associated with a considerable risk of recurrence and melanoma-related death. In our cohort, recurrence identified a subgroup of patients with substantially worse long-term outcomes. Traditional clinicopathological factors, including Breslow thickness, ulceration, and sentinel lymph node status, retained important prognostic value. These findings underline the complexity of thick melanoma and support ongoing efforts to better identify patients at greatest risk.

References

1. Kim SH, Garcia C, Rodriguez J, Coit DG. Prognosis of thick cutaneous melanoma. *J Am Coll Surg.* 1999;188(3):241-247. doi:10.1016/s1072-7515(98)00296-8.
2. Holmberg CJ, Mikiver R, Isaksson K, et al. Prognostic Significance of Sentinel Lymph Node Status in Thick Primary Melanomas (> 4 mm). *Ann Surg Oncol.* 2023;30(13):8026-8033. doi:10.1245/s10434-023-14050-w.
3. Maher NG, Vergara IA, Long GV, Scolyer RA. Prognostic and predictive biomarkers in melanoma. *Pathology.* 2024;56(2):259-273. doi:10.1016/j.pathol.2023.11.004.



ADULT LANGERHANS CELL HISTIOCYTOSIS: A DERMATOLOGICAL DIAGNOSTIC CHALLENGE UNVEILING MULTISYSTEM DISEASE

M. Donati¹, A. Corrà², A. Verdelli³, N. Pimpinelli³, C. Longo¹, M. Caproni³

¹Department of Dermatology, University of Modena and Reggio Emilia, Modena, Italy; ²Dermatology Unit, Ospedale San Bartolo, Vicenza, Italy; ³Section of Dermatology, Department of Health Sciences, University of Florence, Italy

Keywords: Langerhans Cell Histiocytosis, Clinicopathological Correlation.

Introduction. Adult Langerhans cell histiocytosis (LCH) is a rare inflammatory myeloid neoplasm whose cutaneous manifestations frequently mimic common dermatoses, resulting in delayed diagnosis. We report a case in which persistent skin lesions led to the diagnosis of BRAF V600E-mutated multi system LCH associated with a clonal myeloid neoplasm.

Case report. A 67-year-old man with thrombocytopenia of undetermined etiology (2012) and scalp psoriasis (2018) refractory to topical therapy and acitretin developed confluent nodular lesions in the malar regions in June 2020. An initial biopsy was interpreted as impetiginized seborrheic keratosis. Following progressive worsening, a second biopsy (November 2020) showed acanthosis, hyperparakeratosis, and a dense dermal inflammatory infiltrate with necrosis. A presumptive diagnosis of rosacea was made, but the lesions failed to respond to antibiotic therapy. Progressive extension to the scalp and chest, together with ulcerative evolution of the facial lesions, prompted a third biopsy in June 2021, which established the diagnosis of LCH (CD1a+, S100+, BRAF V600E-mutated). Systemic prednisone (0.5 mg/kg/day), initiated while awaiting definitive histopathology, induced partial regression. Subsequent staging revealed multisystem involvement (bone, spleen, lung, ENT). Cladribine was initiated; bone marrow biopsy for persistent thrombocytopenia disclosed an associated myelodysplastic/myeloproliferative neoplasm. Cladribine induced cutaneous remission by December 2022. Cutaneous disease re-

mained stable during follow-up; however, extracutaneous reactivation occurred, including an atypical intramuscular thigh lesion whose biopsy showed granulomatous inflammation with scattered Langerhans cells, together with FDG-PET/CT evidence of sinonasal, periorbital, and supraclavicular nodal involvement. After exclusion of an aggressive neoplasm, dabrafenib plus trametinib was planned for presumed disease recurrence.

Conclusions. This case highlights how persistent or atypical skin lesions may represent the first manifestation of multisystem disease and underscores the importance of repeated clinicopathological correlation when initial investigations are inconclusive. The main differential diagnoses are also discussed. The coexistence of a clonal myeloid neoplasm and the planned use of MAPK-targeted therapy further reflect the biological complexity of adult LCH.

References

1. Allen CE, Merad M, McClain KL. Langerhans-cell histiocytosis. *N Engl J Med.* 2018;379(9):856-68.
2. Acosta-Medina AA, Kemps PG, Zondag TCE, Abeykoon JP, Forma-Borst J, Steenwijk EC, et al. BRAFV600E is associated with higher incidence of second cancers in adults with Langerhans cell histiocytosis. *Blood.* 2023;142(18):1570-5.
3. Razanamahery J, Godot A, Leguy-Seguin V, Samson M, Audia S, Bonnotte B. Impact of BRAFV600E mutation on aggressiveness and outcomes in adult clonal histiocytosis. *Front Immunol.* 2023;14:1260193.



PAEDIATRIC FOLLICULAR MUCINOSIS WITHOUT PROGRESSION TO MYCOSIS FUNGOIDES: A LONG-TERM CLINICOPATHOLOGIC STUDY

A. Di Guardo¹, L. Ambrosio^{1|2}, M. Testa¹, D. Didona¹, F. Moro^{1|2}, A. Rallo¹, G. Di Lella¹, L. Colonna¹, S. Pallotta¹, A. Panebianco¹, L. Fania^{1|3}

¹IDI-IRCCS, Dermatological Research Hospital, Rome, Italy; ²UOC of Dermatology, Department of Medical and Cardiovascular Sciences, "Sapienza" University of Rome, Italy; ³Department of Life Science, Health, and Health Professions, Link University of Rome, Italy

Keywords: Follicular Mucinosis, Pediatric Dermatology.

Background. Follicular mucinosis (FM), also known as alopecia mucinosa, is a rare clinicopathologic entity characterized by mucin deposition within the follicular epithelium, with or without sebaceous gland involvement [1,2]. Since its original description, the main concern has been its possible relationship with cutaneous T-cell lymphoma, particularly mycosis fungoides (MF) [3]. This study aimed to characterize the clinical, histopathologic, molecular, therapeutic, and follow-up features of pediatric FM in a large single-center cohort.

Materials and Methods. We performed a retrospective single-center study including patients aged <18 years diagnosed with FM at a tertiary dermatology referral center in Italy between 2003 and 2026. Demographic, clinical, histopathologic, molecular, treatment, and outcome data were collected from medical records. Histopathologic features, including folliculotropism and epidermotropism, were recorded.

Results. Twenty-three pediatric patients were included: 14 males (60.9%) and 9 females (39.1%), with a mean age at presentation of 12.6 ± 3.0 years. The head and neck region was involved in 21 cases (91.3%) and represented the only affected site in 16 patients (69.6%). Histopathology showed folliculotropism in 16/23 cases (69.6%) and epidermotropism in 13/23 (56.5%), with both features present in 8 patients (34.8%). TCR analysis was available in 12 cases: 8 were negative, 2 polyclonal, and 2 monoclonal. Treatment was mainly conservative and skin-directed, most frequently topical corticosteroids (14/23, 60.9%). At last follow-up, all

12 evaluable patients had achieved CR. No patient with available follow-up progressed to MF.

Conclusions. Pediatric FM in this cohort showed favorable long-term outcomes, frequent complete remission over time, and no progression to MF among evaluable patients in line with previous pediatric series supporting an indolent course [4,5]. Folliculotropism, epidermotropism, or TCR monoclonality should not be interpreted in isolation as evidence of lymphoma. Conservative management with structured clinicopathologic follow-up appears appropriate for most children, while repeat biopsy and closer surveillance should be reserved for persistent, recurrent, extensive, or clinically atypical disease.

References

1. Khalil J, Kurban M, Abbas O. Follicular mucinosis: a review. *Int J Dermatol.* 2021 Feb;60(2):159-165.
2. Gibson LE, Muller SA, Leiferman KM, Peters MS. Follicular mucinosis: clinical and histopathologic study. *J Am Acad Dermatol.* 1989 Mar;20(3):441-446.
3. Pinkus H. Alopecia mucinosa; inflammatory plaques with alopecia characterized by root-sheath mucinosis. *AMA Arch Derm.* 1957;76:419-424.
4. Jin MF, Ali NS, Davis DMR, Johnson EF, Gibson LE. An update on long-term outcomes of pediatric follicular mucinosis over a 20-year period: a retrospective cohort study. *Int J Dermatol.* 2023 Aug;62(8):1056-1059.
5. Zvulunov A, Shkalim V, Ben-Amitai D, Feinmesser M. Clinical and histopathologic spectrum of alopecia mucinosa/follicular mucinosis and its natural history in children. *J Am Acad Dermatol.* 2012 Dec;67(6):1174-1181.



Figure 1. (*a, b*) Clinical presentation of pediatric follicular mucinosis in a patient with multifocal disease involving the face, including the eyebrows, nasolabial folds, cheeks, chin, and neck, with additional lesions on the trunk and extremities. (*c*) Hematoxylin and eosin staining (10×) showing mucinous degeneration of the follicular epithelium with prominent pale intrafollicular material, associated with a dense perifollicular lymphocytic infiltrate and folliculotropism. (*d*) Higher-power inset, hematoxylin and eosin staining (30×), highlighting intrafollicular mucin deposition and the perifollicular lymphocytic infiltrate in greater detail.



SUNITINIB-INDUCED FOLLICULAR OCCLUSION DISORDER OF THE FACE: A CASE REPORT

Z. Frattin^{1,2}, A. Bolzon^{2,3}, A. Corrà², G. Frattin^{2,3}, L. Germini², L. Gnesotto², D. Lai², G. Mioso², E. Pezzolo², L. Schiesari²

¹Department of Medicine, Institute of Dermatology, University of Udine, Italy; ²Dermatology Unit, Ospedale San Bortolo, Vicenza, Italy; ³Unit of Dermatology, Department of Medicine, University of Padova, Italy

Keywords: Target Therapies, Hidradenitis Suppurativa.

Background. Sunitinib is a multi-targeted receptor tyrosine kinase (RTK) inhibitor widely used for the treatment of metastatic renal cell carcinoma (RCC). While cutaneous adverse events such as hand-foot skin reaction and hair depigmentation are common, the paradoxical induction of follicular occlusion disorders is rarely reported. We present a case of follicular occlusion disorder of the face developing in a patient undergoing Sunitinib therapy.

Case Presentation. A 70-year-old male with no prior history of acne or follicular occlusion disorders presented with a 2-month history of painful facial and cervical lesions. The patient had been receiving Sunitinib for metastatic RCC for seven months. Dermatological examination revealed lesions resembling ectopic Hidradenitis Suppurativa (HS) and dissecting cellulitis (DC), with deep inflammatory nodules, fibrous pedunculated papules at the mandibular angle and lateral neck, follicular cicatricial lesions on the nape, and multiple ice-pick scars on the cheeks. Notably, comedones were entirely absent. Lesions were intermittently suppurative. Based on the clinical morphology, the lack of primary comedones, and the temporal correlation with the targeted therapy,

a diagnosis of Sunitinib-induced follicular occlusion disorder of the face was established. A conservative topical approach was chosen to minimize systemic drug interactions. The patient was started on 1% clindamycin gel twice daily.

Results. At the 3-week follow-up, the patient showed a discrete clinical improvement. There was a reduction in both local pain and active suppuration of the inflammatory nodules, although the fibrotic and cicatricial outcomes naturally persisted. The topical treatment was well-tolerated, without interfering with the oncological therapy's safety profile.

Conclusions. Multi-kinase inhibitors targeting VEGFR and PDGFR, such as Sunitinib, can disrupt follicular homeostasis and local angiogenesis, potentially triggering deep infundibular hyperkeratosis and the subsequent inflammatory cascade typical of HS and DC, even in atypical extra-intertiginous locations. The strict absence of comedones crucially differentiates this adverse event from standard acneiform eruptions. This case highlights the importance of recognizing paradoxical inflammatory cutaneous toxicities from targeted therapies.



RETRONICHIA UP TO DATE

A. Podo Brunetti, G. Cannata

Dermatologia Clinica, Università Vita-Salute San Raffaele, Milan, Italy

Retronychchia is a specific form of post-traumatic ingrown toenail at the proximal nail fold, characterized by the formation of multiple stacked nail plates (polymeronychchia). There are three forms of retronychchia: acute, with slowed or arrested nail growth, perionychitis, and polymeronychchia with or without onycholysis; subacute, which is a continuous or episodic occurrence of retronychchia, with perionychchia that may slowly subside or worsen. There is chronic polymeronychchia with po-

lymeronychchia, pachyonychchia due to stacked columnar polymeronychchia, or onychogryphosis, and a shortened nail due to the disappearance of the distal third of the nail bed. Sometimes the nail has a yellowish color. For chronic retronychchia—as a treatment—nail filing performed by a dermatologist is recommended, followed by the application of a cosmetic nail tip, especially in women and during the summer months.

62° CONGRESSO
NAZIONALE ADOI **2026**

17/19
SETTEMBRE
2026

FIRENZE

PALAZZO
DEI CONGRESSI
Piazza Adua, 1

PRESIDENTE
DEL CONGRESSO
Prof.ssa
Marzia Caproni



POSTERS



FROM COMPOUNDING PHARMACY TO PRECISION MEDICINE: THE ROLE OF TAILOR-MADE FORMULATIONS IN AESTHETIC DERMATOLOGY

G. Malara

Università degli Studi di Enna "kore", Italy

Keywords: *Magistral Compounding, Personalized Dermatology.*

Tailor-made formulations have long represented a practical expression of individualized care in dermatology, allowing dose, vehicle, and active ingredients to be adapted to the patient's specific clinical needs and skin characteristics. In aesthetic dermatology, where efficacy, tolerability, sensory acceptability, and adherence are all critical, magistral compounding remains highly relevant as a tool to bridge therapeutic gaps not always covered by standardized commercial products. This presentation explores the evolving role of custom-made formulations as a bridge between traditional galenic practice and modern precision medicine. Compounded dermatologic preparations can optimize treatment in patients with sensitive skin, intolerance to excipients, localized anatomical requirements, or the need for combinations and concentrations not available in industrial formulations. At the same time, precision dermatology is increasingly inte-

grating phenotypic profiling, barrier function assessment, molecular biomarkers, microbiome-related factors, and patient-reported outcomes to refine therapeutic selection. Rather than opposing each other, galenic compounding and precision medicine should be viewed as complementary approaches. The former provides immediate clinical flexibility, while the latter offers a biologically informed framework for treatment personalization. In aesthetic dermatology, this convergence is especially meaningful, because the formulation itself is part of the therapeutic response: vehicle choice can influence penetration, irritation, cosmetic acceptability, and long-term adherence. Ultimately, tailor-made formulations should not be regarded as a legacy practice, but as a dynamic platform where compounding, dermocosmetic technology, and precision dermatology meet to improve efficacy, safety, and patient-centered care.



NODULAR LYMPHANGITIS CAUSED BY *MYCOBACTERIUM CHELONAE*

G. Colombo, E. Banchetti, G. Perazzolli

Dermatology Unit, Ospedale Maggiore, Verona, Italy

Keywords: Nodular Lymphangitis, *Mycobacterium Chelonae*.

A 75-year-old woman was admitted to the cardiology unit for a transfemoral transcatheter aortic valve implantation (TAVI) via the right femoral artery. Her medical history was significant for a previous renal transplantation, for which she was receiving maintenance immunosuppressive therapy with tacrolimus. During hospitalization, the patient developed multiple painful erythematous papules and nodules on both lower limbs, predominantly involving the right leg, arranged in a sporotrichoid pattern [Figure 1]. Some lesions featured central pustules, while others exhibited central necrosis and discharge. Over the following days, the lesions progressively increased in number and size. Due to the progression of the disease, histopathological and microbiological examinations were performed. Skin biopsy revealed par-

tial epidermal ulceration and a dense histiocytic inflammatory infiltrate involving the entire dermis. Ill-defined granulomatous aggregates with scattered multinucleated giant cells were also present. The culture of the biopsy specimen was positive for *Mycobacterium chelonae*. A diagnosis was made of a cutaneous *Mycobacterium chelonae* infection following a surgical procedure, presenting as sporotrichoid nodular lymphangitis in an immunocompromised host.

References

1. Ishikane M, Mitsuhashi T, Motohashi A, Aozasa N. Cutaneous *Mycobacteroides chelonae* Infection. Intern Med. 2021 Apr 1;60(7):1133-1134. doi: 10.2169/internalmedicine.4988-20. Epub 2020 Nov 9. PMID: 33162472; PMCID: PMC8079928.





CHILBLAIN LUPUS: A RARE FORM OF CUTANEOUS LUPUS ERYTHEMATOSUS - A CASE REPORT

G. Perazzolli¹, E. Banchetti¹, E. Melis¹, A. Carletto², G. Girolomoni¹, P. Gisondi¹

¹Section of Dermatology and Venereology, Department of Medicine, University of Verona, Italy; ²Section of Rheumatology, Department of Medicine, University of Verona, Italy

Keywords: Inflammatory Dermatoses, Chilblain Lupus.

Chilblain lupus erythematosus is a rare, cold-induced form of chronic cutaneous lupus that can occur in both genetic and sporadic forms. It is characterized by acral skin lesions and is commonly associated with autoimmunity and type I interferon pathway activation. Diagnosis is based on clinical features and histological findings. While topical and systemic therapies can be effective, the disease is often chronic and relapsing. We describe a case report of a 48-year-old woman with a history of chronic spontaneous urticaria and Raynaud's phenomenon presented with a history of recurrent nodular lesions on the toes since 2015. The lesions, characterized by a burning sensation and worsening during winter, appeared as erythematous to violaceous plaques with light scaling. Laboratory investigations showed positive antinuclear antibodies (1:160) and anti-Smith antibodies, while cryoglobulins and cold agglutinins were absent. The diagnosis of CHLE was confirmed by skin biopsy, which showed perivascular lymphocytic infiltrate, interface dermatitis, and increased dermal mucin, and by nailfold capillaroscopy, which revealed severe microangiopathy and giant capillary loops. Initial management with hydroxychloroquine (200 mg twice daily), topical tacrolimus 0.1%, and warmth protection resulted in only partial improvement. However, after adding methotrexate (12.5 mg/week) to the regimen, the patient achieved almost complete clinical remission within six months. This stable remission has been maintained for six months to date, highlighting methotrexate as an effective add-on therapy for CHLE cases refractory to antimalarials.

References

1. Vinister G, Roongta R, Sinha D, et al. Chilblain lupus. *Mediterr J Rheumatol* 2023; 34(2): 269-270.

2. Doutre MS, Beylot C, Beylot J, et al. Chilblain lupus erythematosus: report of 15 cases. *Dermatology* 1992; 184(1): 26-28.
3. Millard LG, Rowell NR. Chilblain lupus erythematosus (Hutchinson). A clinical and laboratory study of 17 patients. *Br J Dermatol* 1978; 98(5): 497-506.
4. Lambertini M, Vincenzi C, Dika E, et al. Chilblain lupus with nail involvement: a case report and a brief overview. *Skin Appendage Disord* 2018; 5(1): 42-45.
5. Dubey S, Joshi N, Stevenson O, et al. Chilblains in immune-mediated inflammatory diseases: a review. *Rheumatology* 2022; 61(12): 4631-4642.
6. Cribier B, Djeridi N, Peltre B, et al. A histologic and immunohistochemical study of chilblains. *J Am Acad Dermatol* 2001; 45(6): 924-929.
7. König N, Fiehn C, Wolf C, et al. Familial chilblain lupus due to a gain-of-function mutation in STING. *Ann Rheum Dis* 2016; 76(2): 468-472.
8. Lee-Kirsch MA, Gong M, Schulz H, et al. Familial chilblain lupus, a monogenic form of cutaneous lupus erythematosus, maps to chromosome 3p. *Am J Hum Genet* 2006; 79(4): 731-737.
9. Fiehn C. Familial chilblain lupus—what can we learn from type I interferonopathies?. *Curr Rheumatol Rep* 2017; 19: 61.
10. Günther C, Meurer M, Stein A, et al. Familial chilblain lupus—a monogenic form of cutaneous lupus erythematosus due to a heterozygous mutation in TREX1. *Dermatology* 2009; 219(2): 162-166.
11. Günther C, Berndt N, Wolf C, et al. Familial chilblain lupus due to a novel mutation in the exonuclease III domain of 3' repair exonuclease 1 (TREX1). *JAMA Dermatol* 2015; 151(4): 426-431.
12. Ali MSM. LP-204 chilblain lupus erythematosus—a rare encounter. *Lupus Sci Med* 2023; 10(suppl 1): A1-A171.
13. Wenzel J, Brähler S, Bauer R, et al. Efficacy and safety of methotrexate in recalcitrant cutaneous lupus erythematosus: results of a retrospective study in 43 patients. *Br J Dermatol* 2005; 153(1): 157-162.





