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HIGHLIGHTS

Viena

30sep - 3oct
2026

AEDV 35ª edición

HIGHLIGHTS

Viena
30sep - 3oct
2026

Diagnóstico por imagen y Dermatoscopia

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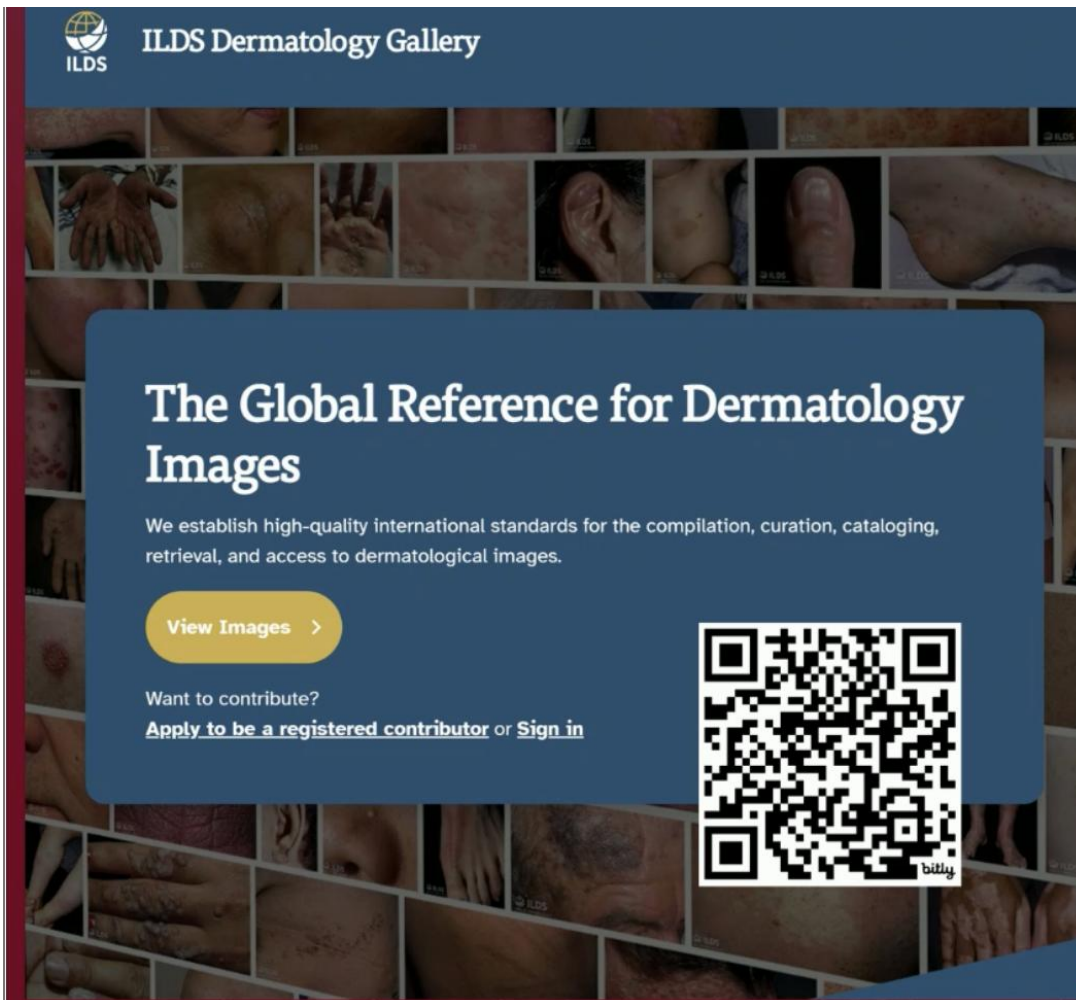
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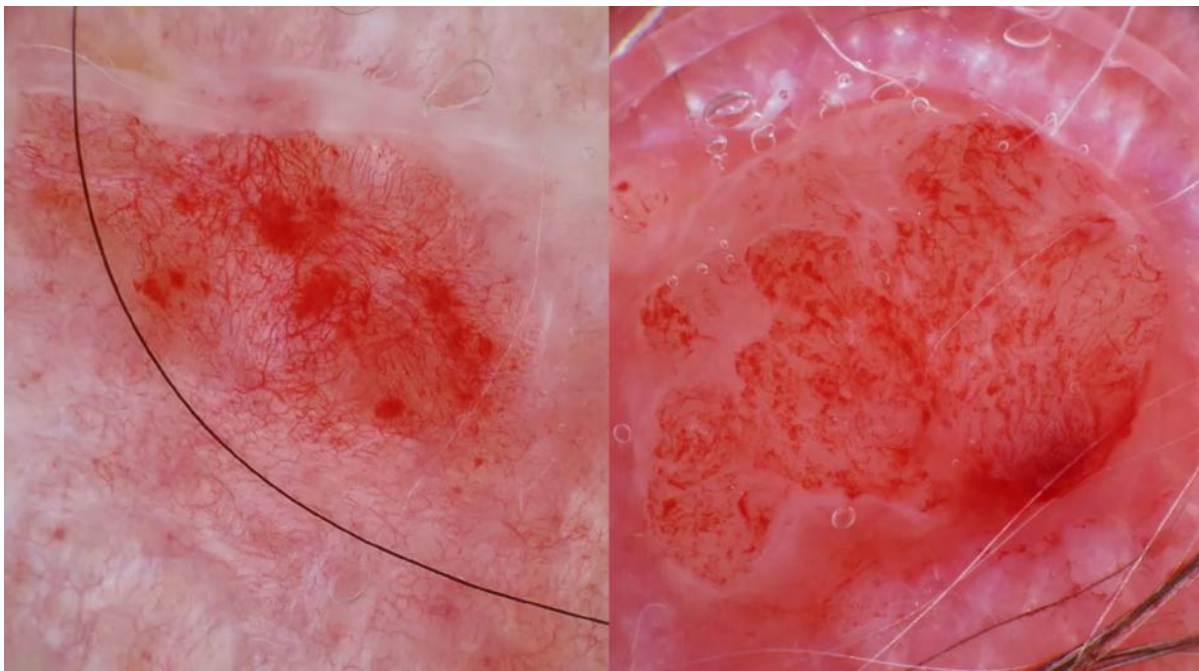
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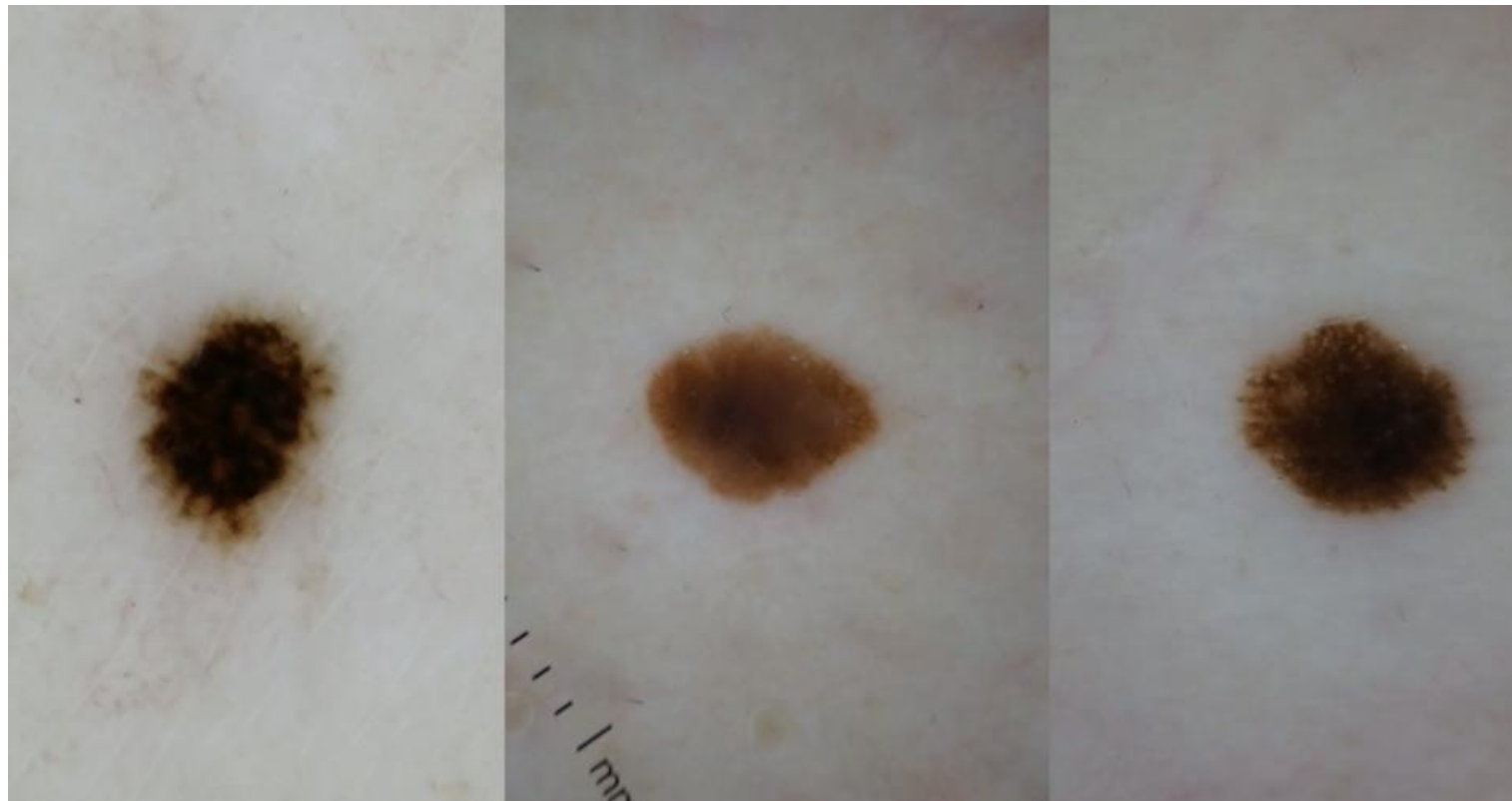
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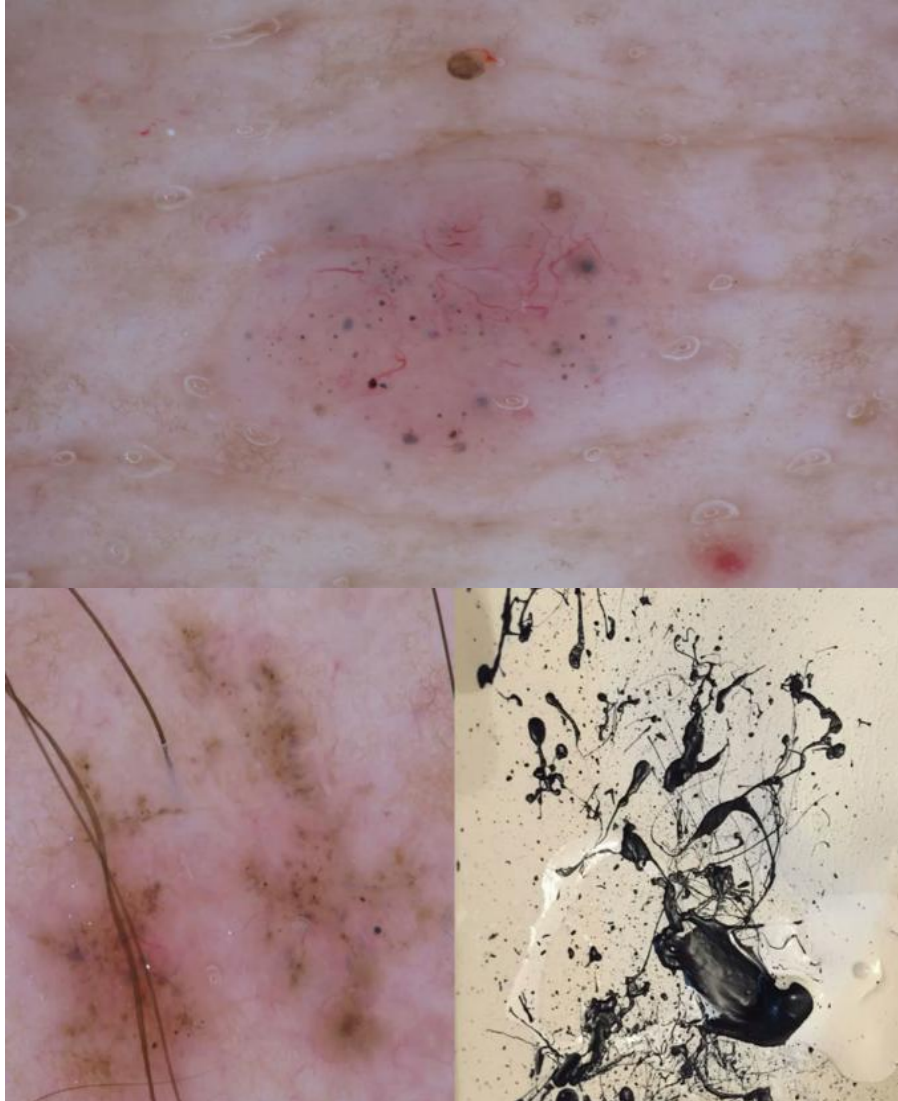


