

E-Poster Abstracts

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Lepromatous Leprosy with Nasal Myiasis Presenting as Epistaxis

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Introduction: In the post-leprosy-elimination era, clinical vigilance is crucial for detecting atypical and advanced presentations. Nasal myiasis in lepromatous leprosy is rare but alarming. We report a rare case of lepromatous leprosy manifesting as nasal myiasis and epistaxis, highlighting the diagnostic and public health implications.

Case presentation: A 38-year-old man presented with epistaxis. Nasal endoscopy revealed myiasis. Dermatological and neurological examination confirmed lepromatous leprosy. Slit skin smear and histopathology established the diagnosis. Multibacillary multidrug therapy was initiated. The patient exhibited classical features of advanced leprosy: leonine facies, superciliary madarosis, nerve thickening, and trophic ulcer. Nasal myiasis was managed endoscopically. The patient showed improvement in therapy.

Discussion: Leprosy should be considered in epistaxis with nasal pathology, even in post-elimination settings. Myiasis may be a marker of undiagnosed advanced disease. Early recognition can curb transmission and morbidity.

ICTD26-ABS-0017

Granuloma Inguinale Diagnosed at Bedside

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Introduction: Donovanosis is a rare, sexually transmitted ulcerative disease caused by *Klebsiella granulomatis*. Its diagnosis is challenging in non-endemic areas.

Case Presentation: A 22-year-old male presented with a painless genital ulcer. Serology for common STIs was negative. On day 4, repeat tissue smear revealed intracellular Donovan bodies, confirming granuloma inguinale. The patient was treated with doxycycline with complete resolution.

Discussion: Early clinical suspicion, repeat smears, and bedside microscopy remain invaluable for diagnosing donovanosis, especially where resources are limited. This case reiterates the need for persistence in diagnosis in non-endemic regions.

ICTD26-ABS-0019

Cutaneous Larva Migrans Acquired in Salalah, Oman: A Hidden Tropical Hotspot Revealed During Khareef Season

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Introduction: Cutaneous larva migrans (CLM) is a parasitic skin infestation primarily encountered in tropical and subtropical regions (1-3). It results from the percutaneous penetration of hookworm larvae, commonly from contaminated soil or water. While CLM is widely documented in many tropical destinations, reports from Salalah, Oman, particularly during the Khareef season, are limited.

Case Presentation: A previously healthy 6-year-old boy was brought to the dermatology clinic with a one-week history of intensely pruritic, erythematous, serpiginous, raised lesions over the dorsum of his right foot. The lesions appeared as slowly advancing, snake-like tracks, increasing in length by several millimeters each day. The child had returned one week prior from a family vacation in Salalah, Oman, where he engaged in barefoot play in wet grassy fields, muddy areas, and shallow lakes during the Khareef monsoon season (July 2024). No similar symptoms were reported among accompanying family members.

The clinical appearance was characteristic of cutaneous larva migrans. No systemic symptoms or lymphadenopathy were observed. Laboratory investigations were not required for diagnosis due to highly suggestive clinical features. The patient was prescribed oral albendazole 400 mg once daily for 5 days, resulting in complete resolution of the lesions with no recurrence on follow-up.

Discussion: CLM is typically associated with exposure to contaminated sand, soil, or water containing infective larvae of animal hookworms, primarily *Ancylostoma braziliense*. Imported cases have been reported globally following exposure to tropical regions (4-7). Salalah, located in southern Oman, transforms into a tropical environment during Khareef season (June to September), characterized by high humidity, lush greenery, and abundant water bodies, creating favorable conditions for parasitic transmission (8). Interestingly, during Khareef, Salalah's unique microclimate closely resembles that of Southeast Asia, with its tropical monsoon-like conditions that are rarely seen elsewhere on the Arabian Peninsula (8).

To our knowledge, this is the first documented case of CLM acquired in Salalah, extending the geographic recognition of this condition into previously unreported temporary tropical microclimates. This case highlights the importance of considering tropical parasitic infections even in regions that experience brief monsoon-like climate shifts. With increasing tourism during Khareef, public health awareness and clinician education on such tropical dermatoses remain crucial for timely diagnosis and management.

ICTD26-ABS-0028

Environment-friendly rural clinic in Central India

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Introduction: India, as a developing nation, still has vast rural regions with limited access to dermatological care. With approximately 16,400 dermatologists in India, with around 10,000 actively practicing. There is roughly one dermatologist for every 140,000 people. The various common skin diseases seen in rural India are Dermatophytic Infections, Eczema, Acne, Melasma, Folliculitis, Telogen effluvium, Hansen's disease, etc. There is a lack of awareness and steroid abuse in rural areas. The cost of treatment is expensive for most rural patients.

Recognizing this gap, we initiated a weekly rural dermatological clinic where consultations and medications are provided completely free of cost. To align with environmental values, we distribute medications in recycled paper bags and adopt eco-friendly practices in our clinic operations.

Objectives: To offer free and accessible dermatological treatment to the underprivileged rural population & to create an environmentally sustainable model for rural dermatological care delivery.



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Methodology: Four years ago, a rural skin clinic was established in Jalalpur village, 25kilometers from Bilaspur city in Chhattisgarh, India. The clinic operates every Friday, treating a wide range of dermatological conditions at no cost to the patients.

In addition to the dermatological services, several eco-conscious initiatives were integrated into the clinic:

- Tree plantation around the premises to combat air pollution
- Chickens and ducks kept on site as natural insect and pest controllers
- A pond stocked with fish to control mosquito breeding and reduce vector-borne diseases.
- Use of recycled paper bags for medicine distribution

Results: Many underprivileged patients got cured and are still being treated for various skin conditions.

Conclusion: The Rural Skin clinic helped many patients to achieve healing and improve their quality of life. The clinic could be an example for the developing nations where dermatological services are available only in the cities.

ICTD26-ABS-0030

A Profile of Cutaneous Diseases in Rural India

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Introduction: Cutaneous diseases are a common health issue in rural India, often exacerbated by environmental conditions, poor hygiene, and limited access to dermatological care. The prevalence of skin disorders in these regions is influenced by factors such as hot and humid climate, socioeconomic status, and awareness levels. Understanding the distribution and pattern of skin diseases is essential to improve healthcare delivery in underserved rural populations.

Objective: The primary objective of this study was to evaluate the profile of cutaneous diseases in a rural Indian population by identifying the most common dermatological conditions and exploring possible contributing factors.

Methodology: A cross-sectional study was conducted during a dermatology health camp organized in a rural area. A total of 152 patients presenting various skin complaints were examined and treated. Clinical diagnoses were made by qualified dermatologists based on visual examination and patient history, without laboratory investigations.

Results: Out of the 152 patients examined, 85 were males and 67 were females. The most common skin condition identified was fungal infection, accounting for 13.8% of cases, followed by acne, seen in 11.1% of patients. Other frequently observed conditions included eczema and bacterial infections. The high prevalence of fungal infections may be linked to the hot and humid climate, while acne could be associated with dietary patterns and inappropriate use of topical steroids.

Conclusion: Fungal infections and acne are the leading dermatological concerns in the rural population studied. These findings highlight the need for increased awareness, early diagnosis, and appropriate management strategies, especially in underserved rural areas of India.



ICTD26-ABS-0054

A Case of Chromoblastomycosis Successfully Treated with Voriconazole Monotherapy.

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Introduction: Chromoblastomycosis is a chronic granulomatous infection of the skin and subcutaneous tissue caused by dematiaceous fungi endemic to tropical and subtropical areas. These melanized fungi invade cutaneous tissue through an inoculation site, resulting in slow-growing warty plaques and cauliflower-like lesions that may ulcerate. The diagnosis of chromoblastomycosis is usually made by the histopathologic identification of clusters of thick-walled cells in the dermis called medlar bodies (muriform cells). Because chromoblastomycosis is a chronic, indolent condition, treatment is challenging and can include surgical excision for mild cases to long-term oral antifungal medications for moderate-to-severe cases.

However, the treatment course is long and may be refractory to treatment, requiring other therapies. Even after treatment is initiated, long-term monitoring is essential to ensure the best patient outcomes and prevent recurrence. A neglected tropical disease, chromoblastomycosis can cause devastating complications such as disabling, irreversible cutaneous fibrosis, as well as psychosocial disturbances.

Case presentation: An 80-year-old male carpenter presented with hyperkeratotic papillomatous plaques over the left side of the buttock for twenty years of duration. In-between areas showed atrophy and scarring. He has significant exposure to wood dust. On examination, there was a positive spectacle sign. Histopathological confirmation done. We started oral Voriconazole 200 mg bd and continued for 6 months. We did frequent liver function monitoring. The verrucous plaques started to flatten with significant improvement of the condition. The hyperkeratotic verrucous plaques completely resolved with atrophic scarring after 6 months of voriconazole therapy.

Discussion: Voriconazole can be an effective treatment for chromoblastomycosis, particularly in cases that are refractory to other treatments. So here in our case, Voriconazole monotherapy alone led to complete cure of Chromoblastomycosis, preventing significant devastating outcomes.

ICTD26-ABS-0060

Lepra Reaction Mimicking Angioedema: A Rare Clinical Masquerade

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Introduction: Leprosy remains a significant public health concern in many tropical regions. While its classical cutaneous and neurological manifestations are well-documented, atypical presentations, especially during lepra reactions, can pose a diagnostic challenge. Angioedema-like facial swelling is an uncommon but misleading feature that can delay diagnosis and appropriate treatment.

Case Presentation: We report a case of a 52-year-old gentleman, presenting with a three-day history of progressive facial and periorbital swelling associated with redness, impairing vision. He was initially diagnosed and treated for angioedema in the emergency department with minimal improvement. The patient had no history of atopy, urticaria, insect bite, drug intake, or systemic symptoms. On examination, non-



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tender erythematous swelling was noted over the upper half of the face with striking periorbital swelling restricting eye opening. On closer clinical examination, a single, large, well-defined hypopigmented patch with minimal scaling in the borders was noted involving the upper half of the face, extending from the forehead till upper border of the lips. There were areas of impaired touch and temperature over the patch. There was no peripheral nerve thickening or sensory impairment. Skin smear and biopsy confirmed the diagnosis of tuberculoid leprosy. The facial edema was attributed to a concurrent Type 1 lepra reaction. He was started on corticosteroids and MDT with a good clinical response.

Discussion: This case highlights the importance of maintaining a broad differential diagnosis when evaluating facial swelling, especially in endemic regions, as the clinical presentation of leprosy is becoming highly variable. Lepra reactions can mimic various dermatological and systemic conditions, including drug rash, angioedema, and cellulitis, due to their inflammatory nature. Misdiagnosis may lead to inappropriate management, delayed MDT initiation, and progression of nerve damage.

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Persistent Pityriasis Versicolor in the Tropics: A Therapeutic Challenge

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Introduction: Tinea versicolor is a common superficial fungal infection caused by *Malassezia* species, particularly prevalent in tropical climates due to heat and humidity. While typically benign and responsive to topical therapy, some cases become chronic or resistant, posing a therapeutic challenge.

Case Presentation: A 25-year-old South Indian male presented with a 3-year history of recurrent, hypopigmented macules on the trunk and shoulders, diagnosed as tinea versicolor via KOH microscopy and Wood's lamp examination. Despite multiple courses of topical antifungals and systemic antifungal therapy with fluconazole and itraconazole, the condition relapsed repeatedly.

A punch biopsy confirmed fungal etiology, ruling out other conditions mimicking a pityriasisiform morphology. Additional treatments, including oral retinoids, topical Whitfield's ointment, and salicylic acid, were ineffective. Ultimately, whole-body narrowband UVB (NB UVB) therapy combined with maintenance topical antifungal and selenium sulfide combination led to a significant clinical improvement, and the patient is currently under follow-up.

Discussion: Persistent tinea versicolor in tropical settings may be due to high environmental humidity, genetic predisposition, immunological factors, or incomplete eradication of *Malassezia* and antifungal resistance. Recalcitrant cases require a comprehensive approach, including accurate diagnosis, systemic treatment, education on recurrence prevention, and consideration of prophylactic regimens.

This case underscores the importance of recognizing resistant or recurrent tinea versicolor as more than a cosmetic issue in tropical climates. Successful management often requires moving beyond topical therapy to systemic agents and patient-centered long-term strategies.



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Unveiling Nature's Tattoo: Dermoscopic Exploration of Cydnidae Pigmentation

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Introduction: Insects are known to cause a variety of skin reactions, frequently presenting with inflammatory changes. Cydnidae, commonly referred to as burrowing bugs, are infrequently encountered in urban environments and are generally considered harmless. However, occasionally, erythematous plaques can be noted. Pigmented lesions caused by stink bugs mimic melanocytic lesions, challenging dermatologists. Here, the role of dermoscopy in the distinction of pigmented macules is described.

Case presentation: A 35-year-old man presented with multiple, asymptomatic dusky brown spots on the soles of both feet, present for the past 5 days. The lesions appeared following a walk through agricultural fields. On examination, irregularly shaped reddish-brown macules were observed, featuring tapering, streak-like extensions. The patient reported no associated pain, itching, unusual sensations, discharge, or any history of prior marks at the same sites.

Pigmentation remained unchanged when rubbed with a water or alcohol swab. Dermoscopic evaluation using DermLite 4 in polarized mode revealed light-brown to dark-brown, structureless areas involving both ridges and furrows, interspersed with patches of unaffected skin. Moth-eaten borders, brown streaks in the periphery, and a few dark-brown lines making an interrupted reticular network are the additional features.

Discussion: Burrowing bugs (Cydnidae- belonging to the family Cydnidae, order Hemiptera, suborder Heteroptera, and superfamily Pentatomoidea) are seen in rural areas during monsoons, feeding on plant roots. They secrete a hydrocarbon-based substance from thoracic and abdominal glands that causes reddish-brown macules on contact, resolving in 10–15 days. Dermoscopy helps identify Cydnidae pigmentation, showing structureless brown to dark brown areas on ridges and furrows with islands of normal skin. Pigment accumulation in furrows likely explains the linear pattern along dermatoglyphics. Dermoscopy also helps differentiate similar conditions: volar nevi show parallel furrow, lattice, or fibrillar patterns; acral lentiginos display homogeneous or reticular designs; while acral melanoma may show a blue-white veil, pseudopods, irregular vessels, and radial streaming.

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Premature Sebaceous Hyperplasia Versus Sebaceous Naevus: A Case That Poses a Diagnostic Challenge

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Introduction & Objectives: Sebaceous gland hyperplasia is a benign condition characterized by enlarged sebaceous glands, commonly affecting middle-aged and older adults. In newborns, it may occur physiologically and regress over time. Premature sebaceous hyperplasia (PSH) refers to sebaceous hyperplasia that develops during puberty.¹

Distinguishing PSH from naevus sebaceus, a congenital hamartoma, can be challenging. Naevus sebaceus often grows during puberty and carries a small risk of malignant transformation.



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Materials & Methods: We present the case of a 12-year-old female referred for a skin lesion on her left cheek. The lesion, present since birth, increased in size and developed a darker centre over the preceding year, coinciding with menarche. She had no significant medical or family history. Examination of the left cheek demonstrated an 8 x 5mm plaque of grouped white globules with central light brown pigmentation.

Results: Due to the changing nature of the lesion, a shave biopsy was performed. Histology showed sebaceous hyperplasia with no adenomatous architectural patterns and preserved mismatch repair protein immunohistochemistry, suggesting a diagnosis of either PSH or naevus sebaceous. The lesion regrew after the biopsy and has remained unchanged and asymptomatic. The patient remains under regular dermatology review.

Conclusion: Differentiating sebaceous hyperplasia from naevus sebaceous can be difficult. In our patient, initial histology suggested PSH, but further assessment indicated possible naevus sebaceous. PSH cases have been reported from birth to 26 years²⁻⁹. Neonatal sebaceous hyperplasia is rare, with cases sometimes misdiagnosed as naevus sebaceous⁶. Our patient exhibits features of both PSH and naevus sebaceous, with the diagnosis remaining equivocal. If this is PSH, it would be the first reported case of neonatal-onset PSH with pubertal changes.

We report this case to highlight to Dermatologists the difficulty in differentiating sebaceous lesions clinically and histologically, and the need for further studies to understand their pathogenesis.

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Absence of Eosinophilia in a 38-Year-Old Immunocompromised Filipino Male with Hyperkeratotic Crusted Scabies

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Aim: This case illustrates clinical and diagnostic findings of crusted scabies in a patient with Human Immunodeficiency Virus (HIV) and makes hypotheses on the absence of eosinophilia.

Methods/Results: A 38-year-old Filipino male with Human Immunodeficiency Virus (HIV) was admitted for pancytopenia and referred to Dermatology for a generalized dermatosis. Patient was non-compliant to antiretrovirals, with a CD4 count of 171 cells/mm³ done 18 months prior. He presented with a 5-month history of extensive, yellow to grayish-brown hyperkeratotic plaques with pinpoint erosions and fissuring, covering approximately 59% of his body surface area. Dermoscopy revealed the novel noodle sign. KOH mounts revealed scabetic mites, while mineral oil scrapings showed numerous scybala and eggs. Histopathologic analysis revealed mites in the stratum corneum, parakeratosis, psoriasiform epidermal hyperplasia, and lymphohistiocytic interstitial and perivascular infiltrates. Despite hypereosinophilia being a characteristic finding in crusted scabies, there was a curious absence of eosinophils on histopathology and peripheral blood samples, likely brought about by severe immunosuppression from HIV, causing bone marrow failure and consequent pancytopenia.

Patient scored a 10 over 12 on the Severity Grading Scale for Crusted Scabies, and was treated with a combination of oral Ivermectin, topical keratolytics, and Permethrin lotion, showing rapid improvement of the crusted plaques over 3 weeks.



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Conclusion: Despite the association of eosinophilia with crusted scabies as well as with low CD4 count, this case shows that the eosinophil count may be low or preserved in the setting of HIV infection with severe immunosuppression and may be linked to bone marrow failure.

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Erythema Nodosum Leprosum Presenting as Lipodermatosclerosis in a 24-Year-Old Filipino Female

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Discussion: A 24-year-old Filipino female consulted via teledermatology for a 2-year history of several erythematous, nontender nodules on the lower extremities, with gradual hyperpigmentation when started on treatment for pulmonary tuberculosis (Isoniazid, Rifampin, Pyrazinamide, Ethambutol). A few similar lesions would occasionally appear on the face, resolving without residuals. In the interim, the patient complained of intermittent bipedal edema, leg heaviness, and nocturnal cramping, with associated hardening of her lower extremities. She had an office job, with no history of trauma, pregnancies, or previous hospitalizations.

On face-to-face consultation, the patient presented with multiple, variably hyperpigmented patches on the bilateral lower extremities, worst on the gaiter area, with beginning upside-down champagne bottle deformity. There were a few areas of slightly edematous, ill-defined plaques previously unseen with teleconsultation. Lesions were neither tender nor hypoesthetic. Biopsy of the plaque revealed nodular and linear aggregates of foamy histiocytes with globi, and lobular and septal panniculitis with dense mixed cell infiltrate of neutrophils, neutrophilic dusts, lymphocytes, and foamy histiocytes. Duplex ultrasound revealed superficial and deep venous insufficiency on both legs. A diagnosis of lipodermatosclerosis from erythema nodosum leprosum was made. The patient was started on multidrug therapy (Dapsone, Rifampicin, Clofazimine), compression stockings, and leg-pumping exercises, with improvement of symptoms.

Erythema nodosum leprosum may uncommonly present as painless nodules. When uncontrolled, involvement of the deep dermis and subcutaneous tissue may progress to become lipodermatosclerosis.

ICTD26-ABS-0081

Treatment Modalities in Chromoblastomycosis - A Case Report

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Introduction: Chromoblastomycosis is a chronic granulomatous implantation mycosis affecting the skin and subcutaneous tissue. It is a neglected tropical disease (NTD) predominantly seen in farming communities, where individuals are exposed to decaying organic material following trauma. We report a case of extensive chromoblastomycosis, highlighting the treatment modalities.

Case Presentation: A 53-year-old previously healthy male presented with an itchy, scaly, erythematous non-healing plaque over the left shoulder and posterior trunk, gradually expanding over ten years. He reported a history of farming a decade ago. On examination, there was a large verrucous hyperkeratotic well-demarcated plaque covering the left posterior trunk, left arm, and anterior chest; a positive spectacle sign; no exophytic growths or bleeding; and no contractures. Histopathology from the lesion demonstrated



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Medlar bodies, confirming chromoblastomycosis. He was commenced on oral itraconazole 200 mg and terbinafine 250 mg daily with acitretin 30 mg daily, later increased to 50 mg. His liver enzymes were monitored monthly. Gradually, the thick plaques, previously impairing his ability to turn and sleep on the affected side, thinned significantly, improving his quality of life. Physiotherapy was initiated to enhance joint mobility.

Discussion: Chromoblastomycosis is due to pigmented fungi that require prolonged treatment. Oral terbinafine and itraconazole are traditional first-line drugs. Some patients develop drug intolerance while others show no response. Physical treatment modalities such as surgery, cryotherapy, and thermotherapy can be effective, but were impractical in this case due to the extensive lesion. Limited evidence suggests that combining immunomodulators, such as acitretin and imiquimod, with antifungal agents provides better outcomes than antifungals alone. As imiquimod was unaffordable for our patient, acitretin was combined with antifungals. This regimen reduced plaque thickness and scaling, showing visible improvement by the fourth month. Our case underscores the potential benefit of combination therapy in managing extensive chromoblastomycosis. Follow-up is ongoing.

ICTD26-ABS-0082

A Case of Localized Cutaneous Leishmaniasis in the Far-Western Region of Nepal Successfully Treated with Oral Miltefosine

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Introduction: Leishmaniasis is an infectious disease caused by different species of the genus *Leishmania* and transmitted by sandflies.¹ Leishmaniasis has three major clinical subtypes: cutaneous, mucocutaneous, and visceral. Lesions of cutaneous leishmaniasis are most commonly present in the exposed areas, with papulonodular being the most common morphological type.² We present a case of a 60-year-old woman living in Darchula (a hilly district of Sudurpaschim Province) who was successfully treated with a 4-week course of oral Miltefosine.

Case Presentation: A previously healthy 60-year-old woman presented to Mahakali Provincial Hospital with a history of a skin lesion on the right side of her lower lip for two months. The lesion was painless, gradually increasing in size, and nonhealing. There was no history of fever, weight loss, or insect bite. The patient had no other significant past or family history.

On cutaneous examination, a single erythematous nodule with peripheral scaling, central crusting, and surrounding erythema was found (Figure 1). There was no regional lymphadenopathy. Complete blood count, liver function, renal function tests, and chest x-ray were normal. The Mantoux test was negative. Incisional Biopsy of the lesion showed numerous LD bodies like organisms within and outside of histiocytes, which confirmed the diagnosis of cutaneous Leishmaniasis. The patient was prescribed oral Miltefosine 50 mg three times daily for a total of 28 days. At the end of treatment, clinical cure was observed in the patient.

Discussion: A study by Pandey et al. found that in most of the patients, lesions were predominant in the facial region, and all were successfully treated with Miltefosine for 28 days.³ Our case also had a facial lesion and was successfully treated with miltefosine.⁴ The differential diagnosis of CL should be considered in the case of chronic, nonhealing, painless lesions occurring on exposed areas of skin, especially in people living in endemic areas.⁵



ICTD26-ABS-0087

Cutaneous Polyarteritis Nodosa in a Child, Precipitated by Mycobacterium Tuberculosis

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Introduction: Cutaneous polyarteritis nodosa is a rare condition limited to the skin, without systemic symptoms. It's a vasculitis involving small to medium-sized arteries. It presents with painful nodules, ulcers, and livedo reticularis-like skin lesions.

Case presentation: A previously healthy, four years old girl presented with two weeks history of fever and painful erythematous nodules in bilateral lower limbs. While the child was being investigated, she developed ulceration over nodules and developed new lesions over the upper limbs, with no associated joint pain. Further, the child had a cough. There was a strong contact history of tuberculosis recently with a family member.

The full blood count with differentials was normal. Inflammatory markers are high. The blood picture is suggestive of ongoing bacterial infection. Chest X-ray was normal. Mycoplasma antibody was negative. The 2D echocardiogram and ultrasound scan of the abdomen were normal. The Deep punch biopsy done from the ulcer showed small to medium vessel vasculitis with panniculitis. The Mantoux test was strongly positive with 15 mm. The respiratory opinion was taken, and the diagnosis of cutaneous polyarteritis nodosa stimulated by *Mycobacterium tuberculosis* was made. Following Anti-tuberculosis treatment, the child's cutaneous lesions healed in 2 weeks.

Discussion: Cutaneous polyarteritis nodosa can be triggered by autoimmune diseases, infections, and certain drugs. It commonly occurs due to various infections, such as streptococcus, hepatitis B, C, and parvovirus. Very rarely, polyarteritis nodosa can be induced by *Mycobacterium tuberculosis*. Histopathology is the principal investigation of choice in diagnosing polyarteritis nodosa. Cutaneous polyarteritis nodosa should be considered as a differential diagnosis in a patient presenting with painful ulcerated nodules. Therefore, this case emphasizes the need to consider polyarteritis nodosa in association with tuberculosis infection.

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Atypical Presentation of Fatal Hemorrhagic Varicella

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Introduction: Chicken pox is a self-limited disease caused by the Varicella zoster virus. Hemorrhagic manifestation is a rare complication in immunocompromised patients. We report a case of fatal hemorrhagic varicella presented with severe epigastric pain.

Case presentation: A 21-year-old male who was diagnosed with nephrotic syndrome on oral prednisolone was admitted to the medical ward with severe epigastric pain, and the following day, he developed a blistering rash. There was no evidence of ischemic heart disease or acute pancreatitis. There was leukocytosis with thrombocytopenia.



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The patient was treated as hemorrhagic varicella, and he eventually died due to hemorrhagic shock resulting from DIC. Varicella PCR was performed, and confirmed the diagnosis of Varicella.

Discussion: Intense abdominal pain is often an early symptom of dissemination, which reveals that multi-system organs are involved, such as the stomach, intestine, and spleen. Visceral infection often presents as epigastric abdominal pain, occasionally involving the right upper quadrant or radiating to the back. Abdominal pain usually presents earlier, before the appearance of the rash, with a mean interval of 6-7 days.

Varicella zoster can be fatal in its severe form. Particularly in immunocompromised patients. Hemorrhagic varicella with visceral involvement can be misdiagnosed as acute myocardial infarction, acute pancreatitis, and acute abdomen, which can delay the proper management of varicella, giving rise to fatal outcomes. In patients with suspected hemorrhagic Varicella infection, intravenous antivirals with supportive treatment need to be initiated as soon as possible to minimize the case fatality rate.

ICTD26-ABS-0097

A Rare Case of Lipoblastoma in a Child

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Introduction: Lipoblastoma is a rare benign tumor that commonly occurs in children younger than three years of age. It originates from embryonic white fat tissue. Histology is the gold standard of diagnosis, and complete resection of the tumor is the treatment of choice.

Case presentation: A one year and two months old child presented with a lump on his right middle finger for 7 months. Initially, the child developed a small nodule, and it gradually increased in size over time and remained asymptomatic. On examination, a firm, well-defined lesion was present around the distal phalanx of the middle finger. Otherwise, the child was healthy. The initial differential diagnosis was lipoma, lipoblastoma, or tenosynovial sheath tumor.

The child underwent basic investigations, including blood count with normal differentials. The plain radiography showed soft tissue swelling around the distal and middle phalanx. Magnetic resonance imaging (MRI) of the right hand was performed, which revealed a non-aggressive, lobulated soft tissue neoplasm on the volar aspect of the distal right middle finger, more likely to be a lipoma.

The patient underwent complete excision of the tumor by a plastic surgeon. The histopathology report showed a lobulated tumor composed of fat, separated by fibrous tissue strands, and formed by lipoblasts, and it was concluded as lipoblastoma.

Discussion: Lipoblastoma commonly occurs as a single, painless lump in the trunk or extremities. It can rarely occur in the head and neck, intrathoracic, or intra-abdominal areas. While lipomas are formed by mature fat cells, lipoblastomas are formed by immature lipoblasts. Histopathology is the key to the diagnosis, and the absence of cellular atypia differentiates it from liposarcoma. The complete excision of the tumor is the treatment of choice, even though some cases of recurrence following excision are reported.



ICTD26-ABS-0100

Hansen disease, complicated by mycobacteria other than tuberculosis.

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Introduction: Hansen disease with recurrent erythema nodosum leprosum reaction on prolonged steroids can be rarely complicated by mycobacteria other than tuberculosis. The weakened immune system of the patient enhanced the ability to develop co-infection.

Case presentation: A 25-year-old previously healthy patient with a history of multiple drug abuse was diagnosed with lepromatous leprosy and recurrent erythema nodosum leprosum reaction in 2019. Initially, he was started on MDT-MB and corticosteroids. He was a frequent defaulter of treatment. While on treatment, he developed multiple ulcers and discharging sinuses over the trunk and groin, which failed to respond to conventional antibiotics. The differential diagnoses considered were ulcerated erythema nodosum leprosum, atypical mycobacteria, or deep fungal infection. After several biopsies and cultures, which became positive for mycobacteria other than tuberculosis. He was started on clarithromycin and ciprofloxacin for mycobacteria other than tuberculosis. The sinuses resolved completely. It was possible to taper the thalidomide used to manage recurrent ENL reaction. The MDT-MB treatment was completed, and the MI index was zero at the end of the treatment. The patient was discharged home. Two weeks after discharge, he had developed shortness of breath and passed away at home. The cause of death was not identified.

Discussion: Leprosy with recurrent and recalcitrant erythema nodosum leprosum reaction has been successfully treated with steroids and thalidomide. Even though the cause of death was not established, it may be assumed that the multiple drug abuse may have contributed. In the literature, only a few cases of leprosy complicated by atypical mycobacteria infection were reported, whereas many cases of leprosy were complicated by *Mycobacterium tuberculosis*. This case highlights the importance of considering other differentials, like the possibility of co-infection, while a leprosy patient presents with ulcers or discharging sinuses.

