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Tinea Incognito Corporis et Capitis in a 54-Year-Old Woman: An Extremely Rare Case Report

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ABSTRACT

A 54-year-old woman presented with a 4-year history of generalized, scaly, and pruritic eruptions that were unresponsive to both topical and systemic corticosteroids. A potassium hydroxide (KOH) preparation revealed septate, branched hyphae, and fungal culture of skin scrapings confirmed *Trichophyton rubrum*, which was susceptible to fluconazole. A diagnosis of tinea corporis et capitis incognito was established, and the patient was treated with topical sertaconazole cream, ketoconazole shampoo, and oral fluconazole (150 mg weekly), leading to complete clinical resolution after 4 months. This case highlights the importance of early recognition and appropriate treatment of tinea corporis et capitis incognito in adults.

INTRODUCTION

Tinea incognito is an atypical presentation of dermatophyte infection resulting from local immunosuppression due to systemic or topical corticosteroid use [1]. Clinically, the lesions lack the well-defined borders, central clearing, and scaling typically observed in classic dermatophytosis [2]. Corticosteroid use may further suppress inflammatory signs, causing tinea incognito lesions to appear less erythematous. The most common causative organism is *Trichophyton rubrum*, followed by *Trichophyton mentagrophytes* and *Epidermophyton floccosum* [3].

CASEREPORT

A 54-year-old woman presented with a 4-year history of generalized, scaly, and pruritic eruptions that were unresponsive to both topical and systemic corticosteroids. Cutaneous examination revealed multiple large, scaly patches covering most of the skin surface, including the trunk, scalp, face, and extremities. The lesions were asymmetrical and exhibited active, elevated borders.

Areas of unaffected skin were noted on the left arm, chest, right thigh, and mid-back (Figure 1a, 1b). The scalp was covered with fine scales, and hair density was reduced (Figure 1c). Three differential diagnoses were

considered: mycosis fungoides, erythema gyratum repens, and tinea corporis, faciei, et capitis. Blood investigations revealed markedly elevated IgE (2483 IU/mL) and eosinophilia (32%), while Liver and Renal Function Tests (LFTs, RFTs), Fasting Blood Sugar (FBS), and HbA1C levels were within normal limits. KOH preparations from the scalp and trunk revealed numerous branched, septate hyphae, confirming the diagnosis of tinea. To further confirm the diagnosis and assess antifungal susceptibility, scrapings were sent for fungal culture and sensitivity testing. The patient was immediately started on oral itraconazole (200 mg once daily), ketoconazole shampoo (topically, once daily), and 2% sertaconazole cream (topically, twice daily). Marked clinical improvement was observed after one week of treatment, further supporting the diagnosis. Fungal culture identified *Trichophyton rubrum*, which was resistant to itraconazole but susceptible to fluconazole and voriconazole.

