Dermatology & Venereology

**Crusted scabies in a patient with systemic lupus erythematosus**

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**Background:** Crusted scabies caused by Sarcoptes scabiei var hominis in immune compromised patients. Usually Not itching. And misdiagnosed as psoriasis, eczema, SD, or a drug reaction. And diagnosis of this cases is mainly by Skin biopsy. It usually started as red patches then developed into thick scaly plaques between the fingers under the nails: causing the nail plates to split. Diffusely over palms and soles. Then developed into thick scaly plaques between the fingers Diffusely over palms and soles. Under the nails: causing the nail plates to split. Rarely presented as pustular psoriasis. History: 29-year-old female patient known systemic lupus on systemic steroids presented by non Itching scaly papules pustules of 2 month duration. Examination: Scalp examination showed: Hyperkeratotic scaly papules and pustules in the scalp. Skin examination showed: Small non-follicular pustules on an erythematous base over limbs and trunk some of them take annular configuration. Differential Diagnosis: Our clinical Differential Diagnosis included: acute generalized pustular psoriasis and acute generalized exanthematous pustulosis. Histopathology: showed mild Marked hyperkeratosis with multiple organism invaginated in epidermis and Superficial perivascular inflammatory infiltration. High power filed showed multiple scabies mites surrounded by parakeratosis. Final diagnosis is Crusted Scabies. **Discussion:** Crusted scabies is a severe hyperkeratosis, psoriasis-form dermatosis. Unlike typical scabies, adults with crusted scabies may lack the characteristic rash or itching. Sites of presentation have been reported on the scalp, face, neck, extremities, trunk, hand, and feet.

**Nonmutilating palmoplantar and periorificial keratoderma**

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**Background:** Olmsted syndrome1 is a rare keratinization disorder characterized by mutilating palmoplantar and periorificial keratoderma as the two major diagnostic features. Some authors believe that atypical cases without this standard combination may not really belong to Olmsted syndrome. Herein, we describe case with congenital nonmutilating palmoplantar and periorificial keratoderma, and discuss its similarity and difference with Olmsted syndrome. History: 3-year-old female presented by bilateral PPK in progressive coarse started after birth with hyperkeratotic lesions around Nose, Mouth, Eyes and Perigenital area. Examination: Skin examination showed bilateral and symmetrical PPK. The lesions were yellowish brown in color, with flexion contractures of the fingers. But no evidence of mutilation has been found, no constriction of the digits and no amputation. But Scalp examination showed thin and easily broken scalp hair with well defined, erythematous and yellowish hyperkeratotic plaques were seen around the mouth, the eyes, nose and genital area. Generally: There is no abnormalities in Growth, Social and Mental function Investigation: work up was done and no abnormalities could be detected in CBC, Liver enzymes, Kidney Function and Bone X-Ray. Final Diagnosis: Nonmutilating palmoplantar and periorificial keratoderma.

**Discussion:** Our clinical DD included: Acrodermatitis enteropathica, Hidrotic ectodermal dysplasia and Olmsted syndrome periorificial keratoderma. Due to severe PPK and normal serum levels of zinc. Acrodermatitis enteropathica excluded. And due to absence nail dystrophy, no eye changes Hidrotic ectodermal dysplasia excluded. And Due to Presence of palmoplantar keratoderma and Periorificial keratoderma so we suspect Olmsted syndrome. But in our case There was no mutilation, no constriction of the digits, no amputation and no nails abnormalities. **Conclusion:** Our case share Olmsted syndrome in the presence of PPK and periorificial keratoderma. But, absence of mutilating PPK and the presence of unique features in our patients suggest a newly described keratinization disorder.

**Multiple basal cell carcinomas after bone marrow transplantation**

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Increased risk of secondary malignancies following both autologous and allogeneic hematopoietic stem cell transplant has been reported. Basal cell carcinomas (BCC) are the most frequent among the cutaneous secondary malignancies. We report here the case of a 47-year-old female patient who developed multiple superficial BCC as well as a few nodular BCC over a period of 10 years following autologous bone marrow transplantation. These tumours were found in non-sun-exposed protected skin. The patient was treated with surgical excision of nodular BCC while photodynamic therapy with methylene blue was used for the superficial BCC. To our knowledge, this is the fourth case of a patient presenting with multiple BCC after bone marrow transplantation.


**Naevus comedonicus complicated by hidradenitis suppurative-like lesions**

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**Introduction:** Naevus comedonicus is characterized by a recurrent suppurative linear arrangement of dilated follicular...