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Trichoscopic Features in Patients with Tinea Capitis: A Retrospective Study from a Tertiary Care Center

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Introduction: Tinea capitis is a dermatophytic infection of the scalp that involves both the skin and hair, and usually affects children. Trichoscopy is a simple, quick, easy, valuable, and noninvasive technique for clinicians in diagnosing patients with scalp lesions, including tinea capitis.

Objectives: To study and evaluate the association of trichoscopic features in patients with different types of tinea capitis in a tertiary care setting



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Methodology: A retrospective study was conducted at Chitwan Medical College, including 30 patients who were clinically diagnosed with tinea capitis between 1st June 2023 and 30th June 2025. Demographic data and trichoscopic images were analyzed and documented. Association of trichoscopic features with inflammatory and non-inflammatory tinea capitis was evaluated.

Results: The mean age of the patients was 8.5+2.7 years. The commonly affected age group was 6-10 (18,60%). Males (19, 63.3%) had a great predisposition, with a male-to-female ratio of 1.7:1. The mean duration of disease was 1.7+0.7 months. Non-inflammatory tinea capitis (25, 83.3%) was commonly recorded. Grey patch (24,96%) was common among patients with non-inflammatory tinea capitis. Scales (27,90%), comma hairs (23,76.7%), broken hairs (20, 66.7%), and corkscrew hairs (15,50%) were the common trichoscopic findings recorded in our study. Comma hairs (sensitivity 92%, specificity 100%, PPV 100%), broken hairs (sensitivity 80%, specificity 100%, PPV 100%), and corkscrew hairs (sensitivity 60%, specificity 100%, PPV 100%) were significantly associated with non-inflammatory tinea capitis, whereas crust and erythema were significantly associated with inflammatory type (sensitivity 60%, specificity 96%, and PPV 75%).

Conclusions: Trichoscopy can be a valuable non-invasive tool in diagnosing tinea capitis and its types. Early recognition of these patterns can facilitate early diagnosis, treatment, and prevention of complications.

Keywords: Tinea Capitis, Trichoscopy

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Unclear neoplasm in the facial area

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Introduction: Skin cancer, especially Basal cell carcinoma (BBC), is the most common malignancy in Caucasians but appears much less frequently in people of color. BCC represents 65% to 75% of skin cancers in Caucasians, 12-35% in American blacks, and 2.8% of skin cancers in African blacks. When skin cancer occurs in people of color, patients often present with an advanced stage, and the therapy is challenging.

Case presentation: We would like to report on a 66-year-old female patient from Eritrea who presented at our clinic last year. She reports a skin change on her nose that has been visible for 6 years and has slowly become larger. The nose showed a flat, bizarrely configured erosion with dark pigmentation and slight elevation in the marginal area. The skin finding was difficult for us to evaluate, and we considered various differential diagnoses. A biopsy confirmed the diagnosis of pigmented BCC. Treatment is generally the same among all racial groups. After discussing the treatment options, the patient underwent radiotherapy.

Discussion: BCC is less common in persons of skin of colour than in lighter-skinned individuals. The low incidence of skin cancer in darker-skinned people is primarily a result of photoprotection provided by increased epidermal melanin, which filters twice as much ultraviolet radiation (UV) as does that in the epidermis of Caucasians. The larger, more melanized melanosomes of darker-skinned groups absorb and scatter more energy than do the smaller, melanosomes of Caucasians. In Germany, BCC is very common and can be diagnosed quickly by experienced doctors. In this case, it was difficult for us as German doctors without frequent contact with patients with dark skin to make the diagnosis. That's why we think international congresses and opportunities for further training are very important.



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

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Introduction: Mycoplasma Induced Rash and Mucositis (MIRM) is an immune-mediated mucocutaneous eruption triggered by *Mycoplasma pneumoniae*. It is characterized by the triad of pneumonia, mucositis affecting at least 2 sites, and variable skin rash. MIRM sine rash is a distinct subtype with isolated mucositis in the absence of cutaneous lesions.

Case report

A 29-year-old previously healthy male presented with fever and cough for 1 week and painful oral and eye lesions with odynophagia and dysuria of 3 days duration. Apart from antipyretics, he has not taken any medications in the recent past. Examination revealed multiple erosions and ulcers involving the lips, entire buccal mucosa, hard palate, and glans penis. There was marked bilateral conjunctival injection with ulcerations and epithelial deficit on the right cornea, with hemorrhagic crusts on the nasal mucosa. There were no vesicles or targetoid lesions on the skin. Respiratory system examination revealed scattered crepitations.

Laboratory studies revealed neutrophilic leukocytosis, elevated C-reactive protein level, and mild transaminitis. Peripheral blood smear showed no evidence of hemolysis. Serum IgM antibodies for *Mycoplasma pneumoniae* were positive. Chest radiograph showed a right lower lobe infiltrate. MIRM sine rash was diagnosed.

The patient received intravenous clarithromycin for 7 days with oral prednisolone 1mg/kg/day tapered over 4 weeks due to severe ocular involvement, antiseptic mouthwash with fluocinolone application for erosions, and steroid ophthalmic solution. The patient achieved complete healing of mucosal lesions with the above treatment.

Discussion: MIRM sine rash is a rare but important differential of acute mucositis. Unlike SJS/TEN, it occurs in younger patients, follows a respiratory illness, has a benign course, and responds well to antibiotics with supportive care. Recognition of MIRM sine rash is important, as misdiagnosis may lead to unnecessary aggressive interventions.

Our case emphasizes the need for clinical awareness of this uncommon variant, which expands the spectrum of Mycoplasma-associated mucocutaneous disease.

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Necrotizing sweet syndrome mimicking necrotizing fasciitis: A diagnostic and therapeutic challenge

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Introduction: Necrotizing sweet syndrome (NSS) is a rare, locally aggressive variant of sweet syndrome that may resemble necrotizing soft tissue infection clinically. In contrast to necrotizing fasciitis (NF), which requires urgent surgical debridement and broad-spectrum antibiotics, NSS typically responds to systemic corticosteroids. Surgical intervention may aggravate NSS due to the pathergy phenomenon.



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Case presentation: A 33-year-old previously healthy female was referred from the surgical unit with a large necrotic ulcer with exposed tendon and bone over the left shin with generalized urticated erythematous papules and plaques. She had initially developed painful purpuric macules on both lower limbs for 10 days, some of which progressed to bullae and then necrotic ulcers.

At the surgical unit, she was clinically diagnosed with NF and was managed with repeated wound debridement, including fasciotomy and intravenous broad-spectrum antibiotics. However, necrosis worsened despite these interventions. Dermatology review raised the suspicion of a neutrophilic dermatosis with pathergy, as the wound deteriorated after each debridement.

Skin biopsy demonstrated papillary dermal edema with mixed neutrophilic and lymphocytic infiltrate, vessel wall necrosis, and red blood cell extravasation. Tissue cultures were sterile. A diagnosis of NSS was established. The patient commenced on intravenous methylprednisolone pulse therapy and biologic therapy, leading to resolution of fever and purpura. The necrotic wound was subsequently managed by a multidisciplinary team including dermatology, plastic surgery, and vascular surgery.

Discussion: Distinguishing NSS from NF at presentation is challenging but vital. While NF necessitates immediate surgical debridement, NSS may worsen with surgery and respond to immunosuppression. This case highlights the importance of early biopsy and microbiological evaluation prior to extensive surgery, and the critical role of close collaboration between surgical and dermatology teams. Maintaining a high index of suspicion for NSS in noninfectious necrotizing dermatoses is essential to optimize patient outcomes and prevent limb loss.

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Ulnar Nerve Abscess in Lepromatous Leprosy: Insights from Three Cases Confirmed by Ultrasound

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Introduction: Leprosy continues to be a significant health concern in tropical countries despite global elimination programs. Peripheral nerve involvement is a hallmark of the disease, with the ulnar nerve being among the most commonly affected. While nerve abscesses are more frequently described in tuberculoid and borderline leprosy, their occurrence in lepromatous leprosy remains rare. Advances in high-frequency ultrasonography now allow early detection of neuritis and abscess formation, aiding timely intervention.

Case Report: We describe three young male patients (aged 25–31 years) diagnosed with lepromatous leprosy presenting with acute neuritis and erythema nodosum leprosum. All developed painful swelling at the elbow with the sudden onset of ulnar neuropathy. Ultrasonography revealed hypoechoic lesions with altered fascicular patterns and increased vascularity consistent with ulnar nerve abscess. Two patients required surgical decompression with epineurotomy and anterior transposition, leading to rapid pain relief and partial motor recovery within 48 hours. The third case was managed conservatively with corticosteroids and immunomodulatory therapy. All patients were maintained on multidrug therapy, oral steroids, and thalidomide, with methotrexate introduced in steroid-dependent cases.

Discussion: This case series highlights an unusual presentation of nerve abscesses in lepromatous leprosy, occurring in the context of Type 2 reactions. Unlike the typical tuberculoid spectrum, our patients developed solitary ulnar abscesses, underscoring the immunopathological variability of leprosy. Ultrasound proved invaluable in diagnosis and guided surgical decisions. Prompt recognition and combined medical–surgical



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management prevented progression of deformities and improved functional outcomes. Nerve abscess should be considered in lepromatous leprosy with acute neuritis. High-frequency ultrasound enables early detection and, when coupled with timely intervention, may reduce disability in affected patients.

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Crabs Skiing in the Axilla: An Unusual Presentation of *Pthirus pubis* Infestation

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Introduction: Tropical parasitic dermatoses remain an important cause of morbidity, often mimicking other dermatological conditions and leading to misdiagnosis. *Pthirus pubis* (crab louse) typically infests pubic hair but can rarely involve axillary hair. Dermoscopy has emerged as a valuable tool for rapid bedside diagnosis of ectoparasitic infestations in resource-limited settings.

Case Report: A 21-year-old male presented with pruritus and papular lesions in both axillae for two months. Clinical examination revealed follicular papules resembling Darier's disease or pseudofolliculitis barbae. Dermoscopy, however, demonstrated multiple crab lice firmly attached to axillary hair shafts, appearing as if "skiing" by gripping adjacent hair. Microscopic examination confirmed *Pthirus pubis*, characterized by a broad body, short antennae, crab-like claws, and narrow mouthparts. The patient was treated with 1% permethrin lotion and counseled regarding contact treatment. At one-month follow-up, he was free from infestation both clinically and dermoscopically.

Discussion: Axillary *Pthirus pubis* infestation is rare and can easily be mistaken for inflammatory dermatoses. Dermoscopy allowed immediate confirmation at the bedside, preventing unnecessary investigations and therapeutic delays. This case underscores the utility of non-invasive dermoscopy in diagnosing tropical parasitic dermatoses. The vivid dermoscopic appearance, likened to "crabs skiing in the axilla," highlights how imagery can aid recognition and teaching. Uncommon sites of *Pthirus pubis* infestation should be considered in patients with axillary pruritus and papular eruptions. Dermoscopy provides a simple, rapid, and reliable diagnostic aid, enabling prompt treatment and reducing morbidity in tropical dermatology practice.

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Phaeohyphomycosis at the Sacrococcygeal Region: An Unusual Presentation Diagnosed by Bedside Tests

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Introduction: Phaeohyphomycosis is a rare fungal infection caused by dematiaceous fungi containing melanin in their cell walls. It typically affects immunocompromised hosts and presents as subcutaneous nodules or abscesses. Involvement of the sacrococcygeal region is exceptionally rare and not well documented.



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Case Report: A 38-year-old female, a sweeper by occupation, presented with multiple tender, punched-out ulcerative lesions over the sacrococcygeal region for two months, associated with purulent discharge and bilateral inguinal lymphadenopathy. She was immunocompetent with no history of diabetes or chronic illness. Bedside 10% potassium hydroxide mount revealed septate branching hyphae with pigmented spores. Tissue smear stained with Giemsa also demonstrated brownish fungal elements. Histopathological examination showed necroinflammatory tissue with pigmented septate hyphae and spores in the dermis and subcutaneous tissue, highlighted by PAS and Grocott's methenamine silver stains. Fungal culture grew *Alternaria* species, confirming the diagnosis of subcutaneous phaeohyphomycosis. The patient was treated with itraconazole 100 mg twice daily for three months, resulting in complete healing of the ulcers with no recurrence at follow-up.

Discussion: This case is unusual due to the rare site of involvement in an immunocompetent host. Bedside diagnostic tools such as KOH mount and tissue smear provided a rapid presumptive diagnosis, later supported by histopathology and culture. Early antifungal therapy resulted in excellent clinical response. Phaeohyphomycosis should be considered in chronic ulcerative lesions at atypical sites, even in immunocompetent patients. Bedside tests can facilitate early diagnosis and timely initiation of therapy, thereby improving outcomes in tropical dermatology practice.

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Disseminated Cutaneous Larva Migrans: A Case Series of Ten Patients from a Tertiary Care Center in South India

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Introduction: Cutaneous larva migrans (CLM) is a zoonotic dermatosis commonly encountered in tropical regions, typically presenting as a solitary or a few serpiginous tracts. Disseminated CLM, characterized by widespread multiple lesions across different body sites, is rare and often underrecognized.

Case presentation: We conducted a descriptive case series of ten patients diagnosed with disseminated CLM between January 2024 and August 2025 at our tertiary care center. Disseminated disease was defined as the presence of more than ten active tracts involving multiple anatomical regions. Diagnosis was made on clinical grounds, supported by dermoscopy and peripheral eosinophilia where available. All patients received systemic antihelminthic therapy.

The study included 8 males and 2 females, aged between 27 years and 64 years, with a mean age of 43.2 ± 10.3 years. Occupations at risk included agriculture, construction work, and frequent barefoot walking. The number of tracts per patient ranged from 13 to 42, most commonly involving the trunk and lower limbs. Intense pruritus was a universal feature, with three patients developing secondary bacterial infection with *Staphylococcus aureus*. Peripheral eosinophilia was noted in 9 patients. All patients were treated with oral ivermectin (200 µg/kg single dose) or albendazole (400 mg daily for 5–7 days). Complete resolution occurred within 1–3 weeks. Recurrence after three weeks of therapy was noted in one patient.

Discussion: Disseminated CLM, though uncommon, may be increasingly seen in tropical countries due to high exposure risks and environmental factors. A high index of suspicion is required to differentiate it from other creeping eruptions. Systemic antihelminthics are highly effective, and preventive strategies such as footwear use, environmental sanitation, and pet deworming remain essential.



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Pigmented Basal Cell Carcinomas in Skin of Color: Insights from a Tropical Dermatology Centre

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Introduction: Pigmented basal cell carcinoma (pBCC) is an uncommon variant of basal cell carcinoma (BCC), comprising about 6% of cases. Melanin within tumor nests imparts a darker hue, often mimicking melanoma or other pigmented dermatoses. In tropical regions like India, where ultraviolet (UV) exposure is high and darker Fitzpatrick phototypes predominate, pBCC represents a clinically significant entity at the crossroads of oncology and tropical dermatology.

Objectives: To analyze the demographic, clinical, and treatment profile of pBCC in a skin-of-color population at a tropical tertiary centre.

Materials and Methods: A retrospective study was conducted at a tertiary care centre in South India using registry data of histopathologically confirmed pBCC cases with complete demographic and treatment details. Non-pigmented BCCs and incomplete records were excluded.

Results: Twenty-eight patients were identified (18 males, 10 females; mean age 62 ± 10.5 years). Most were presented in the sixth and seventh decades, with an average 19-month delay in seeking care. All patients were Fitzpatrick phototype V, with a mean occupational sun exposure of 4.7 ± 1.8 hours daily. No history of PUVA therapy, chemical exposure, or familial skin malignancy was noted. The face was the predominant site, most commonly the nose (35%), cheeks (25%), and forehead (20%). Solitary lesions were seen in 18 patients, while 10 had multiple lesions (2–5 each). Nearly half (46%) had ulceration of long duration. Pigmentation was predominantly peripheral. Sixteen patients underwent surgical excision with reconstruction, while eight were lost to follow-up. No metastasis or mortality occurred during the study.

Conclusion: pBCC in tropical skin-of-color populations is strongly linked to UV exposure and poses diagnostic challenges due to clinical resemblance to melanoma. Awareness, early detection, and timely surgical management are essential to reduce morbidity.

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Post-kala-azar Dermal Leishmaniasis Without Prior Visceral Disease: A Diagnostic Challenge

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Introduction: Post-kala-azar dermal leishmaniasis (PKDL) is a well-recognized cutaneous manifestation of *Leishmania donovani* infection that typically appears after successful treatment of visceral leishmaniasis (VL). It represents an important reservoir for parasite transmission in endemic regions. While most cases arise following treated VL, increasing reports highlight PKDL occurring without a prior history of visceral disease, complicating diagnosis and control strategies. Differentiation from conditions such as leprosy and diffuse cutaneous leishmaniasis is critical, particularly in endemic settings.

Case Presentation: A man in his twenties presented with multiple, asymptomatic, hypopigmented patches on his trunk and neck, persisting for eight years. Additionally, he had discrete, nontender, firm papulonodular lesions involving the central face, ears, limbs, and back for six years, with clustering around



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the perioral and nasal regions. Clinical examination revealed no sensory loss, nerve thickening, or appendageal involvement within the hypopigmented plaques. Laboratory testing demonstrated positive rk39 IgG serology. Histopathological examination showed basal cell vacuolization and a dermal infiltrate composed of lymphocytes, histiocytes, plasma cells, and neutrophils, with well-formed epithelioid cell granulomas and scattered multinucleated giant cells. Giemsa staining revealed Leishman–Donovan bodies, and polymerase chain reaction confirmed *Leishmania* DNA. A diagnosis of PKDL without prior VL was established. The patient was treated with intravenous liposomal amphotericin B (2.5 mg/kg/day for 20 days), leading to marked regression of lesions.

Discussion: PKDL without antecedent VL likely arises from subclinical or asymptomatic infections and poses a significant diagnostic challenge in endemic regions. Clinical overlap with leprosy can delay diagnosis, but the absence of anesthesia and nerve enlargement favors PKDL. Involvement of the perioral and nasal areas serves as a useful diagnostic clue. rk39 serology, although supportive, cannot distinguish between past and current infections; thus, histopathology and molecular assays remain essential for confirmation. Recognition of PKDL without VL underscores evolving disease epidemiology and the importance of high clinical suspicion. Enhanced diagnostic modalities and timely therapy are vital for both individual management and broader leishmaniasis elimination efforts.

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Ulcerated Nodular Swelling in an Immunocompetent Child

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Introduction: Cutaneous tuberculosis (CTB) is a rare manifestation of *Mycobacterium tuberculosis* infection, representing only 1–2% of extrapulmonary TB cases. Among its subtypes, lupus vulgaris (LV) is the most common paucibacillary form. It exhibits diverse morphologies, including plaque, ulcerative, vegetative, mutilating, and tumour-like variants. Because of its protean features, LV can mimic deep fungal infections and atypical mycobacterial disease, making diagnosis challenging, especially in immunocompetent children, where TB is less frequently suspected.

Case Presentation: A 6-year-old immunocompetent girl presented with a gradually enlarging, painless swelling on her left forearm for six months. Initially appearing as a small reddish nodule, it evolved into a 6-cm firm, erythematous to brown nodular lesion with surface ulceration and yellowish crusting. No systemic symptoms or family history of TB were reported. Mantoux testing showed a strong reaction (15 × 15 mm with bullous response). Histopathology revealed basket-weave orthokeratosis, irregular acanthosis, and multiple well-formed epithelioid granulomas with central caseation, surrounded by dense lymphocytic infiltrates. Ziehl–Neelsen staining and PCR for *M. tuberculosis* were negative, and mycobacterial/fungal cultures showed no growth. In light of clinical, histopathological, and immunological findings, a diagnosis of lupus vulgaris was made. The patient received standard weight-adjusted antitubercular therapy per the National Tuberculosis Elimination Programme, with marked improvement and reduction of lesion size within four weeks.

Discussion: This case illustrates the tumour-like, ulcerated form of lupus vulgaris in an immunocompetent child, an uncommon presentation. Differential diagnoses include deep fungal infections (sporotrichosis, phaeohyphomycosis) and atypical mycobacterial infections, but these can usually be distinguished by Mantoux reactivity, histopathological granuloma type, and treatment response. As no single investigation is diagnostic for CTB, integration of clinical, histological, and immunological evidence is crucial. Early



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recognition is vital, given the excellent therapeutic response to antitubercular therapy. This case underscores the need to maintain a high index of suspicion for lupus vulgaris in endemic regions, even in children without immunosuppression.

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Delayed Presentation Chromoblastomycosis Hand Successfully Treated with High-Dose Itraconazole

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Introduction: Chromoblastomycosis is an indolent tropical/subtropical rash, usually confined to the skin, which often presents late, with significant functional impact. Referral is often delayed by the many clinical mimics and low awareness of this WHO-defined, Neglected Tropical Disease. Skin histology is key to the diagnosis.

Case Presentation: A 57-year-old farmer with longstanding Dupuytren's contracture of the right little and fourth fingers presented with a 20-year history of itchy, progressive, scaly plaques on the dorsum of his dominant right hand and the extensor surface of his right elbow. The skin changes restricted upper limb function, with loss of employment. He was systemically well, with no history of diabetes mellitus or immunosuppression. He had sustained a palm frond injury to the dorsum of his right hand shortly before the onset of the rash.

On examination, he had asymmetric, warty, linear, indurated plaques on the dorsum of his right hand, fingers, wrist, and elbow, with associated hand lymphoedema. His left upper limb and skin elsewhere were unaffected. He was systemically well.

Skin biopsy showed epidermal hyperplasia and spongiosis. The superficial dermis demonstrated granulomata and neutrophilic abscesses containing pigmented fungal spores – Medlar bodies. The dermis was sclerotic. The Ziehl-Neelsen stain was negative. There was no evidence of malignancy. Culture was not performed due to limited resources. A diagnosis of chromoblastomycosis was made. Treatment with high-dose itraconazole 200mg bd resolved the epidermal changes and the lymphoedema after 4 months.

Discussion: The patient's chromoblastomycosis was likely due to *Fonsecaea pedrosoi*, given the humid tropical climate of Kumasi, Ghana. He exemplifies the frequently delayed presentation of chromoblastomycosis and its impact on employment. Resolution of the warty hyperkeratosis and lymphoedema has allowed the patient to return to work. In the absence of clear evidence and satisfactory liver biochemistry on itraconazole, he is to continue this therapy for 8 more months.

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Pemphigus Erythematosis Diagnosed Clinically and by Basic Histology in an Under-resourced Tropical Dermatology Service

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Introduction: Extensive investigations are often restricted in tropical Dermatology services. We present a case of the rare immunobullous dermatosis, pemphigus erythematosus, diagnosed clinically and histologically, without the benefit of extended skin autoantibodies and direct skin immunofluorescence, mimicking Senear and Usher in 1926, when the condition was first described.

Case Presentation: We present a 73-year-old woman with a 4-month history of an itchy, symmetrical, vesicular rash on the cheeks, which progressed to her neck and matured into a severely debilitating scaly, crusted, non-scarring, demarcated facial rash. The patient was systemically well, normotensive, had a normal urinalysis, and no other skin, adnexa, or mucous membrane involvement.

Serum creatinine & FBC were normal, and ANA & bacterial skin swabs were negative. Skin haematoxylin and eosin histology showed spongiosis and a neutrophilic & eosinophilic subcorneal blister. Restricted resources meant that an extended range of skin antibodies and direct skin immunofluorescence were not performed.

The distribution and morphology of the rash, combined with the skin histology, led to a diagnosis of pemphigus erythematosus (Senear-Usher syndrome). Treatment with clobetasone butyrate cream and prednisolone 25mg daily for 1 month dramatically resolved the rash, which has remained clear for 4 months off therapy.

Discussion: In the original series of 11 patients with pemphigus erythematosus, described by Senear and Usher in 1926, they characterised the rash by 2 distinctive features: a discoid, non-scarring, butterfly facial eruption, combined with flaccid bullae in a photosensitive distribution, with absence of systemic symptoms. It presents as an overlap of pemphigus foliaceus and lupus erythematosus. Subsequently, distinctive skin immunological features have been described.

We report this case to highlight that clinical observation combined with basic histology can facilitate the diagnosis of pemphigus erythematosus without the benefit of first-world immunological investigations.

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Hair Dye–Induced Dermatoses in the Tropics: A Case Series of 40 Patients from South India

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Background: Hair dye use is widespread in tropical countries due to early graying, cultural preferences, and easy availability of inexpensive products. However, unregulated formulations, combined with high humidity and heat, may predispose individuals to adverse cutaneous reactions. Data on the clinical spectrum of hair dye–induced dermatoses in tropical regions remain limited.

Objective: To describe the clinical patterns of adverse cutaneous reactions to hair dyes in a tropical population.

Methods: We report a case series of 40 patients presenting with hair dye–related dermatoses to the dermatology outpatient department of a tertiary center in South India over a two-year period. Diagnosis was based on clinical history and examination.

Results: The cohort comprised 22 females and 18 males, aged 21–68 years. The most common presentation was allergic contact dermatitis (n=18), followed by pigmented contact dermatitis/hyperpigmentation (n=10), chemical leukoderma (n=7), and angioedema/urticaria (n=5). Facial, scalp, and neck involvement were predominant. Several patients reported use of locally available, unbranded hair dye powders and



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creams. In many cases, reactions were aggravated by repeated application and a lack of awareness of potential risks.

Conclusion: Hair dye-induced dermatoses represent a significant and under-recognized problem in tropical populations, where environmental factors, cultural practices, and lack of cosmetic regulation amplify risk. Greater public health awareness, regulatory oversight, and physician vigilance are needed to mitigate these preventable conditions.

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Childhood Leprosy: An Ongoing Challenge in India

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Background: Childhood leprosy is a sensitive marker of ongoing *Mycobacterium leprae* transmission and highlights gaps in control efforts, particularly in tropical regions. Monitoring pediatric cases is crucial for evaluating program effectiveness and preventing disability.

Objectives: To describe the epidemiological and clinical profile of childhood leprosy at a tertiary centre in south India, assess bacteriological and nerve involvement, and examine household contact patterns relevant to transmission.

Methods: We performed a retrospective review of patients aged 0–16 years diagnosed with leprosy between 2005 and 2024. Data collected included demographics, clinical spectrum (WHO and Ridley–Jopling classifications), lesion distribution, slit-skin smear (SSS), nerve involvement, disability grading, contact history, treatment, and outcomes.

Results: Of 572 leprosy cases, 56 (9.79%) were children (mean age 13.4 ± 1.3 years; 67% aged 10–16). Female predominance was noted (M: F 0.7:1), and 76.7% were from rural areas. Mean illness duration was 1.3 ± 0.7 years. Paucibacillary disease predominated (78.5%); by Ridley–Jopling, borderline tuberculoid was most common (66.07%). Upper extremities (41.07%) and face (25%) were the commonest sites. SSS positivity was 19.6%. Nerve thickening was seen in 3 cases (5.35%), all ulnar. Grade 1 deformity occurred in 8.9%. Household contact was present in 8.9%, and one relapse (1.78%) was recorded. No lepra reactions were documented.

Conclusion: A child proportion of ~10% indicates persistent transmission in this tropical region. Strengthening active case finding, contact screening, school-based surveillance, and community education is essential to detect cases early and prevent disability.

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Neem Twig–Associated Contact Leukoderma: An Underrecognized Contact-Related Dermatoses

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Introduction: Contact leukoderma, a variant of acquired vitiligo-like depigmentation, is increasingly recognized following exposure to various plant- and chemical-derived products. Neem (*Azadirachta indica*) twigs, traditionally used for dental hygiene in India, may act as potential triggers.



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Case presentation: Six consecutive patients presenting with depigmented macules on the lips and oral commissures were evaluated. Detailed history regarding neem twig use was obtained. Other causes of vitiligo were excluded clinically. Patch testing could not be performed. All patients reported daily use of neem twigs before the onset of depigmentation. The leukoderma was localized to sites of direct contact particularly the labial mucosa, vermillion border, and angles of the mouth. Cessation of neem twig use halted further progression in all cases.

Discussion: This series highlights neem twig-induced leukoderma as a probable form of plant-related contact dermatitis. Greater awareness of traditional practices contributing to contact leukoderma is essential, particularly in regions where neem twigs are widely used. Patch testing and chemical analysis of neem extracts may further elucidate the responsible allergens.

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Non-adherence Leading to Erythema Nodosum Leprosum: A Case of Lepromatous Leprosy with Leonine Facies

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Introduction: Leprosy (Hansen's disease) is a chronic granulomatous infection primarily caused by *Mycobacterium leprae*, with *Mycobacterium lepromatosis* also recognized as a causative agent since 2008. If left untreated, it can lead to severe neuropathy and disability. Lepromatous leprosy, the most infectious form, is associated with high bacillary load, systemic involvement, and immune-mediated complications such as erythema nodosum leprosum. Treatment with multidrug therapy is effective, but patient non-adherence remains a major challenge to disease control.

Case Presentation: This case report details a 39-year-old unmarried male mechanic from Colombo, Sri Lanka, initially diagnosed with lepromatous leprosy in December 2023. He presented with leonine facies, madarosis, ichthyosis, saddle nose deformity, symmetrical skin lesions, and peripheral neuropathy. A slit skin smear test revealed a bacterial index of +6 and a morphological index of 15%. Multidrug therapy was initiated, but the patient defaulted and returned in June 2025 with worsened symptoms, including grade 2 disability and erythema nodosum leprosum. A repeated slit skin smear test showed a persistent bacterial index of +6 and a reduced morphological index of 2%, suggesting chronic progression. Multidrug therapy was reinitiated, along with corticosteroids and physiotherapy.

