THE CUTIS

DERMA NEWS BULLETIN

Exploring Dermatology: From Clinics to Scopes

Bimonthly | Monday, 30 March 2025 (Ugadi Edition) | Issue 1

Anchala's Skin Institute,
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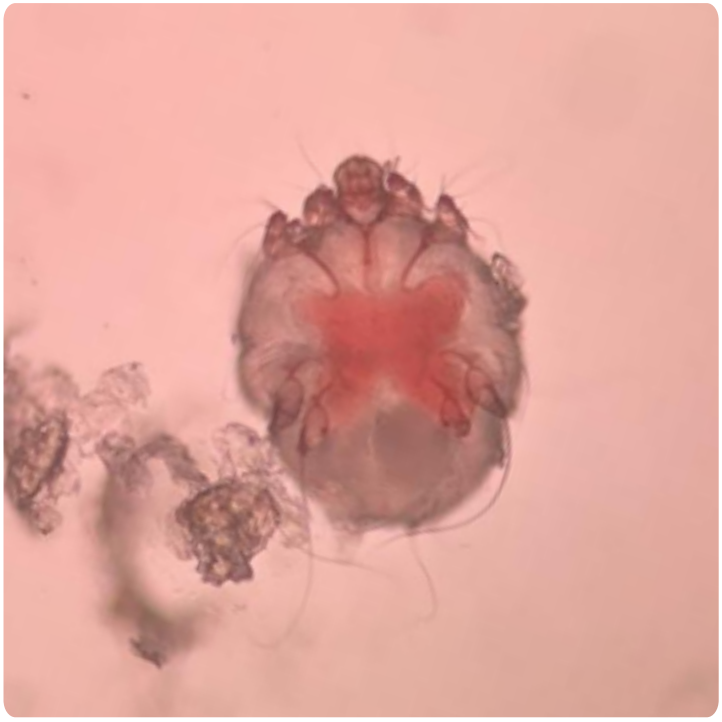
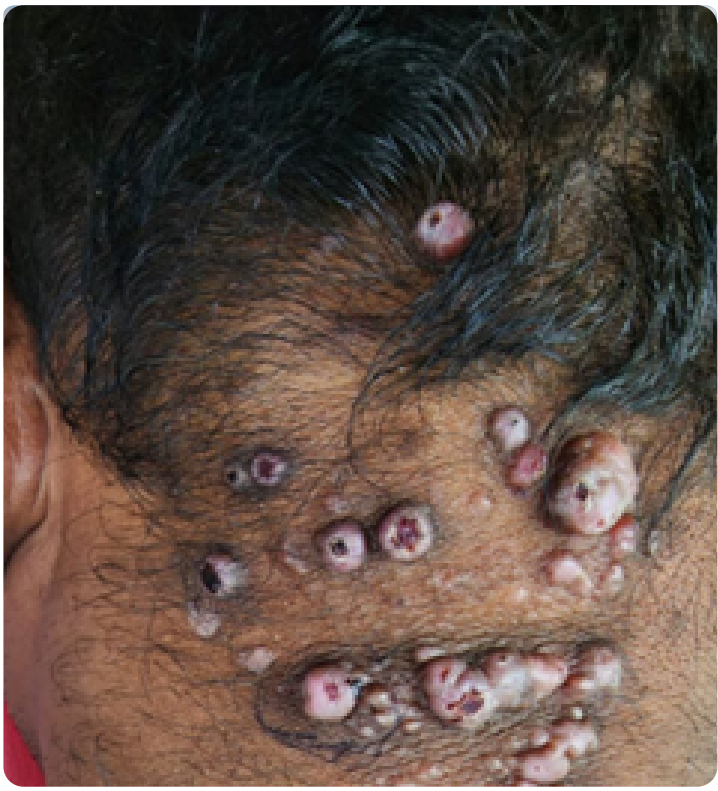
The Cutis Newsletter is back - bringing you dermatology's finest insights, cases, and quizzes.

What's Inside?

- A Free Resource for Dermatologists, by Dermatologists.
- Long cases, short cases, dermoscopy & dermatopathology quizzes, expert insights, and more!
- Bridging Generations of Dermatology Knowledge—With Contributions from Senior, junior Dermatologists and Postgraduates.





🔍 Rare & Interesting Cases
🧠 Dermoscopy & Dermatopathology Quizzes
📖 Expert Opinion and contribution
🏆 Interactive Learning for Practitioners & PG's

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** With contributions from Dermatologists and Postgraduates

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Message from Dr.TSS. Lakshmi (Retd. Professor Dermatology)

Dr. TSS. Lakshmi

Happy Ugadi 2025 !
Reviving a Legacy in Dermatology

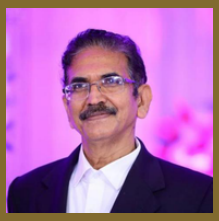
It is with great pleasure that i welcome the reintroduction of THE CUTIS—a bimonthly dermatology newsletter dedicated to sharing clinical knowledge, rare case discussions, and diagnostic challenges. Dermatology is a field that continuously evolves, and initiatives like this serve as invaluable platforms for learning, collaboration, and innovation. it exchanges knowledge, stabilises and strengthens the information.

In this era of rapidly advancing medical science, THE CUTIS will bridge the gap between clinical practice and academic discussions. From intriguing long cases to dermoscopy and dermatopathology quizzes, this newsletter will engage both seasoned practitioners and young dermatologists to refine their diagnostic skills. Skin is not a tail ender , it covers and protects all organs and it is a reflection of what is happening inside.

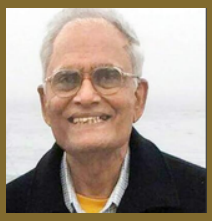
I congratulate Dr. Anchala Parthasaradhi and his team for their dedication in reviving this esteemed newsletter, ensuring that knowledge is freely accessible to all. With the support of senior dermatologists and enthusiastic postgraduates, I am confident that THE CUTIS will continue to inspire and educate generations of dermatologists.

Wishing all readers an enriching and insightful experience!