FINAL DESTINATION: THE PURSE-STRING CLOSURE

M. Crivellari, M. Venturini, P. Monari

Dermatology Department, University of Brescia, ASST Spedali Civili di Brescia, Brescia, Italy

Keywords: Wound Clousure, Purse-String Suture.

Introduction. Surgical excision remains the gold standard for treating skin epitheliomas, specifically basal cell carcinoma (BCC) and squamous cell carcinoma (SCC). Managing post-surgical defects, particularly in aesthetically sensitive areas or regions with limited skin laxity, often requires complex reconstructive techniques. The purse-string suture offers a simple and versatile alternative, capable of reducing the defect's diameter and optimizing scarring outcomes.

Objectives. To evaluate the efficacy, safety, and aesthetic-functional outcomes of the purse-string closure in patients undergoing excision of skin epitheliomas.

Materials and Methods. Patients who underwent surgical excision of skin epitheliomas followed by purse-string closure at our center were evaluated. We analyzed the anatomical site, defect size, histological type, and the degree of diameter reduction achieved. Post-operative complications (in-

fection, dehiscence, necrosis, recurrence), healing time, and aesthetic outcomes—assessed via a dedicated clinical scale (Vancouver Scar Scale) and patient satisfaction—were also recorded.

Results. The technique allowed for a significant reduction in surgical defect diameter, with most cases achieving primary intention healing. Complications were infrequent and minor. Aesthetic results were rated as good-to-excellent in the majority of patients, with high levels of reported satisfaction. No recurrences were observed during the follow-up period.

Conclusions. Purse-string closure is confirmed as an effective, safe, and easily reproducible technique for managing post-surgical defects. It represents a valid alternative to more complex reconstructive procedures in selected sites, allowing for reduced operative time and favorable aesthetic-functional results.



NANOFAT 2.0: EXPERIMENTAL PHASES AND CLINICAL APPLICATIONS

G. Mannino¹, G.A.G. Lombardo¹, S. Tamburino², I. R. Romano³, R. Giuffrida³, D. Lo Furno³

¹Department of Medicine and Surgery, School of Medicine and Surgery, University of Enna "Kore", Italy; ²Chi.Pla Chirurgia Plastica private office, Catania, Italy; ³Department of Biomedical and Biotechnological Sciences, University of Catania, Italy

Keywords: Adipose-Derived Mesenchymal Stem Cells , Fat Graft.

Introduction. Adipose-derived mesenchymal stem cells (ASCs) and their secretomes seem able to promote extracellular matrix production, new collagen deposition, and early revascularization [1-4]. These physiological characteristics make ASCs valuable candidates for regenerative and aesthetic medicine. Several techniques have been devised to obtain a fat graft as rich as possible of ASCs; for example, lipoaspirate enriched with stromal vascular fraction or with previously expanded ASCs have been tested [5-7]. Sequential filtering steps of lipoaspirate have been adopted to obtain "lipogems" [8] and "nanofat" grafting [9] for skin rejuvenation applications. We have developed a 2.0 version of nanofat.

Materials and Methods. The lipoaspirate obtained from healthy donors underwent three separate procedures to obtain: a) the microfat sample, which was not subjected to any further processing; b) the nanofat sample, which was obtained strictly following the nanofat protocol; c) the nanofat 2.0 sample, which was obtained by avoiding the final steps of filtration and squeezing of the lipid emulsion. Mesenchymal stem cell markers were identified using immunofluorescence and flow cytometry and cell viability was assessed in each sample using the MTT assay.

Results. Histological examination showed greater preservation of mature adipocytes in microfat sample, whereas the nanofat and, especially, the nanofat 2.0 sample showed a

higher density of ASCs, featuring a higher proliferative rate, especially in the first few days following collection. Therefore, the nanofat 2.0 resulted the most suitable for transplantation and was successfully used in the treatment of postburn scars in the face and in Vulvar Lichen Sclerosus. Clinically, nanofat-based treatments resulted in significant improvement in tissue quality, with reduction of symptoms such as itching, burning, and dyspareunia, and progressive restoration of elasticity and function within the first months after treatment.

Conclusions. Nanofat 2.0 represent a fat graft substantially enriched with ASCs. Obtainable by minimal manipulation, it is easily injectable and may represent a useful tool for improving skin quality and wound healing, especially when conspicuous volume augmentation is not required.

References

1. Butala P. et al. 2012 doi:10.1097/PRS.0b013e3182589c45.
2. Kalinina N. et al. 2015 doi:10.1186/s13287-015-0209-8.
3. Charles-de-Sá L. et al. 2015 doi:10.1097/PRS.0000000000001123.
4. Mannino G. et al. 2020 doi: 10.1007/s11033-020-05950-1
5. Matsumoto D. et al. 2006 doi:10.1089/ten.2006.12.3375.
6. Yoshimura K. et al. 2008 doi: 10.1007/s00266-007-9019-4.
7. Kølbe S.F. et al. 2013 doi: 10.1016/S0140-6736(13)61410-5.
8. Bianchi F. et al. 2013 doi: 10.3727/096368912X657855.
9. Tonnard P. et al 2013 doi: 10.1097/PRS.0b013e31829fe1b0.



LEBRIKIZUMAB PROVIDES CLINICALLY MEANINGFUL RESPONSE IN FACE AND HANDS IN ADULTS AND ADOLESCENTS WITH MODERATE-TO-SEVERE ATOPIC DERMATITIS: ADHOPE 1 STUDY

L. Stingeni¹, C. Vestergaard², J. Seneschal^{3,4}, S. Weidinger⁵, A. Wollenberg^{6,7,8}, A. Irvine⁹, H. Agell¹⁰, J. Valls Bancells¹⁰, V. Sapena¹⁰, D. Thaçi⁷

¹Dermatology Section, Department of Medicine and Surgery, University of Perugia, Italy; ²Department of Dermatology and Venerology, Aarhus University Hospital, Aarhus, Denmark; ³Department of Dermatology, University of Bordeaux, Bordeaux, France; ⁴Department of Dermatology and Pediatric Dermatology, National Reference Center for Rare Skin Disorders, Hospital Saint-André, Bordeaux, France; ⁵Department of Dermatology and Allergy, University Hospital Schleswig-Holstein, Kiel, Germany; ⁶University Medical Center of Augsburg, Augsburg, Germany; ⁷Institute and Comprehensive Center for Inflammatory Medicine at the University of Lübeck, Lübeck, Germany; ⁸Department of Dermatology and Allergology, LMU Hospital, Munich, Germany; ⁹Department of Clinical Medicine, Trinity College Dublin, Dublin, Ireland; ¹⁰Almirall S.A., Barcelona, Spain

Keywords: Atopic Dermatitis, Lebrikizumab.

Most patients (pts) with atopic dermatitis (AD) have face and/or hands involvement, posing a major psychological burden(1). Lebrikizumab (LEB), a monoclonal antibody that selectively targets interleukin-13, is approved for moderate-to-severe (mod-sev) AD(2-4). We report LEB efficacy in face and hands from ADhope 1 (NCT05990725). ADhope 1 was a 24-Week(W), open-label study in adults and adolescents (12-17 years, ≥ 40 kg), Eczema Area and Severity Index (EASI) ≥ 12 , Investigator's Global Assessment (IGA) ≥ 3 , $\geq 10\%$ body surface area AD involvement, who were not adequately controlled with topical therapies. Prior dupilumab use was allowed. Pts received 500mg at baseline (BL) and W2, then 250mg every 2 weeks (Q2W) until W16, then 250mg Q4W until W24. Topical corticosteroid use was allowed. Outcomes included Face IGA 0/1 with ≥ 2 -point improvement from BL, and Face IGA ≥ 1 -point improvement from BL in pts with Face IGA ≥ 2 at BL, and percent change from BL in modified Total Lesion Symptom Score (mTLSS) to assess response in hands. Treatment discontinuation due to lack of efficacy was classed as non-response; other discontinuations and missing data were handled by multiple imputation. Data collected after prohibited medication use were included. Efficacy was assessed in 247/260 enrolled pts (13 pts excluded due to quality issues). At BL, mean age (standard deviation [SD])=32.8 (14.1) years, 61.1% male,

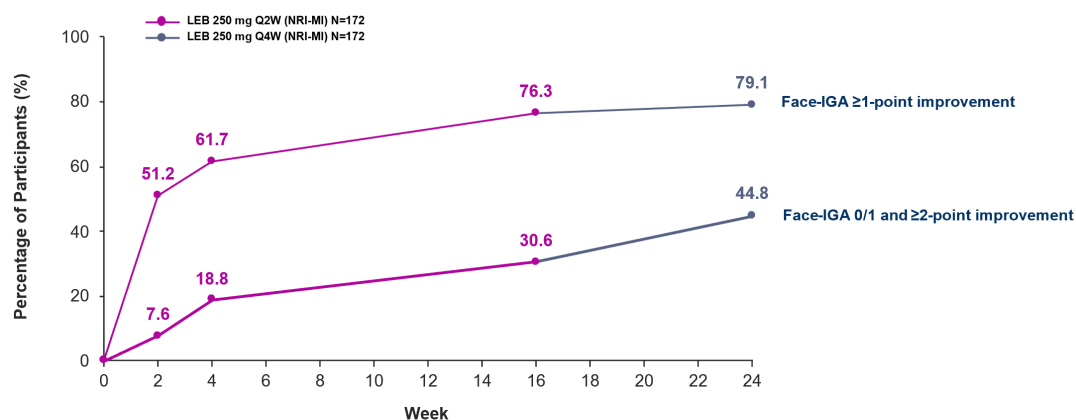
8.5% had prior dupilumab exposure. Mean (SD) EASI=23.1 (9.0), mean (SD) Pruritus Numerical Rating Scale=6.7 (1.6), IGA scores of 3 (moderate) and 4 (severe) were reported in 74.1% and 25.9% of pts, respectively. 69.6% of pts had Face IGA ≥ 2 (15.8% Face IGA=2, mild; 42.5% Face IGA=3, moderate; 11.3% Face IGA=4, severe). 64.0% had AD in their hands (mean [SD] BL mTLSS=9.7 [4.1]). Of pts with Face IGA ≥ 2 at BL (n=172), 79.1% achieved Face IGA ≥ 1 -point improvement at W24 and 44.8% achieved Face IGA 0/1 with ≥ 2 -point improvement at W24 (Fig. 1). Face response correlated with overall body response. Of pts with AD in the hands at BL (n=158), mean percent change from BL in mTLSS progressively increased over time and was -66.3% at W24. LEB provided improvements in AD affecting the face and/or hands. Almost half of the population achieved clear/almost clear skin on the face within 24W of treatment. Findings indicate that LEB is an effective treatment option for pts with mod-sev AD, including those with facial and hand involvement. This study was funded by Almirall, S.A.

References

1. Blicharz L, et al. Ital J Dermatol Venereol 2025;160(2):123-44.
2. Silverberg JI, et al. N Engl J Med 2023;388(12):1080-91.
3. Blauvelt A, et al. Br J Dermatol 2023;188(6):740-48.
4. Simpson EL, et al. JAMA Dermatol 2023;159(2):182-91.



Figure 1. Face Investigator's Global Assessment 0/1 with ≥ 2 -point improvement and Face Investigator's Global Assessment ≥ 1 -point improvement through Week 24 in patients with Face Investigator's Global Assessment ≥ 2 at baseline, modified full analysis set, non-responder imputation-multiple imputation



Restricted to patients with Face IGA ≥ 2 at baseline. Treatment discontinuation due to lack of efficacy was considered as non-response, while treatment discontinuations due to any other reason, as well as any other missing data, were handled through multiple imputation. Data collected after use of prohibited medication was included in the analysis. IGA: Investigator's Global Assessment; LEB: lebrikizumab; mFAS: modified full analysis set; MI: multiple imputation; NRI: non-responder imputation; QXW: every X weeks; W: Week.



EFFICACY AND SAFETY OF LEBRIKIZUMAB IS MAINTAINED UP TO 4 YEARS IN PATIENTS WITH MODERATE-TO-SEVERE ATOPIC DERMATITIS: FIRST YEAR OF ADLONG LONG-TERM EXTENSION TRIAL

L. Stingeni¹, S. Weidinger², A. Irvine³, D. Thaçi⁴, J. Szepletowski⁵, T. Biedermann⁶, H. Agell⁷, Y. Mihaylov⁷, B. Kostov⁷, R. Coll⁷, W. Romero⁸, K. Reich⁹

¹Dermatology Section, Department of Medicine and Surgery, University of Perugia, Italy; ²Department of Dermatology and Allergy, University Hospital Schleswig-Holstein, Campus Kiel, Kiel, Germany; ³Department of Clinical Medicine, Trinity College Dublin, Dublin, Ireland; ⁴Institute and Comprehensive Center for Inflammatory Medicine at the University of Lübeck, Lübeck, Germany; ⁵Division of Dermatology, Venereology and Clinical Immunology, Faculty of Medicine, Wrocław University of Science and Technology, Wrocław, Poland; ⁶Department of Dermatology and Allergy, Technical University of Munich, School of Medicine and Health, Munich, Germany; ⁷Almirall S.A., Barcelona, Spain; ⁸Eli Lilly and Company, Indianapolis, IN, USA; ⁹Translational Research in Inflammatory Skin Diseases, Institute for Health Services Research in Dermatology and Nursing, University Medical Center Hamburg-Eppendorf, Hamburg, Germany

Keywords: Atopic Dermatitis, Lebrikizumab.

Long-term data from advanced treatments in atopic dermatitis (AD) are important to inform clinical practice. Lebrikizumab (LEB) is approved by the FDA and EMA for treating moderate-to-severe (mod-sev) AD in adults and adolescents who are candidates for systemic therapy(1|2). Here we report long-term safety and efficacy from the first 48 weeks (W) of the ongoing 2-year ADlong long-term extension study (NCT05916365), including patients (pts) with up to 4 years' continuous LEB exposure. ADlong evaluated long-term safety and efficacy of LEB following completion of ADvo-cate1&2(3)/ADhere/ADore and the ADjoin extension study(4) (up to 3 years' LEB exposure). Eligible pts to parent studies were adults and adolescents (12-17 years, ≥ 40 kg) with mod-sev AD (Eczema Area and Severity Index [EASI] ≥ 16 , Investigator's Global Assessment [IGA] ≥ 3 , $\geq 10\%$ body surface area AD involvement). Pts in Germany and Poland who

completed ADjoin could enrol in ADlong, excluding those whose last LEB dose was administered >8 W before baseline or developed a LEB-related serious/severe adverse event (SAE). In ADlong, pts received open-label LEB 250 mg once every four weeks (Q4W) regardless of their previous treatment; LEB Q2W could be used if response was

References

1. Almirall Ltd. Ebglyss® (lebrikizumab) Prescribing Information. European Union: Almirall Ltd; 2025. Date of Revision: November 2023.
2. Almirall Ltd. Ebglyss® (lebrikizumab) Prescribing Information. USA: Eli Lilly and Company; 2025. Date of Revision: October 2025.
3. Blauvelt A, et al. Br J Dermatol 2023;188(6):740-48.
4. Guttman-Yassky E, et al. Dermatol Ther (Heidelb) 2025;15(8):2217-32.



LEBRIKIZUMAB FOR PAEDIATRIC PATIENTS AGED ≥ 6 MONTHS WITH MODERATE-TO-SEVERE AD: PHASE 3 ADORABLE-1 WEEK-16 RESULTS

L. Stingeni¹, L. Eichenfield², J. Ornelas³, V. Prajapati⁴, C. Yang⁵, A. Tanaka⁶, S. Weidinger⁷, C. Flohr⁸, E. Swanson⁹, L. Martin¹⁰, S. Daveiga¹¹, R. Gontijo Lima¹¹, H. Elmaraghy¹¹, E. Pierce¹¹, P. Sen¹¹, G. Gallo¹¹, M. Piruzeli¹¹, A. Larkin¹¹, M. Grau¹², Y. Mihaylov¹², A. Paller¹³

¹Dermatology Section, Department of Medicine and Surgery, University of Perugia, Italy; ²Departments of Dermatology and Pediatrics, University of California San Diego School of Medicine, La Jolla, California, US; ³Department of Dermatology, Integrative Skin Science and Research, Sacramento, California, US; ⁴Dermatology Research Institute, Skin Health & Wellness Centre, Probitry Medical Research, and University of Calgary, Calgary, CA; ⁵Chang Gung University College of Medicine, Taoyuan, TW; ⁶Department of Dermatology, Graduate School of Biomedical and Health Sciences, Hiroshima University, Hiroshima, JP; ⁷Department of Dermatology and Allergy, University Hospital Schleswig-Holstein, Kiel, DE; ⁸Department of Dermatology and Population Health Sciences, King's College London, London, UK; ⁹Ada West Dermatology, St Luke's Children's Hospital, Idaho, US; ¹⁰School of Clinical Medicine, UNSW Sydney & Dermatology Department, Sydney Children's Hospital, Sydney AU; ¹¹Eli Lilly and Company, Indianapolis, Indiana, US; ¹²Almirall R&D, S.A., Barcelona, ES; ¹³Dermatology and Infectious Disease, Feinberg School of Medicine, Northwestern University, Chicago, Illinois, US

Keywords: Atopic Dermatitis, Lebrikizumab.

Atopic dermatitis (AD) is the most prevalent chronic inflammatory skin condition impacting 15–20% of children globally, with limited treatment options. Lebrikizumab (LEB) inhibits interleukin (IL)-13, a key driver of AD, and is approved for patients (pts) ≥ 12 years (y), ≥ 40 kg with moderate-to-severe (mod-sev) AD inadequately treated with topicals. The ADorable 1 double-blind phase 3 study (NC-T05559359) evaluated 16 week (W) efficacy and safety of LEB and topical corticosteroids (TCS) vs placebo (PBO) and TCS in pts aged 6 months (m) to <18 y with mod-sev AD. 363 pts were randomised 2:1 to LEB (n=245) or PBO (n=118), stratified by age, region, and baseline (BL) Investigator's Global Assessment (IGA; 3 vs 4). Low-to-mid potency TCS were initiated 2 weeks pre-randomisation. Dosing was weight-based (≥ 40 kg: 500mg W0 and W2, 250mg every 2W from W4; 15– <40 kg: 250mg W0, 250mg every 4W [Q4W] from W2; 6– <15 kg: 125mg W0, 125mg Q4W from W2). Co-primary endpoints were IGA (0,1) with ≥ 2 -point improvement and $\geq 75\%$ improvement from BL in Eczema Area and Severity Index (EASI) at W16. Efficacy analyses used the Intent-to-Treat population; safety analyses used the Safety population. The study is ongoing. Data are reported as LEB vs

PBO, respectively. At BL, mean age: 7.7y vs 7.6y; female: 47.3% vs 54.2%. BL disease characteristics: IGA 3, 74.6% vs 76.3%; prior systemic therapy use, 58.4% vs 67.8%, with prior dupilumab use 12.2% vs 11.0%. Co-primary endpoints at W16: IGA (0,1) and EASI 75 were achieved by 43.5% vs 15.2% (p<0.001) and 62.6% vs 21.6% (p<0.001). Key secondary endpoints at W16: EASI 90, 38.6% vs 11.0% (p<0.001); EASI 100, 13.7% vs 4.6% (p=0.007); ≥ 6 -point improvement in Children's Dermatology Life Quality Index (4-17y, BL ≥ 6), 61.6% vs 36.2% (n=238, p=0.001); ≥ 4 -point improvement in Pruritus Numeric Rating Scale (NRS); (≥ 6 y, BL ≥ 4), 34.5% vs 5.5% (n=196, p<0.001). 41.6% vs 0.0% (n=66, p<0.001) had ≥ 4 -point improvement in Worst Scratching/Itching NRS (<6 y, BL ≥ 4). 57.1% vs 59.3% reported adverse events mostly mild/moderate in severity, with no trial discontinuations. Injection site reactions were similar in the LEB and PBO arms, with no injection site pain reported. LEB was superior to PBO for the co-primary endpoints at W16 in pediatric pts 6m– <18 y with mod-sev AD. No new safety findings were identified at W16 from available data. These results support LEB as a potential first selective IL-13 inhibitor treatment option for this paediatric population.