“Zoon scalpitis”





Melanoma on the
legs is often
structureless



Small brown + blue
globules suggest
micronodular BCC

Pollock sign

Dermoscopic clues to BCC subtype

Vessel morphology and the background colour are the main discriminators

brown structures

Superficial

Low risk

- Short fine superficial telangiectasias
- Multiple small erosions
- Shiny white-red structureless areas
- Maple leaf-like and spoke-wheel areas
- In-focus multiple small blue-gray dots
- No arborizing vessels, no large nests

blue structures

Nodular

Low risk

- Bright, thick, in-focus arborizing vessels
- Large blue-gray ovoid nests
- Multiple blue-gray globules
- Ulceration
- Shiny white blotches and strands
- Translucent, well-defined lesion

Infiltrative / morpheaform

High risk

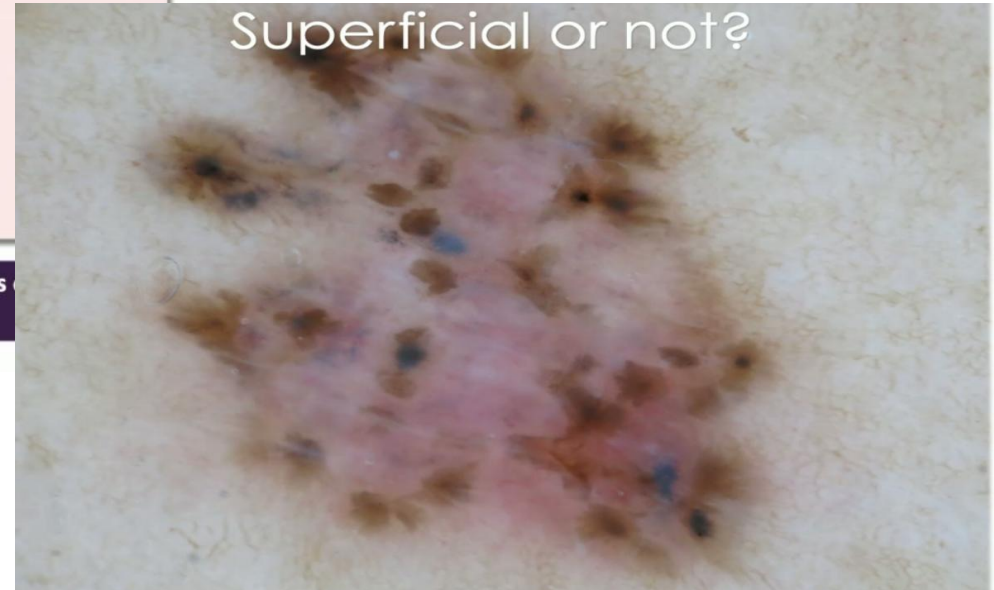
- Fine, thin, sparse arborizing vessels (often out of focus)
- Porcelain-white / white-pink scar-like background
- Shiny white strands
- Small ulcerations
- Ill-defined borders



Fine short telangiectasias + erosions = superficial | bold arborizing vessels + nests = nodular | thin vessels + scar-like background = infiltrative

Lallas A et al.. Br J Dermatol 2014 · Longo C et al.. J Am Acad Dermatol 2014

Superficial or not?