EDITORIAL



Dr. Anchala Parthasaradhi
Chief Editor, THE CUTIS



Dr. T.N. Chowdary
Chief Advisor, THE CUTIS

It brings us immense joy to reintroduce THE CUTIS—a bimonthly dermatology newsletter crafted with the vision of sharing knowledge, sparking discussions, and enhancing dermatological expertise. This initiative, led by the Anchala Skin Institute, is not just a publication; it is a community-driven effort to bring together clinical dermatology, aesthetic advancements, and academic excellence in one place.

This edition features a mix of rare & interesting cases, dermoscopy and dermatopathology quizzes, and expert insights —all designed to challenge, educate, and refine our understanding of dermatology. With contributions from dermatologists and postgraduate students, THE CUTIS stands as a testament to the collaborative spirit of our field.

We welcome feedback, participation, and contributions from all dermatology enthusiasts. Let us make this newsletter a thriving platform for shared learning and growth.

Here's to the journey of knowledge — one case, one quiz, and one insight at a time!

CASE REPORT ON ANGIOLYMPHOID HYPERPLASIA WITH EOSINOPHILIA: A MULTI-MODAL TREATMENT APPROACH

DR.PRASHANTHI VELLANKI[1] | DR.MEENAKSHI SWAIN[2] | DR.VIKRAM KUMAR.A[3] | DR.DEEPALI ANCHALA[4] | DR.ANCHALA PARTHASARADHI[5]

1,3,4,5 - Dermatologists, Anchala Skin Institute, Jubilee Hills, Hyderabad. | 2 - Pathologist, Apollo Hospital, Jubilee Hills, Hyderabad

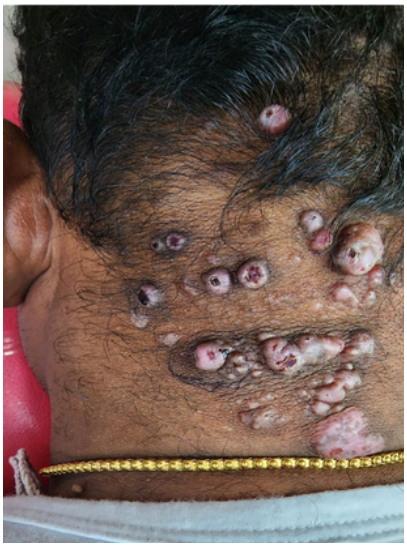
A 48-year-old male farmer presented to our OPD with a one-year history of itchy, mildly painful nodules on the nape of his neck. The lesions initially appeared as slightly elevated papules, which gradually progressed, coalescing into nodules over time, reaching their current state in the past three months. The patient reported intermittent bleeding from the nodules but denied any history of preceding trauma. but the scalp is prone for repeated trauma due to combing, cutting and scratching the hair.

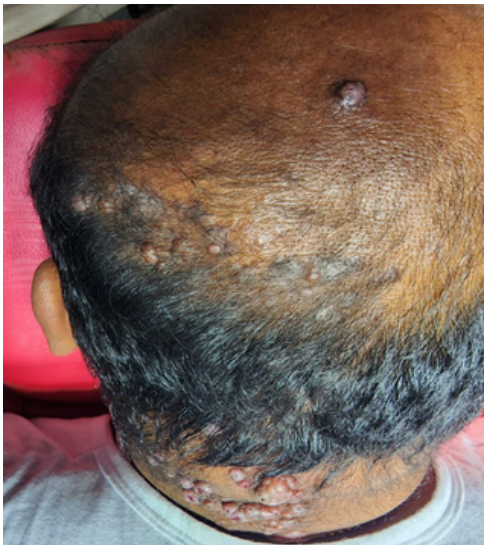
Past Medical History: The patient has had scalp psoriasis for the past six years and has been managing it with topical creams and shampoos. He has no history of diabetes, hypertension, thyroid disease, asthma, or tuberculosis. **Social History**: The patient is married and lives with his wife. He denies any history of smoking, alcohol consumption, or intravenous drug use.

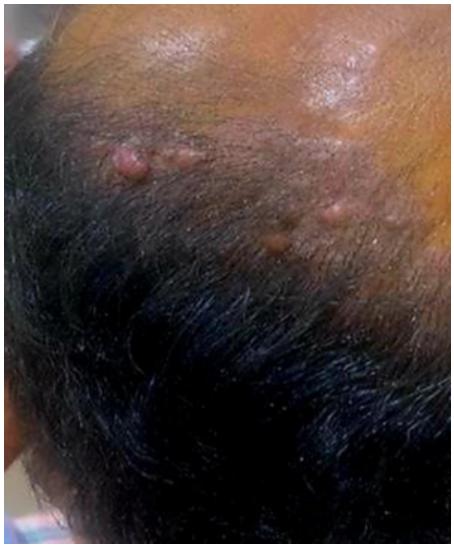
Systemic Examination: Unremarkable.

Cutaneous Examination: Multiple well-defined, discrete to coalescing erythematous to skin coloured papules and nodules were observed in a clustered pattern on the nape of the neck, with a few nodules present on the vertex of the scalp. Scaly, erythematous psoriatic plaques were noted over the crown area. No active bleeding was observed, though crusting was present on the nodules. Regional lymphadenopathy was not palpable.

Differential Diagnosis: the following differential diagnoses were considered: Keloids/Acne Keloidalis Nuchae, Angiolymphoid Hyperplasia with Eosinophilia (ALHE), Kimura's Disease, Kaposi Sarcoma, Multiple Pyogenic Granulomas, Cylindromas, B-cell Lymphomas.

