

Short Communication

Tinea atypica- mimicking lichen planus pigmentosus

Dermatophyte infections of the skin are easy to diagnose and treat if they present with classical manifestation. But when the clinical presentation is modified mimicking other skin diseases due to factors like dermatophyte's characteristics, combination of patient's pathological and physiological conditions, such as excessive washing or sun exposure, or by the use of inappropriate treatment, it is referred to as tinea atypica.¹ We report a case of tinea atypica, imitating and diagnosed initially as lichen planus pigmentosus.

A 60-year-old man presented with an eight-month history of an asymptomatic dyspigmentation on his face and neck that had gradually worsened. He complained of mild pruritis on exposure to sun with no history of topical prescription or over-the-counter medications. Physical examination demonstrated multiple round-to-oval blue-gray hyperpigmented macules and patches with some areas of coalescence scattered symmetrically on lateral aspect of his cheeks and neck (**Figure 1**). There was no dyspigmentation in the trunk or lower extremity. In the groin region he had pruritic erythematous hyperpigmented lesions clinically diagnosed as dermatophyte infection. KOH mount and culture on Sabouraud agar was done from both groin and facial lesions. It revealed hyaline septate branching hyphae from both sites. Patient was prescribed luliconazole cream and oral terbinafine 250mg for 3 weeks. He was advised skin biopsy for the facial dyspigmentation changes after 3 weeks. Trichophyton rubrum was isolated as a causative agent from culture (**Figure 2**). When the patient was reviewed at the end of 3 weeks there was improvement in pruritis with reduction in facial

pigmentation. He was continued with the same antifungal therapy for 5 more weeks with complete resolution of the facial pigmentation and groin lesions.

Currently, there are multiple reports of patients presenting with atypical clinical presentations of dermatophytosis. This often leads to misdiagnosis, difficulties in the management of clinical symptoms and in offering appropriate therapy. Dermatophytosis has been included in the list of great imitators with atypical presentations such as psoriasis-like, eczematous dermatitis-like, seborrheic dermatitis-like, and rosacea-like.²



Figure 1 Facial dyspigmentation.

Figure 2 T.rubrum growth in SD Agar with acidtion.

The host factors responsible for the above changes include host immune dysregulation with Th1 to Th2 shift, Caspase recruitment domain-containing protein 9 (CARD9) gene mutation induced immunodeficiency, atopy, or selective anergy in host, defect in skin barrier function, age and obesity. The agent and environmental factors include change in the species with

decline in the downy form of *T. rubrum*, predominance of *Trichophyton mentagrophytes*, biofilms, increasing MIC of antifungal drugs with antifungal resistance, climatic condition, overcrowding, migration, urban clothing patterns and poor hygiene.³ The atypical manifestations are not only seen as a consequence of corticosteroid therapy but also caused by various factors like dermatophyte invasive capacity, the site of invasion, physiological and/ or acquired condition, such as excessive washing or sun exposure. The term "tinea atypica" include all forms of dermatophytosis that do not present the classic features for both primary and secondary pathomorphosis.⁴ The case reported above is a rare presentation of dermatophyte infection mimicking lichen planus pigmentosus which resolved with antifungal therapy.

References

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