Annals of Medical Resarch
DOI: 10.5455/jtomc.2018.01.017 2018;25(2):290-1

Letter to the Editor

A tinea incognito case report

Dursun Turkmen

Malatya Training and Research Hospital, Dermatology, Clinic, Malatya, Turkey

Dear Editor,

The term "Tinea incognito" (TI) is used for dermatophytosis which alters typical superficial mycosis clinic and causes a difficulty in diagnosis as a result of topical or systemic corticosteroid use (1,2). Tinea incognito cases mostly develop due to iatrogenic reasons. Generally, physicians who prescribe drugs with cortisol are general practitioners or family practitioners (1). It can sometimes develop as a result of steroids patients obtain without consulting a physician and sometimes after steroid use with a misdiagnosis although the patient refers to dermatology. This paper presents a Tinea incognito case which started on the face and spread to one side of the neck and shoulder.

47-year-old female patient referred to our dermatology outpatient clinic with a complaint of pruritus and rashes on the face and neck. Detailed anamnesis showed that she had the complaints for about a year, she had referred to dermatology twice previously and she was given topical corticosteroid and antihistaminic treatment with a diagnosis of eczema, her complaints alleviated but did not go away completely. The case did not have a history of animal contact or similar disease in the family. Dermatologic examination showed that there were macular lesions in the shape of patches on the face and right side of the neck which were not clearly defined, mildly erythematous, squamous in parts and at the level of skin; while there was a wide plaque lesion on the right shoulder region which had a clear edge activation and which was more squamous (Figure 1). Branched septate hyphas were found in the direct examination conducted with 20% potassium hydroxide (KOH) on the squamas taken from the lesions. The case was clinically diagnosed with Tinea incognito and 250 mg/day terbinafine and topical antimycotic was started. In the next control, it was found that the lesion was completely healed clinically and the pruritus had disappeared.

Preparates with cortisone used as systemic or topical suppress immune response and inflammatory reactions and decrease the resistance to infections (3). With the cellular immunity being suppressed, the clinical symptoms resulting from dermatophytosis in the affected individual decrease at first and complaints such as pruritus and burning sensations disappear. However, the underlying fungal infection spreads gradually and subjective complaints exacerbate after the drug is discontinued. Thus, the patient has to use the same drug recurrently and this turns into a vicious circle (4).

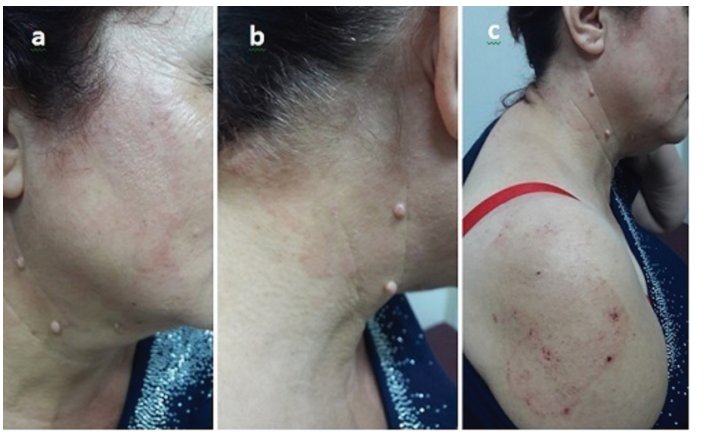

Figure 1 a,b. Macular lesions in the shape of patches on the face and right side of the neck which were not clearly defined, mildly erythematous, squamous in parts and at the level of skin; **c.** Wide plaque lesion on the right shoulder region which had a clear edge activation and more squamous

Common superficial fungal lesions are oval or round, sharply-circumscribed, squamous lesions the edges of which are swollen on the skin, the central parts are partially or completely improved and they are in the shape of annular plaques which show edge activation (5). Depending on the affected area, it can be similar to a great number of diseases such as seborrheic dermatitis (SD), rosacea, psoriasis, eczema, impetigo, neurodermatitis, contact dermatitis, discoid lupus erythematous (DLE), perioral dermatitis, atopic dermatitis, pityriasis rosea (PR) and sarcoidosis (6,7). In TI, classic clinical appearance alters as a result of unsuitable topical steroid use; non-squamous diffuse