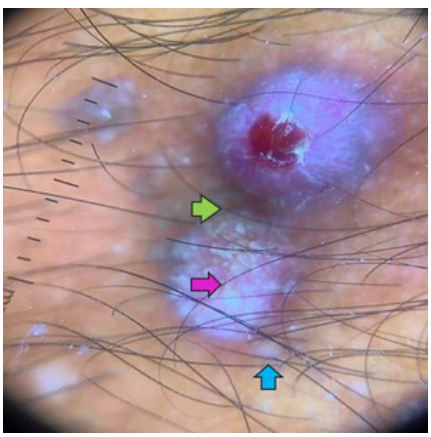


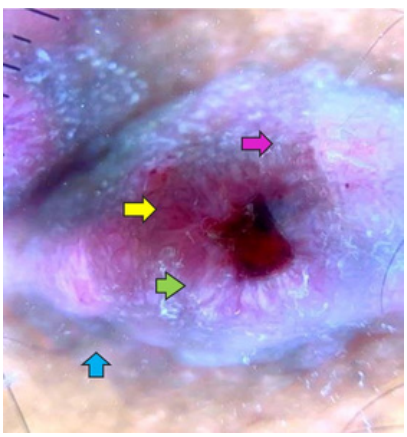


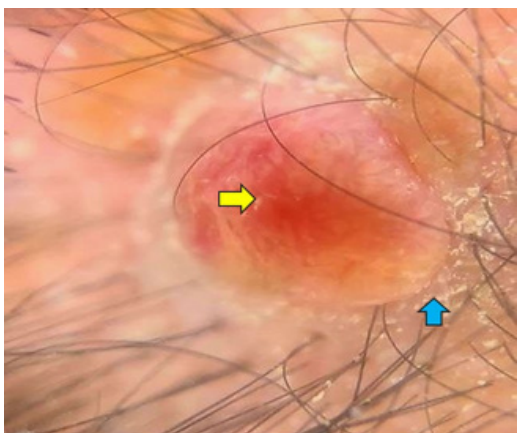


Dermoscopy Findings:

A focal area of red clods (green arrow) was observed, along with dotted and serpentine vessels (yellow arrow). Subtle white lines (red arrow) were noted, along with a peripheral white and brown structureless area (blue arrow).







Investigations: Comprehensive blood tests were performed with the following results:

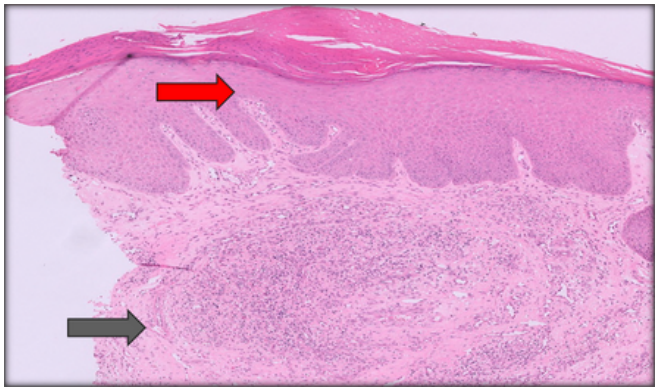
- Complete Blood Count (CBC): Hb – 13 g/dL, Total RBC – 4.7 million/mm³, MCV – 87 fL, MCH – 29.3 pg, MCHC – 33.3 g/dL, Total WBC Count – 7700 cells/mm³, Differential Count: Neutrophils – 64%, Lymphocytes – 23%, Eosinophils – 10%, Monocytes – 3.3%, Basophils – 0%, Platelet Count – 2.5 lakh/mm³ (within normal limits except for peripheral eosinophilia).Liver Function Tests (LFTs): Total Bilirubin – 0.09 mg/dL, Direct Bilirubin – 0.15 mg/dL, Indirect Bilirubin – 0.24 mg/dL, ALP – 49 U/L, GGT – 40.2 U/L, SGOT – 22.9 U/L, SGPT – 36.5 U/L, Total Protein – 7.36 g/dL, Serum Albumin – 3.87 g/dL, Serum Globulin – 3.49 g/dL, A/G Ratio – 1.
- Serum IgE: 136 kU/L (Elevated; Normal <100 kU/L).Viral Markers: HIV 1 & 2, VDRL, HBsAg, and HCV – Non-reactive.

Ultrasound Findings: Ultrasonography of the nodules on the nape of the neck revealed proliferation of subcutaneous blood vessels without arteriovenous shunts.

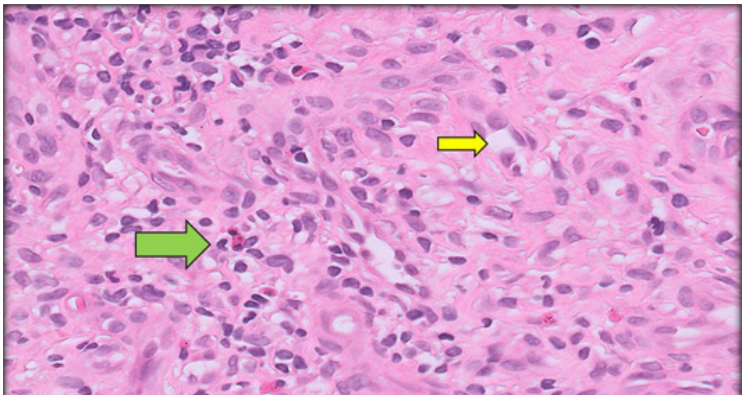
Since the patient had no history of keloidal tendency or trauma, keloids and pyogenic granulomas were ruled out. Additionally, his viral markers were non-reactive, effectively excluding Kaposi sarcoma.

To confirm the diagnosis, a 3.5 mm punch biopsy was performed on one of the nodules and sent for histopathological examination (HPE).

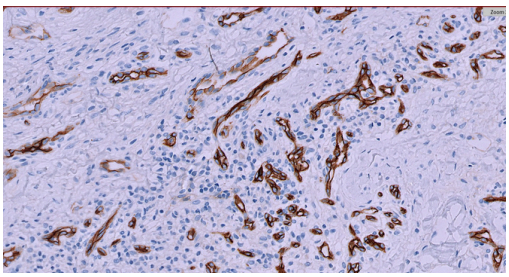
Histopathological Findings: The epidermis exhibited marked orthokeratosis and parakeratosis, along with moderate to marked acanthosis. The upper dermis contained ill-defined aggregates of thin-walled blood vessels, some of which were lined by plump endothelial cells. The intervening stroma showed numerous eosinophils along with occasional lymphocytes. The deeper dermis demonstrated moderate perivascular and periadnexal lymphocytic infiltration, with numerous thin-walled, capillary-sized blood vessels interspersed throughout. On immunohistochemistry (IHC), CD31 and CD34—both reliable vascular markers—were strongly expressed in endothelial cells, confirming the vascular nature of the lesion.



