short course of prednisolone. She remains stable on hydroxychloroquine 200 mg once daily. There have been only 20 reported cases of breast cancer associated with cutaneous sarcoidosis, after a period of 0–360 months. Although postradiotherapy cutaneous sarcoidosis has previously been described, only three had had prior radiotherapy, similar to our patient. In these patients, interstitial lung involvement was reported in all cases. Six patients responded to prednisolone and hydroxychloroquine; a further three were treated with methotrexate. The case highlights the importance of recognizing prior breast cancer as a trigger for sarcoidosis that is frequently associated with interstitial lung disease.

**P10**

**Bullous morphea with objectively assessed response to mycophenolate mofetil: a case with literature review**

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Bullous morphea can occur in any morphea subtype when bullae form on atrophic morphea plaques. It is rare, accounting for 1.4% of morphea cases. The pathogenesis is unknown, but may result from localized trauma and lymphatic obstruction secondary to dermal sclerosis of autoimmune aetiology. There are no standardized treatments. We report a case with objective clinical response to mycophenolate mofetil (MMF). A 74-year-old woman presented with a 12-week history of rapid-onset pruritic, erythematous rash starting on the thighs and abdomen, progressing to involve 80% body surface area. Past medical history included haemochromatosis, type 2 diabetes and hypertension. Examination revealed blistering sclerotic lesions affecting the limbs, abdomen, chest and back, limiting her mobility. Skin biopsy demonstrated an atrophic epidermis with dense collagen bundles and sweat gland compression with focal subepithelial vesiculation, consistent with bullous morphea. She started a tapering course of prednisolone (30 mg daily). Three weeks later, a bullous eruption developed on her lower abdomen. Despite starting MMF 500 mg daily, the blistering worsened, becoming extensive, painful and circumferential on her trunk, groin and lateral thighs. Adding doxycycline 100 mg daily with ultrapotent topical steroids showed inadequate response, so MMF was increased to 1 g twice daily. Prednisolone was increased to 70 mg daily, with significant improvement in the cutaneous oedema and mobility, with reduced skin tightness and pain. No new active lesions developed on follow-up on MMF. Prednisolone was tapered off 4 months later. Localised Sclerodermata Cutaneous Assessment Tool (LoSCAT) scores recorded from the time of MMF dose increase showed improved disease severity with more improvement in disease activity than damage. Bullous morphea is rare and the literature is restricted to case reports and short series. Treatment response has been reported with salazopyrin, MMF, tacrolimus, methotrexate, steroids and phototherapy. However, no cases from our literature search reported objective outcomes with standardized scores. The absence of objectively assessed disease severity in the literature poses a further challenge in comparing treatment outcomes between reports. The LoSCAT is the only validated clinical tool to measure morphea severity over time and allows measurement of clinically significant improvement in disease activity, allowing comparison of intra- and intercase severity. We describe a case of bullous morphea with good response to MMF and prednisolone. This is the first case to demonstrate objective improvement using the LoSCAT score. Using objective disease outcome measures allows disease severity monitoring within patients. Future reports of treatment efficacy in rare conditions should use harmonized objective disease outcome measures to facilitate comparison between cases.

**P11**

**Leser-Trélat sign: can it follow COVID-19 infection?**

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Seborrheic keratosis is a benign brownish–black skin lesion that is almost always seen in middle-aged and elderly populations. The sudden onset and rapid increase in size and/ or number of seborrheic keratoses is called the Leser-Trélat sign, suggesting a paraneoplastic manifestation of internal malignancy. However, eruptive seborrheic keratoses are also described in some nonmalignant conditions such as human papillomavirus infection and HIV infection. Herein, we report a case with Leser-Trélat sign in a patient following COVID-19 infection. A 50-year-old man presented to our dermatology clinic complaining of the sudden appearance of multiple warty-like lesions on his back, which had occurred 2 months after recovery from COVID-19 infection. According to his medical history, the patient presented with cough, fever and dyspnoea about 2 months prior to the appearance of his skin lesions. He was referred to a health centre, where a nasopharyngeal swab was taken, and his polymerase chain reaction test for COVID-19 was positive. In addition, bilateral patchy ground-glass infiltration was reported in his high-resolution computed tomography (HRCT) scan, all in favour of COVID-19 infection. The patient was then treated with acetaminophen, dexamethasone (intramuscular injection), salmeterol and a fluticasone inhaler, and his symptoms improved. Two months after recovery from his mild COVID-19 infection, several small asymptomatic pigmented verrucous papules appeared on his back. Physical examination revealed multiple rough, oval-shaped, brownish papules of varying size. Dermatoscopy of the lesions was also performed. Both clinical and dermoscopic findings were in favour of seborrheic keratosis. In order to reach a final diagnosis, a skin biopsy was performed, and microscopic examination of the biopsy specimen showed hyperkeratosis and well-defined epidermal...
P12

