

Acral pityriasis versicolor - A rare clinical presentation

Tasleem Arif

Postgraduate Department of Dermatology, STDs and Leprosy, Jawaharlal Nehru Medical College (JNMC), Aligarh Muslim University (AMU), Aligarh, India

Corresponding author: Dr. Tasleem Arif, MBBS, MD, E-mail: dr_tasleem_arif@yahoo.com

ABSTRACT

Pityriasis versicolor is a superficial fungal infection of the skin caused by the yeast of the genus *Malassezia* and presents as hypo or hyper pigmented scaly macules. The most commonly affected sites include upper trunk, upper arms, neck and the abdomen. Lesions confined to the acral parts like hands and feet have rarely been reported. In this article the author reports a 40 year old male who presented with multiple hypo pigmented scaly macules confined to the acral parts (hands and wrist). The acral variant of pityriasis versicolor is considered to be a very rare clinical entity which prompted the author to report this case.

Key words: Acral; *Malassezia*; Pityriasis versicolor

INTRODUCTION

It was Eichstedt in 1846 who first noted the disease which is currently called as pityriasis versicolor (formerly tinea versicolor) [1]. Pityriasis versicolor is caused by various species of the genus *Malassezia* like *M. Sympodialis*, *M. Furfur*, *M. Globosa*, etc. Clinically patients present with hypopigmented or hyperpigmented macules which may be asymptomatic or with mild irritation. The sites of predilection include the upper trunk, upper arms, the neck and the abdomen. Less common sites include axilla, groins, popliteal fossae and genitalia [2]. Clinical presentation with lesions confined to the acral parts has rarely been described. The author reports a rare clinical variant of this disease where the lesions are restricted to the dorsal aspects of hands and the wrist.

CASE REPORT

A 40 year old male visited our dermatology department with a chief complaint of multiple asymptomatic hypopigmented macules over dorsal aspects of both hands and wrist for the last one and a half months. There were no such lesions on any other parts of the body. He had no such history in the past. He denied

any such complaints in his family members. On examination, there were multiple discrete scaly hypopigmented macules present on the dorsal aspects of both hands and wrist (Figs 1a - c). The scaling of the macules became prominent on stretching the affected skin (positive Zireli's sign). The examination of hair, nail and mucous membrane was unremarkable. Potassium hydroxide (KOH) examination of the skin scrapings was done which showed multiple short hyphae and spores. He was prescribed topical Sertaconazole 2%

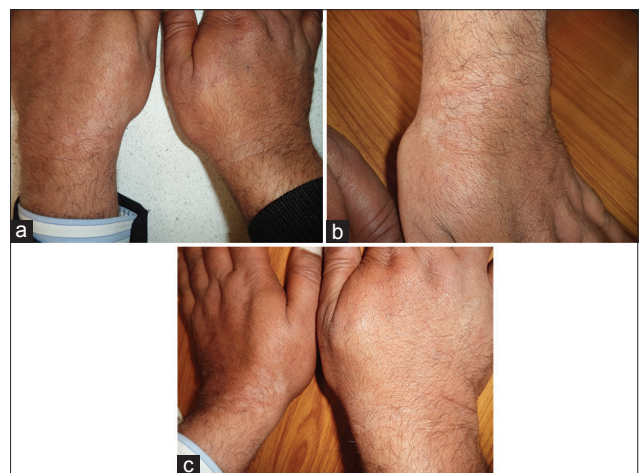


Figure 1 (a - c): Acral pityriasis versicolor: Multiple scaly hypopigmented macules on the dorsal aspects of the hands and the wrist

How to cite this article: Arif T. Acral pityriasis versicolor - A rare clinical presentation. Our Dermatol Online. 2015;6(2):196-197.

Submission: 26.10.2014; **Acceptance:** 11.02.2015

DOI: 10.7241/ourd.20152.53

cream twice daily. In addition, oral fluconazole 400 mg was given weekly for two weeks.

DISCUSSION

M. Furfur and the other related species of the genus *Malassezia*, the causative agents of Pityriasis versicolor, normally live on human skin in amounts which are undetectable on routine KOH examination of stratum corneum [3]. In most cases, Pityriasis versicolor represents a shift in the relationship between the yeast and the human skin. The factors which lead to the development of pityriasis versicolor are multiple. However, the environmental factors and the individual host susceptibility are amongst the major ones. A high temperature and increased humidity in the tropical climates favor the disease. Oily skin, poor nutrition, immunodeficiency, pregnancy and corticosteroid use are the risk factors in the temperate climate [1,2].