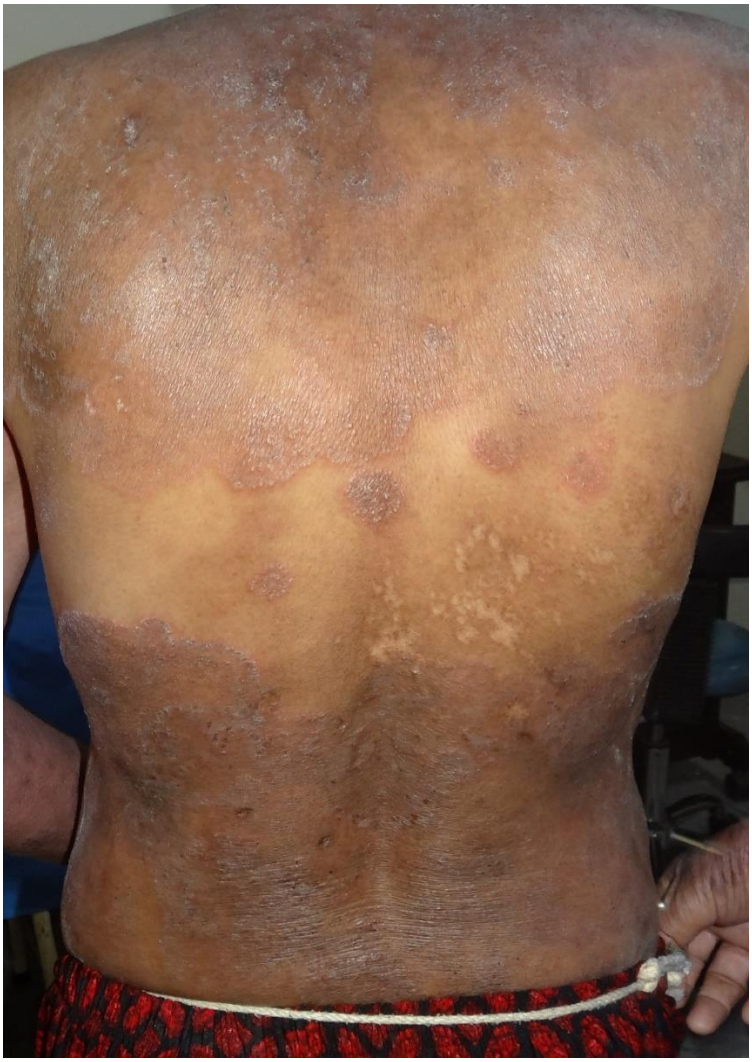

Figure 1a: At presentation: Multiple large, scaly plaques with well-defined, elevated borders on the upper and lower back.

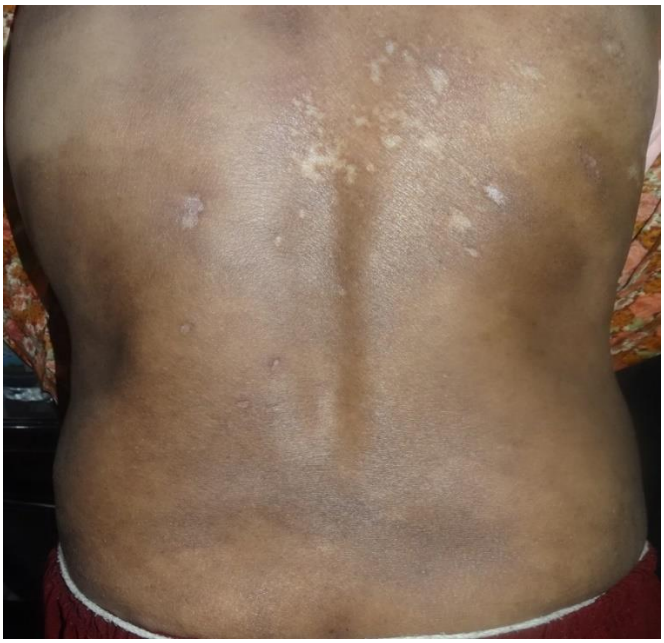

Figure 1b: Four months after treatment: Complete resolution with mild hyperpigmentation and superimposed hypopigmented macules.