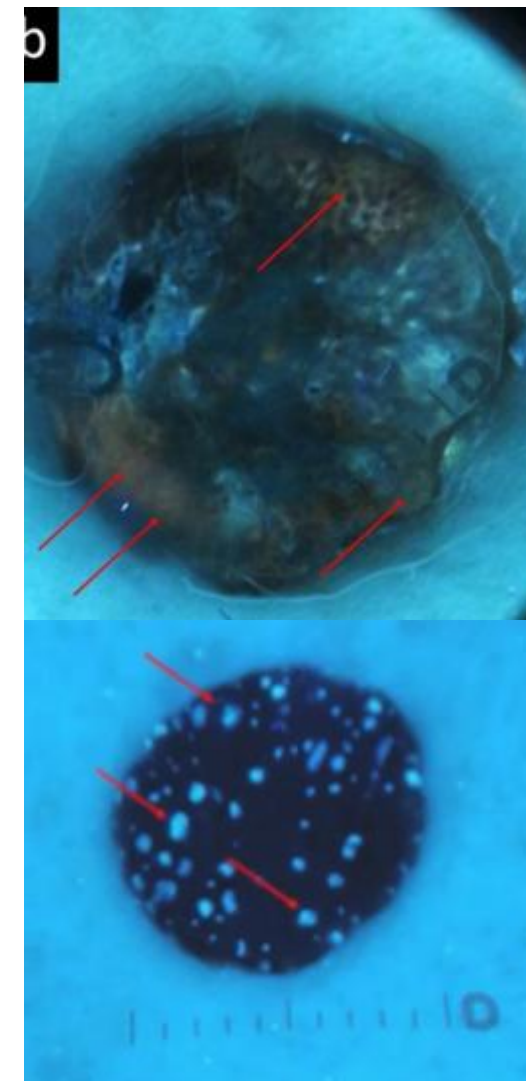


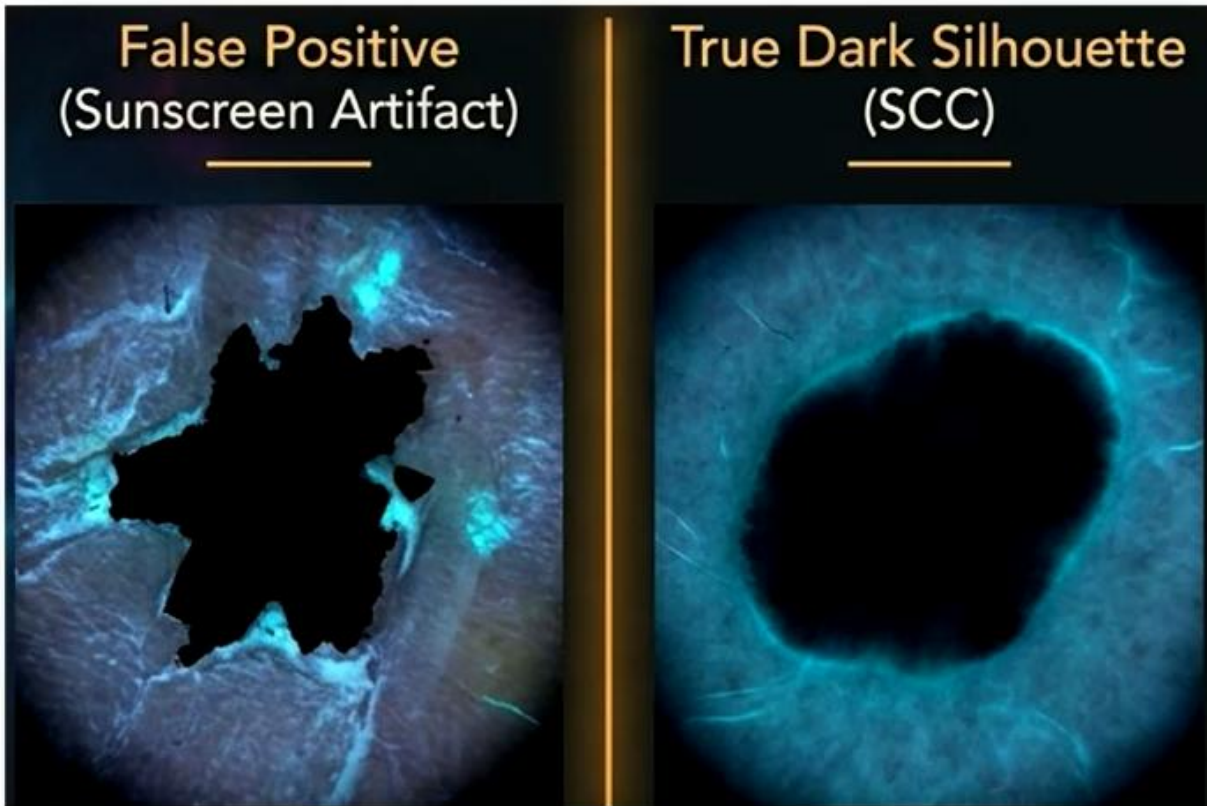
BCC on lower limbs



UVFD: Key published evidence

1	UVFD for diagnosis of skin tumors: multicenter study (Navarrete-Dechent, Pietkiewicz et al., 2026)	J Am Acad Dermatol	n=551; better keratin structures and borders; ochre colour mostly in invasive melanoma
2	Response to Navarrete-Dechent et al. (Erol Mart & Akay, 2026)	J Am Acad Dermatol	Letter responding to #1
3	Absence of ochre fluorescence in acral melanoma (Erol Mart & Akay, 2026)	Int J Dermatol	Challenges the ochre sign in acral melanoma
4	Acral melanocytic lesions: conventional vs sUVRD vs UVFD (Erol Mart, Aydemir, Pietkiewicz, Akay, 2026)	Int J Dermatol	Conventional dermoscopy superior; UVFD complementary
5	UVFD of non-pigmented facial lesions (2025)	Dermatol Ther	n=181; BCC: dark silhouettes, interrupted follicles
6	Polarized dermoscopy vs UVFD of BCC in H- and non-H-zones (2025)	Dermatol Ther	Dark silhouettes 78.8%; better border definition with UVFD
7	UV-enhanced fluorescence dermoscopy in BCC (2024)	Dermatol Ther	n=163; most useful in small, facial, non-pigmented, nodular BCC
8	UVFD for yellow-white globules in BCC (Navarrete-Dechent, Pietkiewicz et al., 2024)	Original study	UVFD detects aggregated yellow-white globules
9	Field cancerization and AK with UVFD after 5-ALA (Korecka et al., 2024)	Photodiagn Photodyn Ther	UVFD to assess field cancerization and AK
10	UVFD: systematic review (2025)	Indian Dermatol Online J	23 articles; promising, mostly level 5 evidence
11	UVFD: Game Changers (2025)	Case series	5 cases where UVFD changed diagnosis or management
12	UVFD of warts and molluscum contagiosum (2026)	Arch Dermatol Res	96.7% of warts showed bluish-white fluorescence
13	UVFD in porokeratosis (Pulgarin & Errichetti, 2024)	J Cosmet Dermatol	Better detection of keratotic ridge; higher interobserver agreement
14	UVFD in segmental porokeratosis (Akay, 2024)	Australas J Dermatol	Case report
15	UVFD in porokeratosis ptychotropica (Akay et al., 2025)	J Dtsch Dermatol Ges	Case report
16	sUVRD reveals hidden pigment network in Reed nevi (Akay & Erol Mart, 2025)	J Am Acad Dermatol	Related 405 nm reflectance technique
17	UVFD in pitted keratolysis (2023)	Case report	Coral-red eccrine dots (probable coproporphyrin III)
18	Lymphocytic UV autofluorescence in lichen nitidus (2025)	JAAD Case Reports	Blue-white fluorescence; "blinking" effect
19	Terra firma-forme dermatosis: dermoscopic and UVFD findings (2025)	Case report	Bright blue clods in mosaic pattern





Interference from **sunscreens**

Inability to differentiate **hemoglobin** from melanin

Uneven **surfaces** (nose, ears)

False positives:

1. Seborrheic keratosis (fluorescent warty surface)
2. Psoriasis (red fluorescence > Protoporphyrin IX).

Five and 10-year evolution of longitudinal melanonychia appearing before the age of 5: A multicenter prospective cohort study from the **International Dermoscopy Society**.

Pham FK, Akay BN, Bahadoran P, Carrera C, Martin LK, Tanaka M, Ogata D, Tromme I, Alvarez-Martinez D, Argenziano G, Bessis D, Dobrosavljevic-Vukojevic DD, Droitcourt C, Guitera P, Hudson J, Lallas A, Marghoob AA, Mijuskovic Z, Scope A, Tuma B, Dalle S, Thomas L.

J Am Acad Dermatol. 2025 Nov;93(5):1324-1327. doi: 10.1016/j.jaad.2025.07.027. Epub 2025 Jul 17.

PMID: 40683359 No abstract available.

Five and 10-year evolution of longitudinal melanonychia appearing before the age of 5: A multicenter prospective cohort study from the International Dermoscopy Society

Early-onset pediatric longitudinal melanonychia (LM), presenting at birth or before age 5, primarily corresponds to congenital or congenital-type nail matrix nevi (CNMN).¹ These CNMN often exhibit clinical and dermoscopic features resembling adult-onset subungual melanoma (SUM), prompting nail matrix biopsies for diagnosis.^{1,2} However, CNMN may also present histological features overlapping with SUM, leading to complete nail unit excision with significant functional and psychological burdens.^{3,4} Assessing the risk of CNMN transformation into SUM and the natural history of CNMN are crucial for guiding clinical management.

This study aimed to evaluate the risk of CNMN progression to SUM and their natural history in a prospective cohort led by the International Dermoscopy Society (IDS). We analyzed the IDS registry of CNMN, an ongoing, prospective collection of clinical and dermoscopic data since 2009.¹ Two nested cohorts were defined: (1) a 5-year cohort including patients with at least 1 dermoscopic photograph at 60 ± 6 months postinitial visit and (2) a 10-year cohort with follow-up at 120 ± 12 months. Patients whose LM completely regressed before these time points were also included. Multivariate analysis was used to identify predictors of LM regression.

We defined four possible outcomes: (1) complete regression (disappearance of LM), (2) progression (widening by ≥10%, new band, darkening, or irregular pattern), (3) partial regression (narrowing by ≥10%, lightening, or regularization), and (4) stabilization (no significant change). Two dermatologists assessed dermoscopic changes, resolving disagreements by consensus.

The demographic data are presented in the Supplementary Table 1, available via Mendeley at <https://data.mendeley.com/datasets/dftj9tprnf/1>. Among all patients, no SUM cases were diagnosed after a median follow-up of 95.5 months (IQR: 63.8-118.5). No invasive SUM features (nodular evolution, nail plate destruction, or ulceration) or metastatic spread were observed. One patient underwent a nail matrix biopsy, confirming a benign junctional nevus.

At the 5-year mark, 57.8% showed LM progression, primarily through widening (Supplementary Fig 1, available via Mendeley at <https://data.mendeley.com/datasets/dftj9tprnf/1> and Table D). A minority showed stabilization (4.7%), partial regression (26.6%), or complete regression (10.9%). At 10 years, 27.0% exhibited continued progression, while 35.1% and 37.0% showed partial or complete regression, respectively. Individual course of each patient is displayed in Supplementary Fig 2, available via Mendeley at <https://data.mendeley.com/datasets/dftj9tprnf/1>.

Four main evolutionary trajectories emerged (Fig 1 and Supplementary Fig 3, available via Mendeley at <https://data.mendeley.com/datasets/dftj9tprnf/1>): (A) early regression leading to complete resolution, (B) early regression followed by later progression, (C) initial progression followed by slow regression, and (D) sustained progression. The 10-year follow-up confirmed the absence of invasive SUM in all cases. Wider baseline LM was associated with longer persistence (hazard ratio = 0.07; 95% CI: 0-0.94, $P = .04$, Supplementary Table II, available via Mendeley at <https://data.mendeley.com/datasets/dftj9tprnf/1>).

In the IDS follow-up cohort of children diagnosed with a CNMN, no SUM was diagnosed, and no patient presented any clinical sign of invasive or metastatic SUM. Most of the CNMN exhibited an initial progression after 5 years of follow-up, then a partial or complete regression after 10 years of follow-up. Limitations include potential selection bias from patient loss to follow-up and the absence of systematic biopsies. In conclusion, watchful waiting may be appropriate for LM appearing before the age of 5.

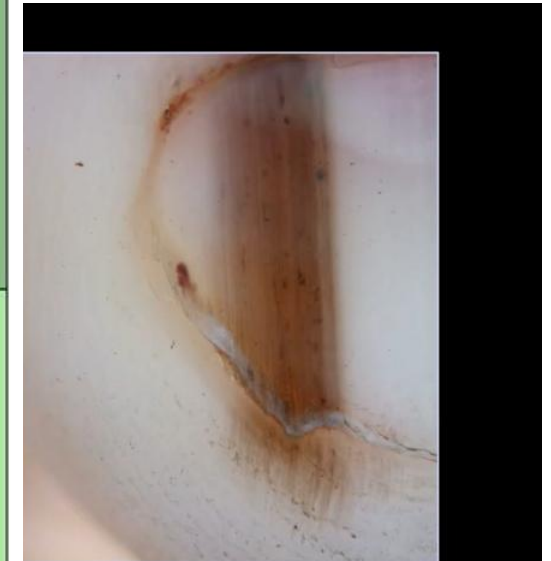
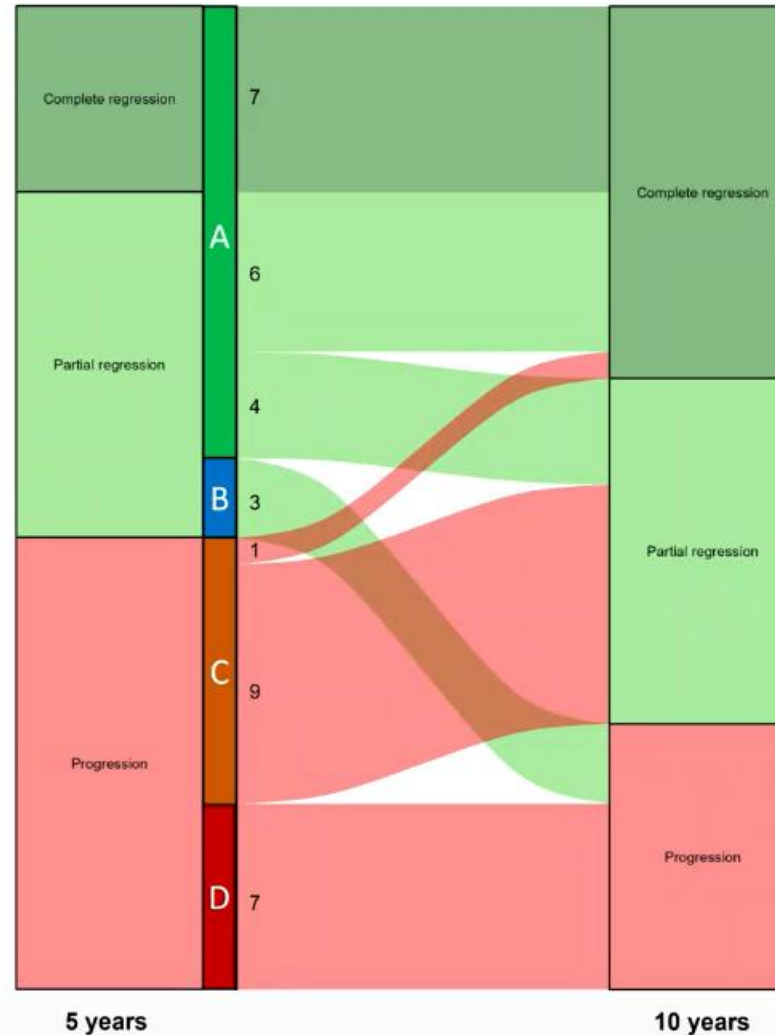
The authors would like to thank all the patients and the participating physicians from all around the world that supported this work.