Received: 24.01.2018 **Accepted:** 23.02.2018 **Available online:** 06.03.2018
Corresponding Author: Dursun Turkmen, Malatya Training and Research Hospital, Dermatology, Clinic, Malatya, Turkey
E-mail: drturkmen44mlt@gmail.com

erythema, papule, pustule, telangiectasia and changes in pigmentation dominate the clinical picture (5,6). In our case, the lesions in the face and neck had neurodermatitis or contact dermatitis appearance. Shoulder lesions had formed last and since the patient could not use the steroid cream completely, edge activation and tinea appearance had not disappeared.

TI cases with different clinical appearances similar to lichenoid, rosacea, psoriasis, poikiloderma, SD, folliculitis, eczema and alopecia have been reported in literature (8). In a multicentered study conducted in Korea by Kim et al. on 283 patients for 9 years, eczema, psoriasis and DLE-like TI were found the most frequently. Dermatitis, impetigo, urticaria, folliculitis, intertrigo, lichen simplex chronicus (LSK) and vitiligo like appearances were also found, though less frequently. while the lesions were found to be most frequently on the face and torso, 91% of the patients were also found to have comorbid fungal infection (9).

While localized Tinea corporis cases respond well to topical antifungal agents, systemic antifungal agents are generally needed in the treatment of TI Since terbinafine intraconazole and fluconazole accumulate in the stratum corneum, they are preferred to griseofulvin (10). However, in tinea incognito treatment, there is no certain data about which agent is better and the period of treatment. Thus, TI cases should definitely be treated and followed with systemic antifungals. Systemic terbinafine and topical antifungal treatment was given to our patient and positive response was taken.

Our purpose in presenting this case is to emphasize examination for superficial fungal infection before starting the treatment in patients who have whole squamous lesions, especially if there is asymmetric involvement. While checking the lesions the patient complains about, the lesions in closed areas should also be controlled in order to see where the lesions extend to. For direct fungal examination, it will be easier to find squamas from areas patients can hardly reach and to make a diagnosis.

Competing interests: The authors declare that they have no competing interest.

REFERENCES

1. Martin AG, Kobayaski GS. Fungal diseases with cutaneous involvement. In: Dermatology in General Medicine. Ed. Fitzpatrick TB, Eisen AZ, Wolff K, Freedberg IM, Austen KF. 5th edition. McGraw Hill Inc, New York, 1999;2347.
2. Şavk Bozkurt E, Karaman Can G, Şendur N. Bir tinea incognito olgusu. T Klin Dermatoloji 2001;11(1):30-3.
3. Hay RJ, Moore M. Mycology. In: Champion RH, Burton JL, Burns DA, Breathnach SM, editors. Textbook of dermatology. 6th ed. Oxford: Blackwell Science; 1998. p.1277-376.
4. Dereli T. Tinea incognito. İnfeksiyon Dergisi 2007;21(Ek):103-12.
5. Yu C, Zhou J, Liu J. Tinea incognito due to microsporum gypseum. J Biomed Res 2010;24(1):81-3.
6. Arenas R, Moreno-Coutino G, Vera L, Welsh O. Tinea Incognito. Clin Dermatol. 2010;28(2):137-9.
7. Calcaterra R, Fazio R, Mirisola C, Baggi L. Rosacea-like tinea incognito due to Trichophyton mentagrophytes. Acta Dermatovenerol Croat 2013;21(4):263-4.
8. Romano C, Asta F, Massai L. Tinea incognito due to Microsporum gypseum in three children. Pediatr Dermatol 2000;17(1):41-4.
9. Kim WJ, Kim TW, Mun JH, Song M, Kim HS, Ko HC, et al. Tinea incognito in Korea and its risk factors: Nine-year multicenter survey. J Korean Med Sci 2013;28(1):145-51.
10. Jacobs JA, Kolbach DN, Vermeulen AH, Smeets MH, Neuman HA. Tinea incognito due to Trichophyton rubrum after local steroid therapy. Clin Infect Dis 2001; 33(12):142-4.