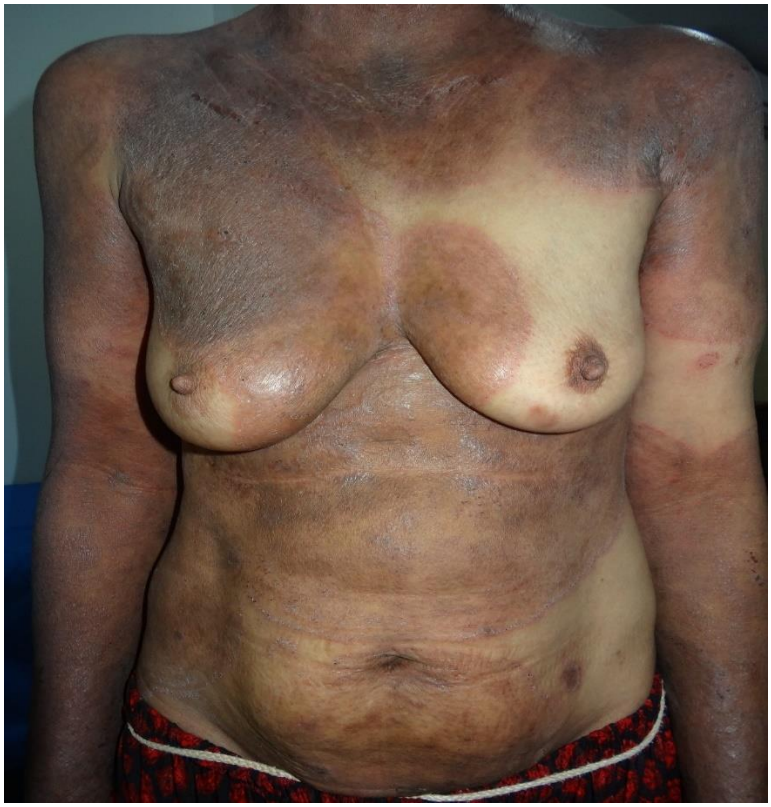

Figure 1c: At presentation: Multiple scaly plaques covering most of the chest, abdomen, and arms, with small patches of unaffected skin.

Consequently, itraconazole was replaced with fluconazole (150 mg once weekly). Based on the clinical presentation, history of corticosteroid use, positive KOH findings, positive fungal culture, and rapid response to antifungal therapy, a diagnosis of tinea incognito was confirmed. Treatment was continued for 4 months, resulting in both clinical and mycological cure, with residual hyperpigmentation (Figure 1d, 1e, 1f).

This case is unique for three reasons: [1] the infection persisted for 4 years before accurate diagnosis and successful treatment; [2] it involved extensive body surface area, including the scalp, which is rarely reported; and [3] it occurred in an older adult woman.

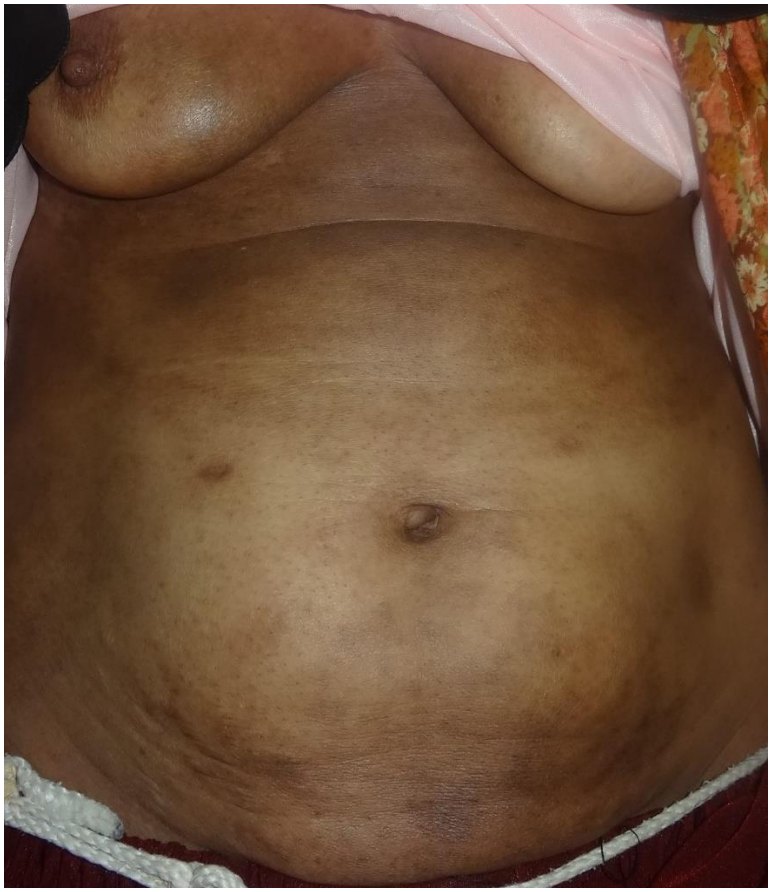

Figure 1d: Four months after treatment: Complete clearance of scaly skin lesions.