Felix K. Pham, MD,^{1,2,3,4} Bengü Nisa Akay, MD,⁴ Philippe Bahadoran, MD, PhD,⁵ Cristina Carrera, MD,¹ Linda K. Martin, MD,⁴ Masaru Tanaka, MD, PhD,⁶ Dai Ogata, MD, PhD,¹ Isabelle Tromme, MD,¹ David Alvarez-Martinez, MD,⁷ Giuseppe Argenziano, MD, PhD,⁸ Duher Bessis, MD, PhD,⁹ Danijela D. Dobrosavljevic-Vukojevic, MD, PhD,¹⁰ Catherine Droitcourt, MD, PhD,¹¹ Pascale Guitera, MD,¹² Jeremy Hudson, MD,¹³ Amelios Lallas, MD, PhD,¹⁴ Asyraf A. Marghoob, MD,¹⁵ Zeljko Mijuskovic, MD, PhD,¹⁶ Alon Scope, MD,¹⁷ Bruna Tuma, MD,¹⁸ Stephanie Dalle, MD, PhD,^{19,20} and Luc Thomas, MD, PhD,^{19,20}

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J Am Acad Dermatol

2025 1



ar” distal pattern, yet not of “signature feature” of

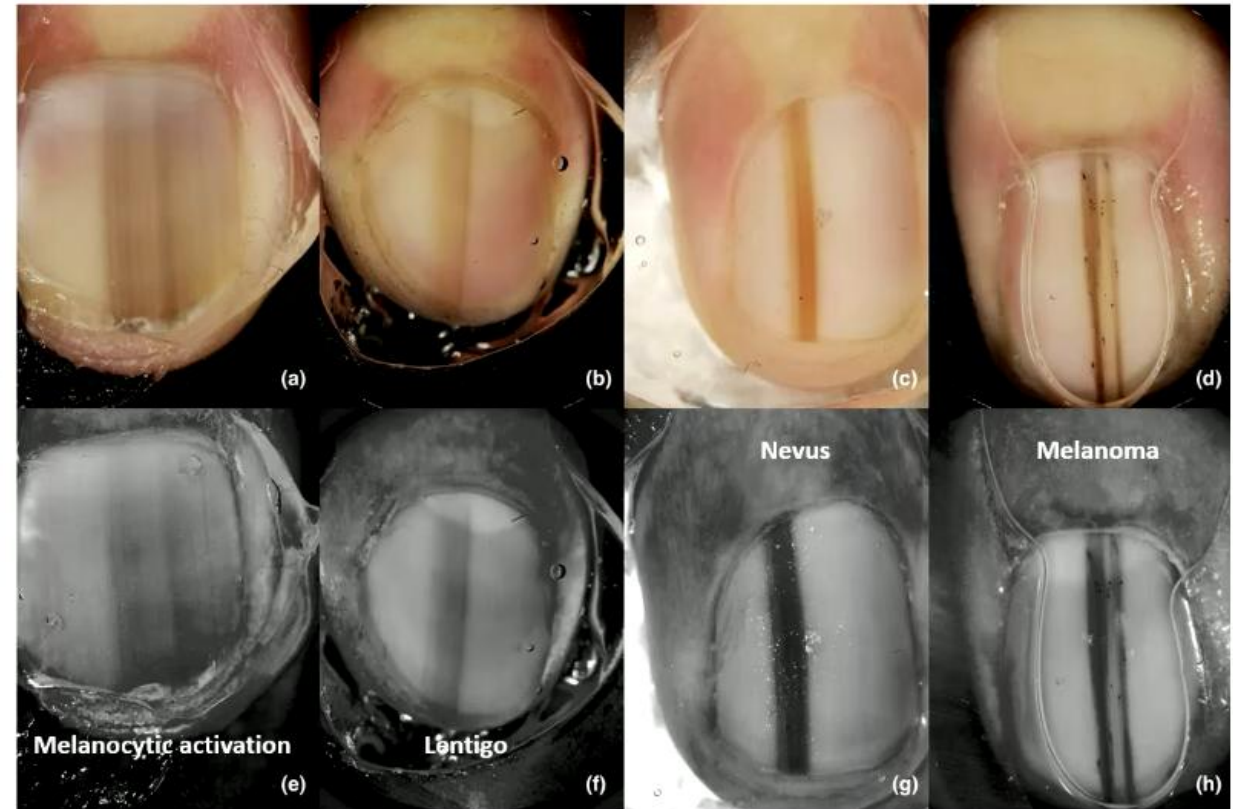


Sub-ultraviolet reflectance dermoscopy (sUVRD) uses a **405-nm violet-blue light source** and exploits differential light absorption and scattering by chromophores to generate **high-contrast greyscale images**, enhancing the visualization of **melanin distribution and pigment density**.

	sUVRD appearance
Melanocytic activation	Faint, low-density light-grey signal, more evident distally with relative proximal sparing
Lentigo	More conspicuous than activation, but still low-to-moderate intensity
Nail matrix nevus	Dense dark grey-to-black signal, beginning proximally
Subungual melanoma	Dark grey-to-black, irregular signal ± black dots/clods

sUVRD may reveal what conventional dermoscopy cannot clearly show: differences in pigment density and distribution.

- **Light / low-density signal** → melanocytic activation or lentigo
- **Dark / high-density proximal signal** → melanocytic proliferation (nevus or melanoma)



Onychotillomania Dentata

- **Onychotillomania dentata** is a newly described subtype of onychotillomania caused by **repetitive anteroposterior friction of the nail plate against the teeth**, rather than the typical manual manipulation with fingers or tools.

Onychoscopy:

- **Lamellar onychoschizia**
 - **Linear furrows aligned with the axis of friction**
 - **Compact subungual keratinous debris**
 - **Nail bed discoloration**
 - **Focal nail plate erosions**
-
- The pattern of linear furrows following the mechanical axis of trauma provides an important clue to the self-induced origin. This is particularly relevant because patients with onychotillomania may deny or be unaware of the behavior, making clinical morphology and onychoscopy central to diagnosis.

Corona-Rodarte E, Jimenez-Cauhe J, Starace M, Iorizzo M, Juanicotena-Madrigal G, Piraccini BM, Morrison B, Asz-Sigall D. Onychotillomania Dentata: A Newly Defined Oral-Induced Pattern of Repetitive Nail Trauma. *Skin Appendage Disord.* 2026 Feb;12(1):65-70.



Is selected-lesion monitoring sufficient?

Barcelona, 2021–2023: 1,274 high-risk patients, 3D TBP plus dermoscopy of selected lesions

The two-step method

Step 1: 3D map of the whole skin. Step 2: dermoscopy of the lesions selected at baseline. New or changed lesions show up in step 1.

46.5%

of the 86 melanomas were found through the map – in lesions nobody had selected for dermoscopic follow-up (40 of 86)

3.3 : 1

excisions per melanoma – 452 lesions removed, 86 melanomas

0.7 mm

mean Breslow of map-detected melanomas, versus 0.5 mm with a dermoscopic record

60%

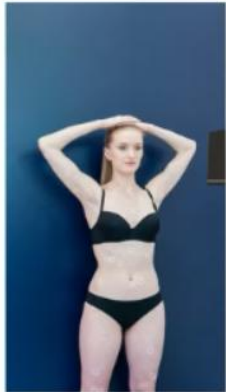
of map-detected melanomas were in situ, versus 76% with a dermoscopic record

The whole-body map finds the melanomas that lesion selection misses

Serra-García et al. Eur J Cancer. 2025;231:116053. Hospital Clínic de Barcelona, VECTRA WB360

Four acquisition approaches

Automation ranges from overview photography to dermoscopic close-ups



Conventional 2D

Standard camera,
fixed poses



Automated 2D

Motorised camera,
guided poses



3D multicamera

92 cameras,
one capture



Automated close-ups

Cabin, non-contact
dermoscopy

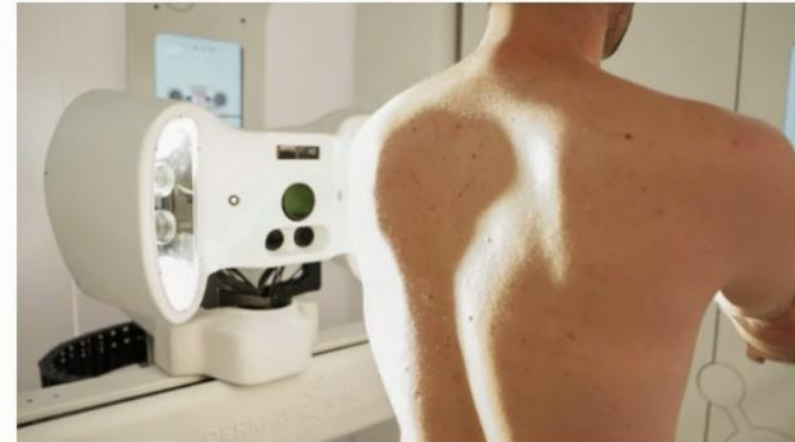
The systems differ in coverage, detail and operator input

DeviScan

Whole-body mapping with automated non-contact dermoscopy



Use: body mapping with automated non-contact dermoscopic close-ups



Drawbacks in our workflow: many images to review, longer scans with many naevi, cabin tolerance

Automated close-ups shift work from acquisition to review

Swan, SquareMind

A robot arm carries the dermoscope over the whole body



Standing patient, autonomous arm



Origin SquareMind, Paris (FR); founded 2019; US\$18 M round April 2026

Capture 3D scan, then the arm images the skin; minutes (3–10 in press)

Regulation FDA Class I listing 2025; CE-marked per company; no EUDAMED entry

Price about €200,000; rental option (French press 2026)

Space examination room, standing patient; footprint not published

Status launch 2026 in EU and US; no peer-reviewed data

Smartphone photography and remote review

A smaller acquisition setup still needs a complete clinical pathway



OptimaScan

Stations such as OptimaScan standardise smartphone body photographs.

Apps such as SkinIO and DermEngine organise serial images and review.

Drawbacks: positioning and coverage still matter. Suspicious lesions need clinical assessment and dermoscopy.

Simpler image capture still requires clinical review and follow-up

How the acquisition workflows differ

Manufacturer specifications; times refer to image capture, not to the visit

System	Overview acquisition	Dermoscopy	Capture time
Conventional 2D	Manual, standardised views	Targeted, manual	10–20 min
FotoFinder ATBM master	Automated 2D, 20 segments	Targeted, video dermoscope	under 3 min
Canfield IntelliStudio	Guided 2D, motorised lift	Targeted, tethered D2	under 2 min
VECTRA WB360	3D, 92 cameras, one capture	Targeted, tagged to avatar	under 1 s; avatar 15 min
Deviskan	Automated 2D with 3D sensor	Automated, non-contact, over 3 mm	about 10 min
Swan	3D scan by robot arm	Automated, whole body	3–10 min (press)
LumoScanner	Rotary beam, RGB and depth	30 µm resolution claimed	not published
OptimaScan	iPhone on a rotating arm	Separate, smartphone	about 1 min