SOLAR LENTIGO TREATED WITH A 2940 NM ERBIUM LASER: ABLATION AND INSTRUMENTAL ASSESSMENT

G.I. Luppino

Dermatological Clinic, University of Catania, Italy

Keywords: Erbium-Lentigo, Lc-Oct.

Solar lentigo (SL) are one of the most common manifestations of cutaneous photoaging, with significant aesthetic, psychological, and social implications. The etiopathogenesis involves complex cellular and molecular mechanisms involving interactions between keratinocytes, melanocytes, dermal fibroblasts, and the vascular component. The diagnosis of SL is based primarily on clinical examination, supplemented by non-invasive techniques such as dermatoscopy and, in selected cases, by the use of advanced technologies such as reflectance confocal microscopy (RCM). A skin biopsy for histological examination is rarely necessary. This invasive procedure is performed in selected cases to rule out pigmented actinic keratoses or, primarily, malignant lentigo. Although numerous techniques have been developed to treat these pigmented lesions, the choice of the ideal protocol depends on multiple factors, including the characteristics of the lesion, the patient's skin type, and individual tolerance to treatments. Among emerging methods, the 2940 nm Er:YAG laser has garnered attention for its ability to combine precise ablation with thermal control, reducing the risk of side effects compared to other laser technologies. At the same time, the development of non-invasive imaging techniques such as linear-field confocal optical coherence tomography (LC-OCT) has opened new avenues in the diagnosis and monitoring of dermatological conditions. This method provides a

detailed assessment of epidermal and dermal structures, allowing for real-time monitoring of treatment-induced morphological changes without the need for invasive biopsies. LC-OCT acquires optical sections in two main modes: vertical scanning (B-scan or en-coupe), which represents a cross-section and shows the stratification of the skin, from the epidermal to the dermal surface. The other mode is horizontal (en-face), which provides a view parallel to the skin surface, highlighting cellular and architectural details at different depths. In the vertical LC-OCT view, the main feature of SL is a continuous, wavy, and bright DEJ. Horizontal features include polycyclic papillary contours, elongated cords, and bulbous projections at the junction, as well as bright spots in the superficial dermis. The integrated use of LC-OCT therefore represents a valuable resource for correlating clinical observations with objective data, improving understanding of therapeutic efficacy, and providing scientific evidence to support clinical decisions. In this context, we sought to study the efficacy of the Er:YAG laser in the treatment of solar lentigo, evaluating both the clinical improvement of the lesions and the morphological changes observed via LC-OCT, investigating the utility of LC-OCT in highlighting pre- and post-treatment skin changes, and correlating clinical data with microscopic changes to obtain a holistic view of the treatment's benefits.



CUTANEOUS LEISHMANIASIS MIMICKING B-CELL PSEUDOLYMPHOMA: A DIAGNOSTIC CHALLENGE IN AN ENDEMIC MEDITERRANEAN AREA

M. Fino¹, A. Zordan¹, N. Di Meo¹, I. Zalaudek¹, S. Sola², C. Massone³

¹Department of Dermatology and Venereology, University of Trieste, Maggiore Hospital, Trieste, Italy; ²Department of Pathology, Galliera Hospital, Genoa, Italy; ³Department of Dermatology, Galliera Hospital, Genoa, Italy

Keywords: Cutaneous-Leishmaniasis, Granulomatous-Disease.

Cutaneous leishmaniasis is a zoonotic disease endemic in several areas of the Mediterranean basin, including Liguria, characterized by heterogeneous clinical and histological features that can complicate diagnosis. We report the case of a male patient with a history of frequent exposure to woodland areas, presenting with a painless small nodule located on the right auricular helix, without systemic symptoms. A skin biopsy revealed a mixed lymphocytic infiltrate, with a predominance of B lymphocytes and granulomatous features, initially diagnosed as a B-cell pseudolymphoma. Topical corticosteroid therapy was therefore initiated, with no clinical improvement. Three months later, due to persistence of the lesion, a second biopsy was performed, showing a prevalent granulomatous dermatitis with an infiltrate

of lymphocytes, plasma cells, and macrophages. Major granulomatous skin diseases, and also *Borrelia*-associated B-cell pseudolymphoma, were excluded through laboratory tests and serological investigations. Giemsa staining and microscopic examination for amastigotes were negative, and confirmatory PCR testing could not be performed. Serological testing for anti-*Leishmania* antibodies resulted in mildly elevated titers. The diagnosis was therefore established on a clinical-serological basis and confirmed *ex adiuvantibus* by the response to Amphotericin B therapy, which led to complete resolution of the lesion. This case highlights the importance of considering cutaneous leishmaniasis in chronic skin lesions involving exposed body areas, and underscores the need to critically integrate clinical, histopathological, and epidemiological data in the diagnostic workup.



THE DIAGNOSTIC COMPLEXITY OF PERSISTENT ERYTHEMA MULTIFORME: A REPORT OF TWO CLINICAL CASES

S. Visinoni, V. Rubino, S. Colabrese, L. Cerchiai, M. E. Baffa, C. Pipitò, R. Maglie, E. Antiga

Dermatology, University of Florence, Italy

Keywords: Persistent Erythema Multiforme, Diagnostic Challenge.

Introduction. Erythema Multiforme (EM) is an acute condition often triggered by infections, primarily Herpes Simplex Virus (HSV). Alongside this classic form, a much rarer chronic variant exists: Persistent Erythema Multiforme (pEM). pEM follows a chronic or relapsing-relapsing path that can persist for years, representing a formidable diagnostic and therapeutic challenge. We report two cases of multi-mucosal pEM.

Materials and Methods. We conducted a retrospective review of the clinical history of two patients presenting with chronic, extensive vesiculobullous eruptions and multisite mucosal involvement. To establish a differential diagnosis with autoimmune bullous diseases, both underwent a workup including: histopathology, Direct/Indirect Immunofluorescence (DIF/IIF), ELISA (anti-dsg1/dsg3, anti-BP180/230), systemic screening for infectious triggers (HSV-1/2 PCR, HBV, HCV), and anamnesis for pharmacological triggers.

Results. Case 1: a 20-year-old female presented with recurrent bullous lesions on the palms and soles and severe orogenital mucosal erosions, which appeared after an antibiotic regimen for *H. pylori* eradication. While DIF, ELISA, and PCR were negative, biopsy revealed subepidermal blistering with satellite cell necrosis, consistent with an EM-like drug eruption. Some flares coincided with NSAIDs intake, while others occurred independently. After failing colchicine, dapsone, and methotrexate due to adverse events, she was transitioned to azathioprine and remains under close observation. Case 2: a 49-year-old female reported a 3-year history of nasal, oral, and genital erosions. Mucous membrane pemphigoid was ruled out by negative DIF/IIF. Histology con-

firmed interface dermatitis typical of EM. Blood screening identified a chronic HBV infection as the likely persistent trigger. Clinical stability was optimized with hydroxychloroquine and methotrexate, reducing mucosal relapses and systemic steroid use.

Conclusions. The differential diagnosis of pEM from autoimmune bullous diseases is a challenge due to the frequent absence of classic "target" lesions and the predominance of mucosal erosions. Diagnosis is often one of exclusion and relies on specific histological patterns. Underlying triggers can be both infective or pharmacological, acting as persistent drivers of the T-cell mediated immune response. A personalized immunosuppressive approach using steroid-sparing agents is essential to achieve clinical stability.

References

1. Lerch M, Mainetti C, Terziroli Beretta-Piccoli B, Harr T. Current Perspectives on Erythema Multiforme. *Clinical Reviews in Allergy & Immunology*. 2018;54(1):177-184.
2. Traves KP, Love G, Studdiford JS. Erythema Multiforme: Recognition and Management. *American Family Physician*. 2020;102(2):107-114.
3. Chang DG et al. Chronic and persistent erythema multiforme: A diagnostic and therapeutic challenge. *Journal of Dermatology*. 2021;48(9):e432-e433.
4. Salgado-Boquete L, et al. Management of Persistent Erythema Multiforme: A Systematic Review. *Actas Dermo-Sifiliográficas*. 2022;113(4):385-395.
5. Zoghail S, Kechichian E, Souaid K, Tomb R, Helou J. Triggers and Management of Persistent Erythema Multiforme: A Recent Update. *Journal of Clinical Medicine*. 2024;13(3):742.



WHERE THE SUN DOESN'T SHINE, UV FLUORESCENCE DOES: DIAGNOSTIC AND THERAPEUTIC INSIGHTS OF UV-INDUCED FLUORESCENCE DERMOSCOPY IN SCROTAL POROKERATOSIS

Z. Fratton^{1,2}, M. Milani³, D. Strippoli⁴, A. Ponziani⁴, F. Fantini⁴, M. Andreassi⁴

¹Department of Medicine, Institute of Dermatology, University of Udine, Italy; ²Dermatology Unit, Ospedale San Bortolo, Vicenza, Italy; ³Department of Pathology, ASST Lecco, Alessandro Manzoni Hospital, Lecco, Italy; ⁴Dermatology Unit, ASST Lecco, Alessandro Manzoni Hospital, Lecco, Italy

Keywords: Porokeratosis, Dermoscopy.

Background. Porokeratosis is a clonal disorder of keratinization histologically characterized by the presence of cornoid lamella, a parakeratotic column overlying a small vertical zone of dyskeratotic and vacuolated cells within the epidermis. Scrotal involvement is rare and often presents a diagnostic challenge due to its subtle clinical appearance and potential overlap with other genital inflammatory and infectious conditions.

Case Presentation. A 62-year-old male presented with a several-month history of mildly pruritic, 1-cm annular lesions on the scrotum. Polarized light dermoscopy failed to clearly identify a peripheral keratotic border. However, 365 nm UV-induced fluorescence dermoscopy (UVFD) revealed a distinct cornoid lamella, appearing as a "double-track" sign. Notably, the lesions exhibited a bright pink fluorescence, suggestive of a *Corynebacterium* superinfection (protoporphyrin production). Initial histological examination reported "skin with hyperorthokeratosis and hyperparakeratosis, elongation of dermal papillae, consistent with post-inflammatory outcomes." Guided by the UVFD findings, a slide review was requested, which successfully identified the diagnostic

parakeratotic column (cornoid lamella). The patient was managed with local disinfection and moisture control. At the one-month follow-up, the pruritus had completely resolved. Re-evaluation with UVFD confirmed the disappearance of the pink fluorescence, while the cornoid lamella remained visible. These findings suggest a link between the *Corynebacterium* infection and the pruritic symptoms.

Conclusions. This case highlights the rarity of scrotal porokeratosis and the innovative role of UV-induced fluorescence dermoscopy as a crucial diagnostic aid. The unexpected finding of pink fluorescence not only facilitated the diagnosis by enhancing the visualization of the cornoid lamella but also provided a rationale for the pruritic symptoms, which can cause severe discomfort in patients with scrotal porokeratosis. UV-induced fluorescence dermoscopy represents a valuable second-level tool to improve diagnostic accuracy and guide the pathologist in cases where standard dermoscopy and initial histology are inconclusive. Furthermore, UVFD can guide therapeutic choices, especially in cases where irritant topicals (e.g. tacalcitol, tacrolimus, topical retinoids) or physical modalities (e.g. cryotherapy) are less advisable.



A MIMIC DERMATOSIS OF THE LEFT EYELID

A. Motolese, A. Conti

Dermatology, Infermi Hospital, AUSL Romagna, Rimini, Italy

Keywords: Metastasis, Eyelid.

A 47-year-old woman presented to our clinic with erythema and pruritus involving the left upper and lower eyelid, with onset approximately 3 months earlier. Previously, she had been evaluated by her ophthalmologist, who treated the lesion as a chalazion without clinical improvement. Subsequently, a private-practice dermatologist diagnosed eyelid eczema and prescribed systemic corticosteroids and topical emollients, again without benefit. At our evaluation, physical examination revealed peri-orbital erythema with mild infiltration and skin induration on palpation, asymptomatic except for mild pruritus. Her medical history was significant for HER2-low stage IV breast carcinoma with liver and bone metastases, under treatment with trastuzumab deruxtecan

and zoledronic acid. A 4-mm punch biopsy of the lesion was performed, and histopathological examination demonstrated dermal localization of infiltrating lobular carcinoma, secondary to breast cancer. Eyelid metastases are a rare occurrence and arise from breast cancer in approximately 50% of cases. They are typically unilateral and may present with a mask-like or monocle-like pattern, appearing as nodules, ulcerations, or edema, thus mimicking inflammatory or infectious conditions and potentially delaying diagnosis. Management is often multidisciplinary and the prognosis is generally poor. Metastatic diseases should be considered in any patient with a known history of cancer who develops a new or unusual eyelid lesion.





CURRENT CHALLENGES IN MODERATE ATOPIC DERMATITIS: AN ITALIAN DELPHI CONSENSUS

I. Marzona¹, A. Costanzo², A. Campanati³, M. Esposito⁴, S. M. Ferrucci⁵, G. Girolomoni⁶, C. Patruno⁷, E. Pezzolo⁸, S. Ribero⁹, M. Rossi¹⁰, L. Stingeni¹¹, L. Politi¹, M. Napolitano¹²

¹Helaglobe Srl; ²Dermatology Unit, IRCCS Humanitas Research Hospital Dermatology, Italy; ³Dermatological Clinic, Università Politecnica delle Marche, Italy; ⁴Biotechnological and Clinical Sciences University of L'Aquila, Italy; ⁵IRCCS Fondazione Ca' Granda, Ospedale Maggiore Policlinico, Italy; ⁶Section of Dermatology, University of Verona, Italy; ⁷Medicine and Health Sciences, Molise University, Italy; ⁸Department of Dermatology, San Bortolo Hospital, Italy; ⁹Dermatology Clinic, University of Turin, Italy; ¹⁰Dermatology Unit, University of Brescia, Italy; ¹¹Dermatology Section, University of Perugia, Italy; ¹²Section of Dermatology, University of Naples, Italy

Keywords: Moderate Atopic Dermatitis, Delphi Method.

Introduction. Moderate atopic dermatitis (AD) represents a clinical “grey zone”, often underestimated and inconsistently managed despite a substantial disease burden. While treatment pathways are well established for mild and severe disease, the moderate stage lacks clear and widely adopted guidance.

Methods. A two-round Delphi consensus was conducted involving Italian dermatology experts. Thirty-one statements were developed based on a structured literature review (PRISMA approach) and evaluated using a 5-point Likert scale. Consensus was defined as $\geq 75\%$ agreement. Following the first round, statements were revised based on panel feedback and re-evaluated in a second round.

Results. Forty-eight dermatologists participated in the first round and 36 in the second. All statements reached consensus in round one. On the basis of the first round comments, 26 final statements were approved. In the second round, the number of statements achieving unanimous consensus increased from 3 to 10, while 14 statements reached an agree-

ment ranging from 90% to 99% and only 2 between 80% and 89%. The consensus highlighted that moderate AD is associated with a significant multidimensional burden, including pruritus, sleep disturbance, psychological impact, and impaired quality of life. Treatment approaches are heterogeneous, with patients often positioned between insufficient topical therapies and conventional systemic treatments, which may present safety limitations. A key unmet need identified is the limited access to innovative targeted therapies (biologics and Janus kinase inhibitors), particularly for patients who do not meet current eligibility criteria despite a clinically relevant disease burden.

Conclusions. Moderate AD is associated with a considerable burden and relevant unmet needs. This Delphi consensus provides practical insights to support improved disease assessment and management and highlights the importance of aligning treatment access with patients' clinical needs. Funding sources: the present work was supported by Incyte who had no role in content development.



IXEKIZUMAB WITH OR WITHOUT TIRZEPATIDE IN ADULTS WITH PSORIASIS AND OVERWEIGHT OR OBESITY: THE TOGETHER-PSO PHASE 3B RANDOMIZED CLINICAL TRIAL

E. Filippi¹, M. Lebwohl², A. Blauvelt³, C. Kartman⁴, C. Leatherwood⁴, K. Gordon⁵, N. Sattar⁶, L. Puig⁷, J. Merola⁸, K. Siu⁴, R. Wang⁴, L. Sun⁴, A. Leung⁹, N. Somani⁴, M. Rueda⁴, A. Cardoso⁴, M. Genovese⁴, A. Armstrong¹⁰, B. Strober¹¹

¹Eli Lilly Italy S.p.A, Sesto Fiorentino, Italy; ²Department of Dermatology, Icahn School of Medicine at Mount Sinai, New York, NY, USA; ³Blauvelt Consulting, LLC, Annapolis, MD, USA; ⁴Eli Lilly and Company, Indianapolis, IN, USA; ⁵Department of Dermatology, Medical College of Wisconsin, Milwaukee, WI, USA; ⁶School of Cardiovascular and Metabolic Health, University of Glasgow, Glasgow, UK; ⁷Department of Dermatology, Hospital de la Santa Creu i Sant Pau, Universitat Autònoma de Barcelona School of Medicine, Barcelona, Spain; ⁸Department of Dermatology and Department of Medicine, Division of Rheumatology, UT Southwestern Medical Center and O'Donnell School of Public Health, Dallas, TX, USA; ⁹Syneos Health, Morrisville, NC, USA; ¹⁰Division of Dermatology, University of California Los Angeles David Geffen School of Medicine, Los Angeles, CA, USA; ¹¹Department of Dermatology, Yale University School of Medicine, New Haven, CT, Central Connecticut Dermatology Research, Cromwell, CT, USA

Keywords: Ixekizumab, Tirzepatide.

Introduction. Overweight and obesity affect 60%-78% of patients with psoriasis, impacting disease severity, treatment response (i.e., complete skin clearance), and clinical outcomes. This trial evaluated efficacy and safety of ixekizumab (IXE) with or without tirzepatide (TZP) in participants with psoriasis and overweight or obesity.

Methods. This is a Phase 3b, randomized, US-based, open-label, 52-week trial (NCT06588283) in adults with moderate-to-severe plaque psoriasis and overweight with ≥ 1 weight-related comorbidity or obesity. Participants were randomized (1:1) to IXE+TZP (n=138) or IXE (n=136) with diet and exercise in both treatment arms. At Week 36, primary endpoint was simultaneous achievement of PASI 100 and $\geq 10\%$ weight reduction. Key secondary endpoints were PASI 100, simultaneous PASI 75 and $\geq 5\%$ weight reduction, and $\geq 10\%$ weight reduction.