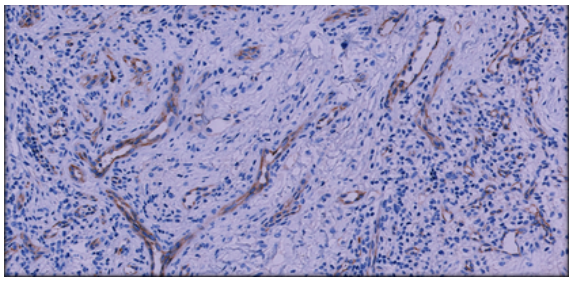
Under 4X magnification, the epidermis exhibits marked orthokeratosis and parakeratosis along with moderate acanthosis.
Red Arrow → Orthokeratotic and acanthotic epidermis.
Blue Arrow → Ill-defined aggregates of thin-walled vessels in the dermis.



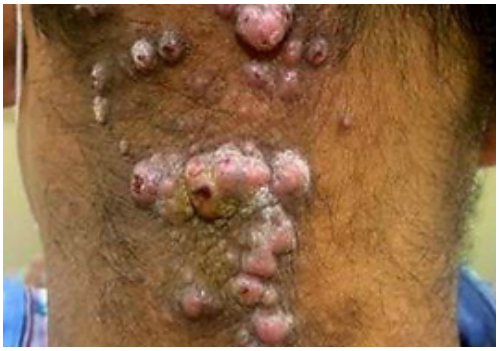
UPPER DERMIS - ill-defined thin walled blood vessels lined by plump endothelial cells (Yellow arrow) & Scattered eosinophils in the stroma (Green arrow)
DEEP DERMIS -perivascular & periadnexal infiltrate of lymphocytes
SUBCUTIS - unremarkable



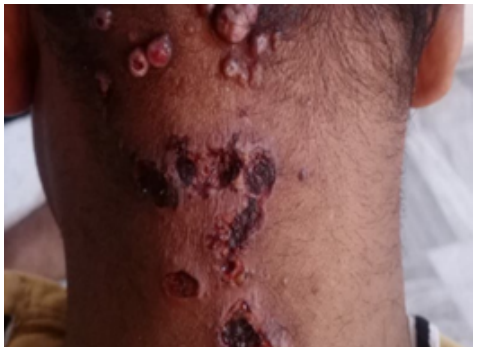
CD31 positivity lining endothelial cells



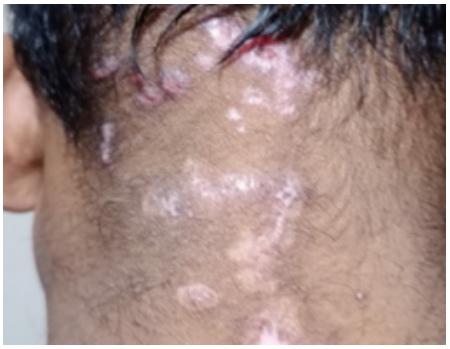
CD34 positivity lining endothelial cells



ALHE at nape of neck



3 months followup, sequential co2 laser



After 2years No recurrence till now

Final Diagnosis: Based on the histopathological and immunohistochemical findings, the features were consistent with Angiolymphoid Hyperplasia with Eosinophilia (ALHE).

Conclusion: It is advisable to biopsy nodular lesions on the scalp and neck to prevent misdiagnosis and ensure appropriate treatment—so, "Think Twice with Scalp Papules." According to the literature, ALHE cases with an earlier onset, prolonged duration, and multiple lesions have a higher risk of recurrence. A combination therapy using oral methotrexate, intralesional steroids, and CO_2 lasers is a novel approach that aids in reducing recurrence

Q. **What is angiolymphoid hyperplasia with eosinophilia?**
ALHE is a rare, benign vascular disorder characterized by solitary or multiple erythematous papulonodules, primarily affecting the head and neck region.

Q. **What is the etiology of ALHE?**
The exact cause of Angiolymphoid Hyperplasia with Eosinophilia (ALHE) remains unclear, but two main hypotheses have been proposed:

- **Benign Vascular Disease (Vasoproliferative Disorder):** ALHE is considered a vasoproliferative condition, with arteriovenous shunts identified in 43% of cases.It has been linked to preceding trauma such as friction, surgery, frostbite, and lacerations.
- **T-Cell Lymphoproliferative Disorder:** Some researchers classify ALHE as a low-grade T-cell lymphoma due to its lymphocytic component.Cases have been reported following trauma, infections, and vaccinations, suggesting a possible immune-mediated response.

Q. **How to differentiate ALHE with kimura disease ,as it is a close differential diagnsois?**

CLINICAL FEATURES	KIMURA DISEASE	ALHE
AGE	20-30 years	30-50 years
SEX	MALE	FEMALE
ETHINICITY	ASIANS COMMONLY	ALL RACES
PRESENTATION	SUBCUTANEOUS NODULES	DERMAL PAPULES OR NODULES
SIZE	2-10 CMS	0.2-6 CMS
SITE	HEAD AND NECK	HEAD AND NECK
DEPTH	DEEP	SUPERFIAL
OVERLYING SKIN	NORMAL	ERYTHEMATOUS
DURATION	LONGER	SHORTER
PRURITUS	NO	SEVERE
LYMPHADENOPATHY	COMMON	UNCOMMON
EOSINOPHILIA	INVARIABLY PRESENT	20% OF CASES
SERUM IgE	INCREASED	NORMAL
RENAL INVOLVEMENT	COMMON	RARE
SALIVARY GLAND INVOLVEMENT	COMMON	RARE
RECURRENCE	15-40%	30%

Q.**Treatment modalities for ALHE?**
Management of Angiolymphoid Hyperplasia with Eosinophilia (ALHE) includes various modalities, such as:
Surgical excision, Laser therapy (pulsed dye laser, CO_2 laser), Systemic or intralesional corticosteroids, Cryotherapy, Topical therapies (imiquimod, tacrolimus), Oral medications (isotretinoin, methotrexate)
Radiotherapy, Biologic and immunotherapy options (interferon alfa-2a, anti–interleukin-5 antibody), Photodynamic therapy (PDT)