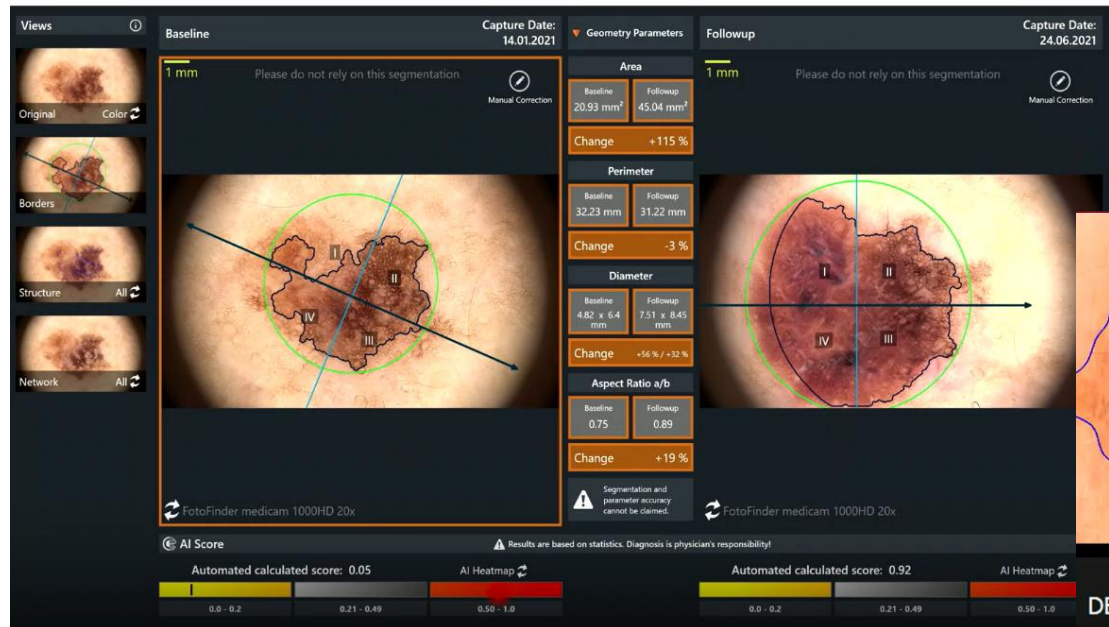
Acquisition time and interpretation time are separate parts of the visit

Manufacturer specifications; Rosés-Gibert 2025; Franchi 2026; company websites, accessed 26 September 2026

Total Body Photography Room



2. AI dermoscopic SCORES:



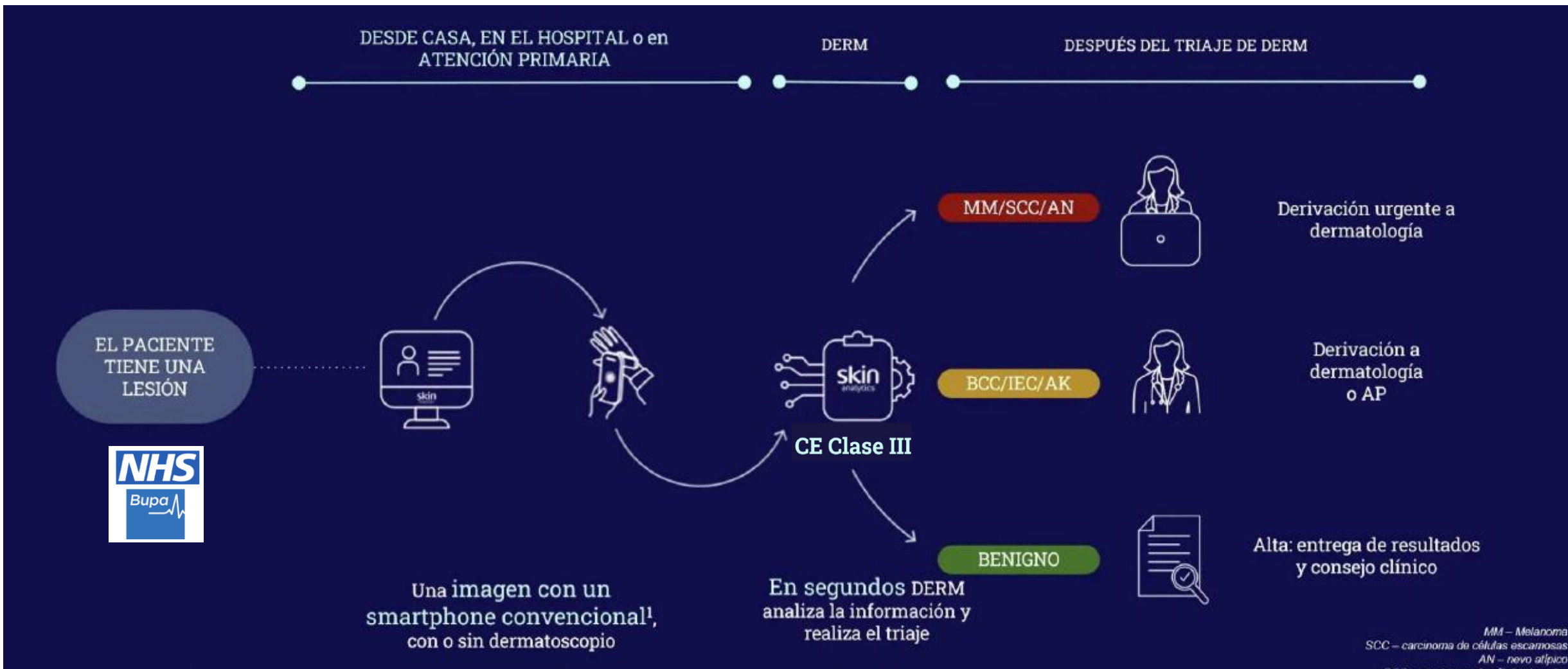
DEXI is for research purposes only.

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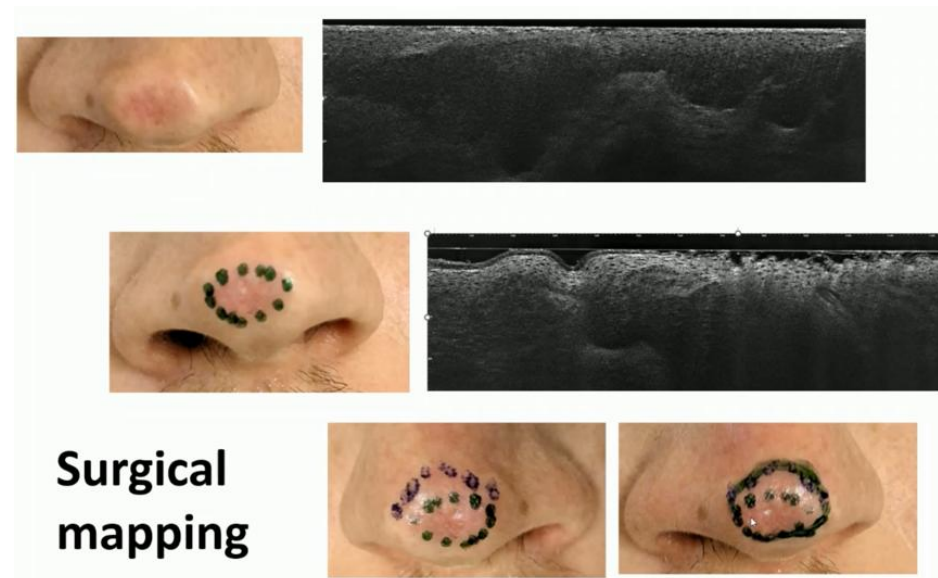
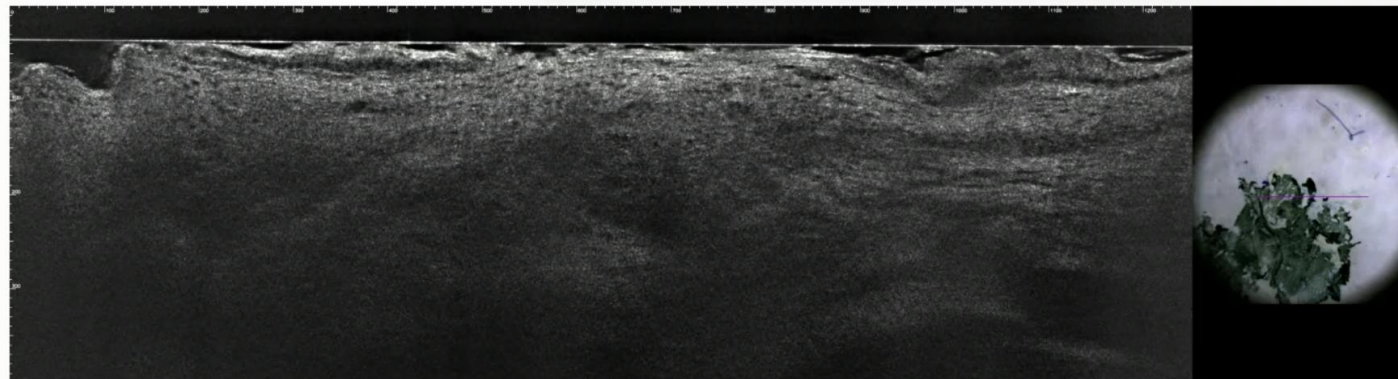


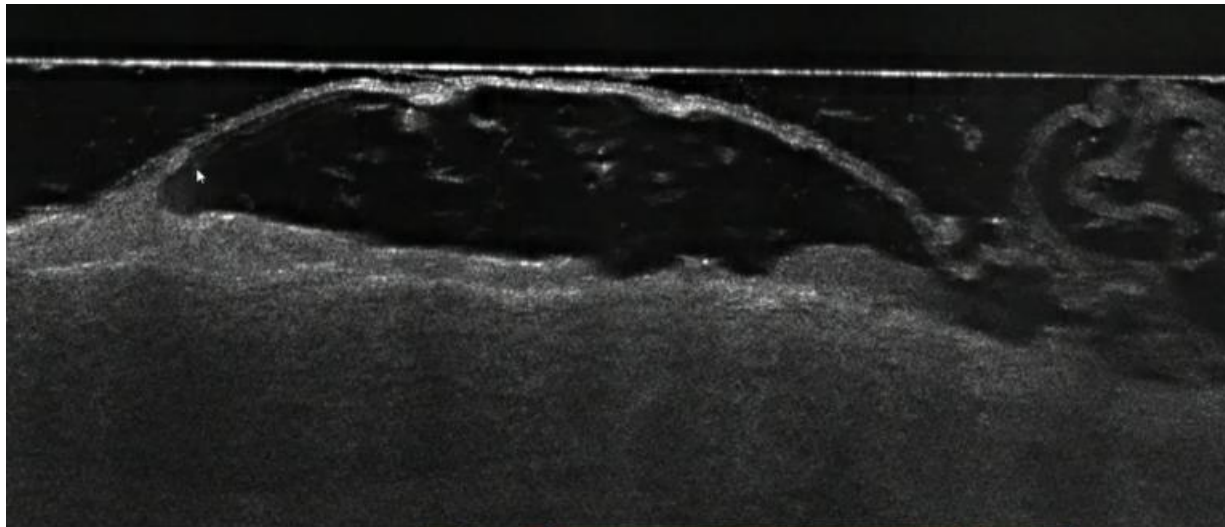


> Int J Oral Maxillofac Surg. 2026 Apr 27:S0901-5027(26)00155-4. doi: 10.1016/j.ijom.2026.04.014.
Online ahead of print.