Results. Among 274 randomized participants (mean age, 45.6 years; 44.9% women; BMI, 39.2 kg/m²; psoriasis duration, 14.6 years; PASI, 19.7), 84.3% completed treatment through Week 36. Overall, 27.1% achieved primary endpoint with IXE+TZP vs 5.8% with IXE (P<.001). 40.6% vs 29.0% achieved PASI 100 (P=.044), 79.9% vs 17.9% simultaneous PASI 75 and $\geq 5\%$ weight reduction (P<.001), and 69.2% vs 9.1% achieved $\geq 10\%$ weight reduction (P<.001), respectively. Adverse events were generally consistent with established drug safety profiles, the most common being gastrointestinal events and injection site reactions. Gastrointestinal events occurred more frequently with IXE+TZP vs IXE.

Conclusions. IXE+TZP vs IXE produced clinically meaningful, statistically significant improvements in skin clearance and weight in participants with challenging psoriasis and overweight or obesity, with no new safety concerns, while providing potential to elevate outcomes.



EARLY AND MAINTAINED TREAT-TO-TARGET RESPONSE WITH IXEKIZUMAB UP TO 5 YEARS IN MODERATE-TO-SEVERE PSORIASIS: A POST-HOC ANALYSIS OF UNCOVER-3

E. Filippi¹, A. Armstrong², J. F. Merola³, M. Megna⁴, X. Man⁵, M. Honma⁶, J-M. Carrascosa⁷, R. Chughtai⁷, K. Fotiou⁸, S. Sabatino⁸, M. Ngantcha⁸, A. Pinter⁹

¹Eli Lilly Italia S.p.A, Florence, Italy; ²University of California, Los Angeles, CA, USA; ³University of Texas Southwestern Medical Center, Dallas, TX, USA; ⁴University of Naples Federico II, Naples, Italy; ⁵Zhejiang University, Hangzhou, China; ⁶Asahikawa Medical University, Asahikawa, Japan; ⁷Hospital Germans Trias, Universitat Autònoma de Barcelona, Barcelona, Spain; ⁸Eli Lilly and Company, Indianapolis, IN, USA; ⁹University Hospital Frankfurt, Frankfurt, Germany

Keywords: Uncover-3, Psoriasis.

Background. The National Psoriasis Foundation recommends evaluating treatment response at Week12, with a target body surface area (BSA) $\leq 1\%$ affected and an acceptable response of BSA $\leq 3\%$. European consensus emphasize a shift from relative outcomes such as Psoriasis Area and Severity Index (PASI) scores of 90/100 towards absolute endpoints including PASI ≤ 22 . Early achievement and long-term maintenance of these treat-to-target (T2T) outcomes are important, providing patients with more days of minimal disease burden.

Methods. UNCOVER-3 (NCT01646177) was a multicenter, randomized, double-blind, placebo-controlled study of ixekizumab in patients with moderate-to-severe psoriasis³. This post-hoc analysis examined T2T outcomes in patients from UNCOVER-3 receiving the label dose of ixekizumab (N=385). Baseline demographics and patient characteristics were similar to those previously presented⁴. Early and maintained response was defined as achievement of T2T goals at Week12 maintained at 5 years (Week264). Assessments included absolute PASI ≤ 2 , absolute PASI ≤ 1 , BSA $\leq 3\%$, and BSA $\leq 1\%$, reported as observed. No statistical testing for significance was conducted.

Results. At Week12, absolute PASI < 2 and PASI < 1 response rates were achieved by 71.7% (n=276/385) and 68.1% (n=262/385) of patients; among responders with available observed data at Week264, 94.5% (n=156/165) and 81.3% (n=126/155) maintained absolute PASI ≤ 2 and PASI ≤ 1 responses, respectively. Additionally, BSA $< 3\%$ and BSA $< 1\%$ response rates were achieved by 62.1% (n=239/385) and 50.9% (n=196/385) of patients at Week12; among these responders, 97.7% (n=128/131) and 88.7% (n=102/115) maintained these targets at Week264, respectively.

Conclusions. These findings demonstrate that early and continuous treatment with ixekizumab results in long-term improvements in skin clearance to 5 years across clinically important T2T outcomes consistent with guidelines recommendations.

References

1. Armstrong A, et al. *Dermatol Ther* (Heidelb). 2024;14(4):933-952.
2. Mahil SK, et al. *Br J Dermatol*. 2019;182(6):1047-1053.
3. Gordon KB, et al. *N Engl J Med*. 2016;375(4):345-356.
4. Rosmarin D, et al. AAD Meeting 2021, poster presented.



CONCOMITANT THERAPY WITH IXEKIZUMAB PLUS TIRZEPATIDE IN ADULTS WITH PSORIATIC ARTHRITIS AND OVERWEIGHT OR OBESITY DEMONSTRATED SUPERIOR DISEASE CONTROL COMPARED TO IXEKIZUMAB ALONE: RESULTS FROM THE PH3B TOGETHER-PSA TRIAL

E. Filippi¹, J. F. Merola², P. Mease³, A. Kivitz⁴, N. Sattar⁵, L. C. Coates⁶, C. E. Kartman⁷, P. Fischer⁷, L. Sun⁷, A. Cardoso⁷, M. C. Genovese⁷, A. Ogdie⁸

¹Eli Lilly Italia S.p.A, Florence, Italy; ²Department of Dermatology and Department of Medicine, Division of Rheumatology, UT Southwestern Medical Center and O'Donnell School of Public Health, Dallas, TX, USA; ³Providence Swedish Medical Center, Seattle, WA, USA; ⁴Altoona Center for Clinical Research, Duncansville, PA, USA; ⁵School of Cardiovascular and Metabolic Health, University of Glasgow, Glasgow, UK; ⁶Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences, University of Oxford, Oxford, UK; ⁷Eli Lilly and Company, Indianapolis, IN, USA; ⁸Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA, USA

Keywords: Together-Psa Trial, Psoriatic Arthritis.

Background. Overweight and obesity occurs in 72-82%[1,2] of patients with psoriatic arthritis (PsA) and is associated with worse clinical outcomes and increased comorbidities[3]. We evaluated efficacy and safety of ixekizumab and tirzepatide (IXE+TZP) compared to ixekizumab (IXE) in adults with active PsA and overweight (BMI>27-<30 kg/m²) with ≥1 weight-related comorbidity or obesity (BMI≥30 kg/m²). Type of Study: TOGETHER-PsA (NCT06588296) is a Phase 3b, randomized, 52-week trial.

Methods. Participants were randomized 1:1 to IXE+TZP or IXE (open-label) using FDA-approved doses. Primary outcome was week 36 simultaneous achievement of ACR50 and ≥10% weight reduction. Key secondaries included ACR50.

Results. Of participants on IXE+TZP (n=138) and IXE (n=133), mean age was 55.0 years, 69.7% were female, BMI was 37.6 kg/m², 71.6% had psoriasis, and 18.8% had failed ≥2 classes of advanced therapies. 31.7% participants achieved primary outcome with IXE+TZP versus 0.8% for IXE (p<0.001). A meaningful difference in ACR50 was observed in IXE+TZP (33.5%) versus IXE alone (20.4%) (multiplicity-controlled p=0.020) with a significant improvement (p<0.05) seen as early as week 4. Improvements were demonstrated in PASI 75/90/100 for IXE+TZP and IXE alone,

with IXE+TZP demonstrating a significant difference in absolute PASI change from baseline (p<0.01). Significant improvements were observed in physical function (HAQ-DI; p<0.001), FACIT-fatigue (p<0.01), SF-36 MCS (p<0.05) and PCS (p<0.001). Adverse events (AEs) aligned with established drug profiles. Treatment discontinuations due to AEs were comparable among treatment groups.

Conclusions. Significant comprehensive improvement in disease activity was demonstrated with IXE+TZP compared to IXE alone in active PsA, with no new safety concerns.

References

1. Eder L, Thavaneswaran A, Chandran V, et al. Obesity is associated with a lower probability of achieving sustained minimal disease activity state among patients with psoriatic arthritis. *Ann Rheum Dis.* 2015;74(5):813-7.
2. Curtis J, Rodriguez P, Probst J, et al. Quantifying the Obesity-Psoriatic Arthritis Nexus: Prevalence, Incidence, and Comorbidities from 19.9 Million US Patients (2018-2024): presentation at RWCS 2026 on 11-14 February 2026 in Maui, Hawaii, USA.
3. Kumthekar A, Ogdie A. Obesity and Psoriatic Arthritis: A Narrative Review. *Rheumatol Ther.* 2020;7(3):447-56.

**PRIMUM NON NOCERE****P. Monari, I. Cattaneo***Dermatology Unit, Spedali Civili di Brescia, Italy***Keywords:** *Merkel-Cell-Carcinoma, Dermoscopy.*

We report a case of Merkel cell carcinoma initially managed inappropriately in the outpatient setting with laser treatment before histological confirmation. The patient was subsequently referred to our Dermatology Unit for biopsy and specialist evaluation. The case is presented with focus on the diagnostic and therapeutic pathway following referral to our center. Particular attention is given to the difficulties generated by prior destructive treatment, which altered the lesion before definitive diagnosis. This case underlines the

importance of histological assessment before performing ablative procedures on suspicious skin lesions. In aggressive neoplasms such as Merkel cell carcinoma, delayed diagnosis and inappropriate treatment may negatively affect clinical management and prognosis. Increased awareness among non-specialist physicians is essential in order to promote early referral and appropriate management of rapidly growing cutaneous lesions.



COMPLICATIONS IN DERMOSURGERY: COMPARISON BETWEEN LITERATURE AND REAL-LIFE EXPERIENCE IN BRESCIA

P. Monari, I. Cattaneo

Dermatology Unit, Spedali Civili di Brescia, Italy

Keywords: *Dermosurgery, Complications.*

Dermatologic surgery is generally considered a safe procedure, although complications remain part of routine clinical practice. The aim of this work is to compare complications described in the literature with those observed in daily clinical activity at our center in Brescia. The study analyzes the real-life experience of dermosurgical procedures performed at our institution, focusing on the most frequent postopera-

tive complications and their management in everyday practice. Our observations suggest partial overlap between published data and clinical experience, while also highlighting differences related to patient characteristics and routine management. Real-life data may provide useful information for improving awareness of complications in dermosurgery and optimizing perioperative management strategies.



INNOVATIVE THERAPEUTIC STRATEGIES IN GENODERMATOSIS: AN ITALIAN MULTICENTRE STUDY

F. Pavan¹, F. Cassalia², S. Giordano³, A. Gelmetti⁴, L. Ventura⁵, F. Caroppo², A. Bassi⁶, F. Martorana⁷, R. Balestri⁸, A. Guglielmo⁹, F. Ambrogio¹⁰, A. Bonvicino³, I. Neri⁴, P. Quaglini³, A. Belloni Fortina¹¹

¹Pediatrics Unit, Department of Women's and Child's Health (SDB), University of Padua, Italy; ²Dermatology Unit, Department of Medicine (DIMED), University of Padua, Italy; ³Department of Medical Sciences, Section of Dermatology, University of Turin, Italy; ⁴Dermatology Unit, IRCCS Azienda Ospedaliero-Universitaria di Bologna, Policlinico S. Orsola-Malpighi, Italy; ⁵Department of Statistical Science, University of Padua, Italy; ⁶Unit of Dermatology, Azienda USL Toscana Nord Ovest, Lucca, Italy; ⁷Section of Dermatology - Department of Clinical Medicine and Surgery, University of Naples Federico II; ⁸Division of Dermatology, Outpatient Consultation for Rare Diseases, APSS, Trento, Italy; ⁹Institute of Dermatology, Azienda Sanitaria Universitaria Friuli Centrale (ASUFC), Udine, Italy; ¹⁰Section of Dermatology and Venereology, Department of Precision and Regenerative Medicine and Ionian Area (DiMePRE-J), University of Bari "Aldo Moro", Italy; ¹¹Pediatric Dermatology Department of Women's and Child's Health (SDB), University of Padua, Italy

Keywords: Genodermatoses, Biologic Therapy.

Background. Genodermatoses are a group of rare inherited disorders affecting the skin and its adnexa. Their clinical presentation is heterogeneous, reflecting the wide underlying genetic heterogeneity. The manifestations have a strong impact on the quality of life and on the duration. To date, there are no therapeutic tools available to treat the condition but we focus on the best possible symptomatic management through topical or systemic therapies.

Aims. The primary aim of the study is to evaluate the clinical efficacy of the biologic agents dupilumab (anti-IL-4/IL-13) and secukinumab (anti-IL-17A) in patients with genodermatosis using two validated scales: the Dermatology Life Quality Index (DLQI) and the Numeric Rating Scale for itch (NRS-itch). Secondary objectives were to assess treatment effectiveness in the two main genodermatosis subgroups, namely skin fragility disorders and keratinization disorders, and to evaluate treatment safety.

Materials and Methods. This Italian multicenter retrospective study involved 8 centers coordinated by the Regional Referral Center for Pediatric Dermatology and Rare Cutaneous Diseases of the University Hospital of Padua. 47 patients with a mean age of 31.6 years were enrolled: 32 pa-

tients were given dupilumab and the remaining 15 secukinumab according to the doses indicated in each data sheet. Efficacy was assessed through DLQI and NRS-itch scores recorded at baseline and during follow-up visits at 3, 6, 9, 12, 18 and 24 months.

Results. A progressive reduction in both DLQI and NRS-itch scores was observed from treatment initiation. At 6 months, DLQI decreased by 54.6% and NRS-itch by 46.8%, corresponding to an approximately 50% reduction in perceived disease burden. Only two patients developed mild adverse reactions, one treated with dupilumab (3.1%) and one with secukinumab (6.7%). Five patients (10.6%) discontinued treatment, mainly because of lack of efficacy.

Conclusions. This multicenter retrospective study, the first reported in the literature with a cohort of 47 patients, demonstrates the relevant and sustained clinical benefit of dupilumab and secukinumab in genodermatoses. After 24 months, DLQI decreased from 19.35 to 7.00 (-63.8%) and NRS-pruritus from 7.96 to 3.00 (-62.3%). The safety profile was favorable, with only two mild adverse events reported. These findings support the need for prospective controlled studies in larger cohorts stratified according to genetic and cytokine-related disease phenotypes.



ATOPIC DERMATITIS AND ULCERATIVE COLITIS: A CASE REPORT ON THE MANAGEMENT OF OVERLAPPING COMORBIDITIES

S. Senatore¹, C. Cardinali¹, A. Pieraccini², F. Taviti¹

¹SOC Dermatologia Pistoia-Prato, USL Toscana Centro, Italy; ²SOC Gastroenterologia ed Endoscopia, USL Toscana Centro, Italy

Keywords: Atopic-Dermatits, Comorbidities.

Atopic dermatitis (AD) and ulcerative colitis (UC) are both considered barrier diseases.¹ The association between AD and inflammatory bowel disease (IBD) has been reported in literature. Cohort studies estimated an increased risk of IBD in AD patients ranging from 27–40% in adults, likely reflecting shared Th2 immunological pathways.² Although Crohn's disease is Th1-driven, UC presents an atypical Th2 profile in which IL-13, produced by natural killer T cells, is the pivotal cytokine rather than IL-4.⁴ In the initial phases, Th1 cytokines prevail; the Th2 profile consolidates only in the late phase.⁵ A 48-year-old patient came to our attention for severe AD involving face and neck. Prior treatments, methotrexate, tralokinumab and dupilumab, had all provided poor results; dupilumab additionally triggered severe conjunctivitis, prompting its suspension. He had been affected by UC since 2005, treated first with mesalazine and subsequently with infliximab, still ongoing due to clinical and endoscopic worsening. His medical history included arterial hypertension, diabetes and, crucially, multiple thromboembolic events. At presentation, erythematous scaly lesions involved face, scalp and neck, with severe periorificial involvement; the conjunctivae were visibly inflamed and lichenification was present at popliteal spaces and ankles. EASI was 9.4, while SCORAD was 57.6, emphasizing the symptomatic burden. Although upadacitinib, a selective JAK1 inhibitor, could have addressed both conditions simultaneously, the patient's thromboembolic history led both dermatologists and gastroenterologists to exclude this option. A multidisciplinary re-evaluation was thus performed. Colonoscopy confirmed clinical remission, allowing infliximab to be suspended. Lebrikizumab, an anti-IL-13 monoclonal antibody, was initiated; unlike other IL-13 inhibitors, it binds IL-13 with

high affinity while preserving natural cytokine clearance, contributing to its favourable safety profile. The patient is currently in follow-up. This case highlights the importance of comorbidities in AD management. The coexistence of AD and UC, sharing Th2 inflammatory patterns, requires a multidisciplinary approach. A prior history of thromboembolic events precluded JAK inhibitors, despite their recognized efficacy in both conditions, ultimately guiding therapeutic decisions towards lebrikizumab, targeting the IL-13 pathway in the context of UC remission.

References

1. Niwa Y, Sumi H, Akamatsu H. An Association Between Ulcerative Colitis and Atopic Dermatitis, Diseases of Impaired Superficial Barriers. *J Invest Dermatol.* 2004;123(5):999-1000. doi: 10.1111/j.0022-202X.2004.23485.x
2. Chiesa Fuxench ZC, Wan J, Wang S, Syed MN, Shin DB, Abuabara K, Gelfand JM. Risk of Inflammatory Bowel Disease in Patients With Atopic Dermatitis. *JAMA Dermatol.* 2023;159(10):1085-1092. doi: 10.1001/jamadermatol.2023.2875 [1]
3. Fuss IJ, Heller F, Boirivant M, Leon F, Yoshida M, Fichtner-Feigl S, Siebeck M, Terabe M, Blumberg RS, Nair N, Strober W. Nonclassical CD1d-restricted NK T cells that produce IL-13 characterize an atypical Th2 response in ulcerative colitis. *J Clin Invest.* 2004;113(10):1490-1497. doi: 10.1172/JCI19836
4. Fuss IJ, Strober W. The role of IL-13 and NK T cells in experimental and human ulcerative colitis. *Mucosal Immunol.* 2008;1(Suppl 1):S31-S33. doi: 10.1038/mi.2008.40
5. Saez A, Herrero-Fernandez B, Gomez-Bris R, Sanchez-Martinez H, Gonzalez-Granado JM. CD4 T-Cell Subsets and the Pathophysiology of Inflammatory Bowel Disease. *Int J Mol Sci.* 2023;24(3):2696. doi: 10.3390/ijms24032696



BEYOND AREA REDUCTION: PULSED DYE LASER TREATMENT OF BASAL CELL CARCINOMA IN A PRELIMINARY REAL-WORLD COHORT

G. Frattin^{1,2}, A. Bolzon^{1,2}, E. Pezzolo¹, L. Germini¹, L. Gnesotto¹, A. Corrà¹, G. Mioso¹, Z. Fratton¹, L. Schiesari¹

¹UOC Dermatologia, Ospedale San Bortolo, Vicenza, Italy; ²Università degli Studi di Padova, Clinica Dermatologica, Italy

Keywords: Basal Cell Carcinoma, Pulsed Dye Laser.

Background. Pulsed dye laser (PDL) is a minimally invasive option for selected basal cell carcinomas (BCCs). Current evidence supports a potential role when surgery is difficult, poorly accepted, or contraindicated, but studies remain heterogeneous and mainly focus on clinical or histological clearance. In nodular BCCs, area-based assessment may be insufficient, as response may occur predominantly along the vertical axis.

Methods. We analyzed a preliminary real-world cohort of patients with histologically confirmed primary BCC treated with 595-nm PDL. Baseline variables included age, lesion site, histologic subtype, risk area, maximum diameter, calculated elliptical area, and clinically measured thickness for nodular lesions. Treatment parameters, pain visual analogue scale (VAS), adverse events, clinical and dermoscopic clearance, and morphometric changes were recorded. For nodular BCCs, thickness reduction was calculated by comparing each lesion at baseline and latest follow-up.