Clinically, patients of pityriasis versicolor present with well defined discrete or confluent scaly macules, which may be hypo pigmented or hyper pigmented [4]. The scaling of macules can be made prominent by stretching the affected skin and is called Zireli's sign [5]. There are many morphological types of pityriasis versicolor reported in the literature which include hypochromic (commonest), hyperchromic, combination of hypochromic and hyperchromic, circinate, erythematous, atrophying, follicular, parasitic achromia (intense skin depigmentation occurring in melanodermic individuals), involving inguinocrural region and simulating erythrasma. Another type resembling pityriasis rubra pilaris has rarely been reported [5-9]. Acral variant of the disease has been rarely reported. Ali Akbar, et al have reported an acral case of the pityriasis versicolor in which an 11 year old boy had reticulated hypo-pigmented macules on hands, feet, elbows and knees in a symmetrical distribution [6]. However, in the present case the lesions are confined to the hands and the wrist which adds more rarity to the present communication and inspired the author to report the same.

The diagnosis of pityriasis versicolor is a clinical one without requiring any laboratory documentation. However, the diagnosis can be confirmed by potassium hydroxide (KOH) examination of the skin scrapings, which demonstrates the characteristic short, cigar-butt

hyphae and spherical, thick-walled yeasts referred to as "spaghetti and meatballs" appearance [4].

The treatment of pityriasis versicolor includes both topical and systemic agents. Various topical preparations include topical azole antifungals, terbinafine 1% cream, 2.5% selenium sulphide in a detergent base, 50:50 propylene glycol in water, 20% sodium hyposulphite solution, nystatin, salicylic acid, etc. The oral antifungals effective in pityriasis versicolor include ketoconazole, fluconazole, itraconazole, etc. [1,2]. In our case, the treatment given included topical sertaconazole 2% cream twice daily along with oral fluconazole 400 mg weekly for two weeks. The hypopigmentation took 2-3 months to recover after the institution of treatment.

CONSENT

The examination of the patient was conducted according to the Declaration of Helsinki principles. Written informed consent was obtained from the patient for publication of this article.

REFERENCES

1. Elewski BE, Hughey LC, Sobera JO, Hay R. Fungal diseases. In: Bologna JL, Jorizzo JL, Schaffer JV, editors. *Dermatology*. 3rd ed. USA: Elsevier Saunders; 2012. p. 1251-84.
2. Hay RJ, Ashbee HR. Mycology. In: Burns T, Breathnach S, Cox N, Griffiths C, editors. *Rook's Textbook of Dermatology*. 8th ed. U.K: Wiley-Blackwell, 2010. p. 36.10-36.12.
3. Brodell RT, Elewski B. Superficial fungal infections. Errors to avoid in diagnosis and treatment. *Postgrad Med*. 1997;101:279-87.
4. Ghosh SK, Dey SK, Saha I, Barbhuiya JN, Ghosh A, Roy AK. Pityriasis versicolor: A clinicomycological and epidemiological study from a tertiary care hospital. *Indian J Dermatol*. 2008;53:182-5.
5. Framil VMS, Melhem MSC, Szeszs MW, Corneta EC, Zaitz C. Pityriasis versicolor circinata: isolation of *Malassezia sympodialis* - Case report. *An. Bras. Dermatol*. 2010;85:227-8.
6. Akaberi AA, Amini SS, Hajhosseini H. An Unusual Form of Tinea Versicolor: A Case Report. *Iran J Dermatol*. 2009;12:30-1.
7. Yang YS, Shin MK, Haw CR. Atrophying Pityriasis Versicolor: Is This a New Variant of Pityriasis Versicolor? *Ann Dermatol*. 2010;22:456-9.
8. Krishnan A, Thapa DM. Morphological and pigmentary variations of tinea versicolor in south Indian patients. *Indian J Dermatol*. 2003;48:83-6.
9. Arif T, Rather S. Follicular pityriasis versicolor-Rare variant of a common dermatological disease. *Our Dermatol Online*. 2015;6:1-2.

Copyright by Tasleem Arif. This is an open access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Source of Support: Nil, Conflict of Interest: None declared.