Impact of line-field optical coherence tomography in preoperative margin assessment of head and neck basal cell carcinoma: a cohort study

A Frosolini ¹, V Chiantini ², G Gabriele ¹, A Cartocci ³, L Tognetti ³, O Massarelli ¹, P Rubegni ³,
P Gennaro ¹, E Cinotti ³





INTRODUCTION
Desquamative gingivitis is a clinical condition characterized by erythema, blisters, and erosions within the gingiva. It may manifest as oral lichen planus or autoimmune bullous diseases, such as pemphigus vulgaris and mucous membrane pemphigoid (MMP) [1,2,3].
MMP remains diagnostically challenging, particularly in cases with isolated mucosal involvement. Differential diagnosis requires histopathological and direct immunofluorescence studies.

Noninvasive imaging techniques such as line-field confocal optical coherence tomography (LC-OCT) enable real-time, high-resolution visualization of mucosal structures.

Here, we present LC-OCT features of MMP and its usefulness in monitoring treatment response.

CASE PRESENTATION
An 87-year-old woman presented with a 6-month history of desquamative gingivitis. Previous treatment with topical corticosteroids had been ineffective. Clinical examination revealed gingival erythema and erosions involving both the maxillary and mandibular gingiva.

LC-OCT imaging demonstrated multilocular subepithelial blistering, appearing as dark hyporeflective areas between the epithelium and the underlying lamina propria. The blisters showed a grayish signal consistent with fluid content. The stratified epithelial architecture and epithelial thickness were preserved. Areas of full-thickness epithelial loss consistent with erosions were also observed. Hyperreflective white dots corresponding to inflammatory cells were observed within the lamina propria and inside the subepithelial blister cavity. The basement membrane zone appeared indistinct, with blurred demarcation between the epithelium and lamina propria.

Direct immunofluorescence confirmed the diagnosis of mucous membrane pemphigoid. Systemic treatment with methotrexate at a dose of 10 mg administered subcutaneously once weekly was initiated, combined with topical fluocinolone acetonide. At 3-month follow-up, clinical examination showed persistent gingival erythema involving the maxillary and mandibular gingiva, with a significant reduction in pain.

LC-OCT imaging demonstrated resolution of subepithelial blistering. The stratified epithelial architecture was continuous, with no areas of epithelial loss. A band of vacuolization was visible along the junction between the stratified squamous epithelium and the lamina propria. Parakeratosis was present within the epithelium. Inflammatory infiltrate persisted.

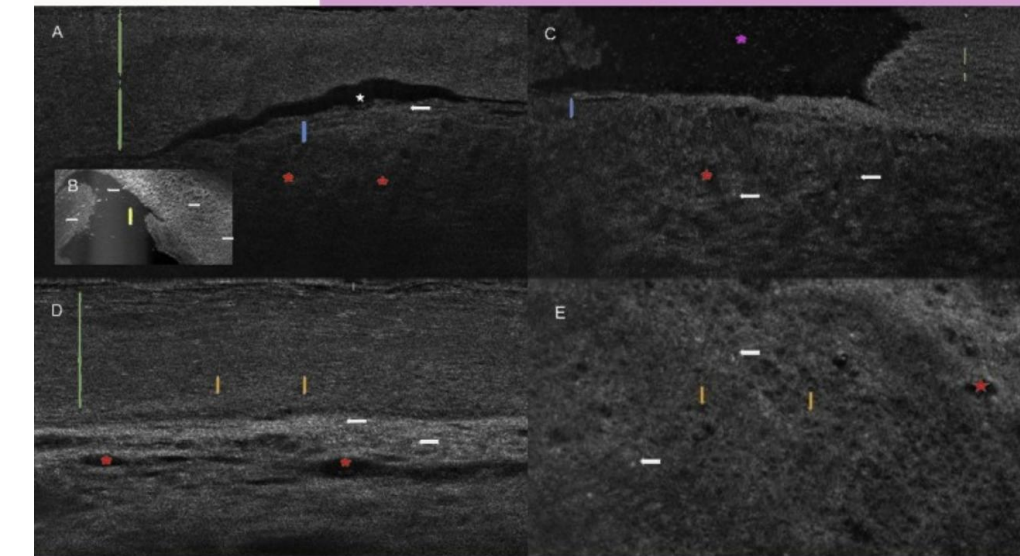


Figure 1. LC-OCT imaging of mucous membrane pemphigoid at baseline (A–C) and after 3 months of methotrexate treatment (D, E). [A, C, E] vertical views; [B, D] horizontal views. White star: multilocular subepithelial blister; yellow arrow: fluid content; blue arrow: indistinct basement membrane zone; white arrows: inflammatory cells; green curly bracket: preserved epithelial thickness; orange arrows: vasculature between the stratified squamous epithelium and the lamina propria; red stars: vascular structures; yellow curly bracket: parakeratosis; pink star: erosion.

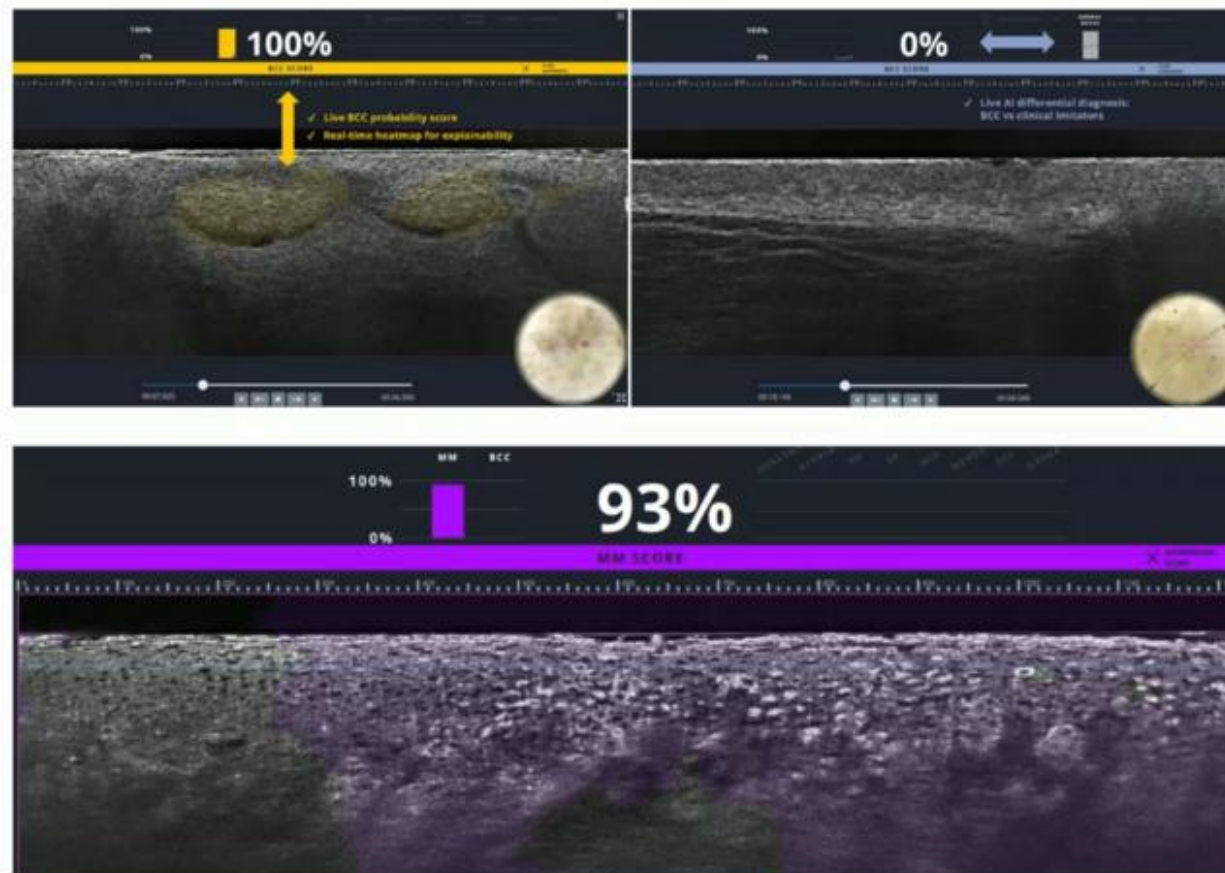
CONCLUSION
In this case, LC-OCT enabled noninvasive visualization of subepithelial blistering and its resolution during methotrexate treatment, correlating with clinical improvement. Despite the absence of erosions at follow-up, LC-OCT revealed persistent microscopic features, including vacuolization and inflammatory infiltrate, suggesting ongoing disease activity. These findings highlight the potential role of LC-OCT in monitoring treatment response and supporting individualized therapeutic decisions in mucous membrane pemphigoid.

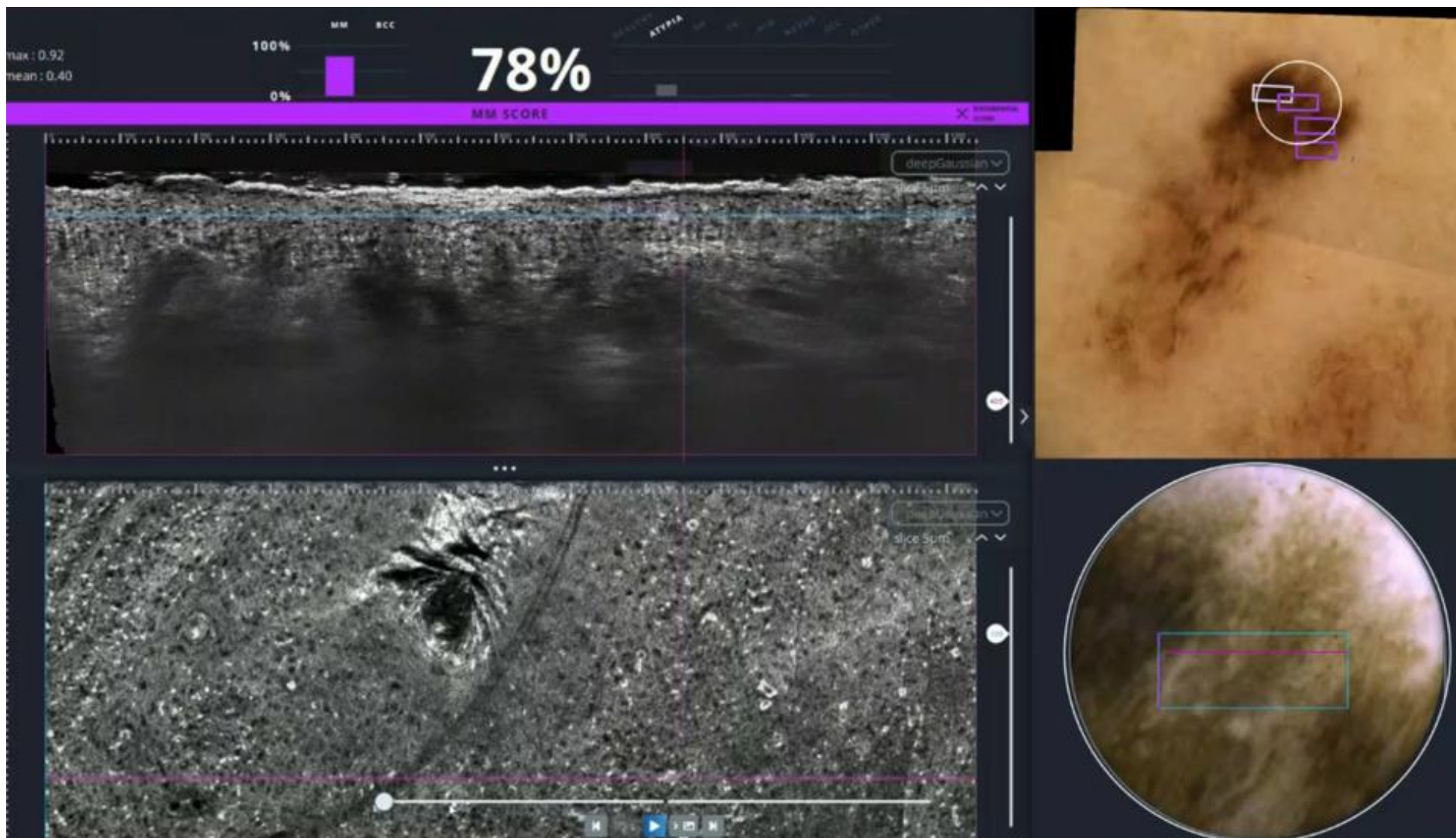
AI model for BCC and melanoma diagnosis

AI assistance for BCC diagnosis
trained on 600k images,
97% diagnostic accuracy, CE marked