Just a bruise? Angiosarcoma in long-standing leg lymphoedema
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We present the case of a 69-year-old woman who presented with a 5-month history of change of skin colour, texture and contour of her left leg, on a background of long-standing bilateral lymphoedema. She attributed the change to an episode of trauma in the garden, but the discolouration was non-resolving. Her past medical history was remarkable for atrial fibrillation and hypertension. On examination she had bruise-to-brown-coloured macules scattered from foot to knee, becoming confluent in places. The skin was thickened and fibrosed, limiting dorsiflexion of the foot. On the medial side of the leg a bruise-like patch also contained darker papules. Doppler ultrasound demonstrated biphasic pedal pulses bilaterally. Based on the history and clinical appearance, angiosarcoma was considered in the differential and she was referred urgently to the local sarcoma multidisciplinary team. Two initial punch biopsies were taken. One demonstrated inflammation; the other showed pleomorphic atypical endothelial cell populations of cells were identified: ductal epithelial cells positive for CD117, CD43 and Ber-EP4 on immunophenotyping, and an outer layer of small cells positive for S100 and smooth muscle actin. Some ducts displayed an epithelial membrane antigen-positive lining. P63, CK5 and CK7 were diffusely positive. Abundant acid mucin was present. The differential diagnosis included adenoid basal cell carcinoma and adenoid cystic carcinoma (ACC). The latter was favoured owing to the presence of two distinct cell populations along with positive immunohistochemical markers CD117 and CD43. Full excision is awaited. ACC is a rare adnexal neoplasm that arises in the skin and is uncommonly presents in the skin. It is rare, occurring in 0.07–0.45% of patients post-radical mastectomy. The incidence in patients with lymphoedema is unknown. Pathogenesis is poorly understood, but it has been suggested that the local immunodeficiency caused by lymphoedema predisposes to oncogenesis (Ruocco V, Schwartz R, Ruocco E. Lymphedema: an immunologically vulnerable site for development of neoplasms. J Am Acad Dermatol 2002; 47: 124–7). The average survival is 5–8 months without treatment and 2.5 years with treatment (Sharma A, Schwartz R. Stewart–Treves syndrome: pathogenesis and management. J Am Acad Dermatol 2012; 67: 1342–8). Clinically, it presents as bruise-like areas or black-to-purple nodules. Histology in this case is typical, although it has a wide morphological appearance and can also present as sheets of mitotically active pleomorphic endothelial cells without vascular channels. Although rare, it is important that clinicians are aware of this entity as diagnosis is often delayed and prognosis is poor.

P13

Adenoid cystic carcinoma: a rare adnexal neoplasm that uncommonly presents in the skin
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An 87-year-old woman presented to dermatology via the 2-week wait skin cancer pathway with a more than 5-year history of a slowly growing raised lesion on her scalp. On examination, the lesion in question was a 7 cm × 9 cm multinodular, firm, telangiectatic tumour, which was mobile over the scalp vertex. There was no palpable cervical lymphadenopathy. An incisional biopsy revealed a basoid tumour with a cribriform growth pattern that was not connected to the epidermis. Two distinct populations of cells were identified: ductal epithelial cells positive for CD117, CD43 and Ber-EP4 on immunophenotyping, and an outer layer of small cells positive for S100 and smooth muscle actin. Some ducts displayed an epithelial membrane antigen-positive lining. P63, CK5 and CK7 were diffusely positive. Abundant acid mucin was present. The differential diagnosis included adenoid basal cell carcinoma and adenoid cystic carcinoma (ACC). The latter was favoured owing to the presence of two distinct cell populations along with positive immunohistochemical markers CD117 and CD43. Full excision is awaited. ACC is a rare adnexal neoplasm that arises in the major and minor salivary glands of the head and neck. It may also arise in secretory glands located in other tissues such as the tracheobronchial tree, oesophagus, breast, lung, prostate, uterine cervix, lacrimal and Bartholin glands, and, of course, the skin. Typically, it presents as a slow-growing firm-to-cystic tumour in the fourth to sixth decade. Initially described by Boggio

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