Results. Seventeen patients with 26 primary BCCs were included: 13 superficial and 13 nodular. Patients were predominantly older, with a mean age of 72.4 years, and several lesions were treated in a context of surgically difficult or infeasible management. Twelve lesions had follow-up assessment. At latest follow-up, mean area reduction was 40.6% overall. Superficial BCCs showed greater area reduction than nodular BCCs (59.7% vs 21.5%), with complete or partial clinical and dermoscopic clearance in all evaluable su-

perficial lesions. Conversely, nodular BCCs showed modest area reduction but marked thickness decrease, with mean and median percentage reductions of 49.4% and 45.0%. Treatment was well tolerated, with mean pain VAS of 1.44/10, no anesthesia, and no major adverse events. Two minor bleeding events were recorded during follow-up.

Conclusions. In this preliminary cohort, 595-nm PDL showed a favorable tolerability and safety profile in selected BCCs, particularly in older patients and surgically challenging cases. Superficial BCCs showed greater area reduction and higher clinical and dermoscopic response than nodular lesions. The main innovative finding is that, in nodular BCCs, thickness reduction was substantially greater than area reduction, suggesting that conventional area-based endpoints may underestimate response. Subtype-specific morphometric assessment, including thickness measurement, may improve response evaluation in future PDL studies.

References

1. Abo Zaken G, Fatirchorani R, Rodriguez B, Garcia-Sellek B. Pulsed dye laser (PDL) in the treatment of basal cell carcinoma: a review. *Lasers Med Sci.* 2025;40:466.
2. Clementi A, Cannarozzo G, Guarino L, et al. Laser therapy in basal cell carcinoma: current evidence, literature gaps and future perspectives. *Bioengineering.* 2026;13:244.
3. Baran KL, Cheung TC, Csank GA, Michaels BM. Pulsed dye laser for treatment of basal cell carcinoma. *Plast Reconstr Surg Glob Open.* 2023;11:e4850.





GENITAL POROKERATOSIS CONFIRMED BY HISTOPATHOLOGY AND REFLECTANCE CONFOCAL MICROSCOPY: A RARE CASE REPORT

G. Frattin^{1,2}, A. Bolzon^{1,2}, E. Pezzolo¹, L. Germi¹, L. Gnesotto¹, A. Corrà¹, G. Mioso¹, Z. Fratton¹, L. Schiesari¹

¹UOC Dermatologia, Ospedale San Bortolo, Vicenza, Italy; ²Università degli Studi di Padova, Clinica Dermatologica, Italy

Keywords: Porokeratosis, Reflectance Confocal Microscopy.

Introduction. Genital porokeratosis is a rare presentation of porokeratosis, a disorder of epidermal keratinization defined by the presence of cornoid lamellae. Because of its uncommon location and variable morphology, it may mimic inflammatory, infectious or neoplastic genital dermatoses, often leading to delayed diagnosis. Reflectance confocal microscopy (RCM) may provide non-invasive clues and help select the most appropriate biopsy site.

Materials and Methods. A 45-year-old otherwise healthy man, with no history of immunosuppression or sexually transmitted infections, presented with multiple pruritic annular plaques involving the inguinal region, inner thigh, penile base and scrotum. The lesions had been present for approximately four years. Clinical examination, RCM and histopathological assessment were performed. A biopsy was obtained from the raised keratotic border of a representative lesion on the right inner thigh.

Results. RCM showed a well-defined peripheral rim corresponding to the clinically visible keratotic border, associated with focal interruption of the epidermal architecture and loss of the physiological honeycomb pattern. Hyperreflective parakeratotic material within the epidermal furrow was observed, suggesting the in vivo counterpart of cornoid lamellae. Histopathology revealed compact hyperkeratosis, focal erosion, moderate-to-severe irregular acanthosis, moderate spongiosis with mild lymphocytic exocytosis, and two areas

of dyskeratosis surmounted by marked hyperparakeratosis, consistent with cornoid lamellae. A moderate discontinuous band-like lymphocytic infiltrate was present in the superficial dermis. PAS, PASD and Alcian blue stains were negative for fungal elements; immunohistochemistry for herpes simplex virus and *Treponema pallidum* was negative. Previous treatment with topical corticosteroids had been ineffective, and the patient is currently receiving acitretin 25 mg/day with clinical follow-up.

Conclusions. This case highlights genital porokeratosis as a rare and underrecognized diagnosis in chronic annular genital and paragenital plaques. The combined use of clinical examination, RCM and targeted histopathology may improve diagnostic accuracy, support biopsy site selection and strengthen clinicopathological correlation in anatomically sensitive areas.

References

1. Valdivielso-Ramos M. Genital porokeratosis. *Actas Dermosifiliogr.* 2008;99:217-220.
2. Dongre A, Adhe V, Sanghavi S. Genital porokeratosis: a rare entity. *Indian Journal of Dermatology.* 2013;58:81-83.
3. Pietkiewicz P, Korecka K, Salwowska N, Kohut I, Adhikari A, Bowszyc-Dmochowska M, Pogorzelska-Antkowiak A, Navarrete-Dechent C. Porokeratoses - A comprehensive review on the genetics and metabolomics, imaging methods and management of common clinical variants. *Metabolites.* 2023;13:1176.





SMART SURGERY FOR SPECIFIC ANATOMICAL DISTRICTS

M. Donini

U.O.C. Dermatologia, Ospedale Civile Venezia, Italy

Keywords: Skin, Extension.

Smart Surgery for Specific Anatomical Districts S.E.M.I. Technique (Skin Extension by Multiple Incisions) This surgical approach enables the approximation of wound margins, even in the presence of substantial tissue loss, without necessitating technically complex local flaps. The procedure involves executing a series of mini-incisions, measuring 3 to 5 mm in length, oriented parallel to the long axis of the surgical defect. These incisions are performed sequentially until the traction tension exerted on the margins is adequately minimized. Each individual incision must extend precisely to the subcutaneous adipose tissue layer. Progression of the mini-incisions is halted once tissue tension is reduced within physiological limits. The cumulative average area of the incisions is approximately 2.5 times the area of the primary surgical defect. This technique has been predominantly applied to defects located on the ankle, foot, lower leg, and forearm. Clinical Advantages of the S.E.M.I. Technique: Tactile Sensitivity: No significant loss of tactile sensitivity compared to the surrounding skin has been observed postoperatively. Deep Tissue Adhesions: No structural adhesions to deep anatomical layers (including tendons, muscles, or bone) have been reported. Donor Site Preservation: Complete absence of scarring correlated with a skin donor site, eliminating secondary morbidity. Comparative Analysis: S.E.M.I. vs. Free Skin Grafts - Vascular Integrity: Demonstrates a lower risk of vascular compromise at the recipient

site. - Aesthetic Preservation: Eliminates the necessity of harvesting tissue from a separate donor site, optimizing overall cosmetic outcomes. - Local Tissue Harmony: Yields a superior localized aesthetic result by utilizing identical adjacent cutaneous tissue from the margins of the surgical defect. - Postoperative Course: Associated with a significantly faster and less complicated postoperative recovery period. - Surgical Efficiency: Characterized as a more rapid and straightforward operative technique. Comparative Analysis: S.E.M.I. vs. Local Flaps - Vascular Safety: Presents a lower risk of localized vascular suffering compared to specific transposition or advancement flaps. - Complication Rates: Minimizes the risk of surgical complications due to the strict absence of extensive tissue undermining. - Cosmetic Outcomes: Provides a superior aesthetic result compared to certain conventional local flaps (e.g., transposition flaps). - Operative Versatility: Operates as a simple and adaptable technique.

References

1. Skin Extension by Multiple Incisions (SEMI) RALPH GAULKE Section Upper Extremity, Foot and Rheuma Surgery, Trauma Department, Medical School Hanover (MHH), Hanover, Germany In vivo 33: 495-500 (2019) doi:10.21873/invivo.11501.
2. Mid- to Long-term Outcomes After Split-thickness Skin Graft vs. Skin Extension by Multiple Incisions. Kern JN, et al. In Vivo. 2019. PMID: 30804125 .



DIAGNOSTIC PITFALLS IN CUTANEOUS ULCERS: ARE THEY JUST ULCERS?

V. Schirripa¹, A. Schirripa²

¹Private Practice Dermatologist, Former Director of the Dermatology Unit, Hospital of Locri, (RC), Italy; ²Specialist in Hygiene and Preventive Medicine, Italy

Keywords: Cutaneous ulcers, Differential diagnosis.

Introduction. Population ageing, increasing frailty, loss of independence and the growing burden of chronic diseases have made cutaneous ulcers a major healthcare issue, affecting approximately two million people in Italy. Although vascular disorders remain the leading cause of skin ulceration, a broad spectrum of other conditions, including rare diseases, may present with similar clinical features, often leading to diagnostic delays and inappropriate management. The aim of this study was to highlight the main diagnostic challenges encountered in patients with cutaneous ulcers and to emphasize the importance of a comprehensive multidisciplinary approach.

Materials and Methods. Several cases of cutaneous ulcers encountered in routine clinical practice were reviewed, including ulcers of neoplastic, infectious, inflammatory, autoimmune and self-inflicted origin. Representative cases of neoplastic ulcers, Leishmania-associated ulcers, factitious dermatitis, inflammatory and occlusive microangiopathies, autoimmune diseases and connective tissue disorders were analyzed. For each case, clinical findings, diagnostic work-up, histopathological features and therapeutic management were evaluated. Extensive clinical photographic documentation supported the analysis.

Results. The reviewed cases confirmed that a significant proportion of cutaneous ulcers arise from causes other than vascular disease. Although neoplastic ulcers account for a relatively small percentage of cases, their prompt recognition is crucial because of their prognostic implications. Infectious ulcers may mimic chronic ulcers of different etiologies and require targeted investigations guided by careful history taking and appropriate microbiological and histopathological examinations. Factitious dermatitis is often character-

ized by a discrepancy between clinical presentation and laboratory or instrumental findings. In such cases, careful assessment and the identification of lesions in easily accessible body areas may raise suspicion of the diagnosis and guide management. Microangiopathic disorders account for approximately 10% of lower-limb ulcers, while autoimmune diseases presenting with ulceration represent a clinically relevant subset of cases. In these settings, ulcers frequently constitute the cutaneous manifestation of an underlying systemic disease. Pyoderma gangrenosum is a notable example and may be associated with inflammatory bowel disease, hematological disorders, hepatic diseases and immunological conditions. In many cases, skin biopsy proved essential for establishing the definitive diagnosis.

Conclusions. The evaluation of patients with cutaneous ulcers should extend beyond the lesion itself. A comprehensive medical history, meticulous general and dermatological examination and targeted diagnostic investigations, including skin biopsy when indicated, are essential for achieving an accurate diagnosis. A systematic multidisciplinary approach facilitates the early recognition of potentially complex underlying diseases, allows the implementation of the most appropriate therapeutic strategy and reduces the risk of diagnostic errors, ultimately improving patient outcomes and quality of life.

References

1. Guarnera G, Papi M. L'ulcera cutanea degli arti inferiori. Monti editore, Saronno (VA) 1998
2. Papi M. Le ulcere microangiopatiche: vasculiti, infiammazione e malattie occlusive dei piccoli vasi cutanei. Marrapese editore, Roma 2008



MORBIHAN DISEASE IN A MAURITIAN PATIENT: A CASE REPORT AND REVIEW OF THE ASIAN LITERATURE

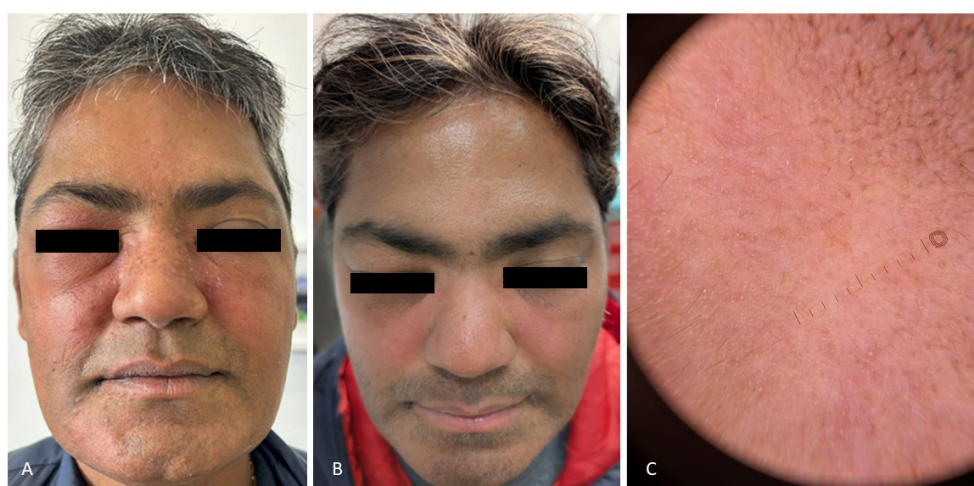
G. Hoxhallari^{1,4}, R. Bortone², A. R. Meduri², B. Tirone², F. Drago³, C. Foti², D. Bonamonte², M. Bellino², G. Ciccicarese¹

¹Unit of Dermatology, Department of Medical and Surgical Sciences, University of Foggia, Foggia, Italy; ²Section of Dermatology and Venereology, Department of Precision and Regenerative Medicine and Ionian Area, University of Bari "Aldo Moro", Bari, Italy; ³Casa di Cura Villa Montallegro, Genova, Italy; ⁴Department of Dermatology and Venereology, Mother Teresa University Hospital Center, Tirana, Albania

Keywords: Morbihan Disease, Asian Patients.

Morbihan disease (MD) is a rare dermatological condition mainly affecting Caucasian patients with persistent facial edema. The cutaneous manifestations cause functional and aesthetic problems, preventing the patients from opening their eyes and disfiguring them. MD is refractory to many therapeutic regimens, and there is no established gold standard treatment. We describe the case of a Mauritian patient with MD and review the literature to examine the clinical features and treatment responses in Asian MD patients. Our case is noteworthy due to the rarity of the disease in Asia and the excellent response to the first-line therapy with oral isotretinoin. In our review, we identified 54 Asian patients with MD (37 males and 17 females). The eyelids were the most common site of persistent edema localization. Although most of the existing literature focuses on the West-

ern populations, MD is probably underestimated in Asian individuals, potentially due to the difficulty in discerning erythema. Among the oral drugs, the best outcomes were achieved with both tetracycline-class antibiotics and isotretinoin. Among topical treatments, tacrolimus 0.1% ointment and ivermectin 1% cream were effective in half of the reported cases. Surgery seems to be the more aggressive but effective therapeutic option. Globally, the clinical-histological findings and treatment outcomes of Asian patients with MD did not differ significantly from those observed in Western patients. In conclusion, MD can be challenging to diagnose and treat and may require a range of topical and oral interventions. Dermatologists should consider the possibility of this rare diagnosis across all phototypes to avoid misdiagnoses and complications.





A GIFT FROM ECUADOR: IMPORTED CUTANEOUS MYIASIS CAUSED BY *DERMATOBIA HOMINIS*

D. Tesauri¹, F. Di Cioccio¹, T. Galeotti¹, L. Bianchi¹, K. Hansel¹, L. Stingeni¹, F. Veronesi², I. Moretta²

¹Dermatology Section, Department of Medicine and Surgery, University of Perugia, Italy; ²Department of Veterinary Medicine, University of Perugia, Italy

Keywords: Cutaneous-Myiasis, Dermatobia-Hominis.

Introduction. Dermatobia (D.) hominis (order Diptera, family Oestridae), a species of botfly whose larvae parasitise humans and other primates, is a major cause of myiasis in Central and South America and should be considered in patients returning from the endemic area [1]. The female of D. hominis uses other insects as carriers of its eggs, most commonly mosquitoes and zoophilous flies, which subsequently blood-feed on humans or other mammals such as cattle, sheep, dogs, cats, and occasionally equids and birds. The warmth of the host's body triggers larval hatching, allowing the larva to drop onto the skin and penetrate through the bite site. Larval development in the subcutaneous tissue proceeds through three stages and usually takes 4-18 weeks to complete [1]. The typical clinical presentation consists of a nodular skin lesion with a central ulceration, seropurulent discharge, and a whitish, tender, moving mass within the nodule, which is highly suggestive of cutaneous myiasis. Patients frequently report intermittent sharp pain in the affected area, progressive enlargement of the lesion, and a sensation of movement within the skin [2,3]. The aim of this case report is to describe an uncommon clinical localization of this parasitosis in a patient returning to Italy from an endemic region, while discussing the diagnostic process and subsequent therapeutic management.

Materials and Methods. A 30-year-old man was referred to our Dermatology Unit by his general practitioner for evaluation of a cutaneous lesion on the right wrist. His medical history revealed recent travel to Ecuador, where he had spent prolonged periods in tropical rainforest environments without the use of insect repellents or other protective measures. Approximately eight weeks after returning to Italy, the patient noticed the onset of a painful erythematous nodule with a small central opening, associated with a pulsatile movement arising from subcutaneous tissue. The lesion slowly and progressively increased in size in the following 2 months. To manage the lesion and confirm the diagnosis, surgical exploration was performed, revealing a larva extending through the subcutaneous tissue down to the muscle fascia. The larva was extracted alive with surgical forceps, fixed in ethanol, and submitted to the Entomology Laboratory of Perugia University for species identification via stereomicroscopic examination. In addition to surgical removal, oral ivermectin (300 µg/kg in single dose) was adminis-

tered as adjunctive therapy to minimize the risk of residual or undetected larvae.

Results. Surgical and parasitological findings confirmed the diagnosis of cutaneous myiasis caused by D. hominis. Stereomicroscopic examination revealed features characteristic with a second-instar larva of Dermatobia hominis. The larva was pyriform, approximately 8 mm in length; the anterior portion was globose and armed with both robust posteriorly directed spines (macrospines) and small spines (microspines). The posterior portion was narrow, attenuated, and devoid of spines, with microspines confined only to the terminal region, where the characteristic posterior spiracles were also visible. Following surgical removal of the larva and adjunctive administration of oral ivermectin, complete eradication was successfully achieved.

Conclusions. Diagnosis of D. hominis myiasis is primarily clinical and may be confirmed by parasitological identification of the extracted larva [4]. In the case series by Calvopina M et al [5], limb involvement accounted for 30% of involved sites; however, wrist localization was not specifically reported, suggesting that this presentation in our patient is uncommon. While the most widely used therapeutic approach consists of occlusion of the central punctum to induce larval asphyxiation and spontaneous expulsion, surgical extraction represents the definitive treatment in the absence of spontaneous expulsion [6], as was performed in our patient. In selected cases, antibiotic therapy (such as ceftriaxone associated with debridement) may be indicated exclusively for secondary bacterial superinfections in this context, ceftriaxone is commonly used in association with debridement and removal of necrotic tissue. Ivermectin, an avermectin that acts as a positive allosteric modulator of glutamate-gated chloride channels (GluCl) and gamma-aminobutyric acid (GABA) receptors, induces flaccid paralysis via hyperpolarization of nerve and muscle membranes and represents an adjuvant or an alternative therapeutic option for larval eradication, especially in unusual anatomical presentations or in multiple larval parasitosis [5,7].

References

1. Kettle DS. "Medical and Veterinary Entomology, 2nd Ed". 1992. CAB International, Wallingford, Oxon, UK. Pp.279-282.
2. Seilmaier M, Ehlert N, Fenzl T, Frühwein N, "Furuncular skin



POSTERS

Dermatological Infectious Diseases (including STDs)

lesions after travel to Brazil [in German]", *Dtsch Med Wochenschr* 136 (2011): 309-312.