+

NEW Multiclass AI prototype
for BCC & Melanoma
trained on 1.6M images





Exploring the Diagnostic Utility of Mucoscopy in Sjögren Syndrome: A Pilot Cross-Sectional Analytical Study

Rahul Nair¹, Pankaj Das¹, Anuj Bhatnagar¹, Varghese Koshy¹, Varun Bajaj¹

¹ Armed Forces Medical College, Pune, India

1 Introduction

Sjögren syndrome (SS) is a chronic autoimmune disorder characterized by lymphocytic infiltration and progressive dysfunction of exocrine glands, resulting primarily in xerostomia and keratoconjunctivitis sicca. Diagnosis is based on a combination of clinical, serological and histopathological findings. Minor salivary gland biopsy remains the diagnostic gold standard because of its high specificity and sensitivity; however, it is invasive and may be associated with postoperative pain, bleeding, infection and transient lower lip numbness¹.

Aim Mucoscopy enables in vivo visualization of oral mucosal microvasculature and salivary duct openings^{2,3}, but its role in SS has not been systematically evaluated. We assessed mucoscopic findings in SS versus healthy controls to determine their diagnostic utility.

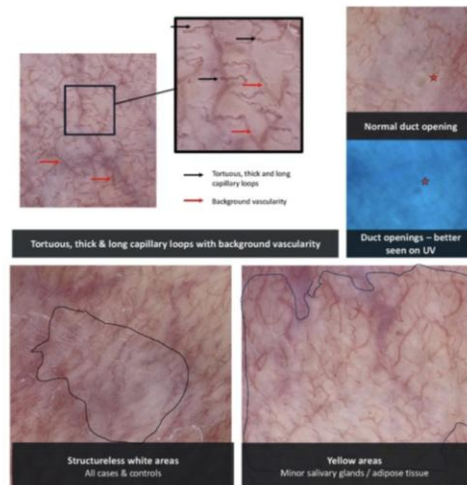
2 Materials & Methods

A pilot cross-sectional analytical study was conducted in **13 patients with primary or secondary SS and 13 age- and sex-matched healthy controls**. Cases fulfilled established diagnostic criteria for SS; controls had no autoimmune disease or xerostomia. Participants with active oral mucosal disorders, recent topical corticosteroid or immunomodulator use, drug- or nicotine-induced pigmentation, pregnancy or lactation were excluded. Standardized lower-lip mucoscopy was performed using **polarized and ultraviolet fluorescence dermoscopy** with a smartphone-attached dermoscope, in maximum lower-lip eversion, with a systematic zigzag scanning technique covering the entire lower lip^{2,3}. Capillary loop morphology, vessel tortuosity, background and periductal vascularity, ductal fluorescence, mucinous secretions and pigmented or structureless areas were compared between cases and controls.

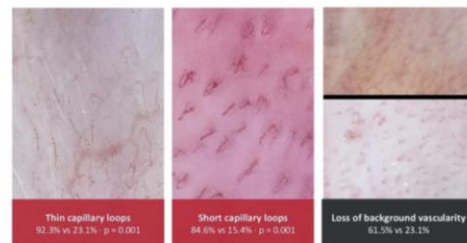


Wrapping the DLS dermoscope in clear film.

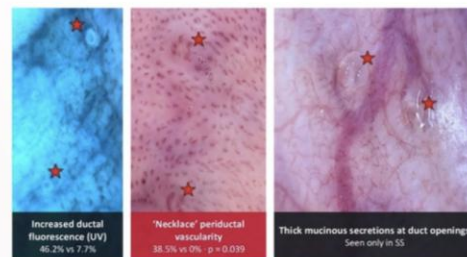
A Normal Patterns



B Vascular Patterns in SS

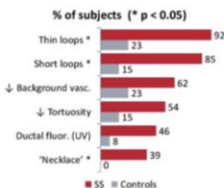


C Minor Salivary Gland Duct Patterns in SS



3 Results

The study population showed marked **female predominance (F:M 12:1)** with a mean age of 39.9 years. **Thin capillary loops** (92.3% vs 23.1%; $p=0.001$) and **short capillary loops** (84.6% vs 15.4%; $p=0.001$) were significantly more common in SS. **Periductal vascularity in a 'necklace arrangement'** was seen exclusively in SS (38.5% vs 0%; $p=0.039$). Loss of background vascularity, decreased vessel tortuosity and increased ductal fluorescence on UV were more frequent in SS but not significant. Thick mucinous secretions at duct openings were seen only in SS. Structureless white and yellow gland-associated areas were present in all participants and were non-discriminatory.



4 Conclusions

Mucoscopy demonstrated reproducible vascular and ductal alterations in SS – particularly **thinning and shortening of capillary loops and increased periductal vascularity** – significantly associated with disease status. Mucoscopy may serve as a **rapid, inexpensive and non-invasive adjunct** for evaluating xerostomia⁴, bridging the gap between clinical suspicion and invasive biopsy¹. Larger multicentric studies with standardized criteria are needed to establish its diagnostic accuracy.

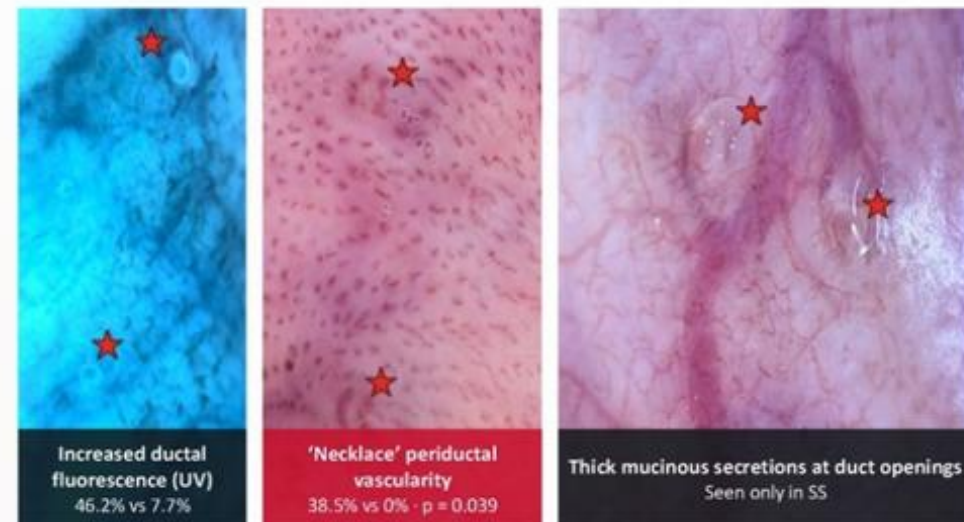
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1. Jorgensen AL, et al. Sjögren's syndrome. *N Engl J Med*. 2016;374:100-110.
2. Nair R, et al. Mucoscopy in Sjögren's syndrome: a pilot study. *Indian J Ophthalmol*. 2018;66:100-105.
3. Nair R, et al. Mucoscopy in Sjögren's syndrome: a pilot study. *Indian J Ophthalmol*. 2018;66:100-105.
4. Nair R, et al. Mucoscopy in Sjögren's syndrome: a pilot study. *Indian J Ophthalmol*. 2018;66:100-105.



B Vascular Patterns in SS



C Minor Salivary Gland Duct Patterns in SS



Thermal Imaging for Monitoring Disease Activity and Treatment Response to UVA1 Phototherapy in Morphea: A Case Report

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BACKGROUND

Although thermal imaging/thermography has been used in the assessment of morphea [1], this imaging modality has not previously been used to assess the response of this condition to phototherapy. We present a case of morphea where thermal imaging has been helpful in monitoring disease activity and response to treatment.

Determining and monitoring disease activity in morphea can be challenging. Currently available validated scoring tools have limitations, and thermal imaging is not routinely used, despite blood flow and skin temperature being important factors when assessing disease activity.

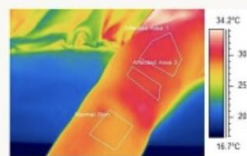
METHODS

The patient is a 47-year-old woman with an eleven-year history of biopsy-proven morphea localised to the left arm, above the anti-cubital fossa. This had been treated with topical clobetasol propionate with no benefit. At the last clinical assessment, she had developed a further adjacent patch unresponsive to topical clobetasol propionate and tacrolimus (Protopic) 0.1% ointment and was referred for Ultraviolet A1 (UVA1) phototherapy (340–400 nm).

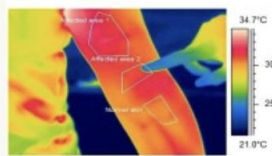
Localised treatment was delivered to the affected areas three times per week using a Sellamed 3000 unit (Sellamed, Germany). The initial dose was 70% of her UVA1 MED, escalated by 20% increments at each visit and adjusted according to erythema response, to a maximum of 60 J/cm². She received a total of 30 exposures over a period of 8 weeks.

Thermal imaging was performed prior to, at the mid-point of, and at the end of treatment using a FLIR SC305 camera (Teledyne FLIR). Images of the lesion and an area of normal skin were imported into Thermacam Researcher 2.10 (Teledyne FLIR) software, where be-spoke regions of interest were drawn around the lesions and an adjacent area of normal skin.

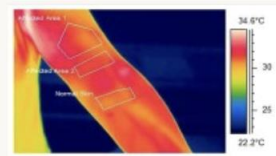
Figures 1-3. Thermography Images



Prior to treatment
Baseline thermal image acquired before the first UVA1 exposure, used to define the lesion region of interest.



Mid term image
Thermal image acquired before the 15th UVA1 treatment.



End of treatment series

CONCLUSION

Determining and monitoring disease activity in morphea can be challenging, and currently available validated scoring tools have significant limitations. Skin blood flow and temperature are important factors indicating disease activity. The reduction in temperature detected by thermography mirrors the clinical response and patient-reported treatment outcome. This case study suggests thermal imaging may be a helpful tool for assessing disease activity and response to phototherapy and there probably value in repeating on a larger cohort of patients.