Discussion: This case highlights the severe consequences of multidrug therapy non-adherence in lepromatous leprosy, including progression to erythema nodosum leprosum and disability. It reinforces the importance of treatment persistence, patient education, and consistent follow-up to prevent complications, reduce erythema nodosum leprosum-associated morbidity, and interrupt transmission. Regular follow-up is essential to ensure timely intervention and improved outcomes.

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Multidermatomal Bullous Herpes Zoster – An Atypical Presentation

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Introduction: Herpes Zoster occurs due to reactivation of the latent varicella-zoster virus and typically presents as a grouped vesicular rash following a dermatomal distribution. Rare variants, such as bullous or multidermatomal zoster, can occur in elderly and immunocompromised individuals and have not been reported in Sri Lanka, and only a few cases are documented in the global literature.

Case Presentation: Here we present an 84-year-old male with multiple co-morbidities, including diabetes, cirrhosis, and chronic kidney disease, who developed multidermatomal bullous herpes zoster involving left C3, C4, and C5 dermatomes (Figure 1). Diagnoses were favoured over other bullous disorders like pemphigus and pemphigoid due to the clear midline demarcation of the lesions (Figure 2) and confirmed by blister fluid polymerase chain reaction (PCR) for varicella zoster DNA. Although varicella zoster is a clinical diagnosis, laboratory confirmation is important in atypical presentations. Intravenous acyclovir was initiated, given his immunocompromised state, and the lesions began to improve by the third day of treatment. However, the patient's hospital stay was complicated by acute kidney injury (AKI) and massive upper gastrointestinal bleeding (UGIB), and he succumbed to illness on the fifth day of admission.

Discussion: Herpes zoster (shingles) results from reactivation of the latent varicella-zoster virus, and frequency increases in older or immunocompromised patients. It typically presents as a vesicular, painful rash in dermatomal distribution, but may present with occasional bullous variants that can be mistaken for other vesicobullous diseases. PCR or Tzanck smear may be helpful if the presentation is unusual. Multidermatomal zoster needs evaluation for underlying immunosuppression. Early antiviral therapy, ideally within 72 hours, improves outcome by reducing complications and mortality, making timely clinical recognition essential.

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Clinical experience and outcomes of 308 nm excimer laser therapy for vitiligo: a pilot study

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Introduction: Vitiligo is a depigmenting autoimmune disease with serious psychosocial repercussions, including stigmatization and emotional distress that severely impact quality of life. Traditional first-line therapies, such as topical corticosteroids, calcineurin inhibitors, and broad-spectrum UVB phototherapy, often have limitations in terms of precision, efficacy, and side effects. The excimer laser is emerging as a more targeted alternative. This study aims to comprehensively evaluate the clinical feasibility and preliminary efficacy trends of the 308 nm excimer laser and to determine the factors influencing its response.

Methods: This is a prospective, single-center, uncontrolled clinical pilot study of 17 patients with vitiligo. Participants underwent twice-weekly sessions of 308 nm excimer laser at a dose of 50 to 500 mJ/cm², meticulously adjusted to achieve minimal erythema response per lesion and following a follow-up protocol of 1 to 6 months. The primary outcome was the degree of repigmentation. Clinical evaluation was performed blindly by 2 dermatologists using two validated scoring systems: the Vitiligo Area Scoring Index (VASI) for quantitative analysis and a semi-quantitative repigmentation scale (categorized as 0-25%, 26-50%, 51-75%, and 75 %) based on the extent of depigmentation.



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Results: One hundred and sixty-four lesions were recorded in these 17 patients aged between 4 and 70 years. Our study demonstrated a significant overall repigmentation rate, with a mean of 43.2% of lesions achieving complete (100%) repigmentation at the 3-month follow-up. Statistical analysis revealed that treatment response was highly influenced by specific patient and lesion characteristics. A significant correlation was found between repigmentation and Fitzpatrick phototype ($p=0.033$). Lighter skin types (III) exhibited superior outcomes compared to darker phototypes (IV-V). Lesion topography also proved to be an important determinant of efficacy; areas traditionally more responsive to UV light, such as the face and neck, showed excellent results. An exceptional response was observed in anogenital lesions.

Conclusion: The 308 nm excimer laser is an effective and well-tolerated targeted modality for vitiligo treatment. Its efficacy is not uniform but is predominantly dictated by some predictive factors. The repigmentation is excellent in light phototypes and UV-sensitive areas. However, to fully optimize treatment protocols and enhance predictive accuracy, further research would provide the statistical power needed to better elucidate the role of additional variables and ultimately enable more personalized and effective therapeutic strategies for vitiligo patients.

Keywords: Excimer, repigmentation, vitiligo

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Refractory Chromoblastomycosis Responding Rapidly to Oral Voriconazole

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Introduction: Chromoblastomycosis is a rare tropical skin disease with a prolonged disease course and significant morbidity. It is caused by pigmented dematiaceous fungi that infect the skin and subcutaneous tissue and cause slow-growing warty plaques and sclerosing lesions. These can cause permanent tissue damage and scarring. The treatment involves systemic antifungals, combining surgical and tissue-destructive methods.

Case presentation: We present a case of a 56-year-old male from Sri Lanka with extensive chromoblastomycosis plaques on bilateral lower limbs up to the thigh area, both upper limbs up to the arms, face, nose, and cheek area, which developed over 8 years. He was on oral Itraconazole and terbinafine combination for more than one year with complementary surgical and cryotherapy. After re-evaluation, he was started on oral Voriconazole treatment. Initial loading dose of 400mg bd for 1st 24 hours, followed by 200mg bd from the 2nd day onwards. We also used electrocauterization and surgical removal specifically for large nodules. From about 1 week into the treatment, the lesions showed marked improvement. There was complete resolution of his facial and some arm lesions by the 3rd week, and 4 months into the treatment, he only had a single plaque on the right foot.

Discussion: This case report with the extensive involvement of Chromoblastomycosis is unique in that this degree of extent is rarely found. Current recommendations state that Itraconazole and terbinafine are the 1st line options, although there are no randomized controlled trials. Often, there is a poor response to these medications, which causes years of disability and loss of employment for patients. It should be reconsidered if voriconazole should be a 1st line agent for extensive Chromoblastomycosis.

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Spectrum Of Mycetoma: A Case Series

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Introduction: Mycetoma is a chronic, granulomatous infection of the skin and subcutaneous tissues, primarily affecting the foot and caused by true fungi (eumycetoma) or filamentous bacteria (actinomycetoma).

Case presentation

Case 1: 48-year-old male with a history of swelling and discharging sinuses on the left foot, releasing black coloured grains for the last 10 years, preceded by an injury to the foot while working in the field. On examination, localised swelling over the bilateral malleoli and sole with a few discharging sinuses. KOH mount and culture of grains confirmed *Madurella mycetomatis*. He was treated with Itraconazole 200 mg twice daily, with clinical improvement over 12 months.

Case 2: 34-year-old male, with a history of swelling in the left foot for 4 years associated with multiple discharging sinuses. On examination, multiple sinuses on the left foot are discharging pale coloured grains, with diffuse swelling of the left foot. Gram stain and Modified ZN stain showed non-acid-fast, gram-positive filamentous bacteria suggestive of *Actinomycetoma*. He was managed with the Modified Welsh regime with significant improvement.

Case 3: 51-year-old male, with complaints of swelling and discharging sinuses, which started after an injury to the right foot in RTA 5 years back. On examination, involvement of bilateral malleoli in the form of hard swelling and multiple sinuses releasing pale coloured grains on probing. Microscopy showed non-acid-fast, gram-positive filamentous bacteria suggestive of *Actinomycetoma*. He was managed with the Modified Welsh regime with clinical improvement.

Discussion: Mycetoma is a neglected tropical disease predominantly affecting individuals in arid and tropical regions, particularly those engaged in agricultural labor. The classical triad of subcutaneous swelling, multiple sinus tracts, and grain-containing discharge is characteristic but not universal, often delaying early diagnosis and leading to bone involvement and deformity if untreated.

Differentiating eumycetoma from actinomycetoma is essential, as the two differ in their etiology, response to treatment, and prognosis. Microscopy, culture, histopathology, and increasingly molecular diagnostic methods (PCR and DNA sequencing) are employed for species identification, which can directly impact therapeutic strategy. Imaging, especially MRI and ultrasound, aids in assessing soft tissue and osseous involvement, influencing the decision of medical vs. surgical management.

Treatment remains prolonged and challenging. Antifungals like Itraconazole, Voriconazole, or Posaconazole are used in eumycetoma, with modest success rates. Actinomycetoma shows better response to multidrug regimens such as cotrimoxazole, streptomycin, and amikacin. However, the lack of standardized treatment protocols and late presentation often leads to disability or amputation.

This series highlights the diverse clinical presentations, microbial etiologies, and treatment responses in mycetoma, emphasizing the need for early diagnosis, multidisciplinary care, and improved access to diagnostic tools in endemic settings.



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Internalized Stigma, Depression, Anxiety, and Substance Abuse amongst Leprosy-affected attending a Tertiary Care Hospital in North-east India.

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Introduction: Leprosy is one of the oldest and most neglected diseases known to cause stigma and discrimination. Multiple psychiatric morbidities have been identified among leprosy-affected persons, including depression, anxiety disorders, and suicide (attempts). The visible impairments, stigma, and discrimination predispose people affected by leprosy to poor mental health. Also, there is meager information on the use of substance disorders in leprosy patients. Hence, the need for a detailed evaluation of the mental health status of persons affected by leprosy

Objectives: To assess for internalised stigma, depression, anxiety, and Anxiety and Substance involvement amongst persons affected by leprosy attending a tertiary care hospital in north-east India.

Methodology: All patients above 18 years of age diagnosed with leprosy within the past 3 years and who were willing to give consent were recruited. After taking informed consent, sociodemographic data were taken along with the leprosy clinical status. Standard questionnaires, DASS 21 for Depression, Anxiety, and Stress, Modified ASSIST for Substance abuse, and LISS for Internalized stigma were used, and scores taken. Results were analysed from the scores accordingly.

Results: Results were assessed from 33 patients. The male: female ratio was 2:1. The majority of the patients were in the age group of 31-50 years. Most of the patients were from the rural areas. According to the Ridley-Jopling classification, 10 belonged to the BT pole, 9 LL, 6 TT, 6 BL, and 2 BB. 16 patients had ongoing treatment, 14 were newly diagnosed, and 2 had completed treatment.

3 reported as having minimal stigma according to the LISS scale. On the DASS 21 scale, 5 had mild, 1 moderate, and 2 severe forms of depression, 3 had mild, 3 moderate, and 1 severe anxiety, and 2 had mild and 2 moderate forms of stress.

The Modified ASSIST scores showed Cannabis use in 4 individuals, 3 reported using Prescription opioids, and 2 reported using Prescription stimulants. One patient, having severe anxiety, mild depression, and stress, reported concomitant use of prescription opioids.

Conclusion: The presence of stigma, depression, anxiety, and substance abuse in leprosy patients may be due to the stigma and discrimination the disease carries. Further case-control studies are required to better analyse these associations and take necessary steps to reduce their burden.

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Association of Metabolic Syndrome in Patients with Vitiligo

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Introduction: Vitiligo can trigger inflammatory processes due to decreased number of melanocytes and their anti-inflammatory effects, as well as oxidative stress. Metabolic syndrome includes hypertension,



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abdominal obesity, dyslipidemia, and glucose intolerance, leading to cardiovascular disease, diabetes mellitus, and stroke. Because of the systemic nature of vitiligo, metabolic syndrome or its components may be observed in vitiligo. Objectives: To observe the association of metabolic syndrome in patients with vitiligo.

Methodology: This case-control study included 54 vitiligo patients and 54 age and sex matched controls according to inclusion and exclusion criteria, diagnosed in the department of Dermatology and Venereology, Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka. Ethical approval for this study was obtained from the Institutional Review Board, Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka. Detailed history, physical examination, and laboratory investigations were done in all participants, and revised National Cholesterol Education Program Adult Treatment Panel III criteria were used for the diagnosis of metabolic syndrome.

Data were analyzed by using SPSS (Statistical Package for Social Sciences) Version 23. Results: Metabolic syndrome was present in 20 (37.0%) patients with vitiligo and in 9 (16.7%) control subjects. The frequency of metabolic syndrome was significantly higher in vitiligo patients compared to controls ($p=0.017$). Systolic blood pressure, diastolic blood pressure, fasting plasma glucose, and mean serum triglyceride level were significantly higher in the patient group than in the control group, whereas serum high-density lipoprotein cholesterol was significantly lower in the patient group than in the control group. There was no significant difference between cases and controls regarding waist circumference.

Conclusions: The presence of metabolic syndrome was higher in patients with vitiligo. Further large-scale studies are needed to establish it.

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A Clinical Case of HIV-Associated Leishmaniasis

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Introduction: Leishmaniasis is a vector-borne protozoan disease caused by parasites of the genus *Leishmania*. Transmission occurs through bites of infected female sandflies (Phlebotominae). Three main clinical forms are recognized: visceral, cutaneous, and mucocutaneous. If untreated, the visceral form is often fatal, cutaneous leishmaniasis presents with ulcerative skin lesions, and the mucocutaneous form may cause destructive changes of the nasopharyngeal mucosa. The causative agents of leishmaniasis are unicellular flagellates. In humans, they exist as intracellular amastigotes, while in sandflies they develop as motile promastigotes. After inoculation, promastigotes transform into amastigotes, which multiply inside phagocytes, causing cell destruction and inflammation. Diagnosis relies on clinical findings and laboratory confirmation. *Leishmania* can be demonstrated by microscopy of smears or biopsy material stained with Romanowsky–Giemsa. Serological tests are of limited value in cutaneous forms.

Case Report: Patient T.A., born in 2005, was hospitalized in February 2023 with a chronic generalized cutaneous process. Since 2017, he had developed multiple nodular lesions on the face and extremities, initially misdiagnosed as photodermatitis. In 2018, he developed herpes zoster, which led to the diagnosis of HIV infection and initiation of antiretroviral therapy. In July 2019, histological examination suggested “granular cell histiocytoma,” but repeat evaluation excluded malignancy. Later that year, leishmaniasis was confirmed. In 2020, he received meglumine antimoniate, which produced partial but incomplete improvement.



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During the most recent admission, the patient had symmetrical papulonodular eruptions, erosions, and ulcers involving the scalp, face, trunk, and extremities. Microscopy of ulcer smears and biopsy specimens confirmed *Leishmania*. Along with antiparasitic therapy, supportive treatment included detoxification, hepatoprotective agents, antibiotics, topical antiseptics, and physiotherapy.

Discussion: This case demonstrates that cutaneous leishmaniasis may run a chronic course, often leading to diagnostic delays, particularly in HIV-positive patients. Coinfection is associated with severe disease and frequent relapses. Early recognition and combined therapy—both specific and supportive—improve prognosis. Greater awareness of leishmaniasis can help prevent misdiagnosis and enhance clinical outcomes.

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Anetoderma: An Uncommon Manifestation of Leprosy

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Introduction: Anetodermas, also known as macular atrophies, are areas of tissue loss and degeneration, causing flaccid skin and herniation. Primary anetoderma occurs independently, while secondary anetoderma occurs when a pre-existing skin disease disrupts the normal repair mechanism.

Case presentation: A 39-year-old male with pale, wrinkled skin lesions reported decreased touch and pain in both feet. Examination revealed loss of eyelashes, thickening of earlobes, nodules, gynecomastia, and atrophic plaques. Multiple acid-fast bacilli were found, indicating lepromatous leprosy. Anetoderma secondary to lepromatous leprosy was diagnosed, and a year of multibacillary therapy was initiated.

A 34-year-old with lepromatous leprosy, who had completed a year of multibacillary therapy, presented with erythema nodosum leprosum features. He had multiple erythematous nodules, atrophic plaques, and fragmented elastic fibres, consistent with anetoderma. He was started on oral prednisolone, which was tapered over 12 weeks.

Discussion: Leprosy, a chronic disease caused by *Mycobacterium leprae*, can cause anetoderma, characterised by skin thinning and loss of elasticity. Leprosy causes irregular, fragmented, and locally aggregated elastic fibre arrangements. Inflammatory cells in leprosy cause changes in the dermis, including neocollagenosis, collagen lysis, elastolysis, and proteoglycan degradation. Once elastic tissue is lost, it cannot be fully regenerated, making anetoderma resulting from elastolysis a long-term complication of leprosy. Anetodermas diagnosed through clinical examination and skin biopsy requires special staining methods like Verhoeff-Van Gieson or orcein staining for confirmation. Though resistant to treatment, a combination of a 595 nm pulsed-dye laser with a 1550 nm non-ablative fractionated laser may offer clinical improvement.

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Primary Cutaneous Actinomycosis Without Systemic Involvement: A Rare Diagnostic Challenge In A Tuberculosis-Endemic Region

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Introduction: Actinomycosis is an uncommon chronic infection caused by filamentous, gram-positive anaerobes of the genus *Actinomyces*. Primary cutaneous disease without systemic involvement is rare and

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often mimics tuberculosis, deep mycoses, nocardiosis, or malignancy, delaying diagnosis. We describe an immunocompetent woman with an isolated upper-back lesion lacking constitutional symptoms or trauma, in whom a misleading positive Mantoux initially confounded judgment. Although cervicofacial actinomycosis is the most prevalent form, primary cutaneous actinomycosis, especially in the absence of mucosal breach or trauma, is exceedingly rare.

Case Presentation: A 37-year-old immunocompetent woman presented with a six-month history of a slowly enlarging lesion over the upper right back, initially appearing as a painless papule that progressed to multiple erythematous papules with intermittent seropurulent discharge. There was no history of trauma or systemic symptoms. Systemic examination was normal. Investigations included complete blood count, liver and renal function tests, HIV and HBsAg serology, chest X-ray, abdominal ultrasound, CBNAAT, and Mantoux testing. Except for a positive Mantoux (15 mm), results were unremarkable. A punch biopsy was taken for histopathological evaluation and special stains, including PAS, Ziehl–Neelsen, and Gram staining.

Histopathology showed filamentous basophilic bacterial colonies surrounded by eosinophilic Splendore–Hoeppli material within a neutrophil-rich infiltrate. PAS and Ziehl–Neelsen stains were negative, while Gram stain demonstrated gram-positive filamentous bacteria, confirming actinomycosis. Cultures were not performed. Based on clinical and histopathological correlation, primary cutaneous actinomycosis was diagnosed. Oral penicillin therapy led to complete resolution within six weeks, with no recurrence at three-month follow-up.

Discussion: Primary cutaneous actinomycosis may present without trauma, pain, or systemic features and can be misdirected by a positive Mantoux in TB-endemic areas. Prolonged antibiotic therapy, usually penicillin-based, is the treatment of choice, often avoiding surgical intervention. This case highlights that recognizing characteristic histopathology and performing a timely biopsy are crucial for accurate diagnosis and effective conservative treatment. If a patient presents with molar-sinus lesions, a differential diagnosis of Actinomycosis should be considered

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Clinical Spectrum of Cutaneous Leishmaniasis: Insights from a Case Series from Nepal

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Background: Leishmaniasis is a neglected tropical disease(NTD) caused by different species of Leishmania and transmitted through the bite of infected female sandflies. The main clinical forms include visceral, cutaneous, and mucocutaneous leishmaniasis. Cutaneous leishmaniasis (CL) is the most common form worldwide and is endemic in over 70 countries. Nepal has been an endemic zone for visceral leishmaniasis (VL) but not of CL. However, reports of CL cases have been increasing. Common clinical features include papules, nodules, or ulcers on exposed areas of the body, often healing with scarring. We present a case series of cutaneous leishmaniasis from Nepal to highlight its heterogeneous presentations, diagnostic challenges, and treatment.

Case Presentation: We report four cases of cutaneous leishmaniasis, diagnosed at the dermatology clinic of a tertiary care center in Nepal. The patients ranged in age from 15 to 61 years, among whom three were female, and one was male. All cases were non-migrants from a non-endemic zone. Clinical manifestations range from non-healing volcanic ulcers to plaque-like presentation on the trunk and erysipeloid presentation on the face. The final diagnoses were confirmed through histopathological examination and direct



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microscopy. PCR-based genotyping was not done due to resource limitations. Two cases were treated with oral miltefosine, and the remaining two with oral itraconazole

Discussion: Cutaneous leishmaniasis is an emerging NTD in Nepal. This case series highlights the variable clinical presentations that can mimic other chronic dermatoses. The observed clinical responses to miltefosine and itraconazole support their use as effective treatment options. Though *Leishmania tropica* / *Leishmania major* are major causative agents for CL, most cases of Nepal are reported due to *Leishmania donovani*. Due to resource limitations, we could not do species identification in our case. Increased clinical awareness and improved diagnostic access are essential for early detection and effective management.

ICTD26-ABS-0206

Relapsed Cutaneous Histoplasmosis with Secondary Hemophagocytic Lymphohistiocytosis in an Immunocompetent Adult: A Case Report

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Introduction: Disseminated cutaneous histoplasmosis in immunocompetent hosts is a rare phenomenon posing a diagnostic and therapeutic challenge. While localized cutaneous disease is typically observed in such cases, relapse with systemic involvement after initial therapy is exceedingly uncommon.

Case Presentation: A 30-year-old female from suburban Northern India, with agricultural exposure, presented to us with asymptomatic, skin-colored papules and plaques on the face and upper trunk for 6 months. HIV and immunological workup were negative. Skin biopsy revealed pseudoepitheliomatous hyperplasia and dense dermal inflammation; GMS and PAS stains demonstrated intracellular *Histoplasma capsulatum* yeasts, confirming localized cutaneous histoplasmosis. She received liposomal amphotericin-B (LAmB) (3 mg/kg IV every other day for three doses, cumulative 9 mg/kg), but was discharged on the patient's request on itraconazole 200 mg twice daily. Clinical remission was observed initially, but she was lost to follow-up for two years.

Later she re-presented with extensive erythematous-violaceous plaques and nodules, fever, weight loss, dysphagia, throat pain, and pancytopenia (Hb- 6.7 g/dL, WBC- $1.8 \times 10^3/\mu\text{L}$, platelets- $84 \times 10^3/\mu\text{L}$) and hepatosplenomegaly. Bone marrow biopsy showed hypocellularity, shift to the left, hemophagocytosis, and abundant morula-like intracellular organisms consistent with histoplasma, along with a repeat skin biopsy confirming disseminated histoplasmosis. She was also suspected of secondary Hemophagocytic Lymphohistiocytosis (HLH) with a high probability.

Treatment initiated with LAmB (3 mg/kg IV alternate-day for two weeks, cumulative 27 mg/kg) followed by itraconazole maintenance. Remarkable clinical and hematological recovery observed during six-month follow-up.

Discussion: This rare case of relapsed disseminated cutaneous histoplasmosis in an immunocompetent patient underscores the necessity of adequate initial amphotericin B dosing and prolonged antifungal maintenance to prevent relapse and life-threatening complications, like secondary HLH, a hyperinflammatory cytokine storm reaction. Early suspicion, vigilant diagnosis, and prompt, guideline-based therapy ensure the favorable outcomes.



ICTD26-ABS-0208

Cutaneous Histoplasmosis in Immunocompetent Individuals: A Case Series on its presentation and management

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Introduction: Cutaneous histoplasmosis in immunocompetent hosts is exceedingly rare, often misdiagnosed, leading to delays in therapy. Exposure to bird droppings remains the primary risk factor, but systemic involvement varies widely. We present three distinct cases to highlight diverse clinical presentations, diagnostic approaches, and treatment responses in patients.

Case Presentations: Case 1: A 35-year-old agricultural machinery mechanic presented with widespread erythematous papules with central crusting, annular plaques, and pruritus. Evaluation revealed pharyngeal erosive lesions, pulmonary infiltrates, and mesenteric & inguinal lymphadenopathy. Diagnosis was confirmed by typical skin histology, fungal culture, urine *Histoplasma* antigen testing, and FNAC of an inguinal lymph node. He received liposomal-amphotericin-B (LAmB) 3-5mg/kg alternate day (total 41 mg/kg) followed by oral itraconazole, achieving significant clinical improvement.

Case 2: A 49-year-old lady engaged in backyard poultry rearing presented with skin-colored umbilicated papules, dysphagia, dyspnea, and weight loss. Imaging and endoscopy revealed laryngeal involvement and extensive necrotic lymphadenopathy (mesenteric, cervical, periportal, peripancreatic, retroperitoneal). Skin biopsy demonstrated intracellular yeasts. She was treated with LAmB 3mg/kg alternate day (total 30 mg/kg), oral itraconazole 200 mg twice daily, and a short course of low-dose prednisolone, resulting in marked resolution of cutaneous and systemic lesions.

Case 3: A 67-year-old man without identifiable exposure risk developed a solitary, painless lower-lip ulcer and hypopigmented macules over the back. Histopathology confirmed *Histoplasma capsulatum*. He received itraconazole 200 mg twice daily for 15 days, stopped due to thrombocytopenia; alongside topical 1% luliconazole, leading to complete ulcer resolution on follow-up.

Discussion: These cases underscore the diverse cutaneous manifestations of histoplasmosis in immunocompetent hosts, from pruritic papules to isolated ulceration, and the necessity of high clinical suspicion in patients with environmental exposure. Comprehensive evaluation, including histology, culture, antigen testing, and imaging, confirms the diagnosis and guides tailored antifungal regimens. LAmB followed by itraconazole achieved rapid and sustained responses in multisystem disease, while localized lesions responded to shorter azole courses. Early recognition and appropriate treatment protocols are essential to prevent progression and ensure optimal outcomes.

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Association of NOD2 Gene Polymorphisms with Leprosy Susceptibility and Reaction: A Systematic Review

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Introduction: Leprosy involves a complex interaction between the bacterium and host immunity. Single-nucleotide polymorphisms (SNPs) in host immune-related genes have been shown to play a role in leprosy, both in terms of susceptibility and reaction. Nucleotide-binding oligomerization domain containing 2



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(NOD2) is a pivotal pattern recognition receptor within innate immunity, critically regulating autophagy and inflammatory pathways, and has been increasingly recognized for its role in leprosy susceptibility and reactional states. Several studies have reported associations between NOD2 gene polymorphisms and leprosy.

Objectives: To identify the association between NOD2 gene polymorphisms and both leprosy susceptibility and reaction patterns, and to evaluate their potential as prognostic tools.

Methodology: A systematic review was conducted across several databases, including PubMed, Google Scholar, and ScienceDirect, to evaluate the association of NOD2 gene polymorphisms with leprosy susceptibility and reaction. The quality of studies included was assessed using the Newcastle–Ottawa Scale.

Results: Six studies out of 351, published between 2010 and 2023, met the inclusion criteria. Significant associations with leprosy susceptibility were reported for NOD2 variants rs8057341, rs1477176, rs2287195, rs8044354, rs3135499, rs7194886, rs76230703, and rs143451164. Among these, rs8057341 and rs1477176 demonstrated protective effects. Two studies also evaluated reactional states, identifying that rs8044354 and rs9932237 are associated with reversal reactions, while rs751271 was linked to reduced risk of reaction development. Overall, the evidence supports a key role of NOD2 polymorphisms in both leprosy susceptibility and reaction risk. These findings suggest that NOD2 polymorphisms may influence host immune recognition of *Mycobacterium leprae* and shape the balance between protective and pathological responses.

Conclusions: NOD2 gene polymorphisms are associated with both leprosy susceptibility and reactional states, although the effects vary across specific variants. Furthermore, this study highlights the potential of NOD2 polymorphisms as prognostic markers, underscoring the need for further studies in diverse populations to clarify their clinical and prognostic implications.

Keywords: gene polymorphism, leprosy reaction, leprosy susceptibility, NOD2, SNP.

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Severe Cutaneous Leishmaniasis Complicated by MRSA Superinfection Due to Delayed Diagnosis: A Case Report from Uzbekistan.

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Introduction: Leishmaniasis is a vector-borne infectious disease caused by *Leishmania* parasites, transmitted to humans through the bite of female sand flies of the genus *Phlebotomus* (in Africa, Asia, and Europe) or *Lutzomyia* (in the New World). The disease is recognized as highly endemic across several regions, including Central Asia; nevertheless, data concerning its prevalence in Uzbekistan remain scarce.

Case Presentation: A previously healthy 54-year-old male patient, who permanently lives in the Kashkadarya region in the southeastern part of Uzbekistan, presented to an external hospital with a chief complaint of a skin lesion. He had a history of a puncture wound, possibly resulting from an insect bite, sustained near a pond. For two years, ineffective treatment was given in different hospitals without clarifying the diagnosis. The patient presented to our medical center with progressive, non-healing cutaneous lesions on his right lower limb. On examination, skin lesions consisted of oval nodules, multiple deep ulcers, and papules. On admission, thrombocytosis and leucocytosis were observed in the CBC; his vital signs and other laboratory findings were within normal limits. During microscopic examination of the discharge from the wound surface, *Leishmania* amastigotes were found, and the diagnosis of cutaneous leishmaniasis was confirmed. Additionally, the MRSA PCR result was positive in the wound sample. The



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patient was discharged after two weeks of intensive treatment with meglumine antimoniate, levofloxacin, and 2% mupirocin ointment.

Discussion: Making an accurate diagnosis of leishmaniasis can be challenging for young physicians. Misdiagnosis may result in secondary bacterial infections and ulceration extending into deeper tissue layers, which can lead to scarring and subsequent loss of skin function in the affected area. This study underscores the necessity of considering cutaneous leishmaniasis in the differential diagnosis, particularly among patients residing in endemic or rural regions and presenting with a history of suspected insect bites accompanied by nodular rash.

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The Sleeping Bacillus: Clinical Reactivation After Decades Of Dormancy

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Introduction: This is a case report of paucibacillary Hansen's disease, which has been dormant for more than 4 decades and has now reactivated.