References:

- Alaidarous A, et al. Angiolymphoid hyperplasia with eosinophilia treated with low-dose methotrexate. JAAD Case Rep. 2015 Sep 27;1(6):342–344.
- Baker MS. Methotrexate as an alternative treatment for orbital angiolymphoid hyperplasia with eosinophilia. Orbit. 2012 Oct;31(5):324-6.
- Granieri G, et al. Angiolymphoid hyperplasia with eosinophilia treated with intralesional and topical corticosteroid combination therapy. Dermatol Reports. 2021 Sep 15;13(2).
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GLIPTINS ASSOCIATED BULLOUS PEMPHIGOID

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DR.PRASHANTHI.V[4] | DR.VIKRAM KUMAR.A[5] | DR.ANCHALA PARTHASARADHI[6]
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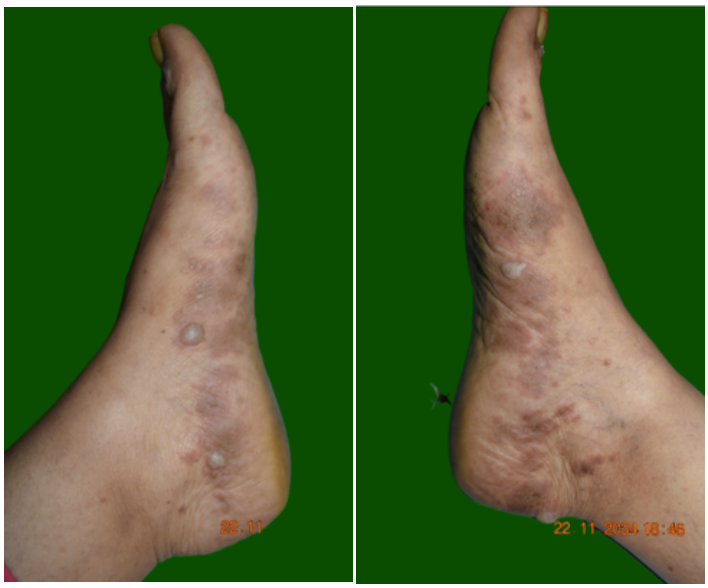
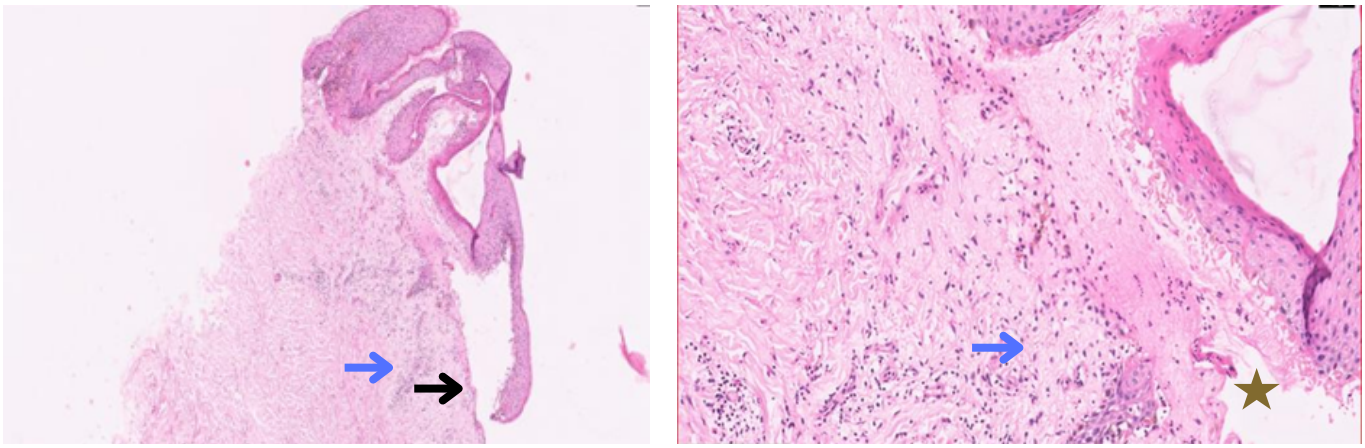
CASE 1: A 50-year-old female presented with intensely itchy, fluid-filled lesions on the sides of soles and palms for 15 days, along with intermittent generalized itching for the past 6 months. She also reported two episodes of urticaria that resolved with antihistamine treatment six months ago.
Medical History: known case of Diabetes Mellitus, was on Linagliptin since 9 months. additionally Ondero Met (Metformin + Linagliptin) was added 4 months later for better glycemic control. No history of hypertension, thyroid disorders, other medications, significant dermatological conditions, or autoimmune diseases.
Cutaneous Examination: : Papulovesicular lesions on both feet, itchy erythematous patches and plaques primarily along the margins of feet, with a few on the soles.
Systemic examination: Unremarkable. Treatment: intially she was given antihistamines and topical steroids but patient came back after 4 days with new bullae along with erythematous plaques with severe itching over both sides of feet, forearms, palms, thighs leading to suspicion of bullous pemphigoid. mucous membrane involvement was not seen.



multiple erythematous plaques with few blisters along the margins of the foot, forearms, palms



H&E Stain: Black Arrow – Subepidermal blister. Blue Arrow – Lymphocytic and eosinophilic infiltrate in the dermis. Star – Fibrin deposition within the blister cavity

- **Treatment Initiated:** Gliptins were stopped after consulting the treating physician. Deflazacort 18 mg daily was given with gradual tapering over 30 days, Omeprazole 20 mg once daily before breakfast. Loratadine 10 mg daily after breakfast. Levocetirizine 5 mg daily at night. Emollient cream and topical moderate-potency steroid (Mometasone + Fusidic acid).

The patient showed significant improvement, with clearing of lesions, and no new lesions were observed during the 1-month follow-up after stopping gliptins.