3. Nunzi E, Rongioletti F, Rebora A, "Dermatobia hominis infestation", *Postgrad Med J* 60 (1984): 162-163.

4. Vydrář D, Čurdová N, "Scrotal myiasis imported from Ecuador: case report and summary of current knowledge", *Klin Mikrobiol Infekc Lek* 31 (2025): 63-67.

5. Calvopina M, Ortiz-Prado E, Castañeda B, Cueva I, Rodriguez-Hidalgo R, Cooper PJ, "Human myiasis in Ecuador", *PLoS Negl Trop Dis* 14 (2020): e0007858.

6. Messahel A, Sen P, Wilson A, Patel M, "An unusual case of myiasis", *J Infect Public Health* 3 (2010): 43-45.

7. Twayana AR, Sunuwar N, Devkota A, Dahal A, Tamang R, Gautam K, "Maggots around colostomy site: a case report" *JNMA J Nepal Med Assoc* 59 (2021):709-711.



WHEN BLISTERING DISEASE AND CUTANEOUS MALIGNANCY MEET: PARANEOPLASTIC BULLOUS PEMPHIGOID ASSOCIATED WITH SQUAMOUS CELL CARCINOMA

L. Melloni, M. A. Carpanese, D. Abbenante, M. Tabanelli

AUSL della Romagna, Ravenna, Italy

Keywords: Bullous Pemphigoid, Squamous Cell Carcinoma.

An 86-year-old woman presented with two concomitant cutaneous conditions: a large occipital nodule progressively increasing in size (Figure 1) and a chronic pruritic eruption with excoriated lesions involving the back and upper limbs. The latter had initially been diagnosed as prurigo nodularis and treated with topical corticosteroids. Indirect immunofluorescence for circulating anti-skin antibodies was negative. While awaiting surgical excision of the occipital lesion, the patient developed worsening pruritus and tense blisters. Based on the clinical suspicion of bullous pemphigoid, subsequently confirmed by histopathology and direct immunofluorescence, a prolonged tapering course of systemic corticosteroids was prescribed, although the patient never started treatment. Remarkably, the blistering disease resolved completely after surgical removal of the occipital lesion. Histological examination identified the tumor as a keratinizing squamous cell carcinoma with trichilemmal differentiation, moderately differentiated and infiltrative, consistent with a malignant proliferating pilar tumor. Given the complete remission of bullous pemphigoid following tumor excision, in the absence of specific therapy or significant medication changes, a diagnosis of paraneoplastic bullous pemphigoid secondary to squamous cell carcinoma was made. This case highlights two clinically relevant aspects. First, according to current European guidelines (1), the diagnosis of bullous pemphigoid should not rely solely on indirect immunofluorescence because false-negative results may occur. Autoantibodies may target antigens other than BP180 and BP230 or epitopes not detected by standard assays. In our patient, serological testing was negative, whereas histology and direct immunofluorescence established the diagnosis. Second, although paraneoplastic autoimmune blistering diseases are more frequently associated with pemphigus, a neoplastic trigger should also be considered in selected cases of bullous pemphigoid. Previous reports have described an association between bullous pemphigoid and squamous cell carcinoma (2-4), suggesting that tumor-related antigens may induce an autoimmune response leading to blister formation (5, 6). This case further emphasizes the close relationship between neoplastic and inflammatory diseases, highlighting the importance of considering an underlying malignancy in atypical presentations of autoimmune blistering disorders.

References

1. Borradori L, Van Beek N, Feliciani C, Tedbirt B, Antiga E, et al. Updated S2 K guidelines for the management of bullous pemphigoid initiated by the European Academy of Dermatology and Venereology (EADV). *J Eur Acad Dermatol Venereol*. 2022 Oct;36(10):1689-1704. doi: 10.1111/jdv.18220. Epub 2022 Jun 29. PMID: 35766904.
2. Bishnoi A, Narang T, Handa S, Vishwajeet V, Saikia UN, et al. Paraneoplastic bullous pemphigoid associated with penile squamous cell carcinoma. *J Eur Acad Dermatol Venereol*. 2018 Apr;32(4):e140-e141. doi: 10.1111/jdv.14635. Epub 2017 Nov 2. PMID: 29024082.
3. Benhiba H, Hassam B. Association of bullous pemphigoid and squamous cell carcinoma of the lip: a simple coincidence? *Pan Afr Med J*. 2015 Apr 22;20:396. doi: 10.11604/pamj.2015.20.396.6804. PMID: 26185586; PMCID: PMC4499320.
4. Deguchi M, Tsunoda T, Tagami H. Resolution of bullous pemphigoid and improvement of vitiligo after successful treatment of squamous cell carcinoma of the skin. *Clin Exp Dermatol*. 1999 Jan;24(1):14-5. doi: 10.1046/j.1365-2230.1999.00396.x. PMID: 10233641.
5. Yamada T, Endo R, Tsukagoshi K, Fujita S, Honda K, et al. Aberrant expression of a hemidesmosomal protein, bullous pemphigoid antigen 2, in human squamous cell carcinoma. *Lab Invest*. 1996 Oct;75(4):589-600. PMID: 8874389.
6. Matsuoka Y, Yamada T, Seishima M, Hirako Y, Owariibe K, Kitajima Y. Transient translocation of hemidesmosomal bullous pemphigoid antigen 1 from cytosol to membrane fractions by 12-O-tetradecanoylphorbol-13-acetate treatment and Ca²⁺-switch in a human carcinoma cell line. *J Dermatol Sci*. 2001 Nov;27(3):206-14. doi: 10.1016/s0923-1811(01)00137-2. PMID: 11641060.





BEYOND THE USUAL CAT: TRICHOPHYTON BENHAMIAE KERION CELSI IN A CHILD WITH CHINCHILLA-ASSOCIATED HOUSEHOLD OUTBREAK

T. Galeotti¹, D. Tesauri¹, P. Caposciutti¹, L. Bianchi¹, S. Crotti², D. Cruciani², K. Hansel¹, L. Stingeni¹

¹Dermatology Unit, Department of Medicine and Surgery, University of Perugia, Perugia, Italy; ²Istituto Zooprofilattico Sperimentale dell'Umbria e delle Marche "Togo Rosati", Perugia, Italy

Keywords: *Trichophyton Benhamiae*, *Kerion Celsi*.

Introduction. *Trichophyton benhamiae* is an emerging zoophilic dermatophyte increasingly reported as a cause of inflammatory tinea in children, including kerion celsi. Due to its variable epidemiological sources and often misleading exposure history, accurate identification of the infection source may be challenging and may require molecular confirmation.

Materials and Methods. We report a pediatric case of extensive dermatophytosis initially managed in the outpatient setting and subsequently hospitalized due to clinical worsening. Clinical evaluation, laboratory testing, mycological examination, and epidemiological reconstruction were performed. Definitive species identification was obtained through molecular sequencing.

Results. A 5-year-old boy presented with multiple erythematous, scaly papulo-squamous lesions involving the face, trunk, gluteal region, and scalp. Initial outpatient management by a community dermatologist included topical antifungal therapy for suspected tinea corporis, with partial improvement. Over the following weeks, scalp involvement progressed to a large inflammatory alopecic plaque with pustulation, crusting, and associated retroauricular and laterocervical lymphadenopathy, consistent with kerion celsi. The patient was therefore referred for hospital admission. On admission, laboratory tests showed mild neutrophilic leukocytosis and elevated inflammatory markers. Systemic therapy with griseofulvin was initiated, together with ampicillin/sulbactam for suspected bacterial superinfection and topical antiseptic/antibacterial treatment (fusidic acid and aqueous fuchsin). Bacterial and yeast cultures from skin swabs were negative. During hospitalization and subsequent follow-up visits, progressive clinical improvement was observed, with crusting of lesions, reduction of the pustular component, and normalization of inflammatory markers. Species identification as *Trichophyton benhamiae* was achieved by fungal culture and confirmed by molecular sequencing. Epidemiological re-evaluation revealed a household zoonotic out-

break. A sibling presented with concomitant tinea corporis of the trunk, successfully treated with topical terbinafine. Domestic chinchillas showed alopecia and pruritus and were subsequently treated, strongly suggesting an animal reservoir as the source of infection. Initial exposure hypotheses, including animal contact during a travel in India and rural accommodation, were considered less relevant. At follow-up, the patient showed marked clinical improvement under systemic antifungal therapy, with resolution of inflammatory signs and residual patchy alopecia of the scalp.

Conclusions. This case highlights a household outbreak of *Trichophyton benhamiae* infection presenting with extensive tinea corporis and kerion celsi in a child, confirmed by molecular identification. It emphasizes the importance of repeated and dynamic epidemiological assessment and awareness of atypical zoonotic reservoirs, such as chinchillas and guinea pigs. Molecular diagnostics can be crucial for confirming emerging dermatophyte species and for accurate outbreak tracing.

References

1. Nenoff P, Uhrlass S, Kruger C, et al. *Trichophyton* species of *Arthroderma benhamiae* - a new infectious agent in dermatology. *J Dtsch Dermatol Ges.* 2014;12:571-581.
2. Nenoff P, Schulze I, Uhrlass S, Kruger C. Kerion caused by the zoophilic dermatophyte *Trichophyton* species of *Arthroderma benhamiae* in a child. *Hautarzt.* 2013;64:846-849.
3. Hattori N, Kaneko T, Tamaki K, Makimura K, Mochizuki T. A case of kerion celsi due to *Arthroderma benhamiae* identified by DNA sequences of nuclear ribosomal internal transcribed spacer 1 regions. *Med Mycol.* 2003;41:249-251.
4. Shiraki Y, Hiruma M, Kano R, Miyamoto C, Ikeda S. Case of tinea capitis caused by *Trichophyton mentagrophytes* (molecular type *Arthroderma benhamiae*). *J Dermatol.* 2006;33:504-506.
5. Bartosch T, Frank A, Gunther C, et al. *Trichophyton benhamiae* and *T. mentagrophytes* target guinea pigs in a mixed small animal stock. *Med Mycol Case Rep.* 2018;23:37-42.





LONGSTANDING GENERALIZED EXTRAGENITAL LICHEN SCLEROSUS WITH GENITAL INVOLVEMENT UNMASKED BY ACUTE INFLAMMATORY DERMATOSIS

V. Corti¹, L. Sanna¹, A. Magnatta¹, R. Daher¹, S. Landini¹, A. Verdelli², M. Caproni²

¹Sezione di Dermatologia, Dipartimento di Scienze della salute, Università di Firenze, Italy; ²S.O.S. Immunopatologia cutanea e malattie rare dermatologiche, P.O. Piero Palagi, Azienda USL Toscana Centro, Dipartimento di Scienze della Salute Università degli Studi di Firenze, Italy

Keywords: Lichen Sclerosus, Extragenital Lichen Sclerosus.

Lichen sclerosus (LS) is a chronic inflammatory dermatosis primarily affecting the anogenital region. LS may cause itching, soreness, dysuria and sexual dysfunction. Extragenital LS occurs in 15-20% in association with anogenital involvement, whereas isolated extragenital lesions are described in only 6% of patients. Extragenital LS most commonly affects the neck, shoulders, and upper trunk and may be pruritic. However, both genital and extragenital LS can be clinically subtle and remain unrecognized for years, leading to delayed diagnosis. In this report, we describe an unusual case of long-standing, diffuse extragenital and genital LS incidentally diagnosed during the evaluation of acute inflammatory nodular lesions of the legs. A 39-year-old woman presented with a three-month history of pruritic nodular lesions on the right pretibial area. Clinical examination, microbiological testing and histopathological evaluation of these lesions were performed. A comprehensive total-body skin examination revealed widespread hypopigmented macules, reportedly appearing after an episode of typhoid fever and stable over time, prompting an additional skin biopsy. The differential diagnosis included extragenital LS and vitiligo. Subsequent clinical follow-up, including evaluation for genital involvement, were carried out. Histopathological analysis of the nodular lesion demonstrated neutrophilic granulocytic dermatitis consistent with a reactive, infective process. The patient's clinical course was complicated by erysipelas, which was successfully treated with amoxicillin/clavulanic acid. Histopathological examination of the hypopigmented macule revealed epidermal atrophy, dermal collagen homog-

enization and a band-like lymphocytic infiltrate, confirming the diagnosis of extragenital LS with an uncommon generalized distribution. Subsequent evaluation disclosed vulvar involvement consistent with genital LS. Systemic treatment with methotrexate combined with high-potency topical corticosteroids was initiated, with partial clinical improvement and good tolerability at initial follow-up. This case highlights the importance of a thorough total-body skin examination and a low threshold for histopathological confirmation, even in long-standing, asymptomatic lesions. In this patient, the occurrence of an acute inflammatory condition enabled the diagnosis of a previously unrecognized chronic dermatosis that might otherwise have remained overlooked.

References

1. Kirtschig G, Kinberger M, Kreuter A, Simpson R, Günthert A, van Hees C, et al. EuroGuiderm guideline on lichen sclerosus: introduction into lichen sclerosus. *J Eur Acad Dermatol Venereol.* 2024;38(10):1850-1873. doi:10.1111/jdv.20082.
2. Arif T, Fatima R, Sami M. Extragenital lichen sclerosus: a comprehensive review. *Australas J Dermatol.* 2022;63(4):452-462. doi:10.1111/ajd.13890.
3. Ganesan L, Parmar H, Das JK, Gangopadhyay A. Extragenital lichen sclerosus et atrophicus. *Indian J Dermatol.* 2015;60(4):420. doi:10.4103/0019-5154.160516.
4. Esse I, Rodriguez KH, Kassels A, Shiu J, Kraus CN. Vulvar lichen sclerosus and vitiligo: overlap and clinical features. *J Am Acad Dermatol.* 2023;89(4):839-841. doi:10.1016/j.jaad.2023.06.016.
5. Kirtschig G, Kinberger M, Kreuter A, Simpson R, Günthert A, van Hees C, et al. EuroGuiderm guideline on lichen sclerosus: treatment of lichen sclerosus. *J Eur Acad Dermatol Venereol.* 2024;38(10):1874-1909. doi:10.1111/jdv.20083.



EXTENSIVE ULCERATIVE-BULLOUS LESIONS IN A PATIENT WITH GRANULOMATOSIS WITH POLYANGIITIS: A DIAGNOSTIC CHALLENGE

F. Fazzari¹, G. Cecchi¹, C. Cardinali², D. Bonciani², F. Taviti²

¹Department of Health Sciences, Section of Dermatology, University of Florence, Italy; ²SOC, Pistoia-Prato Hospital, USL Toscana Centro, Pistoia, Italy

Keywords: Granulomatosis with polyangiitis, Cutaneous vasculitis.

Background. Granulomatosis with polyangiitis (GPA) is an ANCA-associated necrotizing vasculitis affecting small and medium sized vessels. Cutaneous manifestations include palpable purpura, papulonecrotic lesions, nodules and ulcerations. Extensive ulcerative-bullous involvement is uncommon and may represent a significant diagnostic challenge.

Case Report. A 60-year-old man with longstanding GPA involving the kidneys, paranasal sinuses, nose, trachea and eyes, complicated by retinal vasculitis causing unilateral blindness, was admitted because of progressive skin lesions affecting both lower limbs. Previous treatments included cyclophosphamide and rituximab. His medical history was also significant for peripheral arterial occlusive disease, type 2 diabetes mellitus, arterial hypertension and hypogammaglobulinemia. Dermatological examination revealed widespread purpuric plaques, hemorrhagic bullae, necrotic areas and multiple deep ulcerations with fibrinous-necrotic bases. Culture from one ulcer yielded methicillin-sensitive *Staphylococcus aureus* (MSSA), and intravenous amoxicillin-clavulanate therapy was initiated, resulting in only partial clinical improvement. Although bacterial superinfection was documented, the morphology, distribution and severity of the lesions

raised concern for active vasculitic disease or an alternative concomitant pathogenic process. The coexistence of GPA, peripheral arterial disease, hypogammaglobulinemia and secondary infection further complicated the diagnostic assessment. Therefore, repeat skin biopsy and direct immunofluorescence were performed and histopathological evaluation is currently ongoing.

Discussion. Severe ulcerative-bullous lesions are an uncommon manifestation of GPA and may overlap clinically with ischemic ulcerations, pyoderma gangrenosum, infectious complications and other vasculopathic disorders. In this patient, multiple concurrent factors potentially contributing to tissue damage complicated attribution of the lesions to a single underlying mechanism. Careful integration of clinical, microbiological and histopathological findings is essential for accurate diagnosis.

Conclusions. This case highlights the diagnostic complexity of extensive ulcerative-bullous lesions in a patient with GPA and multiple comorbidities. Recognition of overlapping pathogenic mechanisms and close clinicopathological correlation are crucial to guide appropriate management and therapeutic decision-making.



CLINICAL, DERMOSCOPIC AND HISTOPATHOLOGICAL FEATURES OF A RARE CASE OF ERUPTIVE ANNULAR LICHEN PLANUS

V. Filastro¹, M. Ferrante^{2|3}, L. Gini^{2|3}, G. Martelli^{2|3}, M. La Placa^{2|3}, I. Neri³

¹Dermatology Unit, Health Science Department, Magna Graecia University, Catanzaro, Italy; ²Department of Medical and Surgical Sciences, Alma Mater Studiorum, University of Bologna, Italy; ³Dermatology Unit, IRCCS Azienda Ospedaliero-Universitaria di Bologna, Policlinico S. Orsola-Malpighi, Bologna, Italy

Keywords: Annular-Lichen-Planus, Eruptive-Variant.

Introduction. Annular lichen planus (ALP) is an uncommon variant of lichen planus characterized by annular brown-violet plaques with an atrophic or lighter central area. Lesions may be solitary or multiple and typically affect intertriginous regions and male genitalia (glans); less frequently extremities, trunk and neck are involved. ALP is already uncommon, and the eruptive variant is even rarer, with only a few cases described in the literature. Here we report such an eruptive form of ALP observed in the Dermatology Unit of IRCCS Policlinico Sant'Orsola-Malpighi (Bologna).

Materials and Methods. Dermatological clinical examination, manual and digital dermoscopy were performed. A biopsy of one lesion was obtained and histopathological study was carried out.

Results. The patient, a 49-year-old man (Fitzpatrick IV) from Pakistan, had no family history of chronic dermatological or other significant diseases, a personal history of mild hypothyroidism, and no recent travel or drug intake. Annular cutaneous lesions appeared on the right thigh and spread to trunk and both limbs within 15 days. Face, hair, nails and palmoplantar sites were spared; mucosa was in-

involved (genital localization). Lesions showed no extension or grouping after onset. Clinically, they were brown-violet macules-to-plaques with well-demarcated borders, ranging from 1 to 3-4 cm. Patient was asymptomatic except mild pruritus of the glans; notably, the distinctive genital lesions raised the primary diagnostic suspicion of lichen planus. Dermoscopy showed well-demarcated plaques with brownish coloration, whitish-gray margins, fine scaling, lighter centers and peppering-like pattern on thigh and trunk. Histology showed compact orthokeratosis, focal hypergranulosis, vacuolar alteration at dermoepidermal junction, edema, dilated vessels, moderate band-like perivascular lymphocytic infiltrate and papillary dermal thickening, consistent with ALP.

Conclusions. This case represents an exceptionally rare eruptive ALP with widespread involvement and prominent genital lesions. Given the scarcity of ALP cases, especially eruptive forms, this report adds clinical and histopathological data to the limited literature. In conclusion, typical genital lesions originally prompted suspicion of lichen planus, while the combination of widespread localization, classic morphology, dermoscopic peppering and histopathological findings strongly supported and confirmed the diagnosis.



