Letter to Editor

Sir,

Dermatophytic infections are notorious and capable of demonstrating atypical patterns that can mimic other cutaneous diseases. Tinea capitis usually manifest in children. However, rarely it can present in adults with immunodeficiency or may involve elderly individuals. The differential diagnosis of tinea capitis includes multiple conditions, including discoid lupus erythematosus (DLE), scalp psoriasis, lichen planus, seborrhoeic dermatitis, Alopecia areata, impetigo secondary to pediculosis, tinea amiantacea, and other causes of cicatricial alopecia. We herein present a 60-year-old-female who had tinea capitis mimicking DLE.

Sixty-year-old female presented with complaints of the itchy depigmented lesion over the scalp and ears for 2–3 years. It was associated with gradual loss of hair from the scalp. There was no history of photosensitivity, recurrent oral ulceration, skin lesions elsewhere, or any other history suggestive of connective tissue disorder. The general physical examination was normal. On cutaneous examination, there was the presence of diffuse depigmentation over the entire scalp with skip areas in between. Hairs were sparse over this depigmented area. Patchy erythema and whitish semi adherent scaling were observed at places [Figure 1a]. Hair pull test was negative. No black dots or broken hairs were observed. In the ears, depigmented macules were present involving the conchae. There were no dilated follicular pits in the ears. Oral mucosa and nail examination were normal. A provisional diagnosis of DLE was made. Histopathology showed arthrospores (endothrix) [Figure 2a] with Periodic Acid-Schiff stain positivity [Figure 2b]. Following this report, hair microscopy was also performed, which revealed similar findings. Complete blood count and serum biochemistry were normal. HIV serology and chest radiograph were normal. Treatment for tinea capitis was started, in the form of tablet terbinafine 250 mg once daily and ketoconazole 2% shampoo for 6 weeks.

The patient showed marked improvement in the form of subsidence of itching, erythema, scaling, and partial regrowth of hair [Figure 1b]. The dermatophytic fungal infections have the capacity to invade the keratinized tissue (skin, hair, and nails) of humans and other animals to produce an infection.[1] Dermatophytic infections are an important and challenging component of public health.[2] Careful investigations of outbreaks have increased our understanding of fungal diseases, their sources and modes of transmission, and various risk factors for the infections. Adult hair appears to be relatively resistant to dermatophyte infection, probably from the fungistatic properties of long-chain fatty acids found in sebum.[3] Tinea capitis in adults usually occurs in postmenopausal women, presumably from involution of sebaceous glands associated with declining estrogen levels. Patients typically exhibit erythematous scaly patches with central clearing, alopecia, varying degrees of inflammation, and few pustules, though exudative and heavily inflamed lesions also have been described.[4] In the present case, tinea capitis was not kept in the differential diagnosis. However, itchy, red scaly patches and papules of the scalp may represent a dermatophyte infection in the elderly population; clinicians are encouraged to consider this possibility. Transmission is by direct human-to-human contact and contact with objects containing fomites.

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**Figure 1:** Diffuse depigmentation over entire scalp with skip areas. Patchy erythema and whitish semi adherent scaling (a) and post treatment improvement in erythema, scaling and partial regrowth of hair (b)

**Figure 2:** Microphotograph showing arthrospores haematoxylin and Eosin stain, ×10 (a) and Periodic Acid-Schiff stain, ×40 (b)
including brushes, combs, bedding, clothing, toys, furniture, and telephones.[8]

On reviewing literature cases of tinea faciei mimicking chronic cutaneous lupus erythematosus and tinea corporis masquerading subacute cutaneous lupus erythematosus have been reported.[6] A single case report describing lupus erythematosus like lesion in tinea Capitis caused by *Trichophyton tonsurans* has been reported.[7] In our case, the clinical morphology and photodistribution of the lesions led us to make diagnosis of DLE, which turned out to be tinea capitis on histopathology. It has been suggested earlier that one should investigate for dermatophytosis in cases of DLE like lesions of the scalp and skin, in the tropics. We also want to emphasize this, especially in the elderly population.

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 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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Conflicts of interest

There are no conflicts of interest.

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