CASE 2: A 49-year-old female patient, currently on antiretroviral therapy (ART), presented with a three-month history of recurrent blistering episodes affecting the entire body. Her medical history includes chronic kidney disease (CKD), diabetes mellitus, hypothyroidism, and hyperlipidemia and the patient was on polypharmacy with the following medications.

- Tab Virapil (ART), Tab Lyvelsa 20 mg (for kidney stones), Tab Tacrolimus 1 mg (for CKD), Tab Dapagliflozin 10 mg & Tab Vildagliptin M (for diabetes mellitus, since 8 months), Tab Thyronorm 120 µg (for hypothyroidism), Tab Atorvastatin 40 mg (for hyperlipidemia)

Cutaneous Examination: Multiple tense bullae on erythematous and non erythematous base were noted over the hands, thighs, and abdomen, accompanied by erosions and crusting (refer to images). No mucosal involvement was observed.

Investigations:

Routine blood investigations were within normal limits. However, antibody testing revealed:

- BP180: Positive, BP230: Negative. IgE elevated.

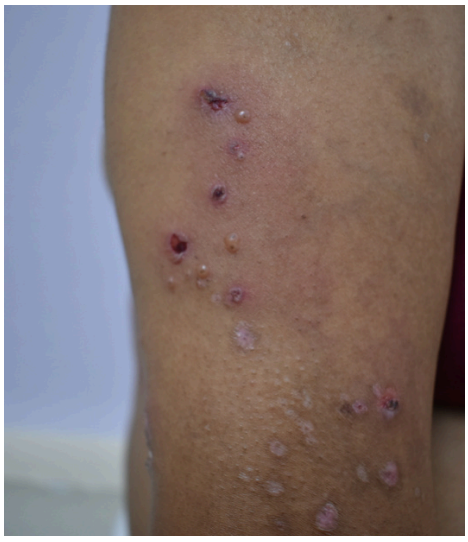
To confirm the diagnosis, a punch biopsy was taken from a vesicle on the thigh for histopathological examination (HPE), along with perilesional skin for direct immunofluorescence (DIF).

Histopathological Findings:

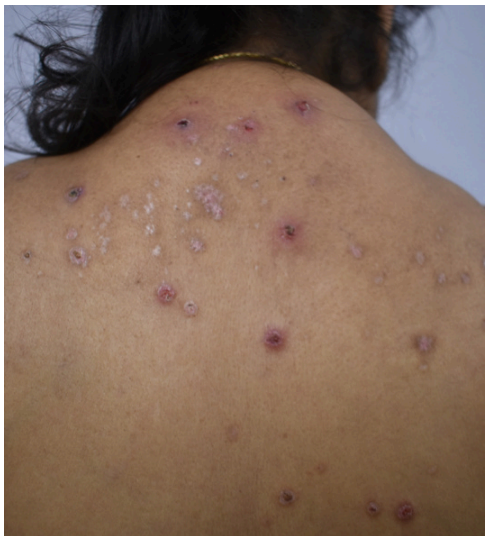
- Subepidermal split with mild basal cell vacuolation in the epidermis
- Superficial dermis showing perivascular lymphocytic and eosinophilic infiltrates
- **Direct Immunofluorescence (DIF) Results:** IgG: 2-3+ deposits along the basement membrane zone, C3c: 1+ deposits, IgM: Negative, IgA: Traces

Diagnosis: Findings were consistent with Bullous Pemphigoid (BP).

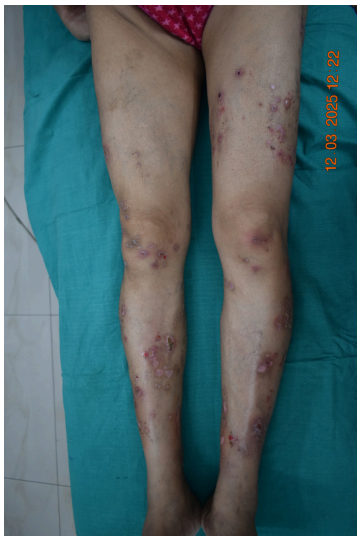
Management & Follow-up: The patient was initiated on tapering dose of oral corticosteroids starting with 24mg for 10 days along with topical steroids , emollients & antibacterials. She has shown a positive response to therapy within 15 days and is being closely monitored and is being followed up. she was advised gliptins after consulting the physician..



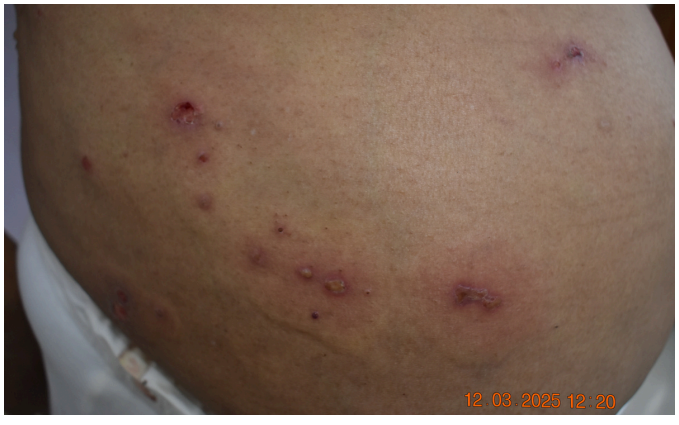
Erosions with crusting & few blisters over right arm



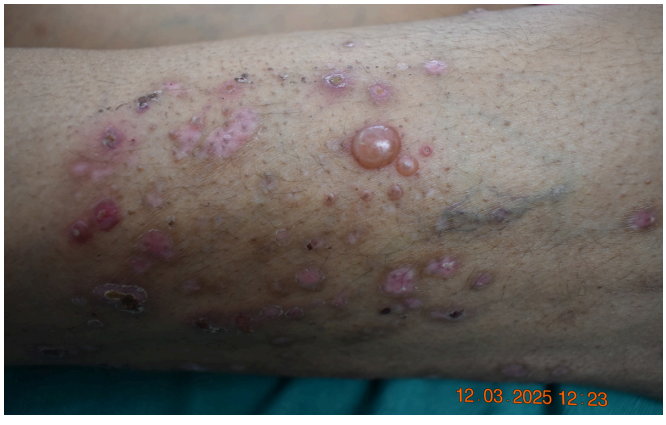
Erosions with crusting, scars & few blisters over upperback



multiple bullae over both lower legs



blisters over abdomen



excoriations and tense bullae over thigh

Discussion:
Drug-Associated Bullous Pemphigoid (DABP) refers to cases of bullous pemphigoid (BP) that exhibit clinical, histological, and immunopathological features similar to the idiopathic form, but are triggered by systemic ingestion or topical application of certain drugs.
Among the known triggers, Dipeptidyl Peptidase-4 Inhibitors (DPP4i), commonly used in the treatment of type 2 diabetes mellitus, have been strongly associated with DABP. Vildagliptin and Linagliptin have been reported to increase the risk of BP by 10-fold and 6-fold, respectively.