TRICHOSCOPIC CLUES TO ALOPECIA NEOPLASTICA SECONDARY TO BREAST CARCINOMA: A CASE REPORT

A. Sechi¹, P. Ferrero^{1/2}, L. Valtellini^{1/2}, G. Perego^{1/2}, A. Marzano^{1/2}

¹Dermatology Unit, Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico, Milan, Italy; ²Department of Pathophysiology and Transplantation, Università degli Studi di Milano, Milan, Italy

Keywords: Alopecia Neoplastica, Trichoscopy.

Introduction. Alopecia neoplastica (AN) is a rare form of scalp metastasis that can present as alopecia and may be associated with variable follicular damage leading to cicatricial changes. Breast carcinoma is the most common source of cutaneous metastases in women and may rarely present as AN. Because its clinical features can mimic inflammatory or autoimmune alopecias, diagnosis is often challenging. We report a case of AN secondary to invasive lobular breast carcinoma and highlight the role of trichoscopy.

Materials and Methods. A 57-year-old woman presented with four recently developed alopecic patches on the vertex and parietal scalp. A few weeks earlier she had been diagnosed with invasive lobular breast carcinoma (ER 70%, PR 60%, Ki-67 10%, HER2-negative). Clinical and trichoscopic evaluations were performed, followed by scalp biopsy with histopathological and immunohistochemical analysis. Systemic staging results were reviewed.

Results. Lesions were asymptomatic erythematous patches <1 cm. Trichoscopy showed partial loss of follicular ostia, yellow dots, a milky-red background, polymorphous vessels (arborizing and glomerular), yellow-orange structureless areas, and hair shaft abnormalities including pili torti, broken

hairs, and black dots. Based on these findings and the recent breast cancer diagnosis, AN was suspected. Histopathology confirmed cutaneous metastasis of invasive lobular carcinoma with CK7, CK pool, and GATA3 positivity. The immunoprofile matched the primary tumor (ER >90%, PR 70%, Ki-67 3%, HER2-negative). Staging revealed suspicious axillary, internal mammary, and retropectoral lymph nodes and diffuse sclerotic bone metastases. Fine-needle aspiration confirmed metastatic breast carcinoma. The patient started abemaciclib and letrozole. At 1-year follow-up, no progression was observed, with partial regression of scalp lesions but persistent cicatricial alopecia.

Conclusions. We describe a case of AN secondary to breast carcinoma in a patient with a recent diagnosis of invasive lobular breast cancer, in whom metastatic disease was identified during staging. AN should be included in the differential diagnosis of cicatricial alopecia, especially in patients with a history of malignancy. Trichoscopy may provide useful diagnostic clues, including loss of follicular ostia, yellow-orange areas, polymorphous vessels, and hair shaft abnormalities. However, histopathology remains essential for definitive diagnosis. Early recognition may facilitate timely oncologic management.



MAMMARY PAGET DISEASE WITH OCCULT DCIS: A RARE MALE CASE

M. Fino¹, C. Brunello¹, N. Di Meo¹, I. Zalaudek¹, S. Sola², C. Massone³

¹Department of Dermatology and Venereology, University of Trieste, Maggiore Hospital, Trieste, Italy; ²Department of Pathology, Galliera Hospital, Genoa, Italy; ³Department of Dermatology, Galliera Hospital, Genoa, Italy

Keywords: Mammary-Paget-Disease, Ductal-Carcinoma.

Mammary Paget disease (MPD) is a rare intraepidermal adenocarcinoma accounting for 1–4% of breast malignancies, usually associated with underlying ductal carcinoma in situ (DCIS) or invasive carcinoma. It is rare in men and may present with atypical clinical features. We report the case of a 74-year-old man presenting with an asymptomatic, asymmetric erythematous plaque with a surrounding brownish pigmented area of the right nipple-areolar complex. Dermoscopic examination revealed non-specific red and white structureless areas with atypical polymorphous vessels, raising suspicion of amelanotic melanoma. Notably, no eczematous changes, erosion, or ulceration of the nipple-areolar complex were present, contributing to diagnostic uncertainty. Histopathological examination of a punch biopsy revealed a predominantly intraepidermal pagetoid proliferation of atypical cells consistent with MPD, with focal invasion of the pap-

illary dermis. Mammography and breast ultrasonography revealed no detectable breast mass or axillary lymphadenopathy. The patient underwent right mastectomy with sentinel lymph node biopsy. Final histopathology confirmed diffuse MPD with focal dermal microinvasion associated with a 5-mm DCIS G1; lymph nodes were negative for metastasis. The final pathological stage was pT1mic pN0(sn)(i–). No adjuvant therapy was indicated, and the patient was enrolled in follow-up. This case highlights an unusual presentation of male MPD. Although histologically consistent with a typical Paget disease, the clinical presentation was atypical due to the absence of the characteristic eczematous changes, erosion or ulceration of the nipple-areolar complex. This clinico-pathological discordance, together with the melanoma-like dermoscopic pattern, represents a relevant diagnostic pitfall.



FIRST-LINE EXTRACORPOREAL PHOTOPHERESIS PLUS INTERFERON- α IN SÉZARY SYNDROME: REAL-WORLD SURVIVAL AND EXPLORATORY BLOOD BIOMARKERS

A. Di Guardo¹, M.P. Accetturi¹, C. Cristofolletti¹, A. Frezzolini¹, E. Scala¹, L. Fania^{1,2}, A. Monopoli¹, M.G. Narducci¹

¹IDI-IRCCS, Dermatological Research Hospital, Italy; ²Department of Life Science, Health, and Health Professions, Link University of Rome, Italy

Keywords: Cutaneous Lymphoma, Sezary Syndrome.

Background. Sézary syndrome (SS) is a rare and aggressive leukemic variant of cutaneous T-cell lymphoma, characterized by erythroderma, peripheral blood involvement by malignant Sézary cells^{1,2}. Management usually requires multimodal strategies. Extracorporeal photopheresis (ECP), alone or combined with interferon- α (IFN- α), is widely used as a first-line option in erythrodermic CTCL, although outcomes are heterogeneous and reliable prognostic biomarkers remain insufficiently defined. The aim is evaluate overall survival (OS) in patients with SS treated with first-line ECP plus IFN- α , and to explore whether blood clonality and Sézary cell immunophenotype are associated with distinct survival patterns.

Materials and Methods. We conducted a retrospective single-center survival analysis of 72 consecutive patients with SS treated with first-line ECP plus IFN- α between 2000 and 2023. Patients were stratified according to extreme survival outcomes. Blood tumor burden was assessed by flow cytometry using a TCR V β repertoire kit combined with anti-CD3 and anti-CD4 antibodies. When applicable, Sézary cells were also identified by the aberrant immunophenotypic profile.³

Results. The cohort included 72 patients, with a median age at diagnosis of 69 years; 39 were female and 33 male. Median treatment duration with ECP plus IFN- α was 18 months. Kaplan-Meier analysis showed a median OS of 59 months and a 5-year survival rate of 44.9%. Thirteen long survivors, defined by OS >80 months, and 13 poor survivors, defined by OS <30 months, were identified. Long survivors showed an early and statistically significant reduction of the expanded TCR V β clone after treatment initiation, suggesting rapid decline of circulating clonal tumor burden. They also more frequently achieved normalization of the TCR V β repertoire during follow-up, whereas poor survivors more often showed persistent clonal expansion.

Conclusions. In this real-world cohort, first-line ECP com-

bined with IFN- α was associated with meaningful long-term survival in SS. The 5-year OS observed appears to lie at the upper end of previously reported ranges, possibly reflecting the role of tertiary-care management, careful blood monitoring and timely treatment initiation. Early reduction of the expanded TCR V β clone and subsequent normalization of the TCR V β profile may represent practical candidate biomarkers of sustained benefit and prolonged survival, although confirmation in larger prospective cohorts is required.

References

1. Willemze R, Jaffe ES, Burg G, Cerroni L, Berti E, Swerdlow SH, Ralfkiaer E, Chimenti S, Diaz-Perez JL, Duncan LM, et al. WHO-EORTC classification for cutaneous lymphomas. *Blood*. 2005 May 15;105(10):3768-85.
2. Scarisbrick JJ, Prince HM, Vermeer MH, Quaglini P, Horwitz S, Porcu P, Stadler R, Wood GS, Beylot-Barry M, Pham-Ledard A, et al. Cutaneous Lymphoma International Consortium Study of Outcome in Advanced Stages of Mycosis Fungoides and Sézary Syndrome: Effect of Specific Prognostic Markers on Survival and Development of a Prognostic Model. *J Clin Oncol*. 2015 Nov 10;33(32):3766-73.
3. Scala E, Abeni D, Pomponi D, Narducci MG, Lombardo GA, Mari A, Frontani M, Picchio MC, Pilla MA, et al. The role of 9-O-acetylated ganglioside D3 (CD60) and {alpha}4{beta}1 (CD49d) expression in predicting the survival of patients with Sezary syndrome. *Haematologica*. 2010 Nov;95(11):1905-12.
4. Gao C, McCormack C, van der Weyden C, Goh MS, Campbell BA, Twigger R, Buelens O, Harrison SJ, Khoo C, Lade S, et al. Prolonged survival with the early use of a novel extracorporeal photopheresis regimen in patients with Sézary syndrome. *Blood*. 2019 Oct 17;134(16):1346-1350.
5. Ling YL, Huang X, Mitri G, Lovelace B, Pham A, Knobler R, Li X, Gao X. Real-world use of extracorporeal photopheresis for patients with cutaneous T-cell lymphoma in the United States: 2010-2015. *J Dermatolog Treat*. 2020 Feb;31(1):91-98.

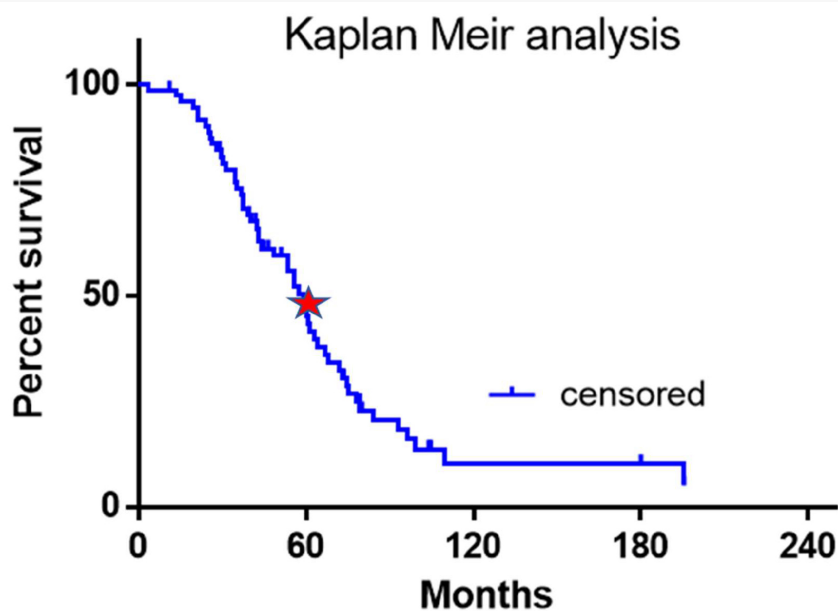


Figure 1. Retrospective survival analysis performed using the Kaplan–Meier estimator in a cohort of 72 patients with Sézary syndrome treated at IDI-IRCCS, Rome, with first-line ECP plus IFN- α between 2000 and 2023, showing a median overall survival of 59 months and a 5-year survival rate (60 months, marked with an X) of 44.9%.



GENERALIZED PLANE XANTHOMA AND NECROBIOTIC XANTOGRANULOMA HERALDING PROGRESSION FROM MGUS TO MULTIPLE MYELOMA: COMPLETE CUTANEOUS RESOLUTION AFTER MYELOMA-DIRECTED THERAPY

M. Di Prete¹, V. Lora², C. Cota¹

¹Dermatopathology Research Unit, San Gallicano Dermatological Institute IRCCS, Rome, Italy; ²Clinical Dermatology, San Gallicano Dermatological Institute IRCCS, Rome, Italy

Keywords: Necrobiotic Xanthogranuloma, Multiple Myeloma.

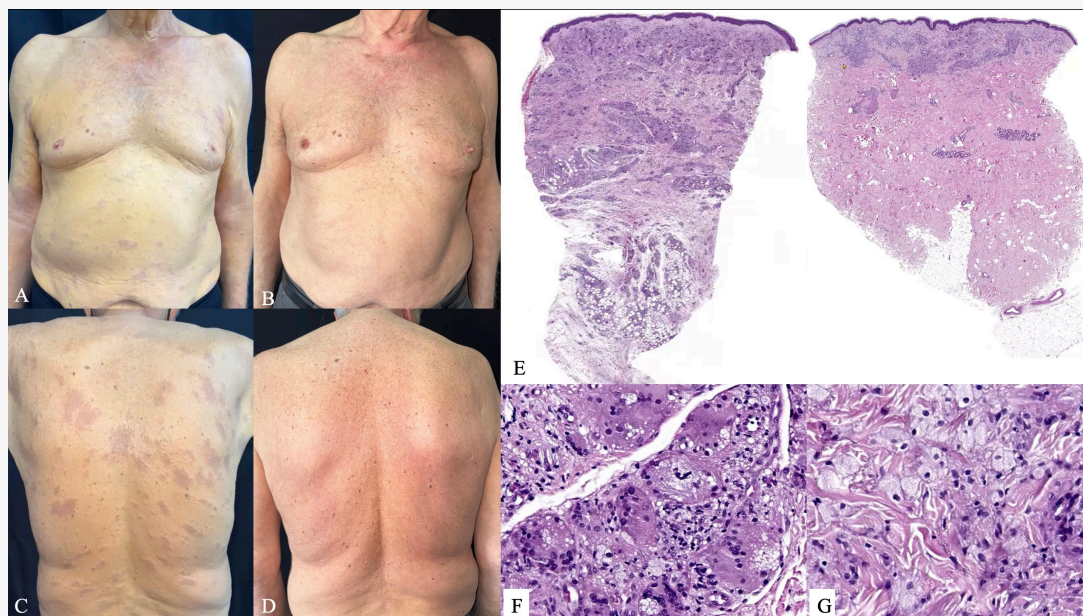
Introduction. Generalized plane xanthoma (gPX) and necrobiotic xanthogranuloma (NXG) are rare xanthomatous disorders. Emerging evidence suggests that normolipemic PX and NXG may represent different manifestations within the same clinicopathological spectrum of paraprotein-associated dermatoses. We describe a case in which the coexistence of gPX and NXG heralded the progression of longstanding monoclonal gammopathy of undetermined significance (MGUS) to overt multiple myeloma (MM).

Materials and Methods. An 80-year-old man with a 17-year history of IgG lambda MGUS presented with a 5-year history of progressively enlarging yellowish skin lesions. Initially, the lesions were superficial and localized but progressively became infiltrated and confluent, eventually involving the trunk and extremities with diffuse yellow discoloration (Figure 1A, C). Serum cholesterol levels and liver enzymes were within normal limits. Three skin biopsies were performed from the back, abdomen, and right arm.

Results. Histopathological examination of truncal lesions revealed a dermal-subcutaneous granulomatous infiltrate composed of foamy histiocytes and multinucleated giant cells, predominantly Touton-type and foreign body-type, consistent with NXG. The arm lesion showed a more superficial

dermal infiltrate mainly composed of xanthomatized histiocytes, compatible with PX (Figure 1E, F, G). Given the well-recognized association between NXG and plasma cell dyscrasias, hematologic reassessment was undertaken and demonstrated progression from MGUS to overt MM. The patient started myeloma-directed therapy with daratumumab, lenalidomide, and dexamethasone. After seven treatment cycles, MM was controlled and complete resolution of all cutaneous lesions was achieved without specific dermatologic treatment (Figure 1B, D). Cutaneous remission persisted one year after treatment initiation, in parallel with sustained hematologic disease control.

Conclusions. The coexistence of gPX and NXG in our patient is consistent with the hypothesis that these entities may represent different paraneoplastic manifestations within a common paraprotein-associated xanthomatous spectrum. Their sudden appearance during a long-lasting MGUS course can signal progression to overt MM. Consequently, their recognition should prompt thorough hematologic reassessment in patients with monoclonal gammopathies. The complete remission of cutaneous lesions following myeloma-directed therapy further supports their paraneoplastic nature.





EARLY COCAINE-INDUCED PERIORIFICIAL DERMATOMUCOSITIS: A CASE SERIES EXPANDING THE CLINICOPATHOLOGICAL SPECTRUM BEYOND MIDLINE DESTRUCTIVE LESIONS

V. Lora¹, M. Di Prete², C. Cota²

¹Clinical Dermatology, San Gallicano Dermatological Institute IRCCS, Rome, Italy; ²Dermatopathology Research Unit, San Gallicano Dermatological Institute IRCCS, Rome, Italy

Keywords: Cocaine-Induced Midline Destructive Lesions, Cocaine-Induced Plasma Cell Dermatom.

Introduction. Cocaine-induced midline destructive lesions (CIMDL) are a well-recognized complication of chronic intranasal cocaine use. However, dermatologists are increasingly encountering earlier mucocutaneous manifestations without osteocartilaginous destruction. We aimed to characterize the clinical and histopathological features of these early lesions and to explore their relationship with the emerging concept of cocaine-induced plasma cell dermatomucositis (cPCDM).

Materials and Methods. We retrospectively reviewed seven patients presenting with persistent ulcerative lesions involving periorifacial sites. Clinical, laboratory, histopathological, microbiological, and radiological findings were collected. Cocaine exposure was confirmed through repeated clinical interviews.

Results. Six patients presented with ulcerative lesions involving the nasal or perinasal region without evidence of cartilage or bone destruction, whereas one patient developed a painful and unusual perianal ulcer following topical

cocaine application. Histopathological examination of biopsy specimens from all patients consistently showed ulceration and necrosis associated with mixed inflammatory infiltrates rich in plasma cells, neutrophils, and eosinophils, without the granulomas and destructive vasculitis typical of granulomatosis with polyangiitis. p-ANCA positivity was observed in two cases. Cocaine use was initially denied by most patients and only disclosed after repeated questioning. Clinical improvement or complete resolution occurred following cocaine withdrawal in patients with available follow-up.

Conclusions. Early cPCDM should be considered in the differential diagnosis of persistent periorifacial ulcerative lesions of unclear origin. Our findings support the concept of cPCDM as an early clinicopathological manifestation within the spectrum of cocaine-related injury and expand its presentation to include atypical periorifacial sites, such as the perianal region. Prompt recognition may prevent progression to destructive disease, avoid unnecessary immunosuppressive treatments, and facilitate timely counselling regarding cocaine cessation.



EXPLORATORY THERAPEUTIC APPROACH IN DERCUM'S DISEASE: IMMUNOMODULATORS AND GLP-1 RECEPTOR AGONISTS

A. Magnatta¹, M. Caproni²

¹Department of Health Sciences, Section of Dermatology, University of Florence, Italy; ²Department of Health Sciences, Rare Disease Dermatological Unit, Section of Dermatology, University of Florence, P. Palagi Hospital, Florence, Italy

Keywords: Dercum's Disease, Treatment.