Case Report: A 67-year-old male presented with complaints of a hypopigmented, dry, hairless patch - devoid of sensations, measuring 10 * 5 cm over the left forearm for a period of 2 years. The left arm had a puckered, depressed scar. The left ulnar nerve was severely tender with grade 1 thickening. On probing further into history, the patient claimed to have had a swelling in his left arm (nerve abscess) 47 years ago, for which incision and drainage were done, and the patient was put on oral medication (?dapsone monotherapy) for 2 years. The patient was provisionally diagnosed as a case of borderline tuberculoid leprosy with neuritis. Slit skin smear did not show any acid-fast bacilli, and biopsy had no granulomas/bacilli. USG showed a perineural abscess. Polymerase chain reaction for the detection of *M.leprae* and drug resistance awaited.

Discussion: This case is notable for the extremely long latency period of 47 years between the initial episode and clinical reactivation. Historically, prior to the introduction of WHO-recommended multidrug therapy (MDT) in 1981, patients with leprosy were often treated with dapsone monotherapy. While effective in controlling disease initially, monotherapy was associated with incomplete bacterial clearance, risk of relapse, and emergence of drug resistance. This patient received 2 years of dapsone monotherapy, which was shorter than the recommended duration even for that era, potentially allowing residual bacilli to persist in a dormant state. The clinical presentation and workup underscore the **paucibacillary nature** of the disease and highlight the challenges of diagnosing late reactivation based solely on conventional microbiology. In such cases, **PCR-based detection of *M. leprae***, as awaited in this patient, can provide definitive evidence of bacterial presence and help identify potential **drug resistance mutations**, which is particularly important in previously dapsone-treated individuals.

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Cervical Myelomalacia Mimicking Hansen's Disease in an Endemic Setting: A Diagnostic Challenge

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Introduction: In tropical regions where Hansen's disease remains endemic, children presenting with trophic changes and sensory loss are frequently presumed to have leprosy. However, non-infectious neurological disorders may closely resemble their cutaneous and neural manifestations. Awareness of such mimics is vital to avoid misdiagnosis and inappropriate therapy.

Case Presentation: A 7-year-old boy presented with a 5-year history of recurrent, unnoticed trauma to the right hand, resulting in multiple raw areas. Clinical examination revealed trophic ulcers, erosions, and scars confined to the right hand, with sensory loss extending from the palm to the forearm and associated motor weakness. No peripheral nerve thickening was detected. A differential diagnosis of Hansen's disease versus a neurological disorder was considered. MRI of the cervical spine demonstrated focal myelomalacia at the C3–C4 level, while contrast-enhanced CT was normal. A final diagnosis of cervical myelomalacia with secondary trophic changes was made, and the patient was referred for neurological management.

Discussion: This case highlights the importance of considering neurological mimics of leprosy, especially in pediatric patients from endemic regions. The absence of nerve enlargement and the presence of combined motor and sensory deficits should raise suspicion for non-infectious etiologies. Advanced imaging modalities such as MRI play a critical role in distinguishing cervical myelomalacia from Hansen's disease. Prompt recognition prevents unnecessary anti-leprosy therapy and facilitates timely neurological intervention, thereby improving long-term outcomes.

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Biologics in Erythema Nodosum Leprosum: Experience with Etanercept in Recalcitrant Cases

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Introduction: Erythema nodosum leprosum (ENL) is an immune-complex-mediated lepra reaction associated with multibacillary leprosy, characterized by painful nodules, neuritis, and systemic inflammation. Conventional therapy relies on Oral Corticosteroids, Thalidomide, and high-dose Clofazimine, but many patients develop chronic or refractory disease with relapses and drug-related morbidity. TNF- α plays a pivotal role in ENL pathogenesis, and anti-TNF agents have emerged as potential alternatives in the management of refractory cases.

Objectives: To evaluate the efficacy and safety of TNF- α inhibitor Etanercept in patients with chronic, severe, recalcitrant ENL unresponsive to standard therapy.

Methodology: Five patients with multibacillary leprosy and recurrent, severe ENL (ENLIST ENL Severity scale >8) despite prolonged Thalidomide and Corticosteroid use were included. After baseline investigations and exclusion of Tuberculosis, Hepatitis B/C, and HIV, patients were administered Etanercept 300 mg subcutaneously twice weekly for 3 months, followed by 300 mg once weekly. Patients were followed for 6–24 months. Primary outcomes were reduction in frequency/severity of ENL episodes, systemic symptoms, and hospitalizations; secondary outcomes included tapering of immunosuppressants and safety profile.

Results: All 05 patients demonstrated substantial clinical improvement, with nodular lesions and systemic symptoms subsiding within 1–2 weeks. ENL recurrence declined markedly, and all patients achieved $\geq 50\%$ reduction in Corticosteroid and Thalidomide requirements. Hospitalization burden decreased dramatically, with 03 patients attaining complete remission of admissions. Quality of life improved consistently across the cohort. No major adverse events, opportunistic infections, or Tuberculosis reactivation were noted.



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during follow-up. These findings parallel published data where etanercept reduced ENL flares and facilitated steroid-sparing regimens.

Conclusion: Etanercept, given as an induction schedule followed by maintenance, appears to be an effective and well-tolerated therapy for refractory ENL. It offers rapid disease control, minimizes immunosuppressant dependence, and reduces hospitalization burden. While encouraging, these results highlight the need for larger, controlled studies to confirm efficacy, determine optimal dosing, and establish long-term safety.

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Geriatric Leprosy in Delhi: A Three-Year City-Wide Study Exposing Hidden Barriers in Timely Detection and Disability Prevention

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Introduction: Leprosy persists in India despite major programmatic gains under the National Leprosy Eradication Programme (NLEP). With rising longevity, older adults (≥ 60 years) represent a neglected subgroup at heightened risk of diagnostic delay, advanced bacterial load, and irreversible disability. These vulnerabilities, compounded by stigma and access barriers, threaten to reverse elimination gains and remain poorly characterised.

Objectives: To delineate the demographic, clinical, and psychosocial profile of geriatric leprosy patients in Delhi, compare outcomes with younger cohorts, and identify programmatic blind spots in timely detection and disability prevention.

Methods: We retrospectively analysed 3,193 newly registered cases (April 2022–March 2025) across Delhi's major centres. Geriatric cases (≥ 60 years) were compared with non-geriatric cases for demographic, clinical, and disability parameters. Psychosocial and access-related barriers were extracted from clinical records and available patient interviews.

Results: Of 3,193 patients, 142 (8.9%) were geriatric—the largest city-wide geriatric leprosy cohort reported from India. Compared with younger cohorts, they had significantly higher mean bacterial index (3.8 vs. 3.2, $p=0.01$), longer diagnostic delay (14.6 vs. 9.1 months, $p<0.001$), more grade 2 disability (18.3% vs. 10.9%, $p=0.004$), and higher mortality (10.5% vs. 7.3%, $p=0.02$). Key barriers included dependence on caregivers for mobility, financial constraints, digital exclusion from tele-health, and persistent stigma delaying disclosure. Despite comparable treatment initiation, late presentation drove excess disability and death.

Conclusions: This first city-wide analysis demonstrates that India's elderly face a disproportionate and preventable burden of leprosy-related disability and mortality. Findings expose systemic gaps beyond clinical care, rooted in psychosocial and structural barriers. Incorporating age-sensitive screening, caregiver-inclusive education, and community rehabilitation into NLEP is essential. These lessons are globally relevant, offering a replicable framework for the WHO's roadmap to zero leprosy by 2030 and safeguarding dignity and disability-free survival for ageing populations worldwide.



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When Hands Claw and Feet Drop: The Price of Late Diagnosis

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Introduction: Hansen’s disease (leprosy) remains a global health challenge despite decades of control efforts. We report three new cases of leprosy presenting with Grade 2 disability at their first healthcare visit in a tertiary care centre in South India, underscoring the importance of early detection and intervention.

Case Presentation

Case 1: A 43-year-old female presented with multiple hypoaesthetic skin patches and numbness of the hands and feet for several months. Examination revealed thenar and hypothenar muscle wasting in both palms, motor deficits, a positive Froment’s sign, multiple trophic ulcers, and partial resorption of digits, consistent with Grade 2 disability. A clinical diagnosis of borderline tuberculoid leprosy was made. She was started on multidrug therapy (MDT) and referred for rehabilitation.

Case 2: A 28-year-old male presented with a single hypopigmented-to-erythematous hypoaesthetic patch on the left leg for six months. Neurological examination showed decreased sensation in the left leg and foot, thickening of the left lateral popliteal and posterior tibial nerves, and foot drop. Slit-skin smear and biopsy supported a diagnosis of borderline tuberculoid leprosy with type 1 reaction. MDT and a short course of oral corticosteroids for neuritis were initiated.

Case 3: A 38-year-old male presented with multiple hypopigmented infiltrated patches and nodules all over the body for several years. Examination revealed leonine facies, decreased sensation in the hands and feet, visible clawing, and weakness of intrinsic hand and foot muscles. Lepromatous leprosy was diagnosed. MDT was initiated, and he was referred for rehabilitation.

Discussion: Although India has reduced the prevalence of leprosy, the presentation of new cases with Grade 2 disability reflects a hidden burden of the disease. Reporting such cases aims to sensitize healthcare professionals to the early signs of leprosy, improve community awareness, and contribute to reducing disability-related morbidity in endemic regions.

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Red Ear and Fever Associated with IgM Chikungunya Antibodies

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Introduction: Chikungunya virus (CHIKV), an Alphavirus transmitted by *Aedes aegypti* and *Aedes albopictus*, typically presents with acute fever, rash, and arthralgia. Although diverse cutaneous findings such as maculopapular eruptions, pigmentation, and vesicubullous lesions have been described, erythema of the auricle or “red ear” is rarely documented. Recognition of this sign may aid early diagnosis and differentiation from dengue and bacterial cellulitis.

Case Presentation: During a 2024 chikungunya outbreak in Madhya Pradesh, five patients (three female, two males; age 3–52 years) presented with erythematous auricle 2–3 days after onset of moderate-to-high fever. Three developed pruritic centripetal maculopapular rash resembling drug exanthem, while two exhibited centrifugal viral exanthems 3–5 days post-fever. One afebrile case had scrotal erosions along with auricular erythema. Four patients showed generalized lymphadenopathy. Serology was positive for IgM



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CHIKV in all, and negative for dengue, measles, rubella, influenza, Epstein–Barr virus, and parvovirus B19. Unilateral or bilateral auricular erythema, presented with or without warmth, tenderness, or burning sensation, and subsided spontaneously within a few days, often preceding the typical rash or arthralgia.

Discussion: The “red ear” sign may represent localized vasodilation from cytokine-mediated inflammation during the febrile phase of chikungunya. Similar findings were reported by Riyaz et al. and Kumar et al., who noted auricular erythema in 4–5 % of patients. Unlike dengue, ear involvement is unique to chikungunya and can prevent misdiagnosis as otitis or allergic dermatitis. Awareness of this underreported manifestation adds diagnostic value and highlights chikungunya’s protean cutaneous spectrum.

Keywords: Chikungunya fever, Red ear, Auricular erythema, Viral exanthem

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Borderline Leprosy Unmasked by COVID-19 Vaccination

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Introduction: Leprosy is a chronic, disfiguring infectious disease. It is traditionally classified into tuberculoid (paucibacillary), lepromatous (multibacillary), and borderline leprosy. In the context of the COVID-19 pandemic, patients with leprosy will also receive the COVID-19 vaccination.

Case presentation: Here we describe a case of borderline leprosy unmasked by COVID-19 vaccination in a 24-year-old Indian male who presented with swelling of the hands, feet, earlobes, and lips 10-15 days after receiving the first dose of the Pfizer-BioNTech COVID-19 vaccination. Past medical history was significant for COVID-19 infection six months prior (from which he recovered without complications) as well as eczema on topical treatment. Physical findings were diffuse and nodular edema of the ears, brow, and face, loss of bilateral eyebrow hair, and edema of the neck. A skin punch biopsy from the ear and the dorsum of the left hand showed a diffuse infiltrate of macrophages and positive Fite stain, while slit skin smear results were positive from the ear, hands, and feet. The patient’s symptoms, clinical and histological findings, were consistent with borderline leprosy in reaction.

Discussion: Given the temporal relationship with the COVID vaccination 10-15 days prior, his reaction was likely unmasked by the COVID vaccine. Treatment with multi-drug therapy and slow taper of prednisolone resulted in marked clinical improvement. To our knowledge, there were no previously reported cases of leprosy reactions with COVID-19 vaccination. This is the first report on COVID-19 vaccination leading to the unmasking of borderline leprosy.

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Unmasking leprosy: Diagnostic challenges in its rare and atypical clinical presentations

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Introduction: Leprosy continues to be perceived as a disease of developing countries, reflecting poor socioeconomic conditions. Early diagnosis and treatment are vital to prevent disability associated with this neurocutaneous infection. The disease displays a wide clinical spectrum, ranging from classic to rare presentations that can pose significant diagnostic challenges. Lucio leprosy, typically confined to Mexico and Central America, is one such rare form often complicated by the Lucio phenomenon, which mimics vasculitis and vasculopathy. Likewise, erythroderma or exfoliative dermatitis as a presentation of lepromatous leprosy is extremely uncommon and easily overlooked due to its broad differential diagnoses. We report two rare presentations of leprosy: Lucio leprosy and lepromatous leprosy presenting as exfoliative dermatitis.

Case Presentation

Case 1: A previously healthy patient presented with rapidly progressive necrotic skin ulcers initially suspected as cutaneous sepsis. Examination revealed multiple retiform necrotic ulcers, shiny infiltrated facial skin with madarosis, and glove-and-stockings type neuropathy. Bilateral ulnar and common peroneal nerves were thickened. Slit-skin smears and histopathology confirmed lepromatous leprosy with necrotizing vasculitis, establishing the diagnosis of Lucio leprosy. The patient responded to corticosteroids and modified multidrug therapy.

Case 2: A 30-year-old male presented with generalized erythema, exfoliative dermatitis, and non-pitting edema of hands and feet. Examination showed infiltrated facial skin and thickened peripheral nerves. Slit-skin smear and biopsy confirmed lepromatous leprosy. Investigations excluded hepatic, renal, and cardiac causes. The patient improved with corticosteroids and multidrug therapy.

Discussion: Leprosy remains a diagnostic challenge due to its protean manifestations. Rare forms like Lucio leprosy and lepromatous leprosy presenting as exfoliative dermatitis require a high index of suspicion, especially in endemic regions. Peripheral neuropathy and characteristic cutaneous findings remain diagnostic clues. Awareness of such atypical presentations prevents misdiagnosis and ensures timely initiation of therapy, reducing disability and transmission.

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A Complex Interplay Of Pellagra, Zinc Deficiency, and Protein Malnutrition – A Diagnostic Challenge

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Introduction: Nutritional deficiencies often coexist in resource-limited settings, presenting with overlapping and atypical cutaneous manifestations that mimic systemic or infectious diseases. Among them, pellagra (niacin deficiency), zinc deficiency, and protein-energy malnutrition remain important yet underrecognized causes of multisystem morbidity. Early recognition of combined nutritional deficiencies is crucial for preventing irreversible neurological and dermatological complications.

Case Presentation: A 48-year-old male from a low socioeconomic background presented with progressive darkening and thickening of the skin over exposed areas, painful fissures of the hands and feet, and generalized scaling for six months. He also reported loss of appetite, weight loss, and intermittent diarrhea. Examination revealed diffuse hyperpigmented, thickened plaques with scaling and fissuring over the forearms, legs, neck (Casal's necklace), and dorsal hands. The skin showed areas of crusting and secondary infection. Hair was sparse and brittle; nails showed transverse ridging. There was generalized wasting and bilateral pedal edema.



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Laboratory investigations showed hypoalbuminemia and mild anemia. Liver and renal function tests were normal. HIV and syphilis serologies were negative. A diagnosis of combined nutritional deficiency—pellagra, zinc deficiency (acute on chronic), and protein-energy malnutrition—was made. The patient was treated with a high-protein diet, niacin supplementation, oral zinc, and wound care. Marked improvement of skin lesions and general condition was observed within a few weeks.

Discussion: This case highlights the diagnostic complexity of overlapping nutritional deficiencies, where one deficiency may mask or exacerbate another. Pellagra is classically associated with photosensitive dermatitis, diarrhea, and dementia, while zinc deficiency causes periorificial and acral dermatitis, and protein deficiency contributes to generalized edema and poor wound healing. In tropical developing regions, socioeconomic deprivation, chronic malnutrition, and infections often precipitate these deficiencies simultaneously. Recognition of the characteristic skin changes and supportive laboratory evaluation enables timely correction and prevents morbidity.

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Not all that thickens is fungal: Diagnostic challenges in chronic lymphedematous dermatoses – Experience from Sri Lanka

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Introduction: Chronic lymphedematous skin changes in tropical settings may present a diagnostic dilemma, as they can resemble a spectrum of infectious, inflammatory, and neoplastic diseases. In such cases, a linear approach based solely on clinical morphology may lead to misdiagnosis. A broader, reflective diagnostic mindset—one that considers alternative yet plausible differentials—is essential to reach accurate conclusions and ensure appropriate management.

Case Presentation: We describe two patients from rural Sri Lanka who presented with long-standing verrucous, hyperkeratotic plaques with nodules over the lower limbs, each initially investigated for fungal and neoplastic processes. Persistent, treatment-refractory lesions prompted histopathological re-evaluation, which revealed dermal fibrosis, dilated lymphatics, and chronic inflammation—confirming Elephantiasis Nostras Verrucosa (ENV).

All patients had underlying chronic lymphatic stasis secondary to recurrent cellulitis and neglected wound care. Mycological cultures were negative and without evidence of filarial infection.

Discussion: This case underscores the importance of reflective diagnostic reasoning when approaching chronic verrucous dermatoses in tropical countries. In resource-limited settings, where conditions such as chromoblastomycosis, tuberculosis verrucosa cutis, and SCC coexist, clinicians must be willing to revisit their diagnostic assumptions. Re-evaluating diagnostic hypotheses, especially when response to standard therapy is unsatisfactory, is key to preventing mismanagement.

Accurate diagnosis in chronic lymphedematous disease requires integrating clinical suspicion, microbiological testing, and histopathology. Cultivating a habit of diagnostic insight—questioning initial impressions and considering broader differentials—can significantly improve patient outcomes.

In tropical dermatology, reflective diagnostic insight is vital for accurate disease recognition. Chronic lymphedematous skin lesions require an open, hypothesis-driven approach that considers atypical presentations and revisits alternative differentials. The Sri Lankan experience demonstrates how shifting from pattern-based observation to analytical reasoning can transform diagnostic accuracy and patient outcomes.



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The Beetle Burn in the Tropics: A Clinicoepidemiological Study of Paederus Dermatitis

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Introduction: Paederus dermatitis, an irritant contact dermatitis caused by Paederus beetles, occurs commonly in tropical regions following accidental crushing of the insect, releasing pederin toxin. Though self-limiting, recurrent outbreaks are frequent during humid months and cause considerable discomfort and anxiety among affected individuals.

Objectives: To assess the clinical patterns, seasonal distribution, and environmental and behavioral risk factors associated with Paederus dermatitis in a tropical coastal population.

Methods: A descriptive cross-sectional study was conducted in a tertiary care hospital in South India over one year. One hundred and twenty clinically diagnosed cases of Paederus dermatitis were included. Demographic details, housing features, lighting type, nearby vegetation, seasonal occurrence, and clinical morphology were analyzed.

Results: Patients ranged from 3–72 years (mean = 34 years); 70 (58.3%) were males and 50 (41.7%) females. Eighty (66.7%) reported sleeping with windows open, while only 2 (1.7%) used mosquito nets. Lighting patterns included fluorescent bulbs in 36 (30%), incandescent bulbs in 27 (22.5%), and both in 57 (47.5%) households. One hundred and ten (91.7%) lived near paddy or sugarcane fields. Seasonal occurrence was 72 (60%) in monsoon, 28 (23.3%) in summer, and 20 (16.7%) in winter. The predominant symptom was burning sensation in 90 (75%) and itching in 22 (18.3%). Common sites were the face and neck in 65 (54.2%), the extremities in 30 (25%), and the shoulders in 12 (10%). Lesion types included dermatitis linearis in 72 (60%), kissing lesions in 28 (23.3%), localized pustular dermatitis in 10 (8.3%), and burnt-out appearance in 10 (8.3%).

Conclusion: Paederus dermatitis shows distinct seasonal clustering during the monsoon and a strong association with agricultural surroundings and nocturnal lighting. Awareness regarding preventive practices such as window screening and mosquito-net use can reduce incidence and morbidity in tropical settings.

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Beyond MDT: Role of PCR in Guiding Management of Persistent Hansen's Disease

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Introduction: Multidrug therapy (MDT) is highly effective in controlling Hansen's disease. However, a small proportion of patients continue to present with persistent or recurrent lesions despite adequate treatment. In these situations, slit-skin smears (SSS) and histopathology may be inconclusive, creating challenges in patient care. Polymerase chain reaction (PCR) can provide confirmation of Mycobacterium leprae and guide further management. We report two cases where PCR played a crucial role in clinical decision-making.

Case Presentation: Case 1: A 53-year-old woman, previously treated with 12 months of multibacillary (MB) MDT, developed a hypopigmented thigh patch and tingling in the lower limbs after 10 years of treatment. SSS was negative, and the biopsy showed indeterminate Hansen's. Retreatment with MB-MDT



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for 12 months yielded no improvement. Repeat biopsy was unchanged, and six months of rifampicin–ofloxacin–minocycline (ROM) therapy also failed. Given ongoing symptoms and patient distress, PCR testing was performed, confirming *Mycobacterium leprae*. She was subsequently started on clarithromycin, ofloxacin, and minocycline (COM) therapy and remains under observation.

Case 2: A 57-year-old woman was diagnosed with Hansen’s disease in 2023 after biopsy and positive SSS at a peripheral centre. She completed 12 months of MB-MDT but developed new hypopigmented patches on her right upper limb within 3 months. A repeat biopsy confirmed active disease. ROM therapy was started, but no response. PCR demonstrated ofloxacin resistance. Therapy was modified to rifampicin, clofazimine, and dapsone.

Discussion: Both cases highlight the clinical dilemma of managing patients with persistent or recurrent Hansen’s disease despite standard MDT and negative bacteriology. Reliance solely on histopathology and smears may delay appropriate therapy. Molecular confirmation and resistance testing provide crucial guidance, particularly when treatment failure or drug resistance is suspected. These cases underscore the importance of integrating PCR-based diagnostics into routine practice for complex Hansen’s presentations, ensuring tailored therapy and sustained patient confidence.

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A rare case of Purpura Fulminans in an Adult: Invasive Meningococcal Disease.

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Introduction: Purpura fulminans (PF) is a life-threatening dermatological condition characterized by acute purpuric lesions and skin necrosis due to microvascular thrombosis. In adults, PF is most commonly triggered by severe sepsis, particularly caused by *Neisseria meningitidis*. Invasive meningococcal disease (IMD) frequently leads to PF in children, but is rare in adults. We present a rare case of PF in an adult with IMD, successfully treated without long-term complications.

Case Presentation: A 32-year-old woman with epilepsy, recently adjusted on higher doses of carbamazepine, presented with fever, vomiting, and convulsions. Her condition worsened with the development of high fever (40°C), hypotension, and generalized tonic-clonic seizures. Physical examination showed purpuric and petechial skin lesions on her limbs and extremities. Initial differential diagnoses included infectious PF (bacterial, particularly meningococcal or rickettsial), toxic epidermal necrolysis, and vasculitis. Laboratory findings revealed elevated C-reactive protein and neutrophil leukocytosis. Blood cultures confirmed *Neisseria meningitidis*, and biopsy demonstrated neutrophilic vasculitis with thrombosis, consistent with PF.

The patient was initially treated with intravenous fluids and empirical antibiotics (cefotaxime and doxycycline). After blood cultures isolated meningococci with sensitivity to cefotaxime, doxycycline was omitted. Despite an initial neurological decline, intensive care management resulted in full recovery. Necrotic skin lesions required specialized wound care and surgical debridement. Chemoprophylaxis was administered to close contacts and healthcare staff.

Discussion: IMD is a serious global health issue, with approximately 1.2 million cases reported annually. Diagnosis of PF is based on clinical presentation, laboratory results, and microbial identification. Early identification and aggressive treatment are critical for favorable outcomes. This case underscores the need for clinical vigilance, a multidisciplinary approach, and the efficacy of timely antibiotic intervention in managing meningococcal infections.



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From Feline Friend to Fungal Foe: Zoophilic Tinea as an Upshot of Human-Animal Lifestyle Interface during Covid Epidemic.

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Introduction: Dermatophytosis, a common superficial mycosis, is transmitted through direct contact with infected persons, animals, and soil or indirect contact through fomites. The presentations of tinea infections range from mild scaling and erythema to severe inflammation, depending on the infecting agent and the immune status of the host. We report a series of zoophilic tinea caused by *Microsporum canis* (*M. canis*) acquired through contact with a cat.

Case series: Five patients aged between 4 and 15 years presented with cutaneous and scalp infections ranging from mild erythematous small annular lesions to kerion affecting the scalp during the covid epidemic. All the cases were diagnosed based on the history of contact with the animal, clinical features, and confirmed by conventional mycological examination as tinea due to *M. canis*. All cutaneous infections were treated with topical antifungal therapy, and the kerion was treated with oral griseofulvin.

Discussion & conclusion: When dealing with suspected zoophilic infections, an effort should be made to identify the source, and prevention of human infection should be attempted. This silent zoophilic tinea epidemic may have been caused by the adoption of cats as a way to combat the boredom of COVID-19 unemployment. Host inflammation in dermatophytosis is responsible for the symptoms associated with the infection and also crucial in eliminating the fungus from the host tissue. However, host inflammation may also be responsible for the sequelae associated with the disease, such as scarring alopecia.

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Granulomatous Cutaneous Reaction Following Ritual Hook Piercing during Thaipusam: A Culture-Linked Dermatologic Entity from South India

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Introduction: Body piercing as part of religious or cultural rituals is common in many tropical regions. The Thaipusam festival, widely celebrated in Tamil Nadu, India, involves ritualistic piercing of the skin with metal hooks or skewers as an act of devotion. Such procedures, often performed without sterile precautions, may lead to infections or granulomatous inflammatory responses. Recognition of these culturally linked dermatoses is important for dermatologists practicing in tropical regions.

Case Report: A 30-year-old male presented with multiple well-circumscribed papules and nodules over the back that appeared two weeks after ritual hook piercing during Thaipusam. Histopathological examination of a biopsy specimen revealed a granulomatous infiltrate composed of epithelioid histiocytes and multinucleated giant cells of both foreign-body and Langhans types. Special stains for microorganisms and cultures were negative, confirming a sterile foreign-body granulomatous reaction.

Discussion: Granulomatous cutaneous reactions following ritual piercings can result from mechanical trauma, retained foreign material, or secondary infection. In tropical climates, humidity and poor aseptic



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conditions may exacerbate such inflammatory responses. This case underscores the intersection between cultural practices and dermatologic disease and highlights the need for awareness, community education, and preventive counseling regarding safe ritual practices.

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Patterns of Cutaneous Tuberculosis and Their Clinico-Histopathological Correlation in Eastern India

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Introduction: Cutaneous tuberculosis (CTB) is a rare manifestation of tuberculosis, accounting for approximately 1–2% of all extrapulmonary cases, yet it presents a diagnostic challenge due to its varied clinical presentations. The spectrum ranges from lupus vulgaris and tuberculosis verrucosa cutis (TVC) to scrofuloderma and tuberculosis cutis orificialis, with disease patterns influenced by host immunity. Accurate diagnosis relies on clinico-histopathological correlation, particularly in high TB prevalence regions like India.

Materials & Methods: A prospective observational study was conducted in a tertiary care centre in Eastern India over one year. Patients with clinically suspected CTB underwent detailed dermatological examination, and demographic data were recorded. Lesional biopsies were subjected to histopathological evaluation, supplemented by GeneXpert or other microbiological tests where indicated.

Results and Discussion: Among the 20 patients, lupus vulgaris was predominant (10 cases), followed by scrofuloderma (5 cases), TB chancre (3 cases), TB cutis (1 case), and papulonecrotic tuberculid (1 case). The age ranged from 6 to 60 years, with a slight male predominance (12 males, 8 females). Histopathology consistently revealed epithelioid granulomas, Langhans giant cells, and caseous necrosis, correlating well with clinical diagnosis in 85% of cases. TB cutaneous lesions were most commonly located on the extremities and face. Early recognition and clinico-histopathological correlation enabled the timely initiation of antitubercular therapy.

Conclusion: Cutaneous tuberculosis, although rare, presents with diverse clinical manifestations in Eastern India, with lupus vulgaris being the most common. Strong clinico-histopathological correlation is crucial for accurate diagnosis and management, emphasizing the need for heightened clinical suspicion in endemic regions.

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When Gout meets Psoriatic Arthritis: A Case Report on the Emerging Entity 'Psout'

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Introduction: Psoriasis is a chronic inflammatory skin disorder that can involve the joints, termed psoriatic arthritis (PsA). Gout, a metabolic arthritis, results from impaired purine metabolism, causing uric acid crystal deposition in joints. The coexistence of PsA and gout, sometimes termed “Psout,” poses diagnostic challenges due to overlapping clinical and radiological features.



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Case Report: A 62-year-old male farmer from Odisha presented with painful swelling of large and small joints for eight years, gradually progressing in an asymmetrical pattern. Subcutaneous nodules with chalky white discharge were noted over the left thumb. Examination revealed tender nodules over wrists and MTP joints, dactylitis, swan neck deformity, and psoriatic nail changes. Laboratory findings included serum uric acid 10.8 mg/dl, ESR 95 mm/hr, CRP 167.43 mg/L, and negative rheumatoid factor. Histopathology showed amorphous eosinophilic deposits surrounded by histiocytes consistent with gouty tophi. X-rays demonstrated juxta-articular osteopenia, erosions, and phalangeal fractures. Based on CASPAR score (3) and histopathology, a diagnosis of “Psout” was established.

