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TINEA CORPORIS MIMICKING SECONDARY AREOLA

To the Editor,

The skin of the nipple and areola is highly specialised, differ structurally from that of the neighbouring chest wall. The openings of lactiferous ducts, sebaceous and apocrine glands are the features of the glabrous skin of the nipple. The areola is almost glabrous with a few vellus follicles, a few apocrine glands, clusters of large sebaceous glands and the so called tubercles of Montogomery.[1] Dermatophytic infections which can involve any part of the skin surface and its appendages, seldom affects the areola and nipple.[2] Recently we had an interesting patient where the condition was localised around the nipple.

An 18-years-old male presented with itchy annular eruption over left breast gradually spreading for last 20 days. There was no history of any topical or systemic medication. No one in the family was suffering from similar problem. The cutaneous lesion consisted of 3 concentric rings of slight erythema with scaling involving areola and surrounding skin of left breast (Fig. 1). The skin of nipple and areola was infiltrated. Clinical diagnosis of tinea imbricata was considered. It was confirmed by microscopy of KOH preparation of scrapings from the lesion, demonstrating, interlacing septate mycelial filaments, however, culture on sabouraud's medium was negative. Topical antifungal therapy was not effective, Patient responded to 6 weeks of systemic griseofulvin therapy, but relapse occurred within 20 days of discontinuing the therapy. Hence, ketoconazole 200 mg. oral daily was prescribed and it was continued for 6 weeks with complete resolution of lesion clinically and microscopically. He was followed up for 6 months without any evidence of further relapse.

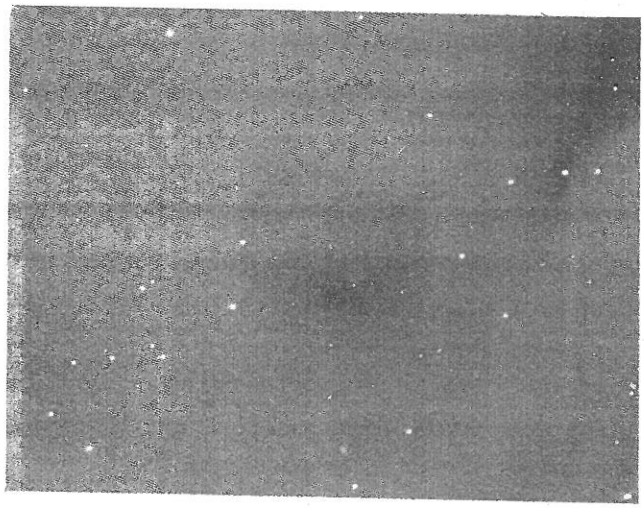

Fig. 1. Concentric rings of scaling around the nipple.

Various patterns of tinea corporis lesions are often attributed to the particular species of fungi.[3] Tinea imbricata, a rare distinct clinical entity, has an unmistakable clinical appearance of patches of fragile, flaky, concentric rings of scaling skin.[3,4] It follows prolonged natural course and treatment failures are common with griseofulvin, as seen in our case.

It is widely believed that free fatty acids on the skin surface hinder the growth of pathogenic organisms and sebum or at least the product of its hydrolysis exerts a fungistatic effect.[5] It is a known fact that tinea capitis becomes rare after puberty when sebum

production increases, and fungi causing tinea pedis preferentially colonize areas which are not supplied with sebaceous glands. Perhaps, for similar reason, the involvement of nipple and areola is an unusual phenomenon after puberty. In our patient, possibly resistant form of fungal infection have been inoculated accidently at that particular site.

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