An Unusual Form of Tinea Versicolor: A Case Report

Ali Akbar Akaberi, MD
Seyed Saeed Amini, MD
Hosein Hajihosseini, MD

Department of Dermatology, Yazd University of Medical Sciences, Yazd, Iran

Corresponding author:
Seyed Saeed Amini, MD
Savaneh-Sukhtegi hospital, Yazd, Iran
Email: s_s_amini@yahoo.com

Received: June 2, 2008
Accepted: May 30, 2009

Abstract

Tinea versicolor is caused by Malassezia furfur and presents as hypo or hyper-pigmented coalescing scaly macules on the trunk and upper arms. Sites of predilection are the sternal region and the sides of the chest, the abdomen, back, pubis, neck, and intertriginous areas. We report a case of tinea versicolor with a reticulated pattern on acral sites. (Iran J Dermatol 2009;12 (Suppl): S30-S31)

Keywords: acral, tinea versicolor, reticulate

Case Report

An 11-year-old boy was visited in our clinic with hypo-pigmented macules on extremities from months ago. There were no symptoms. He had been treated as a case of vitiligo erroneously without success. On examination, symmetrical reticulated hypo-pigmented macules on hands, feet, elbows and knees associated with fine scaling were seen (Figure 1,2). Hair, nail and mucous membranes were intact. To evaluate the color of the lesions, the patient was examined by Wood's light. The yellow hue of the lesions confirmed tinea versicolor. In direct skin smear, fungal elements for versicolor were seen.

Discussion

In 1951, Gordon isolated and characterized the organism M. furfur and renamed it Pityrosporum orbiculare. It is now recognized and accepted that M. furfur is the correct name and that P. orbiculare, P. ovale, and M. ovalis are synonyms. As a yeast, the organism is part of the normal follicular flora.

Figure 1. Reticulated hypopigmented patches on the knees.

Figure 2. Acral reticulated hypopigmented patches.
Cutaneous infections with Malassezia may take three forms: papulosquamous, folliculitis, and inverse tinea versicolor. The most common presentation is scaly hypo- or hyperpigmented macules observed in characteristic areas of the body, including the chest, back, abdomen, and proximal extremities. Less common areas of involvement include the face, scalp, and genitalia. Facial lesions and penile lesions occur fairly commonly in infants and immunocompromised patients. The disease may even occur on the scalp, palms, and soles. The characteristic scale is described as dustlike or furfuraceous. This characteristic feature of the disease can be produced by lightly scraping a scalpel blade over the involved skin. The color of the lesions varies from almost white to reddish brown or fawn-colored. The presenting complaint is usually a cosmetic one because lesions often fail to tan with sun exposure. Pruritus is mild or absent. The eruption is more common during the summer months, particularly in sebum-rich areas of the skin 1-6.

In hypopigmented tinea versicolor, abnormally small and poorly melanized melanosomes are produced but are not transferred to keratinocytes properly. This becomes most conspicuous in dark-skinned people. The fungus is easily demonstrated in scrapings of the profuse scales that cover the lesions. Tape stripping of the lesions can also be performed. Microscopically, there are short, thick fungal hyphae and large numbers of variously sized spores. This combination of strands of mycelium and numerous spores is commonly referred to as “spaghetti and meatballs”. Identification by culture requires lipid enrichment of the media and is rarely done to establish the diagnosis. Wood’s light examination accentuates pigment changes and may demonstrate yellow-green fluorescence of the lesions in adjacent follicles 1.

Tinea versicolor must be differentiated from seborrheic dermatitis, pityriasis rosea, pityriasis rubra pilaris, pityriasis alba, leprosy, syphilis, and vitiligo. In the atrophic variant, the lesions may suggest parapsoriasis, mycosis fungoides, anetoderma, lupus erythematosus, or steroid atrophy 1-7. The diagnosis in all forms of tinea versicolor is generally easily established by KOH examination 1-6. Imidazoles, triazoles, selenium sulfide, ciclopirox olamine, zinc pyrithione, sulfur preparations, salicylic acid preparations, propylene glycol, and benzoyl peroxide have been used successfully as topical agents. Patients should be informed that the hypo- and hyperpigmentation will take time to resolve which is not a sign of treatment failure 1,2,8-12.

To date, acral tinea versicolor, as in our case, has not been reported in the literature.

References