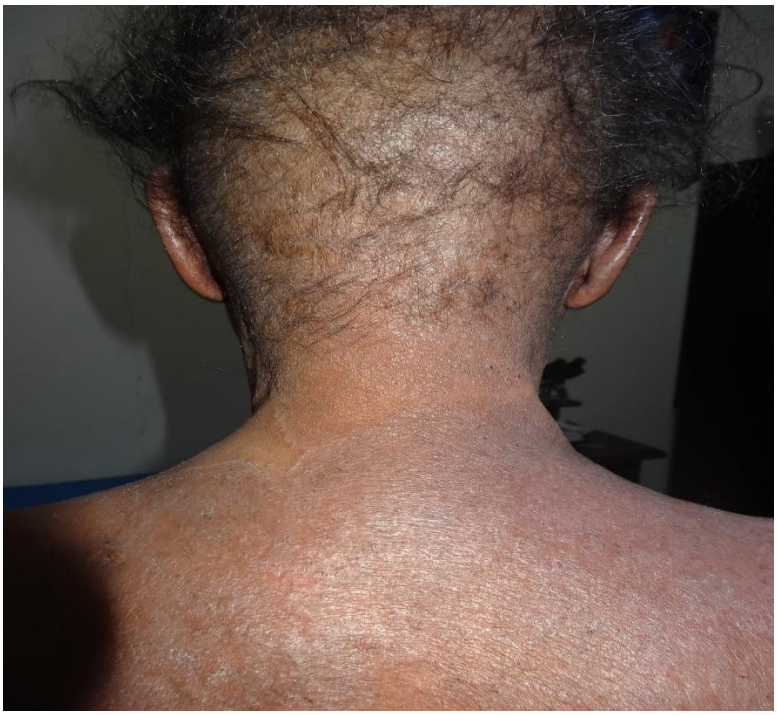

Figure 1e: At presentation: Diffuse alopecia and scaling of the upper back and scalp, with sharply elevated margins.

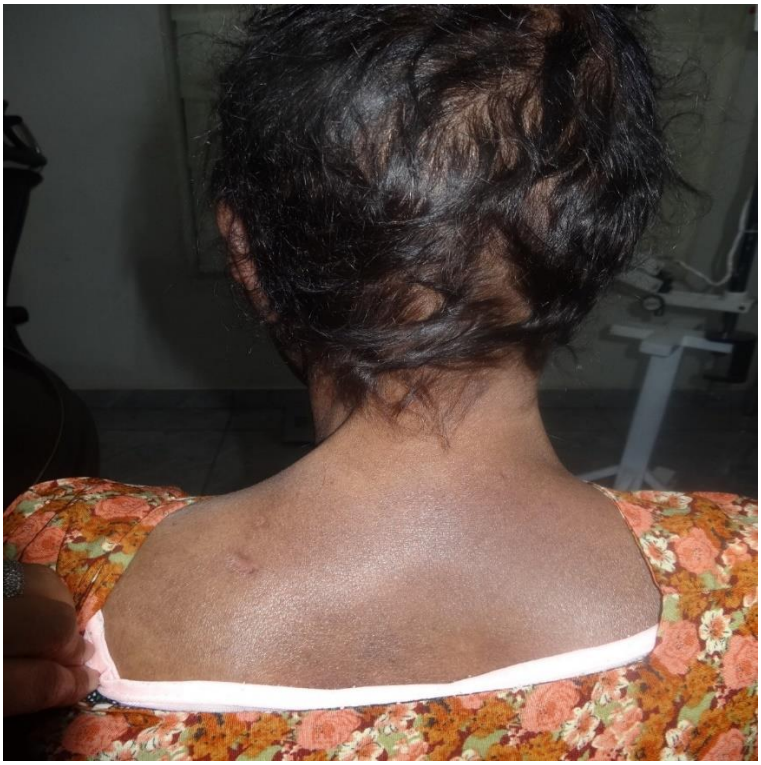

Figure 1f: Four months after treatment: Complete resolution with scalp hair regrowth and mild residual hyperpigmentation on the back.

DISCUSSION

This case was particularly challenging, as it was refractory to both topical and systemic corticosteroids and persisted for 4 years. This raised suspicion of mycosis fungoides, which typically presents with pruritic, scaly lesions that show temporary improvement with steroids but progressively increase in size and number, as observed in the present case [4,5]. The patient's age also supported this differential diagnosis. A punch biopsy was initially considered; however, it was cancelled after the fungal culture results were obtained.

The annular scaly lesions also raised the possibility of erythema gyratum repens, a paraneoplastic dermatosis commonly associated with malignancies of the lung, esophagus, and breast [6]. This condition typically presents with migrating, scaly edges, similar to those observed in this patient.

Given the diverse clinical presentations of tinea incognito, clinicians must maintain a broad differential diagnosis, as it may mimic conditions such as eczema, mycosis fungoides, lichenoid dermatitis, and erythema gyratum repens.

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