Discussion: PsA is a spondyloarthropathy characterized by synovitis, enthesitis, and axial involvement, while gout arises from monosodium urate crystal deposition due to hyperuricemia. Both disorders share inflammatory pathways involving IL-17 and IL-23. Studies report increased prevalence of hyperuricemia in PsA patients, suggesting an immunometabolic link. Overlapping symptoms such as polyarthritis, joint deformity, and tophaceous nodules complicate differentiation. Ultrasound findings like double contour and snowstorm signs can aid diagnosis. Felten et al. proposed “Psout” to describe this overlap, emphasizing careful evaluation in atypical or treatment-resistant cases. Conclusion: Coexistent PsA and gout should be suspected in chronic polyarthritis with atypical features. Recognizing “Psout” ensures accurate diagnosis and tailored management for improved outcomes.

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Ocular Manifestations of Leprosy: Two Cases of Borderline Tuberculoid and Borderline Lepromatous Leprosy Involving the Eye

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Introduction: Leprosy is a chronic granulomatous infection caused by *Mycobacterium leprae*, affecting skin, peripheral nerves, mucosa, and eyes. Ocular involvement occurs in 70–75% of cases, and 5% progress to blindness if untreated. Eye disease results from direct bacillary invasion of the eye, nerve damage, or immunological reactions, with potentially sight-threatening complications such as lagophthalmos, keratitis, uveitis, and corneal opacity.

Case Reports:

Case 1: A 36-year-old male presented with hypopigmented indurated patches on the back and swelling of the left eyelid with a skin-colored plaque lesion associated with a gritty ocular sensation. Examination showed eyelid oedema with a plaque lesion, infiltrated ear nodules, and hypopigmented lesions with sensory loss on the back. Slit-skin smear revealed high bacillary indices (+3 to +4), confirming multibacillary leprosy. The patient was started on WHO MDT-MB, resulting in a marked reduction of eyelid swelling after three months. No intraocular complications were detected on ophthalmological assessment.

Case 2: A 38-year-old female presented with right-sided complete ptosis for a one-year duration. Clinical evaluation revealed an erythematous patch on the eyelid with reduced sensation and a nodular lesion on the inside of the lateral globe. Ocular movements were intact. Fornix biopsy showed granulomatous inflammation suggestive of leprosy. Slit skin smear was negative. The patient was commenced on MDT-MB and is awaiting reconstructive surgery for ptosis.

Discussion: These cases illustrate the different ocular manifestations of leprosy, ranging from eyelid granulomatous plaques to ptosis with intraocular nodules. Early recognition and prompt initiation of MDT



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are essential to prevent progression to sight-threatening complications. Ophthalmological examination by an experienced ophthalmologist allows timely identification of lepra reactions and ocular sequelae.

Leprosy continues to be a significant public health issue due to its potential for preventable blindness. Any eyelid or ocular lesion suggestive of leprosy needs prompt evaluation. Early diagnosis, multidisciplinary management, and routine eye screening are vital to preserve vision in affected patients.

Keywords: Leprosy, Borderline lepromatous, Borderline tuberculoid, Ocular manifestations, Ptosis, Eyelid involvement, Multidrug therapy

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***Mycobacterium abscessus* Skin Abscess in an Immunocompetent Adult Male**

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Introduction: *Mycobacterium abscessus* is a non-tuberculous mycobacterial complex, commonly associated with pulmonary and skin and soft tissue infections in immunocompromised patients. We present an atypical case of a *M. abscessus* abscess formation on the left medial calf of an immunocompetent 77-year-old male following an excision biopsy, which was effectively diagnosed and treated without secondary complications.

Case Presentation: A 77-year-old immunocompetent male was referred to us for a non-healing lesion at the site of a prior excision biopsy. Mycobacteria-specific culture showed growth, presumptively identified as *Mycobacterium chelonae*. Clarithromycin monotherapy was commenced while the culture continued. The isolate was subsequently identified as *Mycobacterium abscessus* subsp. *massiliense* via real-time and fragment analysis PCR. The isolate demonstrated clarithromycin susceptibility, so the existing treatment was continued and the lesion successfully healed.

Discussion: This case adds to the literature demonstrating that *M. abscessus* skin and soft tissue infections can occur in immunocompetent patients. We postulate that post-surgical contamination of the site allowed for bacterial infiltration, highlighting not only the importance of considering *M. abscessus* as a cause of abscess formation in an immunocompetent host, but also the value of patient education and proper wound care post-surgery.

Mismanagement of *M. abscessus* skin abscesses can lead to life-threatening complications. Therefore, a thorough investigation is important to identify the causative organism, through ordering a mycobacterial culture if clinically indicated and then following up with species and subspecies identification, and antibiotic susceptibility testing.

In this case, empirical clarithromycin monotherapy was initiated based on the presumptive identification of the causative organism as *M. chelonae*. Prompt initiation of treatment is important in cases such as this to avoid poor outcomes for the patient. Had the causative organism demonstrated resistance to clarithromycin, the treatment regimen would have been changed accordingly.

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Case Report on Recurrent Staphylococcal Scalded Skin Syndrome (SSSS) - Mimicker of Toxic Epidermal Necrosis

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Introduction: Staphylococcal Scalded Skin Syndrome (SSSS) is an acute exfoliative dermatosis resulting from systemic dissemination of epidermolytic toxins—exfoliative toxin A (ETA) and exfoliative toxin B (ETB)—produced by toxigenic strains of *Staphylococcus aureus*. These serine proteases selectively cleave desmoglein-1, a cadherin-type adhesion molecule localized in the stratum granulosum, thereby disrupting intercellular cohesion and precipitating superficial epidermal detachment. SSSS predominantly affects neonates, young children, and immunocompromised adults and the elderly with renal impairment. Here, we report a diagnostically challenging case of recurrent SSSS in an elderly patient who experienced two discrete episodes within a five-month interval. Both episodes were marked by extensive body surface area involvement, acute kidney injury, and a clinical presentation mimicking TEN.

Case presentations: A 70-year-old male with a background of type 2 diabetes mellitus, hypertension, and dyslipidemia was admitted with a two-day history of fever, vomiting, and diarrhea. Simultaneously, he developed painful, tender skin over the buttocks, lower back, and lower limbs, which progressed to friction-induced desquamation. The affected areas appeared dusky, raising concern for cutaneous necrosis.

One week prior, the patient had received celecoxib for mechanical back pain. On examination, he was febrile and clinically dehydrated. Cutaneous findings included extensive superficial epidermal detachment with a positive Nikolsky sign, involving 40% of body surface area, with sparing of mucosal surfaces.

Laboratory investigations revealed acute kidney injury (serum creatinine: 354umol/L and leukocytosis. Notably, the patient had experienced a similar dermatologic episode five months earlier, which had been managed as *Staphylococcal Scalded Skin Syndrome (SSSS)*. Based on clinical features and prior history, a diagnosis of recurrent SSSS was established. The patient was managed with intravenous anti-staphylococcal antibiotics, supportive care, and renal monitoring.

Discussion: SSSS is an exfoliative dermatosis primarily affecting pediatric populations; adult cases are rare and typically associated with underlying comorbidities such as diabetes, renal impairment, or immunosuppression. In adults, the clinical course is often severe, with increased risk of systemic complications. This patient presented with extensive skin involvement, acute kidney injury, and dusky necrotic areas, initially mimicking toxic epidermal necrolysis (TEN). However, the absence of mucosal involvement and rapid response to intravenous anti-staphylococcal antibiotics confirmed SSSS. NSAID exposure preceding symptom onset may have contributed to diagnostic ambiguity. Recurrent SSSS within a short interval is uncommon and may reflect persistent colonization or impaired toxin clearance. Early differentiation from TEN is critical, as management strategies differ significantly. Prompt initiation of anti-staphylococcal therapy and supportive care remains the cornerstone of treatment.

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Rare case report of Majocchi granuloma in an immunocompromised patient: a diagnostic challenge in a limited-resource clinical setting.

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Introduction: Majocchi granuloma (MG) is a deep follicular inflammation caused by dermatophytes. The clinical presentation of MG ranges from follicular papules to nodules and infiltrated painful plaques that sometimes ulcerate. Lesions can mimic various skin diseases, thereby delaying correct diagnosis. The lack of resources makes it difficult to establish MG using histopathology in most primary hospitals in impoverished countries like Indonesia. Therefore, dermatologists and general practitioners must rely on clinical and simple laboratory observations to diagnose MG.

Case Presentation: A 23-year-old woman with septic shock, pneumonia, congestive heart failure, type 2 diabetes mellitus, and hypoalbuminemia was consulted from the ER. She developed generalized pruritic red-brownish plaques that persisted for five months. She was unconscious, and very limited data can be assembled. Her family only recalled that she applied numerous topical medications, but no improvement was shown. She presented with multiple erythematous to hyperpigmented plaques, follicular papules, and nodules, covered with thick scales. Potassium hydroxide examination of the thick scales and follicular papules showed hyphae and arthrospores. A biopsy was unable to be performed due to the unavailability of periodic acid-Schiff (PAS) staining.

Discussion: The predisposing factors of MG are: trauma, occlusion, local treatment with topical corticosteroids, and immunosuppression. We suspected the least two as the cause in this case. One clinical clue is the presence of associated typical superficial dermatophytoses, which were shown in our patient as tinea corporis and tinea cruris. Her clinical signs are consistent with dermatophyte elements from skin scrapings. Therefore, we concluded MG as the diagnosis. Due to her worsening condition, she perished the next day, and we were unable to record her improvement. This report highlights the importance of early detection of MG based on a thorough history, clinical characteristics, and KOH examination, particularly in limited-resource clinical settings and immunocompromised patients.

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Primary Antimicrobial Resistance in Childhood Leprosy- A case report from the Tertiary Leprosy Care Hospital of North India

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Introduction: Leprosy in children carries an epidemiological significance and can be considered an index of the prevalence of the disease. Despite an effective treatment and global achievement of leprosy elimination in 2005, India continues to bear ~58% of the global childhood leprosy burden.

Case presentation: We present a case of borderline lepromatous leprosy with type II lepra reaction in a 14-year-old male child who presented to us with chief complaints of multiple painful nodules on ear lobes, chin, buttocks, and thighs, with swelling of hands and feet. He had a family history of leprosy (borderline tuberculoid) in his mother. On examination, bilaterally thickening of the ulnar, posterior tibial nerve, right radial nerve, and left lateral popliteal was present. No motor changes were found. The bacteriological examination of the slit skin smear was positive, with a bacteriological index of 4. Since BI was high, antimicrobial resistance testing was done, which showed resistance to rifampicin. The patient was started on 2nd line antimicrobial drugs, Clarithromycin, clofazimine, along with prednisolone. He had completed 6 months of treatment and is doing fine.

Discussion: The emergence of primary drug resistance to rifampicin is an early indication for drug-resistant M. leprae strain transmission in the community. Screening of all new childhood MB cases with high BI is important to detect the presence of molecular mutations for primary drug-resistant strains to DDS, rifampicin, ofloxacin, and clarithromycin.



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Analysis of Dermatology Clinic Registry data from the National Hospital of Sri Lanka: A One –Year Retrospective Descriptive Study

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Introduction: Clinic registry data serve as an essential source for understanding disease distribution and emerging health trends. Analyzing such data supports evidence-based planning for patient management, resource allocation, and health education. The dermatology clinic of the National Hospital of Sri Lanka, Colombo, functions as a tertiary care referral centre, receiving patients from all over the country.

Objective: To describe the demographic characteristics and distribution of skin diseases among patients attending the dermatology clinic over a period of one year.

Method: A retrospective descriptive study was conducted at the Dermatology Clinic (Unit B), National Hospital of Sri Lanka, from 1st August 2024 to 31st July 2025. Demographic data and clinical diagnoses were extracted from the clinic registry.

Results

A total of 2196 Patients were analyzed. The majority were female (55.5%). The mean age was 43, and the mode was 17. Eczema (27%) was the commonest entity, followed by Tinea (19.3%), Psoriasis (5.1%), Acne (4.8%), and Urticaria (3.1%). The age group mostly affected by Tinea was 17 years (4%). Skin Malignancies were identified in 11(0.5%) patients, and cosmetic-induced/steroid-induced skin changes were observed in 42 (1.9%) patients.

Conclusion: Eczema is the most frequent dermatological condition, followed by tinea infection, which showed a higher prevalence among younger individuals. There is a rising concern regarding dermatophyte infections, emphasizing the importance of public education on prevention and early treatment. Continuous analysis of clinic data is vital for identifying evolving disease trends.

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Long-term Effects of Ultraviolet Radiation on Obese Skin

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Introduction: Obesity leads to skin disorders caused by inflammation and aging, similar to the organ damage it induces in the cardiovascular system and kidneys. Individuals with obesity frequently develop inflammatory skin conditions such as psoriasis and atopic dermatitis. We have been investigating the pathophysiological effects of obesity on the skin. Obese skin is highly sensitive to ultraviolet (UV) radiation and exists in a state of latent inflammation. Currently, high levels of UV radiation persist worldwide.

Objectives: This study aims to histologically elucidate the long-term effects of UV exposure on obese skin.

Methodology: Obese model mice (TSOD) and control mice (TSNO) were exposed to UVB irradiation (3.3 J/m², three times per week for four weeks). Dorsal skin samples were collected from 16-week-old male



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mice (n = 6) and examined histologically using hematoxylin and eosin (HE) staining. This study was conducted with the approval of the Animal Research Ethics Committee.

Results: In TSNO mice, thickening of the stratum corneum and epidermis was observed following UV irradiation. Keratohyalin granules and granular cells, which represent a pre-keratinization stage for physical defense, increased. Inflammatory responses tended to subside after four weeks.

In TSOD mice, apoptosis, erosion, acantholysis, and blister formation were observed immediately after UV exposure. By two weeks, the granular layer had reappeared, and recovery of keratinocyte cohesion was confirmed. However, inflammatory changes persisted in the epidermis, dermis, and subcutaneous fat tissue even after four weeks. The keratinization abnormalities in TSOD mice resembled the skin findings typically seen in psoriasis.

Conclusion: In obese skin, acute reactions such as erosion and blister formation were observed in the early stages following UV exposure, and inflammatory changes persisted even after four weeks.

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An Unmasked Leprosy In A Diabetic Patient With Pulmonary Tuberculosis And Extensive Dermatophytosis

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Introduction: Leprosy and tuberculosis are chronic infectious diseases caused by *Mycobacterium leprae* and *Mycobacterium tuberculosis*, respectively. Dermatophyte infections are highly prevalent in Sri Lanka due to multiple predisposing factors. Although each of these infections can occur individually, dual mycobacterial infection is rare, particularly in combination with dermatophytosis. Immunocompromised states play a significant role in such presentations. Increased susceptibility to tuberculosis in patients with leprosy is also considered.

Case presentation: A 52-year-old male with poorly controlled type 2 diabetes mellitus and recently diagnosed sputum-positive pulmonary tuberculosis was referred to the dermatology clinic for widespread itchy lesions over the trunk, groin, and extremities for five months. On examination, classical dermatophyte lesions consistent with tinea corporis and tinea cruris were noted.

Additionally, a 20 cm hypopigmented anaesthetic patch with alopecia was noted over the right forearm. On further inquiry, he stated that the lesion had been present for over twenty years without any symptoms. The right ulnar nerve was thickened but without neuropathic deficits. The clinical features suggested borderline tuberculoid leprosy coexisting with active dermatophytosis and pulmonary tuberculosis. Slit-skin smear for leprosy was negative, but histopathology supported borderline tuberculoid leprosy. The patient was started on multidrug therapy for leprosy without Rifampicin, as he was already on antituberculosis treatment. Antifungal therapy was also initiated.

Discussion: This case highlights how long-standing asymptomatic leprosy can remain neglected and emphasizes the need to identify classical hypopigmented anesthetic patches beyond the presenting complaint. Early detection and treatment of leprosy are crucial to prevent disability and transmission. Some studies suggest increased susceptibility to tuberculosis in leprosy and higher morbidity and mortality. However some studies suggest cross immunity.

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Unusual Multifocal Presentation of Fish Tank Granuloma In An Aquarist



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Introduction: *Mycobacterium marinum* is a non-tuberculous mycobacterium commonly associated with aquatic environments in tropical countries and causes fish tank granuloma in humans following exposure through breaches in the skin barrier. It usually presents as a localized lesion on the upper extremities. Multifocal involvement is uncommon and may pose diagnostic challenges.

Case presentation: A 30-year-old aquarist presented with asymptomatic, slowly progressive skin lesions over the right dorsal thumb and left knee for one year. Both lesions started as small papules that gradually evolved into erythematous plaques. He recalled minor trauma during aquarium cleaning but denied systemic symptoms.

On examination, well-defined erythematous plaques with scaling, crusting, and fissuring were noted over the base of the right thumb and the left knee. There was no regional lymphadenopathy, and systemic examination was normal.

A clinical diagnosis of fish tank granuloma was made, supported by histopathological findings of granulomatous inflammation with epithelioid and giant cells consistent with atypical mycobacterial infection. Culture was not performed due to unavailability. The patient was treated with a clarithromycin and ciprofloxacin combination, which showed marked improvement on follow-up.

Discussion: This case highlights the importance of considering *Mycobacterium marinum* infection in chronic cutaneous lesions associated with aquatic exposure. Although typically confined to the hands and forearms, simultaneous involvement of the thumb and knee represents an unusual multifocal presentation, likely due to multiple inoculation sites.

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Body Regions of Predilection in children with leprosy attending a children's hospital in Sri Lanka

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Introduction: Even though certain body regions are considered sites of predilection for leprosy, the frequency of occurrence of lesions in these sites and their relation to other disease characteristics have not been studied in detail. The study of body regions is even more important in children, since the diagnosis of leprosy in children remains a challenge.

Objectives: The objective was to study the frequency of occurrence of skin lesions in different sites in a cohort of children attending a paediatric dermatology clinic

Methodology: A retrospective analysis of clinical records was carried out. Demographic and clinical data, including the occurrence of lesions in different body regions, obtained from the clinic records of 114 children with leprosy attending the Dermatology clinic, Lady Ridgeway Hospital for Children, Colombo, Sri Lanka, were entered into an Excel worksheet

Results: Records of 114 children, average age 9.41 years (range 2 - 14), 50.9% males, were analysed. 89.5% had a single skin lesion. Upper limb (47.6%), face (28.1%), and lower limbs (26.3%) were the most commonly affected sites. The front of the trunk was less commonly affected when compared to the back of



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the trunk. There was lateral symmetry in both upper and lower limbs. Upper limb lesions were almost equally distributed over the arm, forearm, and elbow. Feet were less commonly affected.

Conclusions: There are sites of predilection for lesions of leprosy in children. These findings help to develop graphic descriptions of areas of predilection for leprosy lesions that would be useful in training health care workers and health volunteers in active case detection. Such clinical descriptions are likely to help in developing algorithms to improve the diagnostic accuracy of leprosy among children.

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Extensive viral warts in a child treated with oral acitretin

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Introduction: Warts are benign proliferations caused by human papillomavirus. It is a common skin disease in children with a prevalence of up to 10%. It can be treated with cryotherapy, topical imiquimod, immunotherapy, electrocauterization, and retinoids.

Case Presentation: A 12-year-old previously healthy girl presented with extensive viral warts over the face, upper limb, and lower limb for a one-year duration. There were extensive warts causing disfigurement to the face. The possibility of epidermodysplasia verruciformis was considered, but the child was not able to undergo genetic studies to confirm it.

The child was initially treated with cryotherapy and topical tretinoin, which caused little improvement. Viral implantation was done, but no results were observed in three months. The child underwent basic investigations, and all were normal. Following that, she was started on oral acitretin 0.5mg/kg daily. After 2 months, significant resolution of lesions was noted, and complete regression of all warts occurred in 6 months with remaining post-inflammatory pigmentation. The drug was tapered off and stopped in another 2 months. She didn't develop any side effects from the drug. The child didn't develop any new lesions, and she is under follow-up.

Discussion: Extensive viral warts can be treated with oral acitretin. Acitretin works by its anti-proliferative and immunomodulatory effects. Continuing the cryotherapy for extensive warts can cause pain, and sometimes scarring and nail plate damage. Short course of oral acitretin for extensive viral warts is a convenient, effective, and safe treatment to regress warts completely with fewer side effects.

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Evidence-based management of actinomycetoma: outcomes following the Cochrane 2018 protocol—a Nepal case series

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Introduction: Mycetoma is a chronic suppurative granulomatous infection of the deep dermis and subcutaneous tissue prevalent in tropical and subtropical regions and is caused by filamentous aerobic bacteria (actinomycetoma) or true fungi (eumycetoma), representing 60% and 40% of cases worldwide,



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respectively. The causative organism enters the subcutaneous tissue, usually of the foot, from contaminated soil or vegetative material through inoculation from a thorn prick or repeated trauma. It commonly affects men, farmers, and field workers. Differentiating eumycetoma from actinomycetoma can be challenging, but required before starting prolonged treatment.

Case Presentation

Case 1: A 50-year-old male demonstrated significant clinical improvement over a one-year follow-up. He has not received treatment for the last six months and showed no recurrence of skin lesions after completing the regimen. This patient had previously been treated with antifungal therapy for eumycetoma for several years without proper investigation.

Case 2: This patient presented with lesions on the thigh in a sporotrichoid pattern, which is atypical for actinomycetoma. Gram staining revealed numerous Gram-positive filamentous branching bacilli. Excisional deep biopsy showed white-colored grains, and histopathology demonstrated pseudoepitheliomatous hyperplasia with a dermal inflammatory infiltrate composed of neutrophils and histiocytes. Magnetic resonance imaging (MRI) revealed the characteristic “dot-in-circle” sign.

Case 3: The third patient, similar to the first, had previously received prolonged antifungal therapy for presumed eumycetoma without a proper diagnostic work-up. Following initiation of the Cochrane 2018 protocol, significant clinical improvement was observed, and no recurrence occurred during follow-up.

Discussion: Early diagnosis of actinomycetoma and differentiating it from eumycetoma is mandatory to prevent tissue destruction, bone invasion, and ultimate loss of function by proper investigative work-up, histopathology, and direct microscopy of discharge. Notably, two patients had previously received prolonged antifungal therapy for presumed eumycetoma without definitive diagnostic confirmation, highlighting the importance of appropriate work-up before initiating therapy.

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Secondary Syphilis Mimicking Mpox in an Untreated HIV Homosexual Male With Penicillin Allergy: One Rare Case Report

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Introduction: Syphilis is known as the “great imitator” due to its diverse and variable symptoms, including mpox. The article highlights the importance of considering syphilis as a potential diagnosis, as it can mimic other diseases such as mpox. The incidence of syphilis has been increasing, particularly among men who have sex with men (MSM); additionally, in people living with HIV populations. Although penicillin is the first line of treatment for syphilis, doxycycline is a well-tolerated alternative agent given its comparable effectiveness.

Case Presentation: This article discusses a case of a 23-year-old MSM patient who presented with symptoms resembling mpox, but was ultimately diagnosed with secondary syphilis. The patient had painless vesicles-pustules and ulcerative lesions on his face and neck, along with maculopapular rash throughout his body. No lymph enlargements were found. Laboratory tests confirmed the presence of HIV and secondary syphilis co-infection; PCR from nasopharyngeal swab for mpox was negative. A skin test for penicillin showed a positive result, indicating a penicillin allergy. Therefore, doxycycline was given as an alternative, simultaneously with ARV, and the rashes resolved.



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Discussion: Although the vesiculo-pustular type is the hallmark of mpox, this disease can have similar clinical findings to other skin infections, including secondary syphilis; however, in our patient, there were lesions on the palms and soles, and the rashes were painless, as is common in secondary syphilis. In the case of penicillin allergy, doxycycline is a preferred alternative agent that shows no treatment failure. Secondary syphilis in patients with concurrent HIV may present with a broad spectrum of cutaneous manifestations. Therefore, especially during outbreaks, one should pay closer attention to other skin conditions such as mpox.

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Rare Case Report of Majocchi Granuloma in an Immunocompromised Patient: A Diagnostic Challenge in a Limited-Resource Hospital

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Introduction: Majocchi granuloma (MG) is a deep follicular inflammation caused by dermatophytes. The clinical presentation of MG ranges from follicular papules to nodules and infiltrated painful plaques that sometimes ulcerate. Lesions can mimic various skin diseases, thereby delaying correct diagnosis. The lack of resources makes it difficult to establish MG using histopathology in most primary hospitals in impoverished countries such as Indonesia. Therefore, dermatologists and general practitioners must rely on clinical and simple laboratory observations to diagnose MG.

Case Presentation: A 23-year-old woman with septic shock, pneumonia, congestive heart failure, type 2 diabetes mellitus, and hypoalbuminemia was consulted from the ER. She developed generalized pruritic red-brownish plaques that persisted for five months. She was unconscious, and inadequate data could be assembled. Her family only recalled that she applied numerous topical medications, but no improvement was shown.

She presented with multiple erythematous to hyperpigmented plaques, follicular papules, and nodules, covered with thick scales. Potassium hydroxide examination of the thick scales and follicular papules showed hyphae and arthrospores. A biopsy was unfit to be performed due to the unavailability of periodic acid-Schiff (PAS) staining.

Discussion: The predisposing factors of MG are: trauma, occlusion, local treatment with topical corticosteroids, and immunosuppression. We suspected the least two as the cause in this case. One clinical clue is the presence of associated typical superficial dermatophytoses, which were shown in our patient as tinea corporis and tinea cruris. Her clinical signs are consistent with dermatophyte elements from skin scrapings.

Therefore, we concluded MG as the diagnosis. Due to her worsening condition, she perished the next day, and we were unable to record her improvement. This research emphasizes the significance of early identification of MG using comprehensive history, clinical features, and KOH testing, especially in resource-constrained clinical environments and among immunocompromised individuals.

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Sequential varicella and herpes zoster in an immunocompetent adult with cervical dermatomal involvement: a rare case report

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Introduction: Varicella and herpes zoster are distinct clinical entities caused by the varicella-zoster virus (VZV). Primary infection manifests as varicella, while herpes zoster occurs due to viral reactivation from sensory ganglia, typically decades later. Sequential or near-simultaneous occurrence of varicella and herpes zoster in immunocompetent adults is exceptionally rare.

Case Presentation: A 45-year-old previously healthy male presented with six days of vesicular eruptions, starting with fever and myalgia. Generalized pleomorphic vesicles appeared consistent with varicella, and within three days of eruption, he developed severe left shoulder pain and grouped vesicles along the C4 and C7 dermatomes, suggestive of herpes zoster. Routine laboratory tests, including HIV serology, were normal. Giemsa-stained vesicular fluid revealed multinucleated giant cells with ballooning degeneration, confirming herpesvirus cytopathic changes. The patient received oral acyclovir 800 mg five times daily for seven days, resulting in complete resolution without postherpetic neuralgia or recurrence.

Discussion: Sequential varicella and herpes zoster in immunocompetent adults is extremely uncommon. Potential mechanisms include transient immune dysregulation, simultaneous exposure to distinct VZV strains, or concurrent herpesvirus reactivation. Cervical dermatomal involvement, although less frequent than thoracic, may present with severe neuropathic pain. Prompt recognition, clinicopathological correlation, and early antiviral therapy are critical for favorable outcomes.

This case underscores the importance of awareness of atypical VZV presentations in immunocompetent adults. Early diagnosis supported by cytology and timely antiviral therapy can lead to rapid recovery and prevent complications.

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Fusarium eumycetoma of the hand following traumatic implantation: A case report

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Introduction: Mycetoma is a chronic granulomatous infection caused by fungi (eumycetoma) or bacteria (actinomycetoma), characterized by the classical triad of tumefaction, discharging sinuses, and extrusion of grains. Common causative organisms include *Madurella mycetomatis*, *Fonsecaea pedrosoi*, and *Acremonium falciforme*. *Fusarium* species is a recognized rare cause of mycetoma, particularly in Southeast Asia. The World Health Organization (WHO) designated mycetoma as a Neglected Tropical Disease (NTD) in 2016. The mycetoma belt spans 30°N to 15°S, encompassing Sri Lanka, where *Fusarium* mycetoma is exceptionally uncommon, making documentation of such cases epidemiologically significant.

Case Presentation: A 55-year-old male sustained a penetrating injury to his right hand from a coconut leaf spine during childhood. The superficial fragment detached spontaneously, while the retained portion served as a nidus for mycetoma development. Gradually, a painless lump emerged on the dorsum, expanding into the mid-palmar space with palmar sinuses discharging grains. Lesions extended to the ulnar ring finger, suggesting communication via lumbrical channels. Microbiological analysis isolated *Absidia corymbifera*, treated with Amphotericin B until a suspected allergy, later yielding *Fusarium* species. Colony morphology



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revealed slow-growing pale colonies with cottony aerial mycelium. Microscopy identified sickle-shaped macroconidia with septate hyaline hyphae, confirming phenotypic identification of *Fusarium*. Magnetic Resonance Imaging demonstrated the pathognomonic “dot-in-circle” sign, with no muscle or bone invasion. Combined surgical debridement and Voriconazole therapy was initiated.

Discussion: *Fusarium solani* is the commonest species in *Fusarium* mycetoma. This case expands the spectrum of environmental fungi causing mycetoma in tropical settings. Global cure rates with antifungals remain low (~30%), underscoring the importance of combined surgical and medical management. WHO advocates strengthening surveillance and mycetoma detection within skin-NTD frameworks to promote early diagnosis and improve treatment compliance, especially in resource-limited settings.

