

Suggested algorithm for refractory or chronic dermatophytosis

Clinically compatible with dermatophytosis*



- Widespread skin lesions, +/- severe pruritus, +/- topical steroid use, **OR**
- International travel or migration (especially from endemic regions (e.g., South Asia)), **OR**
- Contact with known or suspected case, **OR**
- At least 2 weeks of oral terbinafine without improvement in confirmed dermatophytosis

Step 1: Confirm dermatophyte infection if not already done

- Fungal culture from skin scraping or nail clipping for species identification. Consider genetic sequencing and antifungal susceptibility testing using culture specimen. [\[link\]](#).
 - KOH preparation.
- Do not delay treatment while awaiting culture, sequencing, or susceptibility testing results.

Step 2: See review of treatment options and initiate antifungal therapy

(itraconazole is generally 1st line). [\[link\]](#)

Step 3: Treat to clear infection

- Ensure appropriate response, adherence to therapy, and monitor for recurrence.
 - Avoid topical corticosteroids.
- For patients failing therapy**, consider consultation with specialists in fungal disease.

This suggested algorithm should not be considered a treatment guideline for refractory or chronic dermatophytosis.

* Lesions may be atypical. Multiple morphologies are reported. ([link to clinical resources](#)).

** Ensure correct diagnosis, adherence to therapy, no drug interactions. If not already done, consider genetic sequencing and antifungal susceptibility testing. For patients who fail itraconazole, consider consultation with specialists in fungal disease.

Reference:

1. Alireza Abdolrasouli, Roderick J Hay, Antifungal-resistant Trichophyton indotineae: transmission is occurring outside previously identified endemic areas – are we prepared?, *British Journal of Dermatology*, 2024; ljae140, <https://doi.org/10.1093/bjd/ljae140>