REFERENCES

- [1] Detecting and quantifying activity/inflammation in localized scleroderma with thermal imaging. *Skin Research and Technology*. 2019 Mar;25(2):118-123. doi: 10.1111/srt.12619
- [2] Abstract N°: 7496 A pilot audit on the use of medical infrared thermal imaging in the clinical assessment of Morphea J Britton, P Laws, EADV congress, Amsterdam 2024

Correspondence: Jason.Britton@nhs.net

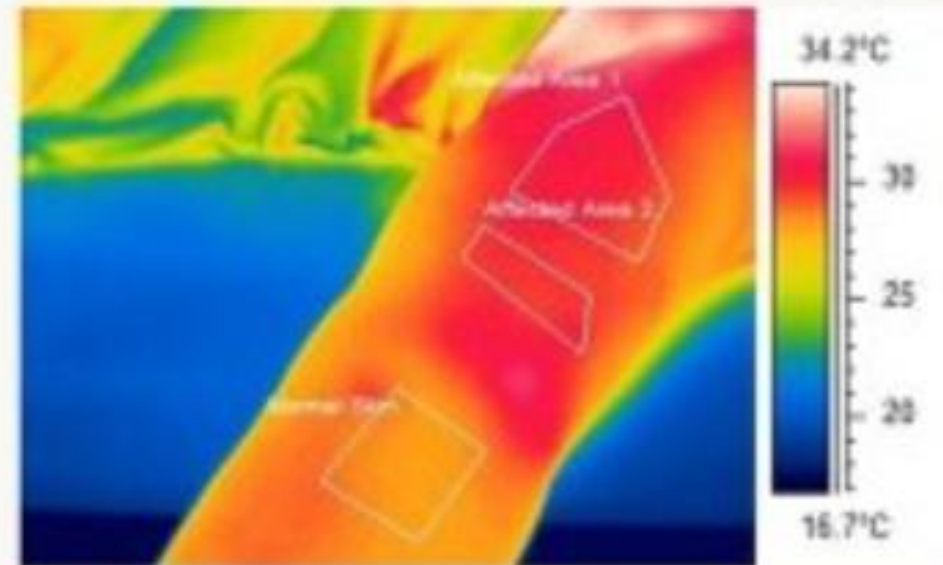
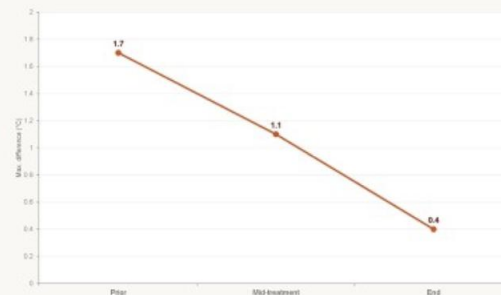
RESULTS

The patient reported softening of the patches of morphea with no evidence of any inflammation. Thermography results from the regions of interest drawn over the images of the lesion and adjacent normal skin are shown in Table 1. The maximum temperature difference between the lesion and unaffected skin fell from 1.7°C prior to treatment, to 1.1°C at the mid-point, to 0.4°C at the end of phototherapy.

Table 1. Region-of-interest results acquired from the thermal images

Visit	Lesion 1 (°C)	Lesion 2 (°C)	Normal skin (°C)	Max. diff. (°C)
Prior	30.2	29.8	28.5	1.7
During	31.8	31.3	30.7	1.1
End	31.4	31.4	31.0	0.4

Figure 4: Max. temperature difference (lesion vs. normal skin) over treatment course



Prior to treatment

Baseline thermal image acquired before the first UVA1 exposure, to define the lesion region of interest



Optical Super-High Magnification Dermoscopy: a Complementary Means in the Diagnosis of Trombiculosis

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Introduction & Objectives

Trombiculosis is a common but underreported ectoparasitosis caused in Europe by the larval stage of *Neotrombicula autumnalis*. Its clinical presentation is nonspecific and may consist of multiple pruritic erythematous macules or papules. Because the larvae are extremely small (200–400 µm), they may be difficult to recognize using conventional 10× dermoscopy. We describe the complementary role of optical super-high magnification dermoscopy in the diagnosis of trombiculosis.

Case Presentation & Methods

A 27-year-old man working in the Tuscan countryside presented with a 3-day history of diffuse intense pruritus. Dermatological examination revealed multiple erythematous macules involving the right side of the trunk, the genitals and the right popliteal fossa. Conventional dermoscopy at 10× showed a tiny bright-yellow structure in the centre of each macule. Videodermoscopy at 40× and optical magnification at 400× (Medicam 1000, FotoFinder Systems) were then performed to better characterize the suspected parasite.

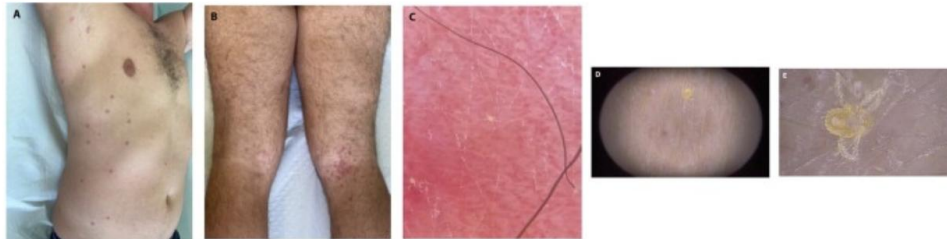


Figure 1. (A, B) Multiple erythematous macules on the right trunk and right popliteal fossa. (C) Conventional 10× dermoscopy showed a tiny golden mite in the centre of the lesion. (D) At 40× magnification the parasite became more evident. (E) At 400× magnification, its golden colour, complete body contour and six legs were clearly visible.

Results and conclusion

The progressive increase in magnification allowed recognition of the six-legged golden-coloured parasite and supported the diagnosis of infestation by *Neotrombicula autumnalis*. Optical 400× magnification provided better visualization of the colour, body contour and leg morphology than conventional dermoscopy. High-magnification dermoscopy may therefore represent a useful complementary method for the rapid and precise diagnosis of trombiculosis, particularly when the minute larvae are easily overlooked at 10× magnification.

The Danger of Super Smartphones in Dermoscopy Imaging: A Case Series Comparing Native Smartphone and Controlled Acquisition

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INTRODUCTION & OBJECTIVES

The **increasing** use of **smartphones** in **dermoscopy** has introduced **advanced computational photography** algorithms that may **alter** image characteristics. While these technologies enhance visual quality, their **impact on diagnostic fidelity remains uncertain**. This study aimed to **evaluate** the **impact** of **smartphone** computational photography on **dermoscopic image fidelity** across multiple clinical cases, as well as its **influence** on **clinical perception**.



CASE PRESENTATION

Four patients with **pigmented skin lesions** were evaluated. Patient 1: a 26-year-old female with a **congenital lesion on the chest**. Patient 2: a 57-year-old female with a **pigmented lesion on the abdomen**, present for approximately one year. Patient 3: a 32-year-old male with a **previously stable lesion** showing **recent changes** over the past two months. Patient 4: a 63-year-old patient with a **pigmented lesion on the face** of unknown duration.

Dermoscopic images were obtained using an iPhone 17 Pro Max coupled to a dermatoscope. Each lesion was **photographed sequentially** using the **native camera** application and **Project Indigo (Adobe)** under standardized conditions.

Images were **evaluated qualitatively**, through quantitative analysis using **ImageJ** (assessing RGB distribution, contrast, and edge definition), and via a **structured questionnaire** completed by dermatologists in training.

Across all cases, **images** obtained with the **native camera** application demonstrated **increased color saturation**, **reduced lesion-to-skin contrast**, and **smoothing** effects that **diminished the visibility** of **fine dermoscopic structures**. In contrast, **controlled acquisition** consistently **preserved color fidelity** and **enhanced visualization** of **subtle structures**. Quantitative analysis revealed **differences** in **RGB distribution** and **edge intensity**, supporting the **presence** of **algorithm-induced alterations** in native images.

A total of **eight** dermatologists in training participated in the evaluation. For **structural visualization**, 75% (6/8) preferred **Image B**, while 25% (2/8) preferred Image A. Regarding **diagnostic confidence**, 62.5% (5/8) selected **Image B**, 25% (2/8) selected Image A, and 12.5% (1/8) reported no difference. **Importantly**, 75% (6/8) indicated that **image selection** would **not influence** their **clinical decision-making**, while 25% (2/8) reported that it would.

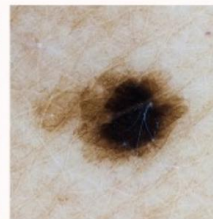


Image A



Image B

Dermoscopic images of the **same lesion** obtained using **different acquisition methods**. **Image A** - Native smartphone image demonstrating **increased color saturation**, **reduced contrast**, and **smoothing** effects with decreased visibility of fine dermoscopic structures. **Image B** - Image obtained using Project Indigo (Adobe) showing improved **color fidelity** and enhanced visualization of **subtle structures**, including pigmented network



CONCLUSION

This case series demonstrates that **computational photography** may systematically **alter dermoscopic features**, both by **artificially enhancing** and by **obscuring** clinically **relevant structures**. Although these changes influenced image preference and perceived quality, their **impact** on clinical decision-making was **limited** in most cases. **Controlled image acquisition** methods may provide **greater fidelity** and **should be considered** in clinical and research settings.

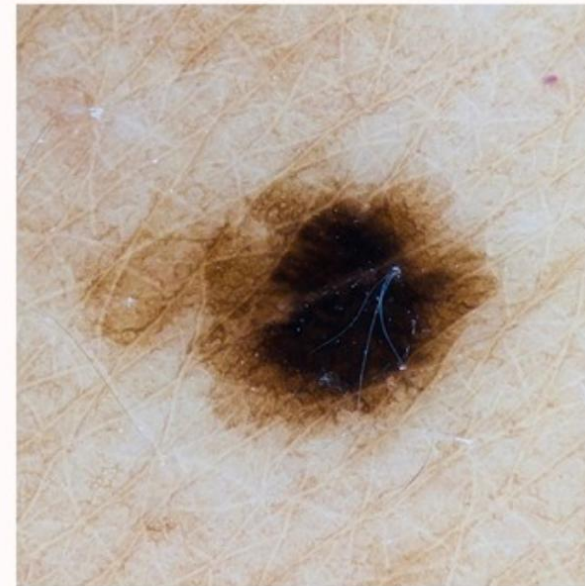


Image A



Image B

- Importancia de **mapeos digitales** para la detección precoz de melanoma: avances en automatización de procesos
- Modelos integrados de **IA multi-nivel** en diagnóstico por imagen: apoyo (cribado y/o diagnóstico), no competencia
- Nuevas técnicas de imagen: **resolución celular in vivo** para diagnóstico y delimitación de lesiones

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La Academia Española de Dermatología y Venereología expresa su agradecimiento al patrocinador UCB, por su especial apoyo y contribución con la actividad formativa Highlights 2026.

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