

Inflammatory tinea corporis

Patricia Chang¹, Engracia Estefania Quijada Ucelo², Roberto Orozco³

¹Dermatologist at Paseo Plaza Clinic Center, Guatemala City, Guatemala, ²General Practitioner, DermaQ Specialized Dermatology Center, Sixtino II, Guatemala City, Guatemala, ³Pathologist at Private Practice, Guatemala City, Guatemala

Corresponding author: Patricia Chang, MD, E-mail: pchang2622@gmail.com

Sir,

Tinea corporis is a dermatophytosis that typically presents as annular, scaly plaques with central clearing and an active, erythematous, raised border. However, when modified by immunosuppressive topical agents such as corticosteroids and calcineurin inhibitors, its appearance may change substantially, leading to diagnostic confusion [1].

A 67-year-old female patient presented with a six-month history of a pruritic lesion located on the extensor surface of her left elbow. The lesion had initially been diagnosed as psoriasis and treated with topical clobetasol dipropionate and tacrolimus. However, the patient showed no clinical improvement. The lesion gradually enlarged and became pruriginous. She had no relevant personal or family history. On physical examination, a well-demarcated erythematous-squamous plaque with reddish nodules on the left elbow was observed (Figs. 1a – 1b). No other cutaneous or systemic findings were seen.

A skin biopsy was taken, considering granuloma annulare vs. inflammatory tinea corporis as the differential diagnoses. Histopathology revealed fungal hyphae and spores between the stratum corneum and stratum granulosum, as highlighted by Periodic Acid–Schiff (PAS) staining (Figs. 2a – 2c). These findings were consistent with inflammatory tinea corporis, hence oral treatment was initiated with terbinafine 250 mg daily for four weeks, leading to complete clinical resolution (Figs. 3a and 3b).

This case highlights how topical immunosuppressants can alter the clinical appearance of dermatophytosis. The absence of the typical annular border and the presence of nodular lesions and a chronic plaque that showed

no response to corticosteroids or tacrolimus raised uncertainty about the diagnosis. Inflammatory tinea may mimic other inflammatory dermatoses, such as psoriasis, eczema, granuloma annulare, or even cutaneous neoplasms [1].

A review published by Belmokhtar et al. described a variety of atypical superficial mycoses enhanced or modified by prior use of corticosteroids or immunosuppressants, noticing the appearance of infiltrated, nodular, or pseudo-tumoral lesions in patients, often mistaken for inflammatory dermatoses [1]. Our patient aligned closely with these clinical features, particularly the persistence of a non-annular, pruritic plaque with nodular components, despite immunomodulators.

A study published by Zacharopoulou et al. described an increase in frequency of non-classical tinea presentations, particularly in patients exposed to inappropriate therapies [2]. They recommended an early histopathology examination and the use of fungal stains in steroid-resistant dermatoses—a recommendation that was fundamental in reaching the correct diagnosis in this case.

Although the clinical suspicion was initially directed to granuloma annulare due to the nodular aspect or deep fungal infection, histological analysis showed fungal structures between the stratum corneum and granulosum, excluding deeper dermatophytosis. This confirmed inflammatory tinea corporis. In reports by Saito et al. and Mehta et al., PAS stain was crucial to identify fungal structures in lesions with atypical morphology or those altered by immunosuppressive therapy [3,4].

Our findings are similar to other authors' reports of atypical forms of dermatophytosis. A case of atypically inflammatory tinea caused by *Microsporium gypseum*

How to cite this article: Chang P, Quijada Ucelo EE, Orozco R. Inflammatory tinea corporis. Our Dermatol Online. 2026;17(2):274-276.

Submission: 03.08.2025; **Acceptance:** 02.10.2025

DOI: 10.7241/ourd.20262.30

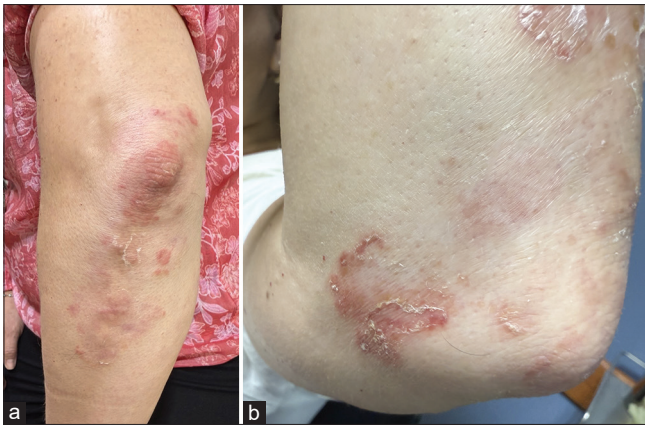


Figure 1: (a and b) Erythematous-squamous plaque with nodular lesions on the left elbow.