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Lymphomatoid papulosis in a young female: a case of mixed types A and E

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Introduction: Lymphomatoid papulosis (LyP) is a chronic, recurrent CD30-positive cutaneous lymphoproliferative disorder presenting with self-healing papules, plaques, or nodules. Despite its benign course, its histopathological features may mimic cutaneous T-cell lymphomas. Importantly, 10–20% of patients may develop secondary lymphomas such as mycosis fungoides or CD30+ anaplastic large cell lymphoma, making accurate diagnosis and long-term follow-up essential.

Case Presentation: A 19-year-old female presented with a 10-day history of a painful, erythematous, ulcerated nodule on the left breast that began as a papule and progressively enlarged. During the past six months, she has had similar lesions over the submammary region, arms, and face, which have resolved spontaneously within weeks. There were no systemic symptoms. Examination revealed an erythematous nodule with central necrotic crusting and post-inflammatory hyperpigmented macules with varioliform scars on the face, trunk, and upper limbs. No lymphadenopathy or systemic abnormalities were detected.

A prior lesion excised under suspicion of abscess showed suppurative granulomatous inflammation with dense histiocytic infiltration. A subsequent biopsy, with differentials including LyP, pyoderma gangrenosum, and insect bite-induced pseudolymphoma, revealed a mixed inflammatory infiltrate with epidermotropism and angioinvasion by lymphocytes. Immunohistochemistry showed strong CD30 and CD68 membranous positivity and CD8 expression in a subset of T cells, confirming LyP (mixed types A and E). The patient was started on low-dose methotrexate and scheduled for regular follow-up.

Discussion: LyP is a rare cutaneous disorder with histologic features suggestive of malignancy but a benign, recurrent course. Diagnosis depends on clinicopathologic and immunophenotypic correlation and exclusion of lymphoma. Management varies with disease extent, from observation in mild cases to systemic therapy for widespread disease. Lifelong monitoring is critical due to the risk of malignant transformation.

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Uncommon presentation of chromoblastomycosis leading to a diagnostic pitfall

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Introduction: Chromoblastomycosis (CBM) is a chronic subcutaneous mycosis caused by dematiaceous fungi, most frequently *Fonsecaea* species. It is classified as a neglected tropical disease and commonly affects agricultural workers in tropical and subtropical regions. Clinically, CBM demonstrates polymorphic lesions that often resemble other granulomatous disorders, such as lupus vulgaris (LV). The typical predilection of CBM is often observed in the lower limb and is rarely found in sun-exposed areas. Because of these similarities, diagnostic pitfalls are common, leading to delayed treatment and worse outcomes. This case report highlights the uncommon clinical presentation of chromoblastomycosis that may lead to a diagnostic pitfall.

Case Presentation: A 61-year-old male farmer presented with erythematous plaques with partial hypopigmentation and scarring on the face, neck, chest, and back, accompanied by mild pruritus persisting for 20 years. He had previously been diagnosed with LV and underwent six months of anti-tuberculosis treatment at a previous hospital; however, the lesions continued to progress. Physical examination revealed irregular violaceous plaques with cicatricial from and verrucous borders alongside black dots. Potassium hydroxide (KOH) preparation demonstrated the presence of copper penny bodies, and fungal culture identified *Fonsecaea pedrosoi*. Histopathological analysis revealed granulomatous inflammation with copper penny bodies, confirming the diagnosis of CBM. The patient was started on oral itraconazole 200 mg/day and remains under treatment.

Discussion: This case highlights the diagnostic challenges of CBM, particularly when lesions occur at uncommon sites such as the face and trunk, where LV is often suspected. Although both CBM and LV exhibit granulomatous histopathology, CBM is distinguished by the presence of pathognomonic copper penny bodies. Lack of improvement following anti-tuberculosis therapy should prompt reconsideration of the diagnosis. This case underscores the importance of integrating clinical findings with direct microscopy, culture, and histopathological examination to achieve accurate diagnosis and appropriate management.

Keywords: Chromoblastomycosis, diagnostic pitfall, medlar bodies, itraconazole, uncommon lesion

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Community-Acquired Pneumonia Triggering Severe Erythema Nodosum Leprosum During Pregnancy

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Introduction: Erythema Nodosum Leprosum (ENL) is a type III hypersensitivity reaction induced by excessive inflammation against *Mycobacterium leprae* bacteria, which may occur before, during, or after completing multidrug therapy (MDT). Infection can trigger ENL and often occurs in pregnancy. Community-acquired pneumonia (CAP) is one of the most common infections in pregnancy, occurring in approximately 0.5–1 per 1,000 pregnancies, and is associated with increased fetal mortality. During pregnancy, ENL may present as a severe reaction with more than 20 painful nodules, accompanied by fever, myalgia, and malaise.

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Case Presentation: A 28-year-old woman with a history of multibacillary leprosy had completed 12 months of MDT two years earlier. At 28-30 weeks of her second pregnancy, she presented with 25 painful erythematous nodules over the face, trunk, and extremities, accompanied by fever, arthralgia, and dyspnea (ENLIST score: 10). Slit-skin smear showed BI 0 and MI 0, with chest X-ray revealing pneumonia and laboratory findings of anemia and leukocytosis. Treatment consisted of intravenous methylprednisolone 62.5mg once daily, Levofloxacin 750mg once daily, Ceftriaxone 1g twice daily, and oral N-acetylcysteine 200 mg three times daily. On the 5th day, a cesarean section was performed for fetal distress. The infant passed away 3 hours postpartum from respiratory failure to hyaline membrane disease, neonatal pneumonia, prematurity, and very low birth weight. Nodular lesions gradually improved (ENLIST score: 5), and by the 9th day, lesions had faded with improved dyspnea (ENLIST score: 4).

Discussion: Alterations in cell-mediated immunity (CMI), downregulation of Th1 and shift toward Th2 immunity during pregnancy, combined with infection, can trigger severe ENL reactions. Decreased T-helper and NK cells further increase susceptibility to infections such as CAP, which may worsen ENL severity and lead to poor fetal outcomes. Multidisciplinary therapy with corticosteroids and broad-spectrum antibiotics effectively improves ENL and maternal outcomes.

Keywords: CAP, Pneumonia, Pregnancy, Severe Erythema Nodosum Leprosum

ICTD26-ABS-0326

Two Faces of Granulomatous Scarring Alopecia: Infectious and Non-Infectious Mimics of Common Dermatoses

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Introduction:

Granulomatous scalp disorders can closely resemble common inflammatory dermatoses such as tinea capitis, discoid lupus erythematosus, or psoriasis, often leading to delayed diagnosis and inappropriate therapy. Identifying the underlying cause is crucial, as infectious and non-infectious granulomatous diseases require distinctly different management approaches.

Case Series: Two female patients presented to the Dermatology Unit, National Hospital of Sri Lanka, with scarring alopecia secondary to granulomatous inflammation of differing etiologies.

Case 1: A 47-year-old woman with bronchial asthma presented with a six-month history of scalp pruritus, pain, and progressive patchy hair loss. Examination revealed a large patch of scarring alopecia with crusting, scaling, matted hair, and pustules over the vertex. She had received oral griseofulvin and terbinafine without improvement. Scalp biopsy demonstrated granulomatous inflammation; fungal and Ziehl–Neelsen stains were negative. Pus culture yielded *Staphylococcus aureus* (MRSA), while fungal and TB cultures showed no growth. Subsequent mycobacterial culture confirmed *Mycobacteria other than tuberculosis* (MOTT). The patient showed marked improvement within two weeks of treatment with oral ciprofloxacin and clarithromycin.

Case 2: A 78-year-old otherwise healthy woman presented with a five-year history of progressive, pruritic, patchy scalp hair loss. She denied systemic symptoms. Examination revealed an erythematous, scarring alopecic patch with whitish scaling over the vertex. Histology demonstrated non-caseating granulomas consistent with sarcoidosis. ESR was 27 mm/h, serum calcium was normal, and the chest radiograph showed early basal bronchiectasis. Fungal, TB, and MOTT studies were negative. She was managed as scalp sarcoidosis and showed marked clinical improvement with oral prednisolone.



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Discussion: These cases highlight the diagnostic challenges of granulomatous scarring alopecia in tropical, resource-limited settings. Both infectious and non-infectious granulomatous disorders can mimic common scalp dermatoses. Comprehensive histopathological and microbiological evaluation is essential for accurate differentiation and effective, etiology-specific management to prevent irreversible cicatricial alopecia.

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Actinomycetoma of the Lower Limb: A Diagnostic and Therapeutic Challenge in a Resource-Limited Tropical Setting

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Introduction: Actinomycetoma is a chronic granulomatous infection of the skin and subcutaneous tissue caused by filamentous bacteria such as *Actinomyces* or *Nocardia*. It commonly affects the lower limbs of adults in tropical regions, characterized by swelling, sinus formation, and granular discharge. Delayed diagnosis and inadequate treatment may lead to fibrosis, deformity, and functional impairment. Differentiating actinomycetoma from eumycetoma and other chronic infections is essential, as management strategies differ significantly.

Case Presentation: A 45-year-old previously healthy male from Piliyandala presented to the National Hospital of Sri Lanka in September 2025 with a five-year history of painless swelling around the right knee, extending to the upper thigh and lower leg. The skin was indurated, hyperpigmented, with multiple discharging sinuses containing yellowish, blood-tinged fluid. He had a fixed flexion contracture with reduced range of motion. There was no trauma or systemic symptoms. The patient had been investigated and treated at multiple centers with poor response and inconsistent adherence.

Histology showed granulomatous inflammation with filamentous organisms consistent with *Actinomyces*; fungal stains were negative. Bacterial, fungal, and TB/MOTT cultures showed no growth. ESR was 110 mm/h and CRP 92 mg/L. MRI demonstrated infective myositis without osteomyelitis. He was started on oral co-trimoxazole and IV gentamicin (amikacin unavailable). Renal functions remained stable, but gentamicin was stopped after a high-frequency (4 kHz) hearing notch was detected on day 12. Oral linezolid was substituted, and physiotherapy was initiated. After two weeks, discharge reduced and induration softened.

Discussion: This case illustrates the chronic, disabling course of actinomycetoma and challenges in resource-limited tropical settings. Histopathology is crucial when cultures are negative or unavailable. Combination antimicrobial therapy with close toxicity monitoring can achieve favorable outcomes. Early physiotherapy and functional support are essential to prevent deformity and preserve limb function, particularly in patients with poor prior treatment response and inconsistent compliance.

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Multiple Skin Nodules as a Sign of Relapsed Systemic Anaplastic Large Cell Lymphoma in an Adolescent

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Introduction: Anaplastic large cell lymphoma (ALCL) is a rare T-cell non-Hodgkin lymphoma, accounting for 2–3% of all non-Hodgkin lymphomas. While primary cutaneous ALCL is well documented, secondary cutaneous involvement from systemic ALCL is an uncommon presentation and can signify disease progression or relapse. Early recognition is key to timely management.

Case Presentation: A 15-year-old patient with a history of systemic ALCL presented with multiple, rapidly enlarging, firm nodules and plaques over the face, trunk, and extremities. Lesions were tender and non-ulcerated, and this was her second episode within the past year, after which she defaulted on treatment. She also complained of exertional dyspnoea. Skin biopsy revealed acanthosis of the epidermis and a heavy, nodular dermal infiltrate composed of atypical lymphoid cells, including large pleomorphic cells, with small reactive lymphoid cells observed in the background. Immunohistochemistry for CD30 showed strong and diffuse membrane positivity in large cells, confirming cutaneous metastasis of systemic ALCL. CD3 and CD20 were negative, and ALK-1 testing was not performed due to unavailability.

Discussion: Cutaneous metastasis in systemic ALCL is rare, especially among paediatric and adolescent populations. It can mimic infections, drug reactions, or other malignancies, thereby complicating the diagnostic process. Recognising skin involvement holds substantial clinical significance, as it can indicate relapse and bears prognostic implications. Histopathology combined with immunophenotyping is essential for establishing a definitive diagnosis. Early detection facilitates prompt systemic therapy and guides clinical management. This case highlights the importance of vigilance for new skin lesions in patients with a history of systemic ALCL, emphasising the crucial role of dermatological assessment in ongoing follow-up care.

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Basal Cell Carcinoma of the Finger — An Unusual Acral Presentation

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Introduction: Basal cell carcinoma (BCC) represents the most common form of cutaneous malignancy, accounting for approximately 80% of non-melanoma skin cancers. It primarily occurs in sun-exposed regions of the head and neck and exhibits a strong association with ultraviolet radiation exposure. Conversely, its occurrence on acral areas, such as the fingers, is exceedingly rare, with only a limited number of cases documented in the literature. Due to its atypical location, BCC of the finger may be misdiagnosed as benign conditions – including tropical infections or chronic ulcers- leading to diagnostic delays.

Case Presentation: We report the case of an 81-year-old male who presented with a gradually enlarging lesion on the index finger of the right hand over three years. The lesion was initially treated conservatively as eczema at the primary level without significant improvement. On examination, it appeared as a crusted hypertrophic lesion involving most of the dorsal aspect of the distal phalanx with rolled margins. After treatment with keratolytics, it revealed an exophytic, fleshy plaque with bleeding and nail dystrophy. Other hypertrophic lesions were observed on both palms; however, he had no known arsenic exposure. There was no associated pain, lymphadenopathy, or systemic symptoms. Biopsy demonstrated interconnected downward extension of basaloid cells in the epidermis to the deep dermis with scattered mitotic figures. Surface ulceration and perineural invasion were present. The diagnosis was malignant tumour, with basal cell carcinoma being more favoured.

Discussion: BCC of the finger is an uncommon presentation and should be included in the differential diagnosis of persistent or atypical acral lesions. Early identification and histopathological confirmation are



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crucial to prevent diagnostic delays and to facilitate complete excision, thereby avoiding local recurrence or functional impairment. This case highlights the significance of considering malignancy in non-healing finger lesions when assessing chronic or atypical presentations.

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Oral Omega-3 Fatty Acid Intake Enhances Dermal Collagen in Ultraviolet B Radiation-Irradiated Obese Mice

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Introduction: Obesity impairs skin physiology, increasing susceptibility to pressure ulcers and delayed wound healing due to reduced dermal thickness and collagen fiber (Hirt et al., 2018; Ibuki et al., 2012). Obese skin is also more sensitive to UVB-induced inflammation. Our previous study demonstrated that oral intake of omega-3 fatty acids, which has declined with rising obesity rates, improves epidermal barrier function in obese mice (Horie et al., 2024). However, its effect on dermal collagen remains unclear.

Objectives: To investigate the effect of oral omega-3 fatty acid intake on dermal collagen in UVB-irradiated obese mice.

Methodology: TSOD obese mice were divided into Control and Omega groups (n=6/group). The Control group received sterile distilled water, while the Omega group received linseed oil orally for 8 weeks. Dorsal skin was irradiated with UVB (40 mJ/cm²), followed by gross observation and tissue collection. Skin samples underwent hematoxylin-eosin (HE) and Sirius red staining to assess dermal thickness and collagen fiber density. mRNA expression levels of collagen-related enzymes were also analyzed. The study was approved by the Yokohama City University Animal Experiment Committee (F-A-23-051).

Results: Gross observation revealed increased redness in the Omega group compared to the Control group. Histological analysis showed a thicker dermis and higher collagen fiber density in the Omega group. Additionally, mRNA expression was significantly elevated in the Omega group.

Conclusions: This study indicated that oral intake of linseed oil, rich in omega-3 fatty acids, increased dermal thickness and collagen density in UVB-irradiated obese mice. As reduced collagen and dermal thinning are risk factors for pressure ulcers in obesity, oral linseed oil intake appears to strengthen obese skin by upregulating collagen synthesis enzymes.

ICTD26-ABS-0338

An Unusual Presentation of Fish Tank Granuloma: A Case Report

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Introduction: *Mycobacterium marinum* infection, also known as fish tank granuloma, is an uncommon cutaneous non-tuberculous mycobacterial infection acquired through exposure to contaminated water or fish following minor trauma. It typically presents as a chronic, indolent lesion, but atypical sites and variable morphology can pose diagnostic challenges.



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Case Presentation: A 16-year-old schoolboy presented with multiple papules and nodules over both elbows for ten months following trauma from a fall into a gutter. The lesions began as small papules at the injured sites and gradually enlarged, coalescing into hyperpigmented plaques. There were no ulcerations, sporotrichoid spread, or lymphadenopathy. Histopathological examination showed non-caseating granulomas composed of Langerhans-type and foreign-body giant cells with a mixed inflammatory infiltrate. Special stains for acid-fast bacilli and fungi were negative. These findings favored a diagnosis of *Mycobacterium marinum* infection. The patient was treated with oral clarithromycin 500 mg and ciprofloxacin 500 mg, both twice daily, for eight weeks. The plaques gradually flattened during follow-up with continued therapy.

Discussion: *Mycobacterium marinum* is responsible for approximately 45% of reported non-tuberculous mycobacterial skin infections. Clinical manifestations range from papules and nodules to verrucous or ulcerated plaques, occasionally exhibiting sporotrichoid spread. The organism is generally susceptible to quinolones, macrolides, tetracyclines, and aminoglycosides. Combination antibiotic therapy is preferred to prevent resistance and recurrence, with treatment typically lasting 1 to 2 months after clinical resolution. This case underscores a rare bilateral presentation of fish tank granuloma in an immunocompetent adolescent, emphasizing the importance of early clinical suspicion and combined antibiotic therapy to achieve complete recovery and prevent chronicity.

ICTD26-ABS-0339

***Phaeoacremonium* Subcutaneous Fungal Infection in a Post-Kidney Transplant Patient - A Case Report**

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Introduction: *Phaeoacremonium parasiticum* is a rare, heterogeneous group of fungi that has a wide distribution in the environment. It can cause phaeohyphomycosis commonly in post-kidney transplant patients with immunosuppression. It can cause subcutaneous abscesses, cysts, eumycetomas, osteomyelitis, arthritis, myositis, and disseminated diseases like fungemia and endocarditis.

Case presentation: A 63-year-old post-kidney transplant patient on multiple immunosuppressive medications for eight years presented with multiple asymptomatic nodules and ulcers over the left leg, feet, and dorsum of the hands for three months, without a preceding history of trauma. On examination, there were multiple ulcerated exophytic nodules over the left leg, feet, and dorsum of hands without regional lymphadenopathy and hepatosplenomegaly. His histopathology revealed a dense neutrophilic infiltrate in the dermis with a negative Grocott's methenamine silver stain. Direct microscopy of his skin tissue revealed sclerotic cells and fungal filaments, and fungal culture was positive for *Phaeoacremonium* species, which are sensitive to itraconazole and voriconazole. He was started on oral itraconazole 100mg twice daily in combination with surgical debridement of larger nodules over the left leg, dorsum of hands, and feet, with good clinical response.

Discussion: Multiple asymptomatic nodular ulcerated growths in a post-kidney transplant patient on immunosuppressive therapy, together with neutrophil-predominant inflammation in dermis, raise the suspicion of deep fungal infection of the skin, which needs to be further confirmed by direct microscopy and fungal culture, and it needs to be treated with systemic antifungal therapy to prevent dissemination.

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Clinico-dermoscopic Study Of Conidiobolomycosis- A Case Series From India

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Introduction: Conidiobolomycosis is a rare subcutaneous mycosis caused by Conidiobolus spp and is characterised by rhinofacial edema and infiltration. There are no published case series describing dermoscopy of conidiobolomycosis.

Objectives: To describe the clinical and dermoscopic features of Conidiobolomycosis in an Indian population.

Methodology: A retrospective study on dermoscopy of clinicohistopathologically and microbiologically proven conidiobolous seen between 2017 and 2024 at a tertiary hospital in South India was conducted. Clinical details were reviewed from the medical records, and dermoscopic evaluation was done by reviewing the images stored in the nonpolarized videodermoscope Fotofinder systems GmbH.

Results: There were 5 patients with conidiobolomycosis whose dermoscopy was recorded. All the patients were male with a mean age of 43.4 +/- 13.4 years. The disease duration ranged from 3 to 72 months. Involvement of the centrafacial area was present in all, forehead and lip involvement in 2 (40%) each. Four patients (80%) had an intermediate disease, and 1 (20%) had a late disease. All the patients with intermediate disease had a stereotypical presentation, and one with late disease had facial elephantiasis. Histopathology showed splendor hoespli phenomenon in all the patients. Tissue cultures in all the patients (100%) grew Conidiobolus spp, of which 2 of the isolates were identified as Conidiobolus coronatus. On dermoscopy, all had areas of milky red and orange-yellow hue with multiple yellow and brown dots. Perifollicular pigmentation and absence of scales were noted in all (100%), brown linear lines and brown perifollicular concentric circles in 3 (60%) each. The vascular features noted were linear vessels (5,100%), linear and branched vessels (3, 60%), and red clods (2,40%).

Conclusion: The majority of patients had an intermediate disease. The most common dermoscopic features include multiple yellow and brown dots and linear vessels in a background of milky red and orange-yellow hue.

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Body region predilection in leprosy: a descriptive study at a children's hospital and central leprosy clinic, Sri Lanka

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Introduction: Leprosy is a chronic infectious disease affecting the skin and peripheral nerves. Certain body regions are considered sites of predilection for lesions, but the frequency of involvement and its relationship with other disease characteristics have not been studied in detail. This is particularly important in children, as diagnosis in this age group remains challenging.

Objective: To determine the frequency of leprosy skin lesions in different body sites among children and adults attending two specialized clinics in Sri Lanka.



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Methodology: Demographic and clinical details were obtained from the clinic records of 114 consecutive children attending the dermatology clinic of Lady Ridgeway Hospital from 2017 to 2024, and 210 consecutive adults attending the central leprosy clinic from 2020 to 2023. Data were extracted and entered into Microsoft Excel for analysis.

Results Records of 114 children and 210 adults were analyzed. Gender distribution differed significantly between children (50.9% males) and adults (68.2% males). A single lesion was observed in 89.5% of children compared to 53% of adults. In children, the most commonly affected sites were the upper limbs (47.6%), face (28.1%), and lower limbs (26.3%), with upper limb lesions distributed almost equally over the arm, elbow, and forearm. In adults, the elbow (46%), forearm (28%), and face (24.4%) were most frequently affected. Elbow and foot involvement were significantly higher in adults. Lesions were largely symmetrical in both groups, and the knees were less frequently affected than the elbows.

Conclusions: Distinct sites of predilection exist for leprosy lesions in both children and adults, with notable age-related differences, particularly in elbow involvement. These findings can guide the development of graphical maps of predilection sites and diagnostic algorithms to enhance active case detection and improve the diagnostic accuracy of leprosy in both children and adults.

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Hidden in Plain Sight: The Diagnostic Value of Dermoscopy in Pediculosis Corporis

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Background: Pediculosis corporis is an ectoparasitic infestation caused by the body louse, often underdiagnosed due to its subtle presentation and association with poor hygiene. The condition can mimic chronic pruritic dermatoses, leading to unnecessary investigations or treatment delays. Dermoscopy provides a rapid, non-invasive method to identify ectoparasites, offering diagnostic clarity in such elusive cases.

Case Presentation: A 75-year-old male from a low socioeconomic background presented with generalized pruritus of four months' duration. Cutaneous examination revealed linear excoriations, brownish hyperpigmentation, and mild lichenification over the back, while the scalp and pubic regions were unaffected. Differential diagnoses considered were senile pruritus, scabies, and drug-induced itch. Routine laboratory investigations were within normal limits. Careful inspection of the clothing seams revealed motile insects. Dermoscopy (Heine Delta 30, 10×, non-polarized) demonstrated multiple live lice attached to garment fibers, while dermoscopy of the skin showed excoriations without mites or burrows, ruling out scabies.

Microscopic examination (40×) confirmed the presence of an adult louse with an elongated abdomen and terminal claws. In this case, the diagnosis of *P. humanus corporis* was made based on the site of infestation. The lice were identified exclusively in the seams of the patient's clothing, and no lice were detected on the scalp or body hairs. As clothing-dwelling behavior is a well-recognized feature of *P. humanus corporis*, this clinical finding allowed us to confidently distinguish it from *P. humanus capitis*. The patient was advised on hygiene measures, disinfection of clothes and bedding, and prescribed topical permethrin 5% cream. At two weeks, pruritus had resolved completely.

Discussion and Conclusion: This case emphasizes the significance of dermoscopy in unveiling hidden ectoparasitic infestations. By allowing direct visualization of lice on clothing, dermoscopy facilitates quick,



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accurate diagnosis, reduces misdiagnosis, and supports timely management. Incorporating dermoscopy into routine dermatologic evaluation enhances the detection of neglected parasitic dermatoses in resource-limited settings.

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Histoid Hansen's Disease: A Report of Two De Novo Cases

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Background: Histoid Hansen's disease is an uncommon and well-defined variant of lepromatous leprosy, originally described by Wade in 1963. It is characterized histologically by spindle-shaped macrophages packed with acid-fast bacilli, typically lacking globi formation. Although traditionally associated with relapse or dapsone resistance, de novo histoid cases are increasingly being recognized in the post-elimination era.

Case Presentation We report two de novo cases of histoid Hansen's disease with distinctive clinical patterns.

Case 1: A 35-year-old male presented with multiple shiny, dome-shaped papules over the ear helices, chest, back, and extremities. Slit skin smear revealed a bacteriological index of 6+, and histopathology demonstrated a Grenz zone with spindle-shaped foamy macrophages arranged in fascicles and sheets.

Case 2: A 70-year-old male developed multiple firm nodules over the right forearm, ear helices, and back. Biopsy showed a thinned-out epidermis with a subepidermal Grenz zone and foamy histiocytes arranged in a storiform pattern, with numerous slender acid-fast bacilli on the Wade-Fite stain. Both patients were diagnosed with histoid Hansen's disease and treated with multidrug therapy (rifampicin, clofazimine, and dapsone).

Discussion and Conclusion: Histoid Hansen's disease may clinically resemble xanthomas, neurofibromas, or dermatofibromas. Recognition of its characteristic histopathological features—spindle-shaped histiocytes in a whorled or storiform arrangement with solid-staining bacilli—is crucial for accurate diagnosis. A high index of suspicion and early detection remain vital to curb transmission and prevent disability in the post-elimination era of leprosy.

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Cutaneous manifestations as the first clue in late-onset autologous graft-versus-host disease following stem cell transplant

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Introduction: Cutaneous manifestations are often the earliest and most distinctive features of graft-versus-host disease (GVHD). Although classically seen following allogeneic haematopoietic stem cell transplantation (HSCT), a GVHD-like syndrome due to loss of self-tolerance can rarely occur after autologous HSCT, termed auto-GVHD. GVHD can be classified as acute and chronic, with the acute form



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typically presenting within 100 days post-transplant. Late-onset presentations, particularly beyond two years post-transplant, are uncommon. Here, we present a case of auto-GVHD presenting five years post-transplant, where dermatological features were crucial in establishing the diagnosis.

Case presentation: A 54-year-old man with multiple myeloma, treated with bortezomib-based chemotherapy followed by autologous HSCT, presented five years later with recurrent fever, neutropenia refractory to granulocyte colony-stimulating factor (G-CSF), pleural effusion, and new-onset cutaneous eruptions. Examination revealed erythematous papules, nodules, and hyperpigmented scaly plaques predominantly over the trunk and upper limbs, without mucosal involvement. Skin biopsy demonstrated basal cell vacuolar degeneration, lymphocyte exocytosis, and a dense perivascular and periadnexal lymphoplasmacytic infiltrate, which were consistent with interface dermatitis suggestive of GVHD. After exclusion of infections such as tuberculosis, haematological malignancies (including myeloma recurrence), and auto-inflammatory syndromes, the patient was diagnosed with a late-onset auto-GVHD. The patient showed marked clinical and haematological improvement with systemic corticosteroids, followed by maintenance with ruxolitinib due to steroid dependence.

Discussion: Dermatological assessment and skin biopsy are important to establish the diagnosis in atypical presentations of GVHD, such as in this case, which presented beyond the classical post-transplant timeframe, leading to a diagnosis of persistent, recurrent, late-onset acute GVHD. Characteristic interface dermatitis in an appropriate clinical context should prompt consideration of this rare but treatable condition.

ICTD26-ABS-0356

Neglected Case of Chromoblastomycosis

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Introduction: Chromoblastomycosis is a chronic subcutaneous mycosis caused by dermatiaceous (pigmented) fungi. It is a neglected tropical disease (NTD) that affects individuals following traumatic implantation of fungal elements into the skin. Longstanding neglected cases can result in extensive disfigurement, secondary bacterial infection, and even malignant transformation. We report a case of extensive Chromoblastomycosis to highlight potential treatment modalities.

Case presentation: A 50-year-old mason, who was previously well, came with asymptomatic, slowly growing skin lesions over the left hip and left lower back for a duration of > 20 years. On examination, there were multiple, well-demarcated, erythematous, verrucous, hyperkeratotic plaques with surface spectacle sign over the left-sided hip and L/ lower back, arranged in an annular manner with satellite lesions. No regional lymph node enlargement, no evidence of secondary bacterial infection / malignant transformation. Dermoscopic examination showed reddish-brown to black dots on the surface. Skin biopsy, which demonstrated spores, confirmed the diagnosis of chromoblastomycosis. The patient was started on oral itraconazole 200mg two times daily with regular monitoring of liver function, in combination with a limited area of cryotherapy. The lesion is gradually improving.

Discussion: Chromoblastomycosis requires prolonged treatment. Oral itraconazole and terbinafine are the traditional first-line treatment. Some patients develop drug intolerance while others show no response. Physical treatment modalities such as surgical excision and cryotherapy are also effective, but in this case, less applicable due to the extensive nature. Limited evidence suggests that combining immunomodulators such as imiquimod with antifungal agents yields better outcomes than antifungal agents alone. With the commencement of oral itraconazole, the size of the lesion is gradually improving and the patient is on regular follow-up with liver function monitoring.

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When Leishmania Wore the Face of a Mimicker

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Introduction: Facial nodular eruptions are a diagnostic dilemma for dermatologists. They can be seen in a number of inflammatory and infectious conditions. Clinicopathological correlation is needed to establish a diagnosis.