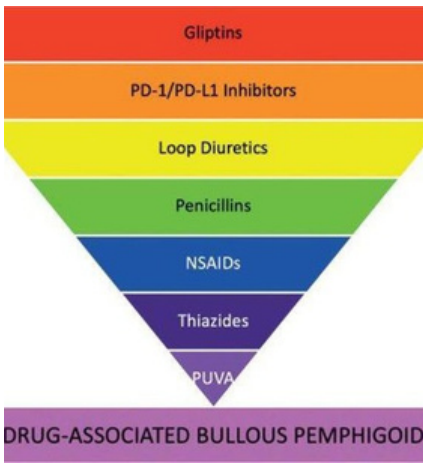
Characteristics of DABP:

- DABP can occur with gliptins from 6 days to 6 years of treatment within a mean latency of 3-4 months.
- Tends to occur in younger age group compared to classical BP.
- Has varied presentations, sometimes involving palms and soles, which is uncommon in classical BP.
- Histopathology shows a marked eosinophilic infiltrate.
- Immunofluorescence pattern in DABP resemble those of classical BP.
- Serum eosinophilia is often observed.
- Patients with DPP4i(gliptins)-induced BP frequently present with IgG1 autoantibodies against BP180, while IgG4 autoantibodies are less commonly seen (38.9% of cases).

The patients were diagnosed with DABP based on the following observations:

- In our patients symptoms appeared **3 months (case1) & 5 months (case2)** after initiating Linagliptin and worsened after adding Ondero Met.
- Both of our patients are less than 50 years of age which is less than age for typical bullous pemphigoid.
- Both the patients had lesions more on extremities when compared to trunk
- In both patients BP180 antibody was positive, BP230 was negative and Serum IgE was elevated.
- Lesions started resolving faster after discontinuing gliptins. in one patient the lesions resolved completely within 1 month of oral steroid usage.

Conclusion:
With the increasing number of medications being linked to DABP, clinicians should maintain a high index of suspicion, particularly in patients with recent drug initiation or polypharmacy. Early recognition and withdrawal of the offending drug can lead to significant improvement and prevent unnecessary long-term immunosuppressive therapy.



PD -1 programmed cell death protein 1 ,
PDL-1 programmed death ligand 1(Anti cancer)

	Drug-associated bullous pemphigoid	Idiopathic bullous pemphigoid
History	Patient is often subject to polypharmacy.	Patient may be subject to Polypharmacy
	Recently introduced drug therapy	No recently introduced drug therapy
Clinical findings	Tendency toward younger age groups	Tendency towards older age groups
	Lesions on normal appearing skin	Lesion on erythematous or urticarial base
	May resemble other entities such as erythema multiforme, or pemphigus	Often classic features of pruritus followed by development of large tense bullae
	Mucosal involvement may be present	Mucosal involvement is very rare
	May have involvement of palms and soles	Frequent involvement of the Extremities

THROUGH THE LENS

DERMOSCOPY OF SCABIES INFECTION

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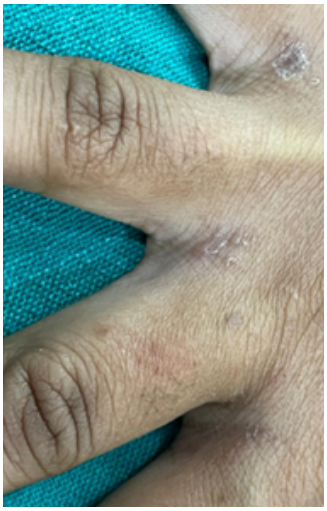
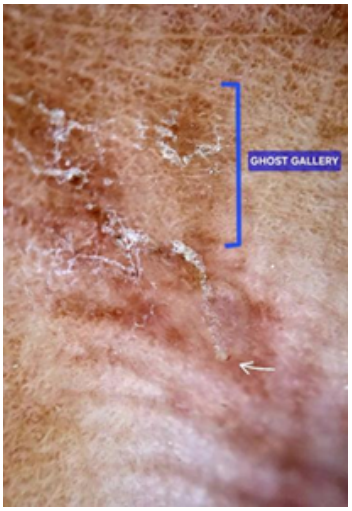
1,2,3 - Dermatologists, Anchala Skin Institute, Jubilee Hills, Hyderabad.



Clinical image



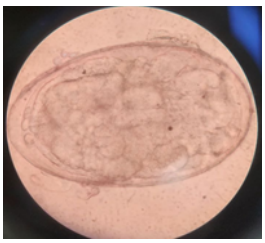
Dermoscopy demonstrating burrow of scabies

Gentian violet enhanced burrow tract of scabies

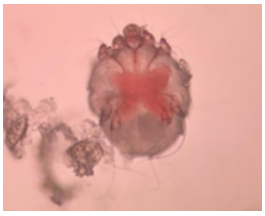
Scabies is a common parasitic skin infestation caused by Sarcoptes scabiei var. hominis, an obligate human ectoparasite. The mite progresses through four life stages: egg, larva, nymph, and adult.

- Larva: Possesses three pairs of legs.
- Adult Mite: Has four pairs of short legs, with the front two featuring elongated peduncles tipped with small suckers.
- Female Mite: Measures approximately 0.4 × 0.3 mm, with the rear two pairs of legs bearing long bristles.
- Male Mite: Smaller, around 0.2 × 0.15 mm, with the third pair of legs adorned with bristles.