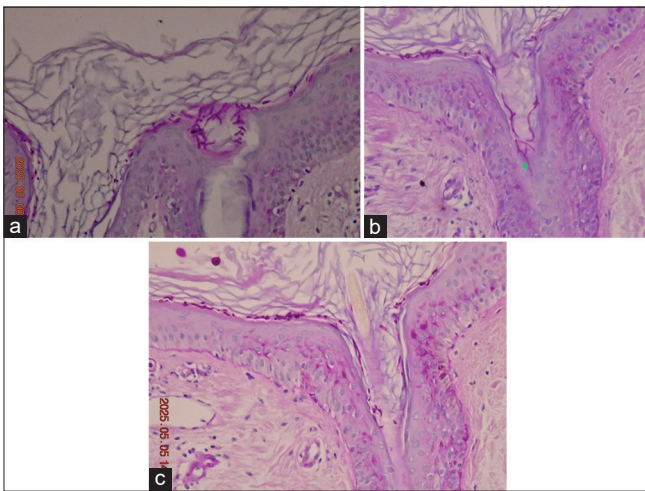


Figure 2: (a and b) Skin biopsy: Histopathological examination with PAS stain showing fungal hyphae and spores between the stratum corneum and stratum granulosum. (c) Histopathological examination with PAS stain showing fungal hyphae and spores around the entrance of the hairy infundibulum.

was reported by Torres-Guerrero et al., underscoring the necessity of mycological confirmation for effective treatment and the importance of considering geophilic agents as causative microorganisms of uncommon presentations of tinea corporis [5]. In order to broaden the range of atypical presentations, Hashas et al. described the dermatophytid phenomenon, in which hypersensitivity reactions occur at distant skin sites from the primary lesion, without active fungal elements [6]. Additionally, Karimi et al. reported tinea in a psoriatic patient, initially mistaken as a psoriasis flare, demonstrating how underlying chronic dermatoses and topical corticosteroid use may mask fungal infections and delay diagnosis [7].

Although the clinical features of the lesion partially resembled *tinea incognita*, histology confirmed the

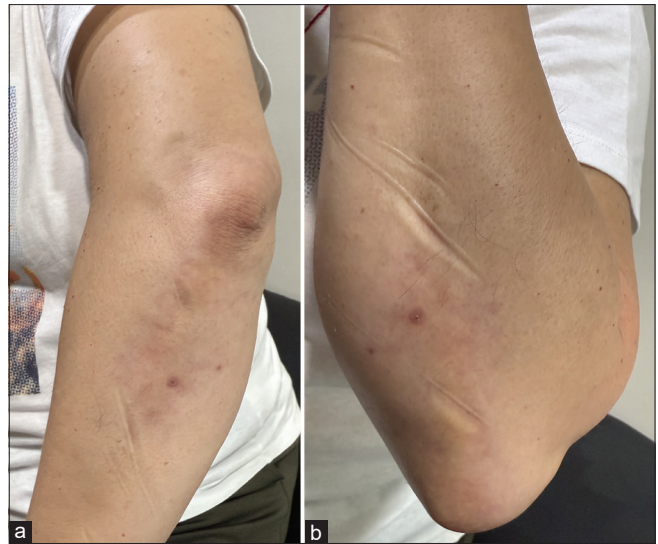


Figure 3: (a and b) Complete clinical resolution after four weeks of oral terbinafine treatment.

diagnosis of inflammatory tinea corporis limited to the epidermis. This case underscored the importance of considering dermatophytosis in chronic, treatment-resistant plaques and supported the approach of taking early biopsies and the use of fungal stains in unclear cases to ensure diagnostic accuracy and guide effective therapy.

Consent

The examination of the patient was conducted according to the principles of the Declaration of Helsinki.

The authors certify that they have obtained all appropriate patient consent forms, in which the patients gave their consent for images and other clinical information to be included in the journal. The patients understand that their names and initials will not be published and due effort will be made to conceal their identity, but that anonymity cannot be guaranteed.

REFERENCES

1. Belmokhtar Z, Djaroud S, Matmour D, Merad Y. Atypical and unpredictable superficial mycosis presentations: A narrative review. *J Fungi*. 2024;10:295.
2. Zacharopoulou A, Tsiogka A, Tsimpidakis A, Lamia A, Koumaki D, Gregoriou S. Tinea incognita: Challenges in diagnosis and management. *J of Clin Med*. 2024;13:3267.
3. Saito R, Sawada M, Ishizaki S, Harada T. A case of inflammatory tinea corporis by *Epidermophyton floccosum*. *Nihon Ishinkin Gakkai Zasshi*. 2008;49:211-5.
4. Mehta N, Choudhary R, Bhari N, Baskaran N. Tinea corporis masquerading as inflammatory papulo-squamous disease. *Indian Dermatol Online J*. 2023;14:719-20.
5. Torres-Guerrero E, Espinoza-Hernández CJ, Arroyo-Camarena S, Atoche-Díquez CE. Tinea caused by *Microsporum gypsum*. *Our Dermatol Online*. 2018;9:380-5.
6. Hashas FZ, Douhi Z, Mejjati K, Soughi M, Elloudi S, Baybay H,

- et al. Dermatophytid in tinea capitis: A phenomenon to keep in mind. *Our Dermatol Online*. 2023;14:333-4.
7. Karimi S, Aboudourib M, Hocar O, Amal S. Adult tinea in a psoriatic patient. *Our Dermatol Online*. 2024;15:100-1.

Copyright by Patricia Chang, et al. 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: This article has no funding source.

Conflict of Interest: The authors have no conflict of interest to declare.