Dercum's disease (DD) is a rare chronic disorder characterized by painful subcutaneous lipomas, predominantly affecting overweight or obese middle-aged women. According to lesion distribution and extent, Hansson et al. classified DD into four types: generalized diffuse (I), generalized nodular (II), localized nodular (III), and juxta-articular (IV), although mixed forms may occur [1]. The aetiology remains unclear, and evidence for medical treatments is limited. Surgical approaches may reduce pain but are often followed by relapse and are difficult to apply in extensive disease. We report a patient with DD treated with multiple medical strategies. A 66-year-old woman with a mixed type II+IV DD has been followed since 2023 at the Rare Disease Unit, Section of Dermatology, University of Florence. Visual Analogue Scale (VAS), Dermatology Life Quality Index (DLQI), and BMI were assessed at each visit. She presented with painful subcutaneous masses, first noted 15 years earlier and recently worsened, associated with a 20 kg weight gain. She also reported memory and gait impairment. Examination revealed multiple discrete, painful lipomas (ultrasound-confirmed) in the right popliteal region, thighs, and trunk, along with diffuse cutaneous hyperalgesia. Diagnosis of mixed type II+IV DD was made. Baseline DLQI, VAS, and BMI were 8, 6, and 27.6 kg/m², respectively. Infliximab (5 mg/kg i.v at weeks 0,

2, 6, and 15, followed by 120mg s.c. every two weeks starting at week 24) was initiated and was associated with clinical improvement, lasting approximately two years. At clinical worsening, methotrexate (12.5 mg s.c. weekly) was introduced. Given metabolic comorbidities (overweight and type 2 diabetes), semaglutide (3 mg daily, increased to 7 mg after 4 weeks) was added. The patient experienced progressive pain reduction, together with a total weight loss of 6 kg over 15 months. Given the favorable clinical response, infliximab was discontinued at T30, with no relapse at T36. Infliximab was apparently associated with a stable improvement in quality of life, VAS and BMI (DLQI -88%, VAS -100% and BMI -4.3%) over 21 months. The combination therapy methotrexate + semaglutide was also associated with improvements (DLQI -83%, VAS -80%, BMI -10%) lasting for 15 months, ongoing. Immunomodulators and incretin-based therapies may be a promising strategy in DD patients refractory to conventional therapies and with extensive disease, where surgery is not feasible.

References

1. Hansson, E.; Svensson, H.; Brorson, H. Review of Dercum's Disease and Proposal of Diagnostic Criteria, Diagnostic Methods, Classification and Management. *Orphanet J Rare Dis* 2012, 7, 23, doi:10.1186/1750-1172-7-23.



DERMATOMYOSITIS AS A CUTANEOUS SENTINEL OF OCCULT INTRAMUCOSAL RECTAL ADENOCARCINOMA: THE CRITICAL ROLE OF DERMATOLOGIC RECOGNITION AND MALIGNANCY SCREENING

L. Sanna, M. Caproni

Dermatology, University of Florence, Italy

Keywords: Dermatomyositis, Screening.

Dermatomyositis (DM) is an idiopathic inflammatory myopathy characterized by distinctive cutaneous manifestations and a well-established association with malignancy. Adult-onset DM carries the highest cancer risk among idiopathic inflammatory myopathies, with most malignancies occurring within three years of disease onset. Current international recommendations support systematic and risk-stratified cancer screening as an essential component of patient evaluation. A 67-year-old woman presented with a two-month history of erythematous skin lesions associated with muscular asthenia predominantly affecting the scapulohumeral and glenohumeral girdles. Physical examination revealed violaceous erythema of the dorsal hands and forearms, periungual erythema with telangiectasias, symmetric erythema involving the cervico-interscapular, lumbosacral and gluteal regions, the décolleté, lateral abdomen and thighs, and bilateral flagellate erythema of the scapular and dorsal areas. A skin biopsy was performed for histopathological examination and direct immunofluorescence. Autoimmune screening and rheumatologic evaluation were requested. Given the suspicion of cancer-associated DM, comprehensive oncologic

screening was undertaken. Histopathological examination demonstrated diffuse vacuolar degeneration of the basal layer, superficial and deep perivascular and interstitial lymphocytic infiltrates, and dermal mucin deposition, consistent with interface dermatitis and supportive of DM. Cancer screening revealed fecal occult blood positivity. Colonoscopy identified an 18-mm distal rectal lesion associated with a 20-mm pseudopedunculated nodule. Histopathological analysis demonstrated a serrated adenoma with high-grade dysplasia and intramucosal adenocarcinoma with a clear implantation base. Prednisone 50 mg/day was initiated, resulting in significant improvement of the cutaneous manifestations. This case highlights the importance of recognizing DM as a potential paraneoplastic syndrome. Dermatologic findings prompted targeted malignancy screening, leading to the diagnosis of intramucosal rectal adenocarcinoma at a potentially curable stage. In line with emerging international recommendations, standardized and risk-based cancer screening should be considered an integral component of the diagnostic work-up of adult-onset DM to facilitate early cancer detection and improve patient outcomes.



DIFFUSE ERYTHRODERMA IN A COMPLEX GERIATRIC PATIENT: A DIAGNOSTIC AND THERAPEUTIC CHALLENGE

M.R. Nasca, M. Celsa, G. Micali

Clinica Dermatologica, Università di Catania, Italy

We describe the case of a 71-year-old man with diabetes, hypertension, and metastatic lung cancer who was being treated with pembrolizumab (anti-PD-L1). He was initially referred for consultation due to the onset of a dermatological presentation characterized by urticarial plaques and intensely pruritic bullous lesions, strongly suggestive of bullous pemphigoid (BP). Since laboratory tests (histological examination with immunofluorescence and ELISA) confirmed the suspected diagnosis of BP, pembrolizumab—the presumed iatrogenic cause of the condition—was discontinued in consultation with the oncology team, and systemic therapy with deflazacort and dapsone was initiated, resulting in clinical improvement and remission of the bullous manifestations. However, during follow-up, after tapering the treatment, a generalized erythrodermic condition developed, accompanied by furfuraceous desquamation. When a paraneoplastic origin was suspected, a new skin biopsy was performed; the findings (histopathological examination with immunofluorescence) confirmed the diagnosis of erythrodermic pemphigoid.

The patient was therefore started on oral erythromycin therapy (1.5 g/day), which, in combination with tapering doses of deflazacort, ultimately led to complete clinical remission. In addition to the classic presentation, pemphigoid (PB) can present in various atypical forms, including localized and non-bullous variants. Among these, erythrodermic pemphigoid represents a rare and difficult-to-diagnose manifestation that can mimic inflammatory or paraneoplastic erythroderma. We considered the case in question worthy of mention because it offers multiple and interesting points for discussion, pertaining not only to the rarity of the clinical variant of erythrodermic pemphigoid but also to the possible triggering role of anti-PDL1 agents in this specific case, as well as the challenges generally associated with the therapeutic approach in patients with fragile pemphigoid and multiple comorbidities. In this regard, we highlight the excellent results achieved with the use of erythromycin, an older but well-tolerated antibiotic with anti-inflammatory and immunomodulatory properties that, in our case, proved decisive.



DERMATOLOGY, RHEUMATOLOGY, AND SKIN ULCERS: CASES OF PRACTICAL INTEREST

M. Nicolini

Ast ANCONA-Regione Marche, UOC Dermatologia Ospedale Carlo Urbani Jesi (AN), Italy

Chronic skin ulcers represent a complex clinical challenge. They often constitute the initial manifestation or a complication of underlying systemic rheumatic diseases. The differential diagnosis requires a careful clinical evaluation to distinguish between purely vascular and immune-mediated etiologies. We therefore analyze the effectiveness of a shared diagnostic and therapeutic pathway involving dermatologists,

rheumatologists, and other specialized disciplines. The goal is to optimize the time to diagnosis and to personalize both local and systemic treatment. The dermatologist often plays a sentinel role in the early diagnosis of many immune-mediated diseases, but only a multispecialty approach allows for the treatment not only of the ulcer as a local lesion but also of the systemic disease that contributes to its chronicity.



THE HISTORY OF HOSPITAL DERMATOLOGY AND VENEREOLOGY DATES BACK TO ANCIENT TIMES AND HAS A BRIGHT FUTURE AHEAD

L. Valenzano

To better understand and evaluate the role of the hospital dermatologist, we must go back a long way—namely, to the origins of dermatology as a medical specialty, since that is when the long and winding path of training and evolution for the medical specialist, and thus for the hospital dermatologist, began. We will therefore trace together—albeit in

broad strokes—the key events and most significant figures in the complex and fascinating history of our discipline, following the major stages of the evolution of the medical arts (Instinctive, Priestly, Magical, Folk, and Scientific-Technological).



POSTERS

LEBRIKIZUMAB FOR PAEDIATRIC PATIENTS AGED ≥ 6 MONTHS WITH MODERATE-TO-SEVERE AD: PHASE 3 ADORABLE-1 WEEK-16 RESULTS

L. Stingeni¹, L. Eichenfield², J. Ornelas³, V. Prajapati⁴, C. Yang⁵, A. Tanaka⁶, S. Weidinger⁷, C. Flohr⁸, E. Swanson⁹, L. Martin¹⁰, S. Daveiga¹¹, R. Gontijo Lima¹¹, H. Elmaraghy¹¹, E. Pierce¹¹, P. Sen¹¹, G. Gallo¹¹, M. Piruzeli¹¹, A. Larkin¹¹, M. Grau¹², Y. Mihaylov¹², A. Paller¹³

¹Dermatology Section, Department of Medicine and Surgery, University of Perugia, Italy; ²Departments of Dermatology and Pediatrics, University of California San Diego School of Medicine, La Jolla, California, USA; ³Department of Dermatology, Integrative Skin Science and Research, Sacramento, California, USA; ⁴Dermatology Research Institute, Skin Health & Wellness Centre, Probit Medical Research, and University of Calgary, Calgary, Canada; ⁵Chang Gung University College of Medicine, Taoyuan, Taiwan; ⁶Department of Dermatology, Graduate School of Biomedical and Health Sciences, Hiroshima University, Hiroshima, Japan; ⁷Department of Dermatology and Allergy, University Hospital Schleswig-Holstein, Kiel, Lübeck, Germany; ⁸Department of Dermatology and Population Health Sciences, King's College London, UK; ⁹Ada West Dermatology, St Luke's Children's Hospital Idaho, USA; ¹⁰School of Clinical Medicine, UNSW Sydney & Dermatology Department, Sydney Children's Hospital, Sydney, Australia; ¹¹Eli Lilly and Company, Indianapolis, Indiana, USA; ¹²Almirall R&D, S.A., Barcelona, Spain; ¹³Dermatology and Infectious Disease, Feinberg School of Medicine, Northwestern University, Chicago, Illinois, USA

Background and Objectives. To evaluate the efficacy and safety of lebrikizumab compared to placebo (PBO) in patients 6 months to <18 years of age with moderate-to-severe atopic dermatitis (AD) in the randomised, double-blind, PBO-controlled, Phase 3 ADorable-1 study (NCT05559359). AD is the most prevalent systemic chronic inflammatory skin condition in children, affecting 15–20% worldwide¹. There is a significant unmet need due to limited treatment options: only one biologic option is approved for use in patients as young as 6 months of age with moderate-to-severe AD. Lebrikizumab binds interleukin-13 with high binding affinity and slow dissociation rate. Interleukin-13 is a key driver of AD pathogenesis. Lebrikizumab is currently approved for adolescent patients aged ≥ 12 years, weighing ≥ 40 kg with moderate-to-severe AD.

Methods. Key inclusion criteria. Age ≥ 6 months to <18 years. Weight minimum ≥ 6 kg for all patients, and <40 kg for patients aged ≥ 12 to <18 years. EASI score ≥ 16 . IGA score ≥ 3 (on a 0–4 scale). $\geq 10\%$ body surface area (BSA) involvement. Diagnosis of AD per American Academy of Dermatology criteria, with duration requirements tiered by age: – ≥ 12 months if the participant was ≥ 6 years old – ≥ 6 months if 2 to <6 years old – ≥ 3 months if 6 months to <2 years old Key exclusion criteria. Prior treatments before baseline: – Dupilumab within 8 weeks (enrollment of patients with prior dupilumab use was capped at <20% of the study population) – Other biologics within 5 half-lives (if known) or 16 weeks, whichever is longer TCS standardisation. Two weeks before the baseline visit, a standardised topical corticosteroid (TCS) treatment was initiated for all patients and continued through the end of the study. TCS use was tapered upon lesion clearance (IGA $\leq 2 \rightarrow 3 \times/\text{week}$; IGA 0 $\rightarrow$ stop), alongside daily non-medicated emollient use throughout the study Rescue medication. Rescue medication included high or ultra-high-potency TCS, and any systemic AD treatment Analysis populations. Efficacy analyses used

the overall Intent-to-Treat (ITT) population. Safety analyses used the Overall Safety population Statistical analyses. Treatment comparisons used the Cochran-Mantel-Haenszel test stratified by geographic region, age group at first visit and disease severity. Primary method of handling missing efficacy data (non-responder imputation/multiple imputation [NRI/MI]): – Patients who received rescue medication were analysed as non-responders – For patients who discontinued treatment for any reason, observed data after treatment discontinuation were used; Markov chain Monte Carlo multiple imputation was used to handle the remaining missing data. The family-wise type 1 error is controlled at a 2-sided level of 0.05 using the graphical multiple testing strategy. The overall ITT population is defined as all randomised patients from Cohort 1 and all randomised patients from Cohort 2 who either complete or have an opportunity to complete treatment through Week 16 at the time of the data cut. The Overall Safety population is defined as all randomised patients from Cohorts 1 and 2 who received ≥ 1 dose of study treatment and who either complete or have an opportunity to complete treatment through Week 16.

Conclusions. In the Phase 3 ADorable-1 study, lebrikizumab demonstrated statistically significant and clinically meaningful efficacy versus PBO, meeting both co-primary endpoints of Investigator's Global Assessment (IGA) 0/1 with ≥ 2 -point improvement and Eczema Area And Severity Index (EASI) 75 at Week 16 in patients aged 6 months to <18 years with moderate-to-severe AD. Treatment with lebrikizumab resulted in consistent improvements in key measures of disease severity and symptoms (skin clearance, itch relief and quality of life). The safety profile of lebrikizumab in ADorable-1 was consistent with prior studies in adult and adolescent patients with moderate-to-severe AD, and no new safety findings were identified over 16 weeks of treatment. These results provide evidence supporting interleukin-13-targeted therapy as a novel treatment for a broad paediatric

POSTERS

population.

KEY FINDINGS

Figure 1: Lebrikizumab was superior to PBO for both co-primary endpoints at Week 16 (p<0.001)
Co-primary endpoints at Week 16

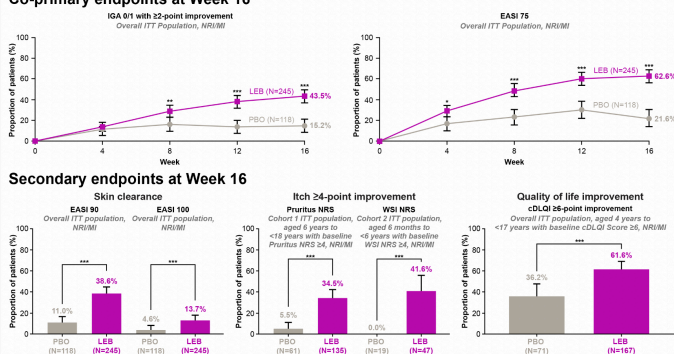


Table 1: Adverse events

All data are n (%)	PIO + TC5 Jan 11	LEB + TC5 Aug 04
TEAE	70 (59.3)	140 (57.1)
TEAE by severity*		
Mild	35 (29.7)	91 (37.1)
Moderate	32 (27.1)	46 (18.8)
Severe	3 (2.5)	3 (1.2)
Deaths	0	0
Serious AE	3 (2.5)	3 (1.2)
TEAE related to study treatment	9 (7.6)	32 (13.1)
TEAE discontinued from study due to AE (including death)	0	0
AEs of Special Interest		
Eosinophilia		1 [†]
Infections	50 (42.4)	96 (39.2)
Herpes infections (oral herpes and acyclovir hepatitis)	1 (0.8)	1 (0.4)
Parasitic infections	0	0
Skin infections	10 (8.5)	6 (2.4)
Conjunctivitis cluster [‡]	6 (5.1)	18 (7.3)
Keratitis cluster	0	0
Interdigital reactions [§]	3 (2.5)	5 (2.0)

[illegible]



FULMINANT SJS/TEN-LIKE PEMPHIGUS VULGARIS WITH HIGH ANTI-DSG1 TITERS AND CMV REACTIVATION: AN IMMUNOLOGICAL CHALLENGE

R. Daher², A. Verdelli¹, L. Sanna², V. Corti², A. Magnatta², S. Landini², M. Donati³, I. Bonanni¹, A. Corrà⁴, V. Ruffo Di Calabria⁵, E. Mariotti⁶, C. Della Bella⁷, L. Giovannoni⁸, M. D'Elis⁷, A. Moggi Pignone⁹, M. Caproni¹

(1)Rare Dermatological Diseases Unit, Department of Health Sciences, University of Florence, Florence, Italy; (2)Section of Dermatology, Department of Health Sciences, University of Florence, Florence, Italy; (3)Dermatology Department, University of Modena and Reggio Emilia, Modena, Italy; (4)-Dermatology Unit, Ospedale San Bortolo, Vicenza, Italy; (5)SSD Dermatologia, Cardinal Massaia Hospital, Asti, Italy; (6)Unit of Dermatology, Azienda USL Toscana Nord Ovest, Lucca, Italy; (7)Department of Molecular and Developmental Medicine, University of Siena, Italy; (8)UOC Ricerca e Sviluppo Clinical Practice, AOU Careggi, Florence, Italy; (9)Department of Experimental and Clinical Medicine, Division of Internal Medicine, University of Florence, Italy

Keywords: Pemphigus-Vulgaris, Anti-Desmoglein-1.

Introduction. Pemphigus vulgaris (PV) is an autoimmune blistering disease driven by IgG autoantibodies against desmoglein (Dsg) 1 and 3. Rare fulminant variants may mimic Stevens-Johnson syndrome/toxic epidermal necrolysis (SJS/TEN). We report an exceptionally severe SJS/TEN-like PV in a previously healthy woman, focusing on its immunological basis and management.

Materials and Methods. Case report of a 55-year-old woman with an unremarkable history. The work-up included histology, direct (DIF) and indirect immunofluorescence (IIF), anti-Dsg1/Dsg3 ELISA, a viral panel and malignancy screening; disease activity was scored by PDAI.

Results. The patient developed rapidly progressive mucocutaneous erosions evolving into extensive epidermal detachment (PDAI activity 25), without drug trigger or fever. Histology showed suprabasal acantholysis; DIF revealed intercellular IgG1 and C3; IIF was positive (1:80). ELISA demonstrated markedly elevated anti-Dsg1 (107.5 IU/mL) with only modest anti-Dsg3 (9.6 IU/mL). Anti-envoplakin was negative and malignancy screening unremarkable, while rat-bladder IIF was unavailable. CMV reactivation (IgM positive) was detected and treated with ganciclovir. The Dsg1-dominant, discordant profile together with complement-fixing IgG1/C3 de-

position supports antibody- and complement-mediated acantholysis as drivers of the SJS/TEN-like phenotype. Combined rituximab and intravenous immunoglobulin achieved rapid re-epithelialization. At 12-month follow-up the patient was in complete clinical and serological remission (PDAI 0; anti-Dsg negative), with no malignancy.

Conclusions. This case expands the clinical spectrum of PV, showing that high anti-Dsg1 titers, complement activation and CMV-related immune dysregulation can converge to produce a life-threatening SJS/TEN-like phenotype. Early B-cell-directed therapy combined with immunoglobulin can be life-saving, and prolonged oncological surveillance remains warranted.

References

1. Schmidt E, Kasperkiewicz M, Joly P. Pemphigus. *Lancet*. 2019;394:882-894.
2. Harman KE, Seed PT, Gratian MJ, Bhogal BS, Challacombe SJ, Black MM. The severity of cutaneous and oral pemphigus is related to desmoglein 1 and 3 antibody levels. *Br J Dermatol*. 2001;144:775-780.
3. Ahmed AR, Spigelman Z, Cavacini LA, Posner MR. Treatment of pemphigus vulgaris with rituximab and intravenous immune globulin. *N Engl J Med*. 2006;355:1772-1779.