Scabies is diagnosed clinically most of the times but dermoscopy and microscopic examination help in ascertaining the diagnoses in doubtful cases.
In our case, a patient presented with generalized nocturnal itching, primarily affecting the web spaces, underarms, and genital region. Clinical examination revealed multiple papules and excoriations. Dermoscopy of the web spaces highlighted characteristic burrows. To enhance visualization, gentian violet was applied before obtaining scrapings for microscopic examination. Under 100x magnification, an adult mite and a scabies egg containing a developing larva were identified. The dermoscopic findings from our case are illustrated below.



Baby mite in a egg



Adult mite with butterfly sign

Dermoscopic Findings in our case

BURROW	Movement path of the scabies mite in the stratum corneum of the patients - highly diagnostic.
TRIANGULAR SIGN/ DELTA WING SIGN/ HAND GLIDER SIGN	Brownish triangular structures in the shape of hang glider corresponding to the head and anterior legs of the mite.
JET CONTRAIL SIGN	The front of the parasite is recognized as a dark triangle resembling a delta wing of a jet. Immediately after, the tunnel produces a series of micro bubbles resemble jet contrail.
WAKE SIGN	The burrow (black lines) and the wake-shaped scale (dashed line) together presenting a Y-shaped lesion (pattern of scale reminiscent of the "wake" left on the water surface by a moving object)
GHOST GALLERY	When the mite is at the end of its life cycle or after therapy also the other parts of the tunnel undergo the normal processes of rearrangement of the skin, becoming thin and polycyclic keratinic edges of a ghost gallery.
LADYBUG SIGN	Mite shows an opalescent body with several scattered little dark dots, which correspond to the "bristles" on the body that guarantee, among other functions, the adherence of the mite within the tunnel.
BUTTERFLY SIGN	Gut area of mite which appear well demarcated and reddish in color

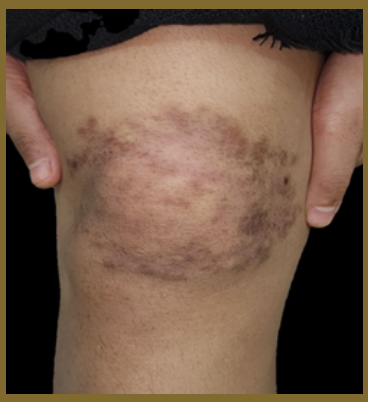
PHOTO QUIZ

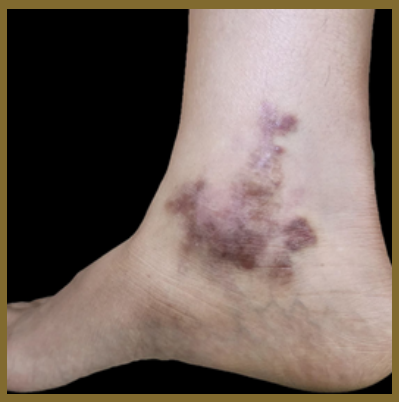
DR.VIKRAM KUMAR.A[1] | DR.TEJAL MODY[2] | DR.PRASHANTHI VELLANKI[3] |DR.ANCHALA PARTHASARADHI[4]

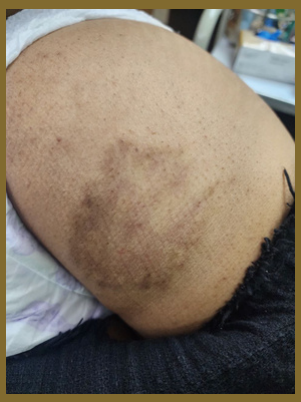
1,,3,4 - Dermatologists, Anchala Skin Institute, Jubilee Hills, Hyderabad. | 2- Pathologist, Apollo Hospital, Jubilee Hills, Hyderabad

A 32-year-old female presented with a 6-month history of pruritic round to oval and irregular patches on the left knee, right foot, and buttocks, which gradually increased in size. she is a healthy person not on any medications. she has pets in our house.

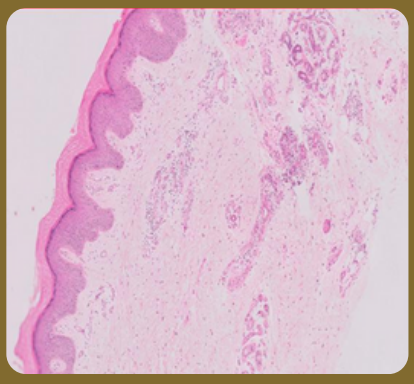
what are the clinical, dermoscopic, and histopathological findings. what would be your most likely diagnosis ?







Dermoscopy of foot lesion



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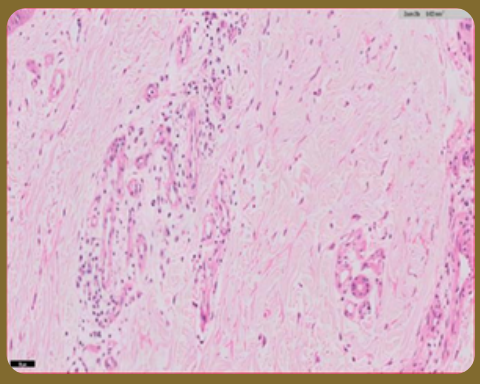

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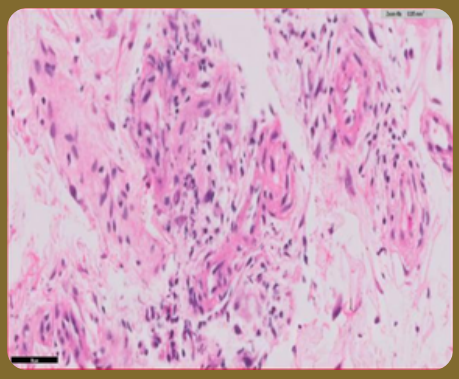

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Please submit your Photo Quiz answers to thecutisderma@gmail.com—prizes will be awarded for correct answers!

We also welcome dermatologists to contribute articles to THECUTIS. Please send your submissions to thecutisderma@gmail.com