Case Presentation: A 43-year-old man presented with asymptomatic, persistent hyperpigmented and skin-coloured nodules over the midfacial region, nose, chin, and lips for the last 5 months. The lesions started over the tip of the nose and gradually increased in number and size to involve the entire nose. On examination, there was symmetrical involvement of the mid face and nose with well defined skin coloured nodules resembling a cobblestone-like appearance. There was no lesional sensory loss or earlobe infiltration or madarosis. Genital mucosa not involved. Systemic examination and nerve examination were within normal limits. LL Hansen, Lupus Miliaris Deseminata Faciei, granulomatous rosacea, sarcoidosis, PKDL (Post kala azar dermal leishmaniasis), and sebaceous hyperplasia were considered as differentials. Slit skin smear showed numerous Leishmania donovani bodies, and the serology rk 39 test was found to be positive. A diagnosis of PKDL was made, and the patient was started on Miltefosine. A good response to Miltefosine was seen, and clinical lesions showed resolution after 12 weeks.

Discussion: Post-kala-azar dermal leishmaniasis is a condition seen as a sequelae of inadequately treated or untreated visceral leishmaniasis. Extensive mucocutaneous involvement can be seen. It is more commonly seen in India, Nepal, Bangladesh, and other tropical countries. Early diagnosis is key as PKDL can cause significant morbidity.

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Aleukemic Leukemia Cutis as a presenting symptom of acute myeloblastic leukemia- two case reports

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Although hematological malignancies are relatively common, initial presentation with skin involvement is rare. Cutaneous infiltration of neoplastic leukocytes can lead to specific manifestations such as leukemia cutis (LC) or lymphoma cutis, while nonspecific lesions like Sweet's syndrome, vasculitis, or erythema nodosum are also reported. LC usually occurs at or soon after the diagnosis of leukemia, but in rare cases, it precedes systemic involvement, termed aleukemic leukemia cutis (ALC), where skin lesions represent the earliest sign of developing leukemia.

We report two such cases that presented with skin lesions prior to systemic involvement, and a diagnosis of leukemia was made solely on skin biopsies.

A 72-year-old female presenting with skin-colored, non-tender, infiltrated nodules, with a generalized distribution, has had a facial appearance of leonine facies for two months. Hypopigmented anesthetic lesions, peripheral lymphadenopathy, hepatosplenomegaly, or systemic symptoms were not detected. The second patient was a 91-year-old male previously investigated for thrombocytopenia presenting with generalized skin plaques, nodules, and ulceration for 2 months. He was afebrile and pale, but no peripheral lymphadenopathy or organomegaly was noted.



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Basic hematological and radiological tests were done in both patients, and they were normal except for thrombocytopenia without any atypical cells in the second patient. Diagnosis of Aleukemic leukemia cutis due to acute monoblastic leukemia was made purely by skin biopsy and immunohistochemistry. The peripheral blood showed atypical cells a few weeks later in both patients.

Discussion: Cutaneous involvement in acute leukemia is fairly uncommon and may present as specific skin lesions like LC. Although LC typically presents at the time of diagnosis, occasionally this may precede the involvement of blood or bone marrow (ALC). In these patients, the skin lesions are the primary and initial sign of a developing leukemia. ALC most commonly presents as multiple papules and nodules and infiltrated plaques, but it may also present as macules or ulcers. Infiltration of the face may result in leonine facies.

It is a significant challenge for a dermatologist to diagnose ALC without any hematological abnormality, and it can mimic many common diseases like leprosy, sarcoidosis, and lymphoma.

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Concurrent Dapsone-Induced Methemoglobinemia and Hypersensitivity Syndrome in a Patient with Indeterminate Leprosy

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Introduction: Dapsone, an antimicrobial used in the standard multidrug therapy (MDT) for leprosy, can rarely cause severe adverse reactions, such as methaemoglobinaemia and dapsone hypersensitivity syndrome (DHS). The concurrent occurrence of both reactions in the same patient is rare. HLA-B*13:01 positivity is considered a major genetic risk factor for developing DHS, particularly among Asian populations. We report a patient with indeterminate leprosy who developed both dapsone-induced methemoglobinemia and hypersensitivity syndrome simultaneously and was later found to be HLA-B*13:01 positive, suggesting a pharmacogenetic predisposition.

Case presentation: A 32-year-old female diagnosed with indeterminate leprosy was initiated on WHO MDT-PB (rifampicin and dapsone) therapy. Three weeks later, she developed a generalised erythematous maculopapular rash, lymphadenopathy, fever, malaise, and dyspnoea with oxygen saturation of 85% despite oxygen supplementation. Chest X-ray was normal. Methemoglobinemia (16%) was detected, which was treated with methylene blue, with which the patient's dyspnoea and saturation improved. Over the subsequent days, her exanthem progressed, resulting in generalised exfoliation with raised transaminases, direct hyperbilirubinemia without eosinophilia or atypical lymphocytes. Infectious causes were excluded with a normal procalcitonin and negative blood cultures.

Skin biopsy revealed a superficial perivascular lymphocytic infiltrate with eosinophils consistent with DHS. Dapsone was withdrawn, and high-dose systemic corticosteroids commenced, leading to gradual resolution. She developed several relapses while tapering corticosteroids, necessitating the use of ciclosporin. Genetic testing revealed HLA-B*13:01 allele positivity.

Discussion: The simultaneous occurrence of both dapsone induced methemoglobinemia and DHS is rare and poses a diagnostic challenge. A high degree of clinical suspicion is warranted to detect these adverse drug reactions early and to reduce the associated morbidity and mortality. Further studies are warranted to determine the prevalence of the HLA B*13:01 allele in the Sri Lankan population and to evaluate its use as a potential screening tool for safer dapsone prescribing.

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12-Year-Old Child Having Lepromatous Leprosy with High Bacterial Index - Case Report

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A 12-yr old girl was brought to our Outpatient department with concerns of multiple painless nodules over her body, predominantly over her face, chin, and ear lobes for one year. On examination, she is an active child. She has multiple painless nodules over her face and chin. Both of her ear lobes were thickened and nodular. She did not have anaesthetic patches or deformities.

Her investigations revealed Iron deficiency anaemia, Haemoglobin of 7.4 gm%, MCV – 64.1, baseline liver function, and renal function were within normal limits. Skin smear done revealed high positivity, 5 + (100-1000 bacilli in an average field). On family screening, it was found that two of her close relatives were having Hansen's disease with positive skin smear.

After explaining about the disease, the need for prolonged treatment, she was started on Multibacillary Multi-Drug Therapy. Dapsone was not given in view of anaemia. She was dewormed and started on Iron supplementation. She is 6th born to her parents. Her father's occupation is to take care of buffaloes, and her mother passed away from breast cancer a year ago. She has not attended school in view of poverty.

Prevalence of Hansen's disease with high bacterial index among children, indicative of the disease transmission, is a concern.

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Unmasking the Unusual: Atypical Manifestation of Post-Kala-Azar Dermal Leishmaniasis

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Introduction: Post-Kala-Azar Dermal Leishmaniasis (PKDL) is a chronic mucocutaneous complication seen predominantly after treatment of visceral leishmaniasis (kala-azar) in endemic regions such as the Indian subcontinent. PKDL challenges public health efforts towards leishmaniasis elimination due to its reservoir potential. Although typically presenting with hypopigmented macules and papules, clinical variability can lead to misdiagnoses, particularly in areas with a high prevalence of Hansen's disease

Case Presentation: We report the case of a 58-year-old male from rural India who developed persistent, polymorphic cutaneous lesions one year after the onset of lower limb edema. Multiple nodular and verrucous outgrowths, ulceration, oozing, and crusting were noted on his feet, while additional skin-colored nodules and infiltrated plaques appeared on his back and thighs. No motor or sensory deficits were present.

The patient's history included recent multibacillary therapy for suspected lepromatous leprosy. Differential diagnoses included lepromatous leprosy, deep mycoses, PKDL, and cutaneous T-cell lymphoma. Key laboratory findings included negative slit skin smears for lepra bacilli and fungal cultures, but Giemsa-stained impression smears and histopathology confirmed Leishman-Donovan bodies, supporting PKDL diagnosis. Serological testing and a positive rK39 assay further corroborated this. The patient responded favorably to 12 weeks of oral miltefosine with complete lesion resolution.



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Discussion: This case emphasizes the polymorphic nature of PKDL and the need for a high index of suspicion in atypical presentations, critical for timely intervention and control of leishmaniasis transmission in endemic regions.

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Clinical Profile of Patients with Hansen's Disease in a Secondary Hospital – A Six-Year Retrospective Study

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Introduction: Leprosy is a chronic infectious disease caused by *Mycobacterium leprae*, which affects the skin and nerves. It is a disabling disease and can cause significant morbidity and stigma.

Objectives

To describe the clinical and treatment profile of patients with Hansen's Disease at a secondary hospital.

Methodology: A retrospective study of confirmed cases of Hansen's Disease who presented to the Dermatology department of a secondary care hospital in South India from March 2019 to September 2025 (5 ½ years) was conducted.

Results: During this study period, 51 patients were diagnosed with Hansen's disease. The mean age at presentation was 43.08 years (SD 17.9), and 56.9% of the patients were male.

The largest number of patients fell in the Borderline Tuberculoid spectrum (25.5%), followed by Pure Neuritic (21.6%) and then by Borderline Lepromatous (19.6). The majority of the patients were multibacillary (90.2%) and were given WHO MBMDT; 40.8 % of all patients were slit-skin smear positive.

A significant 42% of patients presented one year or more after the onset of symptoms, and 35.3% of patients had WHO Grade 2 disability. Immunological complications were seen in 52.9% of patients (Type 1=29.4%, Type 2=19.6%, and Neuritis alone=3.9%). Oral steroids were given in 49% of all patients. Drug-induced complications were seen in 16 patients (31.4%), the most common being dapsone induced anaemia.

Conclusion: A large number of patients presented to our hospital in late stages of the disease with significant disability, and many had immunological complications. The high skin smear positivity and high disability grade among our patients are indicators of delayed detection. This may be an indicator that there are pockets of undetected leprosy, which may result in continuing disease transmission. The delay in presentation points to a lack of adequate awareness among the general population even today.

ICTD26-ABS-0370

Nail Disorders Mimicry Onychomycosis After Chemotherapy; A Case Report

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Introduction: Chemotherapy medications have been associated with a variety of nail disorders. The most common nail changes reported include leukonychia, Beau's lines, brittle, thin nails, and nail hyperpigmentation, which may be diffuse or horizontal. The nails change sometimes mimicking onychomycosis. We reported a case of nail disorders mimicking onychomycosis that arose following docetaxel treatment every 3 weeks.

Case: An 81-year-old man presented with a nail disorder after receiving chemotherapy for his prostate cancer. The patient complained that all of his nails were damaged. He thought the nail disorders were caused by a fungal infection, and topical ketoconazole 2% was given by himself for 2 weeks; however, the nails worsened. He received docetaxel at a dose of 75 mg/m² once every 3 weeks for his prostate cancer treatment. After 3 cycles of chemotherapy, his nail changes began to appear without itch or pain. The nail examination showed dyspigmentation on the proximal, onychodystrophy, onycholysis, and leukonychia; there was no inflammation of the fingertip skin. Dermoscopic findings were onycholysis, onychomadesis, onychoschizia, and Beau's lines, and the KOH examination was negative. He received 10% urea lotion as a moisturizer and was also educated about his nail disorders.

Discussion: Antimitotic agents such as taxanes, docetaxel, and anthracyclines are the antineoplastic regimens mostly associated with nail changes. Nail changes after chemotherapy involve multiple or even all 20 nails and usually appear in a temporal relation with the drug intake, due to an acute insult of the nail matrix epithelium. The exact mechanisms for this complication are unclear. Because of the specific kinetics of nail formation and growth, it is important to note that the occurrence of these nail toxic effects is often delayed relative to treatment initiation. There is no protocol for treating nail disorders after chemotherapy, and they can often persist for many months after finishing the treatment.

ICTD26-ABS-0394

Case Report: *Serratia Marcescens* Mimicking Cutaneous Tuberculosis

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Background: Chronic granulomatous dermatoses can mimic infectious or autoimmune conditions, posing diagnostic and management challenges. *Serratia marcescens* is an uncommon cause of cutaneous infection, typically affecting immunocompromised individuals.

Case Presentation: A 30-year-old iTaukei woman presented in September 2024 with multiple soft nodules and ulceration over both upper limbs and chest, including an elongated sloughy ulcer on the left forearm. She appeared undernourished and had a firm, fixed left submandibular lymph node. Initial differentials included cutaneous lupus erythematosus, cutaneous tuberculosis, and pyoderma gangrenosum. Histopathology from the right cheek and right shoulder showed acute on chronic granulomatous inflammation, with the latter demonstrating focal caseating necrosis, raising suspicion for TB.

However, swabs and repeat skin biopsies were negative for *Mycobacterium tuberculosis* on histology and DNA testing. On incision, a nodule produced a coral-red discharge characteristic of *Serratia marcescens* (SM), suggesting an alternative diagnosis. The patient had previously received one month of anti-tuberculosis therapy with poor response, followed by appropriate antibiotic therapy and local wound care, resulting in steady wound healing.

Discussion: The case underscores the importance of clinicopathological correlation in chronic ulcerative dermatoses. SM can clinically and histologically mimic cutaneous TB, particularly in malnourished or immunocompromised hosts.



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Conclusion/ Learning Point: Persistent or atypical ulcerative lesions not responsive to anti-tuberculosis therapy should prompt reconsideration of diagnosis. Secondary or opportunistic infections such as SM may present with granulomatous inflammation, emphasising the need for microbiological culture. SM is an uncommon cause of ulcers and nodules.

ICTD26-ABS-0398

Paraneoplastic Pemphigus in a patient with adenocarcinoma of the breast after four years of completion of cancer treatment -A Case Report

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Introduction: Paraneoplastic pemphigus (PNP) is an autoimmune blistering and erosive mucocutaneous syndrome associated with an underlying neoplasm. It is primarily associated with lymphoproliferative disorders, and uncommonly with malignancies of epithelial origin.

We report on a case of a 74-year-old female who presented with severe mucocutaneous flaccid bullae and erosive skin lesions, who is resistant to treatment, suggestive of PNP.

Case presentations: A 74-year-old female presented to the dermatology clinic with progressive bullous and erosive skin lesions involving the oral cavity. She was diagnosed with adenocarcinoma of the left breast and had undergone a mastectomy with axillary clearance in 2021 and is currently on tamoxifen. The patient had severe oral erosions involving the lips with hemorrhagic crusts, conjunctival erosions, intact flaccid blisters on the neck and upper back of the chest, with large areas of erosions.

With the skin biopsy for histology, direct immunofluorescent, and clinical features, a diagnosis of paraneoplastic pemphigus was made. Hematological and extensive radiological analysis did not reveal any abnormality or recurrence of breast CA. The patient was managed with intravenous antibiotics, pulse and oral systemic steroids, intravenous rituximab, intravenous immunoglobulin, and supportive care.

Discussion: PNP is a life-threatening autoimmune disease characterized by severe mucocutaneous blisters and erosions. It is mostly seen in association with lymphoproliferative disorders, and infrequently in some solid tumors, but is very rare in association with breast cancer. The diagnosis of PNP is based on clinical features, histology, direct and indirect immunofluorescence (DIF and IIF), and immunoprecipitation tests. Immunocompromised state due to malignancy itself, drugs, and extensive defects of the skin barrier may lead these patients to be extremely susceptible to infection and had to treat very causally

In conclusion, this case demonstrates that CA breast can be a rare cause of PNP, which could be associated with poor prognosis if not identified promptly. Early recognition of the disease and successful control of both the underlying cancer and skin lesion are important.

ICTD26-ABS-0400

Shifting Aetiology of Onychomycosis in Sri Lanka

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Introduction: Onychomycosis, a fungal infection of the nail characterised by discolouration and thickening of the nail plate, is a prevalent condition worldwide. While dermatophytes have long been considered the



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primary causative agents, recent evidence indicates a notable epidemiological shift, with yeasts and non-dermatophyte moulds (NDMs) increasingly implicated. Recognising this changing trend, we conducted a study to investigate the evolving aetiology of onychomycosis in Sri Lanka, with particular emphasis on the emerging predominance of non-dermatophyte fungi.

Objective: To describe the spectrum of fungal pathogens isolated from nail samples of patients suspected of having onychomycosis received at the National Reference Laboratory for Mycology over one year.

Methods: A retrospective analysis was performed on nail samples submitted between July 2024 and June 2025 for fungal culture. Demographic data, potassium hydroxide microscopy results, and culture findings were extracted from laboratory records.

Results: A total of 334 samples were analysed: 100 from males and 234 from females. Thirty-six samples were from patients less than 18 years of age. There were 108 (32.3%) fingernail samples and 226 (67.7%) toenail samples. In 133 (39.8%) samples, fungal elements were observed with 10% potassium hydroxide. Fungal hyphae (n=71) and yeasts (n=42) were commonly observed, while in a minority, only fungal spores/arthrospores were seen. Of the 229 (68.5%) positive cultures, 20 yielded mixed growth of fungi. The most frequently isolated fungi were *Candida* spp. (24.9%), *Aspergillus* spp. (22.1%) and *Fusarium* spp. (20.3%). *C. parapsilosis* was the predominant yeast species. Less frequent isolates included *Scytalidium* spp. (7.2%) and *Cladosporium* spp. (6.7%). Only two *Trichophyton* isolates were recovered. Eighty-five samples were negative for both microscopy and culture.

Conclusion: *Candida*, *Fusarium*, and *Aspergillus* species were the leading causes of onychomycosis in this cohort, while dermatophytes were rare. These findings highlight a shifting epidemiology in tropical climates and emphasise the importance of considering yeasts and NDMs in diagnosis and treatment strategies.

ICTD26-ABS-0402

Testing Options for Chromoblastomycosis: Current Practices and Emerging Diagnostic Tools in Tropical Dermatology

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Background: Chromoblastomycosis (CBM) is a chronic fungal infection caused by melanised fungi such as *Fonsecaea*, *Cladophialophora*, and *Phialophora* species. It is most prevalent in tropical and subtropical regions where laboratory infrastructure is often limited. While diagnostic advances such as molecular assays and mass spectrometry have improved species identification, the value of simpler, accessible methods such as superficial skin scrapings has been largely overlooked.

Objective: To examine the diagnostic utility of superficial skin scrapings in detecting muriform (sclerotic) cells, highlighting their role as a rapid, low-cost tool for CBM diagnosis in resource-poor tropical settings.

Methods: Recent literature, case observations, and clinical experiences were reviewed to compare diagnostic yield, turnaround time, and feasibility across available techniques, including direct microscopy, histopathology, and culture. Special attention was given to the performance of superficial skin scrapings

Findings Superficial skin scrapings, when examined with potassium hydroxide (KOH) or fungal stains, reliably demonstrate characteristic muriform cells and can serve as a frontline diagnostic method. Histopathology and culture provide confirmatory and species-level identification but require greater resources and longer processing times. Molecular and proteomic tools (PCR, sequencing, MALDI-TOF MS) offer precision but remain largely inaccessible in endemic, low-resource regions. Integrating simple microscopy-based screening may enhance early detection, reduce diagnostic delays, and improve treatment outcomes.



ICTD26-ABS-0403

Case Series: Scabies complicating Dupilumab therapy for atopic dermatitis

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Introduction & Objectives: Classified as a neglected tropical disease in 2017 by the World Health Organisation, scabies infestation caused by the *Sarcoptes scabiei* mite is a common dermatological condition.¹ Modes of transmission include prolonged skin-to-skin contact with an infested individual or contact with contaminated surfaces. Dupilumab is a recombinant human immunoglobulin G4 monoclonal antibody that inhibits type 2 inflammation.

Materials & Methods: We present a case series of four patients who had scabies diagnosed while on dupilumab treatment for atopic dermatitis. The Type 2 immune response is the primary immune response for both ordinary and crusted scabies, and dupilumab inhibits this response. This inhibition could be the reason behind treatment resistance and crusted presentations in this case series.

Conclusion: Clinicians should be aware of the possible development of scabies in patients on Dupilumab and the potential of scabies masquerading as atopic dermatitis at the time of instituting this medication.

ICTD26-ABS-0405

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

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

A 59-year-old male presents with a 12-month history of an asymmetrical, scaly plaque on the left forearm that has been slowly increasing in size. The lesion is not pruritic or painful and has had no exudate. Past medical history included atrial fibrillation on apixaban, benign prostatic hypertrophy, and a cardiac stent. The patient was a retired print worker who enjoyed gardening. 4mm punch biopsy of the left forearm revealed superficial dermal fibrosis with mild pseudoepitheliomatous hyperplasia and granulomatous inflammation with scattered multinucleate histiocytes. There were giant cells with pigmented structures exhibiting moderate staining for PAS, compatible with Medlar bodies, suggestive of Chromoblastomycosis. Patient was on rosuvastatin, rendering Itraconazole not a possible treatment option, and instead underwent curettage and cautery with two bouts of cryotherapy freeze and thaw cycle as treatment.

Initial 6-month review revealed no evidence of recurrence, but a 12-month follow-up noted a crusted area on the distal aspect of the scar. Shave biopsy performed revealed a squamoproliferative lesion with pigmented organisms suggestive of recurrence of chromoblastomycosis. Further excisional biopsy was performed with no evidence of chromoblastomycosis.

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



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Dapsone induced agranulocytosis with neutropenic sepsis in a patient with borderline tuberculoid leprosy

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Introduction: Leprosy remains an endemic public health concern in Sri Lanka, with approximately 2,000 new cases detected annually despite effective multidrug therapy (MDT). Dapsone, a core component of MDT, significantly reduces relapse and transmission but carries the risk of dose-dependent and idiosyncratic hematologic toxicity. Agranulocytosis, although uncommon (0.2–0.4%), can rapidly progress to fatal sepsis if unrecognized. The condition results from toxic hydroxylamine metabolites that suppress myeloid precursors and induce immune-mediated neutrophil destruction. Early symptoms such as fever, sore throat, and malaise should prompt urgent evaluation. We report a case of dapsone induced agranulocytosis with neutropenic sepsis and oxidant hemolysis in a patient with borderline tuberculoid leprosy, emphasizing the need for vigilant monitoring and rapid intervention.

Case Presentation: A 66-year-old woman receiving adult multibacillary MDT (rifampicin, clofazimine, and dapsone) presented one week after her second MDT card pack with fever, sore throat, malaise, and dyspnea. Examination revealed mild cervical lymphadenopathy but no skin rash or hepatosplenomegaly. Investigations showed severe neutropenia (WBC $2.7 \times 10^9/L$; ANC $0.1 \times 10^9/L$) and elevated C-reactive protein (230 mg/L). The peripheral smear demonstrated normocytic erythrocytes with bite and blister cells, suggestive of oxidant hemolysis. Blood and urine cultures were sterile.

Dapsone was promptly discontinued, and intravenous cefuroxime was started for empirical coverage. Supportive measures included emollients, paracetamol, and transfusion of one unit of packed red blood cells for anemia. Fever resolved within 48 hours, and the absolute neutrophil count normalized over five days. The patient was discharged after six days on rifampicin and clofazimine, with counseling on regular blood count monitoring.

Conclusion: Dapsone induced agranulocytosis, though rare, remains a serious and potentially fatal complication of leprosy therapy. Early recognition, immediate cessation of dapsone, and initiation of broad-spectrum antibiotics are crucial for survival. Granulocyte colony-stimulating factor and transfusion support may accelerate hematologic recovery in severe cases. This report underscores the need for routine complete blood count monitoring during the initial months of therapy, patient education on early warning signs, and pharmacovigilance in MDT programs to ensure early detection and prevent fatal outcomes while maintaining treatment efficacy.

Keywords: Dapsone; Agranulocytosis; Leprosy; Neutropenic sepsis; Oxidant hemolysis.

ICTD26-ABS-0410

A Diagnostic Dilemma: Hansen's disease v/s Secondary Syphilis – when mimicker is mimicked

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Introduction: Leprosy is a chronic granulomatous infection that particularly affects skin and nerves but can also involve various internal organs in the course of time. In 1990, the WHO proposed the global goal of eliminating leprosy by the end of the 20th century. Despite the commitment of governments, researchers, and healthcare workers worldwide, disease control has not yet been achieved. Leprosy, due to its propensity to affect nerves, is the leading cause of disability all over the world.

Diagnosis depends on the classical presentation:

- Hypopigmented/ hyperpigmented/erythematous patch/plaque with hypoaesthesia/ anaesthesia
- Enlarged nerves
- Acid-fast bacilli on a slit skin smear or skin biopsy.

Hence, atypical and perplexing presentations of leprosy can pose a diagnostic dilemma.

Case Presentation: A 30-year-old male presented with complaints of multiple red raised lesions with flaking that first appeared on the face, progressively increasing in extent to involve the trunk, limbs, palms, and soles. The lesions on palms and soles developed 3 weeks prior to reporting to our institute. There was no history of fever, headache, or arthralgia. H/ O polygamous relationship present.

On Examination: No nerve thickening, multiple discrete erythematous scaly patches and plaques present on trunk, limbs, and bilateral palms and soles.

On Investigation: VDRL titer 1:8, TPHA - negative, Biopsy turned out to be Borderline lepromatous leprosy with slit skin smear showing BI of 6+

Discussion: The diagnosis of leprosy is based on classical presentation and in-depth examination. Leprosy is a great imitator, and unusual presentations are known to occur. Therefore, reporting and knowledge of atypical cases help prevent delay in diagnosis, which can have deleterious effects on the patient and society.

ICTD26-ABS-0411

A Paradox of Patterns: Erythema Nodosum Leprosum Presenting as Palmar Pustulosis – A Diagnostic Conundrum

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Introduction: Lepre reactions are acute inflammatory episodes that disrupt the typically chronic and quiescent course of Hansen's disease. Erythema Nodosum Leprosum (ENL) is considered an immune complex-mediated reaction characterized by painful erythematous papules, plaques, and nodules associated with constitutional symptoms such as fever, malaise, and arthralgia. Apart from the classic presentation, atypical forms such as bullous, hemorrhagic, erythema multiforme-like, or Sweet's syndrome-like patterns have been reported.

Case Presentation: Two cases of previously diagnosed lepromatous leprosy, recently started on Multidrug Therapy (MDT), presented to our OPD with pustular and vesicular eruptions affecting only the palms, associated with fever, malaise, joint pain, and Grade 1 neuritis. On examination, there were no other classic features of ENL, such as evanescent erythematous papules, plaques, or nodules seen elsewhere in the body. Based on history and a high degree of suspicion, the diagnosis of ENL was made and confirmed with a biopsy from pustules/vesicles present on the palms. Both patients responded well to systemic steroids, thalidomide capsules, and NSAIDs, along with the continuation of MB MDT.

Discussion: ENL usually presents with classical features. However, many atypical presentations have been reported, and one should suspect atypical ENL in the following cases.

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- Patients from an endemic area or with a history of contact with a lepromatous relative.
- Acute skin eruptions accompanied by constitutional symptoms.
- Systemic complaints such as arthralgia, neuritis, red eye, and lymphadenopathy.
- Existing cutaneous lesions suggestive of leprosy.

Conclusion: Reporting atypical cases is crucial in raising awareness about masquerading presentations, posing diagnostic challenges. Any delay in the diagnosis of ENL worsens the prognosis and treatment outcomes in the form of worsening disability and deformity, thereby increasing social isolation and stigma.

ICTD26-ABS-0412

Leprosy beyond the Textbook: A Diagnostic Challenge

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Introduction: Leprosy has existed in our society since time immemorial. It usually presents with classical features like Hypopigmented/hyperpigmented/erythematous patch/plaque with hypoaesthesia/ anasthesia and thickened, enlarged nerves. But leprosy, with a wide clinical spectrum, can present with atypical presentation, which could pose a diagnostic dilemma and diagnostic delay.

Case Presentation

Case	Presenting Complaints	Examination	Differentials	Investigation
21-year-old male	Multiple erythematous scaly plaques and patches all over the body, involving the palms and soles. No H/O fever, lethargy/joint pain present. H/O polygamy	Erythematous scaly plaques involving bilateral palms and soles, no nerve thickening or sensory loss	Secondary Syphilis, Reiter's disease, Psoriasis,	SSS +6 Biopsy – Borderline lepromatous leprosy
46-year-old female	2-4 Discrete flat pale lesions on forearms and nape of neck for 1 year, which gradually turned into red raised lesions.	Sensation intact. Nerves not thickened.	?Polymorphous Light Eruptions ?Photo Aggravated ACD	Biopsy Borderline Lepromatous Leprosy SSS negative
33-year-old female	Multiple asymptomatic skin colored to red raised lesions on the forehead for 7-8 months	Sensation intact Nerves not palpable	?Polymorphous Light Eruptions ?Photo Aggravated ACD	Biopsy Indeterminate Hanes's disease
52-year-old female	Recurrent unilateral peri-orbital swelling associated with mild pain, with centrofacial erythema since 4-5 months	Sensation intact Nerves not palpable	?Connective tissue disorder ?Rosacea	Biopsy Borderline Tuberculoid Leprosy with ENL



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Discussion: Leprosy is the leading cause of disability all over the world. Diagnosis of leprosy lies in classic clinical features and demonstration of Acid Fast Bacilli in Slit Skin Smear/ Biopsy. However, leprosy is a great imitator and unusual presentations are reported in all the poles of leprosy, which can pose a diagnostic dilemma and delay. The diagnostic delay caused by atypical presentation leads to increased chances of deformity and transmission of disease to contacts; knowledge and reporting of atypical presentation are of utmost importance.

Conclusion: This Case series highlights the atypical presentation of leprosy, which prevents diagnostic delay, which can have deleterious effects on the patient and society as a whole.

