Correspondence

CSA but also we need to report the case to appropriate authority, failing which we are liable to be punished with 6-month imprisonment.

Financial support and sponsorship Nil.

Conflicts of interest There are no conflicts of interest.

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Table 1: Instructions to the practitioner tackling a patient of child sexual abuse

Do's

Be patient and calm.

Let the victim know you are listening. e.g.,:- nod your head.

Show right attitude.

Acknowledge how the victim is feeling.

Give the victim the opportunity to ask what they want. You may ask “How can we help you.”

Encourage the victim to keep talking. You may ask, “Do you want to tell me more?”

Wait until the victim has finished talking before asking questions.

Encourage the victim to keep talking. You may ask, “Do you want to tell me more?”

Do not finish the victim’s thoughts.

Allow for silence.

Stay focused on the victim’s experience and offering them support.

Report all cases of suspected CSA to appropriate authority.

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Tinea Corporis Bullosa Secondary to Trichophyton Verrucosum: A Newer Etiological Agent with Literature Review

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Sir,

A 45-year-old female presented with multiple itchy patchy skin lesions with scaling all over the body since 2 months. It was followed by itchy fluid-filled lesions with raw areas and crusting on bilateral thighs, chest, back, and abdomen since one month. She had a history of contact with cows and buffalos. There was no history of trauma, insect bite, or recent intake of medicine. On cutaneous examination, there were multiple bullous lesions filled with clear fluid, which ruptured within 2–3 days to leave behind erosions and crust over an erythematous background, involving approximately 50% of the body surface area (BSA) [Figure 1]. The surrounding area was associated with multiple erythematous, polycyclic plaques with scaling which were severely pruritic. These lesions were symmetrically distributed on the chest, axillae, back, buttocks, arms, and legs. There was no mucosal, palm, sole, and nail involvement.
Family and past history were unremarkable. Nikolsky and bulla spread signs were negative. Both Tzanck smear and potassium hydroxide preparation revealed hyphal elements. All other hematological and biochemical investigations were within normal limits. Serology for HIV, hepatitis B (HBV), and hepatitis C (Hep C) were negative.

Histopathology showed subepidermal bulla with fungal hyphae present in the stratum corneum [Figure 2]. Direct-immunofluorescence (DIF) from perilesional skin was negative. Dermatophytes in stratum corneum were also confirmed on periodic acid–Schiff (PAS) stain. Fungal culture on Sabouraud dextrose agar (SDA) was positive for *Trichophyton verrucosum*. As the patient had already taken tablet fluconazole without any response, she was started on tablet terbinafine and clotrimazole cream. After 1 month of treatment, there was recurrence, so she was started on capsule itraconazole 100 mg twice daily with topical luliconazole cream for 2 months, which led to complete clearance of lesions.

Dermatophytic infection may rarely be present with unusual manifestations, one of them is tinea corporis bullosa. On extensive search of English literature, we found only 11 cases of tinea corporis bullosa. It was first reported by Costello in 1952.[1,2] Then, in 1970, Cullen and Loannides reported 3 cases.[2] Terragni et al. coined the term “tinea corporis bullosa” for such a rare presentation.[3] The literature review is given in Table 1.[3–6] Previously, it was called tinea corporis bullosa annularis in which vesicobullous lesions were limited to the borders of the plaque. But, in our case, the bullous lesions were distributed all over the plaque, which is different from other previously described cases and is similar to the case described by Padhiyar et al.[4]

In our case, the causative organism was *Trichophyton verrucosum*. This organism is distributed globally and is usually associated with dermatophyte infection of cattle,[3] also called “cattle ringworm disease.” Transmission to the human is rare and is more frequent among humans who are in close contact with animals, especially cows. In our case, the patient had a long history of contact with animals, such as cows and buffalo. It is a zoophilic dermatophyte, which may produce an inflammatory response in the affected areas. This inflammatory response may lead to hypersensitivity reactions to the dermatophyte, which might be implicated in bulla formation accompanied by dermal infiltrate.[3] This may be the reason for the unique characteristic widespread distribution of the bullous lesions all over the affected areas in our patient.

There are two important facts in our case. First, after a detailed search of the literature, this may be the first case of tinea corporis bullosa due to *T. verrucosum*. Secondly, dermatophytic infections caused by *T. verrucosum* are usually localized. There are only a few case reports of extensive tinea corporis caused by *T. verrucosum*, of which the first patient was HIV positive,[8] the second patient had a history of use of corticosteroids,[9] and the third patient was a 3-year-old boy.[7] Our patient did not have any history of immunosuppression or the use of steroids. Thus, probably this may be the first report of extensive tinea corporis due to *T. verrucosum* in an adult immunocompetent patient.

Keeping in view of the recent alarming increase in the incidence of dermatophytosis in our country, it is mandatory that the dermatologist fraternity be made aware of the unusual presentations of dermatophytosis secondary to *T. verrucosum*.

**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for

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**Figure 1:** Multiple bullous lesions (Red arrow) with crusting and erosions (Green arrow) on erythematous plaque and multiple polycyclic lesions with scaling on the surrounding areas

**Figure 2:** (a) Histopathology reveals subepidermal bulla with inflammatory infiltrate in the upper dermis (H and E, ×40) (b) Fungal hyphae in stratum corneum (marked with a green arrow) (H and E, ×100) (c) Direct immunofluorescence of perilesional skin was negative (×100)
his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Nil.

**Conflicts of interest**
There are no conflicts of interest.

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**Table 1: Characteristics of patients diagnosed with Tinea corporis bullosa**

| Author         | Year | Age/Sex | Causative organism | Similarity with other Autoimmune diseases | Treatment                                                                 |
|----------------|------|---------|--------------------|--------------------------------------------|---------------------------------------------------------------------------|
| Bennion SD     | 1989 | 20 yr/Female | *Trichophyton rubrum* | -                                          | Treated topically with clotrimazole cream for 2 weeks with complete resolution |
| Terragni et al.| 1993 | 63 yr/Female | *Microsporum canis*  | -                                          | Not mentioned                                                             |
| Veraldi et al. | 1996 | 27 yr/Female | *Microsporum canis*  | -                                          | Griseofulvin (500 mg/day) for 40 days with complete regression of lesions  |
| Azfar et al.   | 2009 | 14 yr/Male | *Trichophyton tonsurans* | -                                          | Not mentioned                                                             |
| Mares et al.   | 2012 | 41 yr/Female | *Trichophyton schoenleinii* | -                                          | Terbinafine 250 mg/day for 3 weeks and topical application of 1% ciclopirox olamine cream led to complete healing within 2 weeks |
| Aalfs and Jonkman | 2012 | 48 yr/Female | *Microsporum canis* | Mimicking Linear IgA bullous dermatosis    | Terbinafine 250 mg/day for 4 weeks with topical ketoconazole cream with complete disappearance of lesions |
| Padhiyar et al. | 2018 | 29 yr/Female | *Trichophyton mentagrophyte* | Mimicking bullous pemphigoid | Itraconazole 100 mg twice daily and topical luliconazole for 11/2 months leads to a clinical and mycological cure |