ICTD26-ABS-0415

Pegylated Liposomal Doxorubicin and Paclitaxel for Epidemic Kaposi Sarcoma in Sub-Saharan Africa: A Scoping Review

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Introduction: Epidemic Kaposi Sarcoma (KS), an AIDS-related malignancy driven by HIV-associated immunosuppression, remains a major cause of morbidity and mortality in sub-Saharan Africa (SSA). KS typically manifests as multifocal vascular tumours with characteristic skin lesions. Conventional doxorubicin, often part of ABV (adriamycin, bleomycin, vincristine) regimens, remains a common treatment option despite concerns about efficacy and toxicity. Alternative agents such as Pegylated Liposomal Doxorubicin (PLD) and Paclitaxel (PTX) are highly effective, but their use may be limited by cost and availability. Evidence for PLD and PTX in KS treatment in SSA is limited.

Objectives: This scoping review aimed to map existing research on PLD and PTX for epidemic KS in SSA, examining studies for treatment outcomes, care models, and implementation barriers.

Methodology: A systematic search was conducted in August 2024 across CENTRAL, Embase, MEDLINE, and trial registries. Eligible studies included epidemic KS patients treated with PLD or PTX in SSA. Data extraction focused on study design, population, interventions, and outcomes. The review followed PRISMA-ScR guidelines; quality was assessed using Joanna Briggs Institute checklists.

Results: Of 147 records screened, 12 met inclusion criteria: one randomised controlled trial (RCT), eight cohort studies, and one case report. An additional RCT comparing PLD and PTX is planned, and one cohort study is ongoing. Most studies were from Malawi, Mozambique, Tanzania, and Uganda. Adoption of PLD is constrained by high cost, supply chain issues, and infrastructure needs. Diagnostic limitations further delay treatment. Integrated care models combining chemotherapy, antiretroviral therapy, and community support improved retention and survival.

Conclusions: PLD and PTX are effective and well-tolerated, with PTX showing superior progression-free survival compared to conventional regimens. PLD offers favourable safety and quality-of-life profiles. However, implementation is hindered by systemic barriers. Current guidelines largely rely on high-income country data, underscoring the urgent need for context-specific RCTs.

ICTD26-ABS-0418



Case Report: Klippel–Trénaunay Syndrome in a 40-Year-Old Male

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Introduction: Klippel–Trenaunay Syndrome (KTS) is a rare sporadic congenital vascular disorder characterized by the classical triad of capillary malformations, venous abnormalities, and hypertrophy of bone and soft tissue. It usually presents at birth or early childhood, most commonly affecting the lower limb. Clinical severity ranges from cosmetic deformity to serious complications such as chronic venous insufficiency, thrombosis, bleeding, and limb length discrepancy. Early diagnosis and multidisciplinary management are essential to reduce morbidity.

Case Report: A 40-year-old man presented with progressive asymmetrical enlargement of the right lower limb and widespread skin discoloration involving the face, trunk, and extremities since birth. He complained of gradual limb enlargement associated with heaviness and occasional pain. There was no history of trauma, ulceration, infections, deep vein thrombosis, or similar family illness.

Cutaneous examination revealed multiple well-defined port-wine stains predominantly over the right side of the face, trunk, and lower limb. The right lower limb showed marked hypertrophy of soft tissues and bones with increased girth and length compared to the left limb. Prominent, tortuous varicose veins with areas of hyperpigmentation and skin thickening were noted.

Facial asymmetry due to soft tissue hypertrophy over the right cheek and lips was present. Intraoral examination showed vascular malformations with engorged veins over the tongue and oral mucosa. No bruit was detected. Systemic examination was normal.

Doppler ultrasonography demonstrated venous ectasia with deep venous insufficiency and no arteriovenous fistula. Laboratory investigations were within normal limits. A diagnosis of KTS was made, and the patient was managed conservatively with compression therapy, limb elevation, skin care, and thrombosis prevention, with regular follow-up advised.

Discussion: KTS results from abnormal vascular and mesenchymal development. The lower limb is involved in most patients, though facial and truncal involvement may occur. Capillary malformations appear at birth and darken with age, while venous abnormalities lead to chronic venous insufficiency and limb hypertrophy. The absence of bruit and arteriovenous fistula helped differentiate KTS from Parkes Weber syndrome. Complications include venous stasis, thrombosis, bleeding, and limb length discrepancy. Management is mainly conservative, with compression therapy as the cornerstone. Selected cases may require interventional or surgical treatment.

This case highlights the classical presentation of KTS persisting into adulthood and underscores the importance of long-term multidisciplinary care.

ICTD26-ABS-0422

Case Report: Crusted Scabies in an Immunocompetent Individual

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Introduction & Objectives: Crusted scabies, also known as Norwegian scabies, is a rare and severe variant of the common scabies infestation caused by *Sarcoptes scabiei* var. *hominis*. It is typically associated with immunocompromised individuals. Its occurrence in immunocompetent individuals is uncommon and may



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lead to misdiagnosis. Early identification is crucial to prevent widespread transmission and initiate appropriate combined therapy.

Case Presentation: I present the case of a 38-year-old male, immunocompetent with no known comorbidities, poor hygienic condition, who presented with a 2-month history of severe pruritus and progressively worsening crusted skin lesions. The condition began with mild itching and erythematous papules over the trunk, and rapidly progressed to involve the feet, elbows, scalp, and trunk over the next 1 month. With normal systemic examination. Physical examination revealed extensive hyperkeratotic, yellow-grey crusted plaques on the hands, feet, elbows, and scalp, Fissures over the palms and soles, Diffuse xerosis, excoriation marks, and mild erythema. The diagnosis was confirmed by skin scraping. Treatment of oral Ivermectin, along with topical Permethrin 5%, keratolytic therapy, and 1st and 2nd Generation antihistamine and environmental decontamination

Discussion: Crusted scabies is a severe form of scabies characterized by an overwhelming mite burden, thick crusted plaques, and high infectivity. It is classically associated with immunosuppression; however, this case demonstrates its occurrence in an immunocompetent host, especially in a third-world country like Pakistan. The pathogenesis in immunocompetent individuals may relate to delayed diagnosis, genetic susceptibility, or exaggerated hyperkeratotic response. Early clinical suspicion, aided by dermoscopy and confirmatory skin scrapings, is essential to avoid complications and prevent community spread. Combination therapy with oral ivermectin and topical permethrin remains the standard of care, particularly in crusted scabies where monotherapy is inadequate. Close monitoring, hygienic counseling, and treatment of all contacts are mandatory to prevent outbreaks due to the high mite load.

ICTD26-ABS-0425

Case Report: Chronic Discoid Lupus Erythematosus Presenting with Facial Plaques

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Introduction: Chronic Discoid Lupus Erythematosus (DLE) is the most common form of cutaneous lupus, presenting as well-defined erythematous plaques with adherent scale, follicular plugging, dyspigmentation, and scarring, especially on sun-exposed facial areas. Lesions slowly progress to show central atrophy with peripheral hyperpigmentation and active inflammation. DLE is usually localized to the skin, but a small subset may show serologic abnormalities or rarely progress to systemic lupus erythematosus. Early diagnosis and photoprotection are essential to prevent permanent scarring and disfigurement.

Case Report: A 35-year-old male presented with multiple, well-defined erythematous plaques with central atrophy and peripheral hyperpigmentation over the malar area and nose for 8 months. The lesions were slowly progressive and associated with a mild burning sensation on sun exposure. No history of photosensitivity, joint pain, oral ulcers, or systemic symptoms was reported.

Cutaneous examination revealed well-demarcated, scaly erythematous plaques with areas of scarring and hypopigmentation distributed symmetrically over the malar region and bridge of the nose, sparing the nasolabial folds. Routine hematological and biochemical investigations were within normal limits. ANA and anti-dsDNA were negative. Skin biopsy showed epidermal atrophy, follicular plugging, basal cell degeneration, and dense perivascular and periappendageal lymphocytic infiltrate consistent with Chronic Discoid Lupus Erythematosus (CDLE).



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The patient was treated with topical corticosteroids, hydroxychloroquine 200 mg twice daily, and advised strict photoprotection. Significant improvement was noted after 8 weeks, with a reduction in erythema and scaling.

Discussion: CDLE is a chronic cutaneous form of lupus that can cause disfiguring facial lesions if untreated. Early diagnosis and combined antimalarial and photoprotective therapy lead to favorable outcomes.

ICTD26-ABS-0426

Liposomal AP39 gel restores mitochondrial health and reduces inflammation in tropical dermatoses

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Introduction: Persistent inflammation, oxidative stress, and mitochondrial dysfunction drive tissue destruction and delayed healing in tropical dermatoses such as cutaneous leishmaniasis, Buruli ulcer, and chronic tropical wounds. These conditions are characterised by elevated IL-6, hyperactive MMPs, and mitochondrial ROS accumulation, which impair fibroblast function and prolong ulceration. Hydrogen sulfide (H₂S) is a potent modulator of mitochondrial function and inflammation, but its therapeutic potential is limited by instability and rapid release. AP39, a mitochondria-targeted H₂S donor, offers precise mitochondrial delivery, and liposomal encapsulation enhances stability, controlled release, and dermal penetration, opening the door to a new class of mitochondria-focused therapeutics for inflammatory skin disease.

Objectives: This study aimed to evaluate whether a liposomal AP39 topical gel can restore mitochondrial function and attenuate inflammation-associated matrix degradation in human dermal fibroblasts, providing proof-of-concept for a mitochondria-targeted adjunct therapy for tropical inflammatory skin conditions.

Methodology: Hydroxypropyl-methylcellulose gels (5% w/v) containing liposomal AP39 (0.005% w/w) were formulated. Human dermal fibroblasts were stimulated with TNF- α (1 ng/mL, 3 h) to model the cytokine-rich microenvironment seen in chronic tropical lesions. Following 24-hour treatment with liposomal-AP39 gel (100 nM), IL-6 and MMP-9 secretion (ELISA), cell viability, and mitochondrial oxidative stress (TMRM) were quantified.

Results: TNF- α -stimulated fibroblasts exhibited elevated IL-6 (60.3 ± 5.6 pg/mL) and MMP-9 (386.4 ± 10.13 pg/mL). Liposomal AP39 gel was non-toxic up to 700 nM and significantly reduced IL-6 (to 39.5 ± 4.34 pg/mL) and MMP-9 (to 243.1 ± 12.3 pg/mL; $p < 0.0001$). TMRM analysis showed reduced mitochondrial superoxide accumulation, indicating improved mitochondrial function and reduced oxidative stress.

Conclusion: Liposomal AP39 gel represents a first-in-class, mitochondria-targeted approach to combat inflammation-driven tissue damage in tropical dermatoses. By simultaneously suppressing cytokine overactivation, protecting mitochondria, and preserving matrix integrity, this strategy holds promise as an innovative adjunct therapy for chronic and inflammatory tropical skin diseases.



ICTD26-ABS-0430

Beyond Expected Borders: Cutaneous Leishmaniasis Emerging from Non-Endemic Coastal South India

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Introduction: Cutaneous leishmaniasis (CL) is a chronic protozoal skin infection transmitted by phlebotomine sandflies, presenting as persistent papules, plaques, or ulcers. In India, CL is primarily endemic in Rajasthan, Bihar, Uttar Pradesh, West Bengal, and parts of Jharkhand, with only sporadic cases elsewhere. Because CL may mimic other granulomatous dermatoses, its diagnosis outside endemic zones is often challenging. This case describes CL arising in non-endemic coastal South India, underscoring the need to consider atypical differentials even when traditional epidemiologic indicators are lacking.

Case Presentation: A sixty-five-year-old woman from Kasaragod, coastal Kerala, presented with a 9-month history of a slowly enlarging swelling on the left cheek, occasionally tender but without discharge, fever, weight loss, or systemic symptoms. She had type 2 diabetes mellitus and hypertension.

Examination revealed a solitary erythematous, indurated plaque with central crusting. Based on the chronicity and morphology, lupus vulgaris, scrofuloderma, and cutaneous leishmaniasis were considered as differentials. Consequently, a skin biopsy for histopathology was performed, keeping these in consideration despite the patient reporting no travel to any endemic region.

Histopathology revealed macrophages containing numerous basophilic organisms with a nucleus and rod-shaped kinetoplast, further highlighted by Giemsa stain, thereby establishing the definitive diagnosis of cutaneous leishmaniasis. The patient is currently being treated with oral itraconazole.

Discussion: The occurrence of CL in a non-endemic coastal district reflects shifting epidemiologic boundaries and suggests the possibility of localized vector habitats, ecological changes, or previously unrecognized transmission pockets. Phlebotomine sandflies have limited flight ranges, typically only a few hundred meters, supporting these observations and aligning with emerging reports from southern India.

This case highlights the importance of considering CL in chronic plaques even in regions traditionally regarded as non-endemic, reinforcing the need for continued surveillance, awareness of evolving vector ecology, and heightened clinical vigilance in recognizing changing disease patterns.

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Intertrigo-Like Dermatitis Secondary to Doxorubicin

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Introduction: Doxorubicin is a chemotherapeutic agent used in the treatment of solid tumours[1]. It is associated with risk of cardio toxicity and myelosuppression; there is also risk of dermal disorders like intertrigo-like eruption, diffuse follicular rash, melanotic macules, and maculopapular rash.[2] Hereby, we present a case of a 56-year-old female with intertrigo-like dermatitis secondary to doxorubicin.

Case Report: A 56-year-old female was diagnosed with soft tissue sarcoma over the knee one year ago and was treated with radiotherapy followed by chemotherapy. Chemotherapy was initiated in June 2024 with lyophilized doxorubicin hydrochloride, administered at a dose of 75 mg every 21 days. Two days after



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the sixth cycle of chemotherapy, the patient developed itching over the left popliteal fossa, which rapidly progressed to raw areas with increasing size. This was accompanied by pain and watery discharge. There was no history of application of any irritants or native medications over the lesion, nor any history of fluid-filled lesions. There was no oral or mucosal involvement. She is a known case of type 2 diabetes mellitus. On examination, multiple erosions with maceration and surrounding hyperpigmentation were observed over the left popliteal fossa (Fig. 1A). KOH examination showed no fungal elements. Based on clinical findings, she was diagnosed with intertrigo-like dermatitis secondary to doxorubicin. She was started on systemic antibiotics and topical antifungal creams. The lesion began resolving within two days (Fig. 1B). Prophylactic systemic corticosteroids were advised prior to the next chemotherapy cycle to minimize the risk of recurrence.

Discussion: Doxorubicin is derived from the *Streptomyces peucetius* bacterium. It has been used as a chemotherapeutic agent since the 1960s. It belongs to the anthracycline group of chemotherapeutic drugs. It is commonly used in the treatment of solid tumors, soft tissue sarcoma, leukemia, and lymphoma. It produces adverse effects such as cardiotoxicity and myelosuppression. It is usually administered 21 days apart.

Skin manifestations are divided into six types: palmoplantar erythrodysesthesia, intertrigo-like dermatitis, follicular rash, maculopapular rash, melanotic rash, and recall phenomenon [2]. Symptoms commonly develop 2 to 12 days after chemotherapy. The pathological mechanism of intertrigo-like dermatitis is not clearly known. According to various studies, palmoplantar erythrodysesthesia is the most common, followed by intertrigo-like dermatitis.

Clinically, these lesions appear as vesicles or bullae, which then progress to erosions. Intertrigo-like dermatitis mostly involves skin folds or pressure areas. These lesions can be confused with tinea cruris, inverse psoriasis, atopic dermatitis, and candidal intertrigo.

They can be treated with topical antifungals alone or in combination with topical steroids. Symptomatic management is also provided. Systemic steroids can be started prophylactically before the next cycle of chemotherapy to minimize the chances of developing similar adverse effects. Cutaneous adverse effects are more common with pegylated liposomal doxorubicin compared to other formulations. In our patient, lyophilized doxorubicin was administered.

Conclusion: Pegylated liposomal doxorubicin is used to reduce adverse effects like cardiotoxicity and myelosuppression, but cutaneous side effects are more common compared to other forms. But in our case, even in the lyophilized form of doxorubicin, cutaneous manifestations are seen. Doxorubicin plays a vital role in the treatment of life-saving conditions like malignancy. Doxorubicin has now become an inevitable drug. Knowing the side effects of a drug not only helps to treat side effects but also helps to reduce morbidity and mortality. Hence, improving the quality of life in patients.

ICTD26-ABS-0439

When Genetics Paints the Skin: A Rare Case of Beckwith–Wiedemann Syndrome and Pigmentary Mosaicism

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Introduction: Beckwith–Wiedemann syndrome (BWS) is a rare congenital overgrowth condition resulting from epigenetic changes on chromosome 11p15.5. It presents with diverse clinical features such as lateralized overgrowth, macroglossia, omphalocele, hyperinsulinism, and an increased risk of tumors.



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Pigmentary mosaicism, which arises from chromosomal abnormalities, manifests as areas of hypo- or hyperpigmentation in a mosaic distribution. We present a case of Beckwith–Wiedemann syndrome occurring in association with pigmentary mosaicism.

Case Report: A 10-day-old large for gestational age male term baby born to a 20-year-old primi, non-consanguineous marriage, spontaneous conception with no co-morbidities. Was referred to the dermatology department in view of hyperpigmented lesions over the trunk. On examination, multiple well-defined hyperpigmented macules arranged in a linear pattern are present over the trunk and limbs. Diagnosis of Pigmentary Mosaicism Type 1 was made. On further examination, the baby had macroglossia, hemi-hyperplasia, macrosomia, bilateral ear lobe creases, left ear posterior helical pits, and placentomegaly. Ophthalmological examination was done to rule out retinitis pigmentosa. Genetic testing showed a gain of methylation in ic1 and loss of methylation in ic2 of the 11p15 locus, suggestive of Beckwith-Wiedemann syndrome caused by paternal uniparental disomy.

Discussion: Beckwith-Wiedemann syndrome (BWS) is a growth disorder with variable expression—affected individuals may exhibit multiple, few, or even a single characteristic clinical feature. While accelerated growth is commonly observed during late fetal life and early childhood, the growth rate typically normalizes by seven to eight years of age. The rarity of Beckwith–Wiedemann syndrome, combined with its unusual association with pigmentary mosaicism in this case, adds to its clinical significance. We present this case for its uniqueness, emphasizing that early diagnosis can significantly reduce both morbidity and mortality.

ICTD26-ABS-0442

Factors Associated with Hepatitis and Rising ALT in Patients Receiving Multi-Drug Therapy for Leprosy

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Introduction: Hepatotoxicity is a recognized adverse effect of multidrug therapy (MDT) for leprosy, attributed to several components rather than a single agent. Rising alanine aminotransferase (ALT) levels and drug-induced hepatitis often necessitate treatment modification, yet comparative evidence on patients who continued versus changed their MDT regimen remains limited.

Objectives: To describe ALT dynamics during MDT, determine the proportion developing hepatitis, identify factors associated with hepatitis, and compare baseline ALT values and ALT rise between patients who continued their initial regimen and those who required a change.

Methodology: A retrospective analysis of MDT-treated patients from 1 January 2016 to 31 December 2023 was conducted using clinic records. Non-parametric statistical tests were applied due to non-normal data distribution.

Results: A total of 493 patients were included (mean age 40.2 ± 16.8 years; 69.2% male). Median baseline ALT was 26U/L (IQR 17.25–42.45), and the median ALT rise during treatment was 6.9U/L (IQR –1.05 to 16.8). Hepatitis occurred in 5.5%.



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Hepatitis was significantly associated with receiving MDT-MB (6.9% vs. 2.5%), higher baseline ALT (median 31U/L vs. 26U/L), and a larger ALT rise (median 114 U/L vs. 6 U/L). Age and sex were not associated with hepatitis. Baseline ALT demonstrated an inverse correlation with elevation of ALT, while the time to maximum ALT correlated positively with the rise ($p<0.05$).

When comparing treatment continuation versus regimen change, baseline ALT values were statistically comparable (27U/L vs. 24.15U/L; $p=0.23$). However, the ALT rise was significantly higher in the regimen-change group (median 10U/L vs. 6U/L, $p<0.05$), consistent with the development of ALT-related adverse reactions prompting modification.

Conclusions: ALT elevations and hepatitis are important toxicities during Leprosy-MDT. Higher baseline ALT, MDT-MB, and larger ALT rises are key indicators of hepatotoxicity. Although regimen-change and no-change groups start with similar baseline ALT levels, greater ALT elevation characterizes those requiring treatment modification.

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The Echo of Infestation: Eczematous Pediculid – A Case Series

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Introduction: This is a case series of three young girls who presented with an atypical clinical picture of eczematization predominantly over extremities, who were diagnosed as id eruptions secondary to pediculosis capitis.

Case Report

Case 1: A 9-year-old female came with pruritic, diffuse, hyperpigmented plaques over bilateral upper and lower limbs, face, and neck for 10 days. On scalp examination, there was florid infestation with nits and lice with tender, occipital lymphadenopathy. On probing further into history, the patient had low mood and anhedonia. On evaluation, she was found to have iron deficiency anemia. Psychiatric evaluation was done, and the patient was diagnosed with mild depression according to ICD-10.

Case 2: 14-year-old female with itchy, oozy, erythematous, discrete plaques with surrounding eczematization over bilateral feet, legs, and forearms for two weeks. There were several nits found in her scalp.

Case 3: 13-year-old female with discrete, well-defined, hyperpigmented papules and plaques over bilateral forearms and legs for 20 days. Multiple lice and nits were found over the scalp. The patient had tender occipital lymphadenopathy and moderate anemia (9g/dl).

All three cases were treated with oral steroids along with oral ivermectin – 2 doses. Topically, the scalp was treated with a permethrin rinse, and cutaneous lesions with topical steroid + antibiotic creams. Patients improved symptomatically, and oral steroids were tapered and stopped.

Conclusion: Pediculosis humanus capitis has an antigen in its saliva, which triggers an inflammatory response, leading to pruritus and subsequent impetiginization. Although id eruptions can be attributed to a variety of etiologies, in the paediatric age group, pediculosis capitis infestation should not be forgotten. Chronic infestation can also lead to anemia. Mild depression was also found in one of the patients in this series. Hence, an eye for detail and thorough evaluation is necessary.



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Retrospective Analysis of the Clinical Spectrum of Cutaneous Infections Presented to the Skin Clinic at District General Hospital, Horana, Sri Lanka

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Introduction: Numerous cutaneous infections are presented to the skin clinics in Sri Lanka throughout the year. DGH Horana is one of the tertiary care hospitals in the western province of Sri Lanka. It caters to a large population in the surrounding suburbs,

Objectives: To analyse the prevalence of the clinical spectrum of cutaneous infections presented at their first visit to the skin clinic at DGH Horana.

Methodology: Data collection was carried out retrospectively, using clinic registers of 6 months from 1st of June to 30th of November 2025. Data was analysed with percentages of sex, age, and clinical pattern distribution.

Results: Total study population was 2456 over 6 months with 46.5% males, 53.5% females, age variation of 13.7% <5yrs, 26.4% 5-12 yrs, 25.3%, 34.6% >18yrs in vivid clinical patterns, including Bacterial 19.4%, viral 34.4%, fungal 46.2% in origin.

Conclusion: In the skin clinic of DGH Horana, the most common cutaneous infection presented was fungal infections, and the least common was bacterial infections in the study group. The age group mostly affected was found to be the >18 yrs group, while the least affected age group shown in the study was the < 5 yrs group. High prevalence was seen in the order of fungal, viral, and bacterial infection presentations, respectively.

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Xeroderma Pigmentosum: A Case Series

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Introduction: Xeroderma pigmentosum is a rare autosomal recessive genodermatosis caused by defects in the nucleotide excision repair pathway, resulting in impaired correction of ultraviolet-induced DNA damage. Cumulative ultraviolet exposure leads to progressive pigmentary changes, cutaneous atrophy, ocular involvement, and early development of skin malignancies. Early diagnosis and strict photoprotection are crucial in reducing morbidity and mortality.

Case Presentation: We report two pediatric cases demonstrating the clinical variability of xeroderma pigmentosum.

The first case was a 10-year-old boy who presented with diffuse freckling and mottled hyperpigmentation over photoexposed areas since early childhood. He developed an ulcerated, crusted plaque over the nasal bridge. Histopathological examination confirmed well-differentiated squamous cell carcinoma arising in a background of xeroderma pigmentosum.

The second case was an 8-year-old boy with xerosis and diffuse freckling associated with hyperpigmented and hypopigmented macules over sun-exposed areas. There was no clinical or histopathological evidence of malignancy.



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Both children had marked photosensitivity, photophobia, and conjunctival pigmentation without neurological deficits. There was no significant family history. These cases illustrate variable clinical severity despite comparable age and environmental exposure.

Discussion: Xeroderma pigmentosum exemplifies defective DNA repair, manifesting as extreme photosensitivity and early carcinogenesis. The occurrence of squamous cell carcinoma in the first decade underscores the aggressive malignant potential. Early recognition, lifelong ultraviolet avoidance, regular dermatologic and ophthalmologic surveillance, and genetic counseling are essential to reduce complications and improve long-term outcomes.

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Angiokeratoma of the Penis: A Clinical Mimicker of Genital Pathology

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Introduction: Angiokeratoma of the penis is a benign vascular condition characterized by dilated capillaries in the superficial dermis with overlying epidermal hyperkeratosis. It commonly presents as multiple dark red to violaceous papules over the genitalia. Although harmless, the lesions may cause anxiety due to their appearance and occasional bleeding, often leading to concern about sexually transmitted infections.

Case Presentation: A 45-year-old male presented with multiple dark, raised lesions over the glans penis and distal shaft for three years. The lesions gradually increased in number and were associated with occasional bleeding following minor trauma. There was no history of pain, pruritus, discharge, dysuria, ulceration, or high-risk sexual behavior. Cutaneous examination revealed multiple discrete, well-defined, dome-shaped papules measuring 2–5 mm, dark red to violaceous in color with a hyperkeratotic surface. No inguinal lymphadenopathy was noted. Routine investigations and serological screening for sexually transmitted infections were normal. Histopathology confirmed the diagnosis of angiokeratoma.

Discussion: Angiokeratoma results from superficial dermal vascular ectasia and may be associated with local trauma or increased venous pressure. Differential diagnoses include genital warts, melanocytic lesions, and pyogenic granuloma. Accurate clinical recognition is essential to avoid misdiagnosis and unnecessary anxiety. Treatment is indicated for symptomatic or bleeding lesions and includes electrocautery, cryotherapy, or laser ablation. Patient reassurance and follow-up remain key components of management.

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Blaschkitis in a Child: A Rare Acquired Blaschko Linear Inflammatory Eruption

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Introduction: Blaschkitis is a rare acquired inflammatory dermatosis characterized by eruptions distributed along the lines of Blaschko. It is predominantly described in adults and is uncommon in children, where it may be misdiagnosed as lichen striatus, linear psoriasis, or inflammatory linear verrucous epidermal nevus. Recognition is essential to ensure appropriate management and to differentiate it from other linear dermatoses.



E-Poster Abstracts

Case Presentation: A 4-year-old previously healthy girl presented with a 3-week history of multiple pruritic erythematous scaly plaques arranged linearly over the left flank, buttock, and lower limb. Additional scattered linear plaques were noted on both upper limbs and the right thigh. All lesions followed the lines of Blaschko. There was no preceding history of infection, vaccination, new topical application, or drug intake.

Dermoscopic evaluation showed dotted vessels over a pink background with focal white scales. A 3-mm punch biopsy from an active lesion revealed spongiotic dermatitis with superficial perivascular lymphocytic infiltrate and absence of psoriasiform hyperplasia, supporting the diagnosis of blaschkitis.

The child was treated with a mid-potency topical corticosteroid for two weeks, followed by topical tacrolimus as maintenance therapy. Marked clinical improvement was observed by the fourth week, with near-complete resolution at eight weeks, leaving mild post-inflammatory dyspigmentation.

Discussion: Blaschkitis in children is rare and may present with multifocal linear lesions, leading to diagnostic uncertainty. Clinicopathological correlation is crucial to distinguish it from other Blaschko-linear dermatoses. Early recognition and appropriate topical therapy result in favorable outcomes and prevent unnecessary investigations or aggressive treatments.

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Cutaneous Leiomyoma: A Rare Unilateral Dermatoses

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Introduction: Cutaneous leiomyomas are rare benign tumors arising from smooth muscle cells, most commonly from the arrector pili muscle (piloleiomyomas). They may present as solitary or multiple painful papules and nodules, and can be associated with hereditary syndromes such as multiple cutaneous and uterine leiomyomatosis and hereditary leiomyomatosis with renal cell carcinoma (HLRCC)

Case Report: A 25-year-old male presented with complaints of painful, itchy red bumps over the left side of the body for 2 years. The lesions began as a single papule over the leg and gradually increased in number over 3–4 months, involving the left trunk and left upper and lower limbs. Pain was exacerbated by cold exposure and touch. He had previously been treated as a case of folliculitis without improvement. There was no family history of similar complaints. He was recently diagnosed with hypertension and was on treatment.

Cutaneous examination revealed multiple well-defined papules and deep-seated nodules distributed unilaterally over the left trunk and extremities, along with follicular keratotic papules suggestive of keratosis pilaris.

Skin biopsy showed a well-circumscribed dermal tumor composed of spindle-shaped cells arranged in interlacing fascicles and whorls, without mitosis or necrosis. Immunohistochemistry demonstrated smooth muscle actin (SMA) positivity, confirming the diagnosis of cutaneous leiomyoma

Discussion and Management: Cutaneous leiomyomas are often painful due to nerve impingement. When multiple, evaluation for the fumarate hydratase (FH) gene mutation is recommended due to association with HLRCC. The patient was started on nifedipine for symptomatic relief, advised regular blood pressure monitoring, and counseled regarding genetic testing and periodic renal imaging. Early recognition is essential to identify associated systemic risks and provide appropriate surveillance.