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Mimics and Masquerades: Unusual Cutaneous Presentation of Tinea Corporis

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Introduction

Tinea corporis, commonly known as ringworm of the body, is a superficial fungal infection caused primarily by dermatophytes such as Trichophyton species. Classic presentations include annular, erythematous plaques with central clearing and a scaly, active border features that typically facilitate clinical diagnosis. However, in recent years, clinicians have observed an increasing number of atypical presentations that deviate significantly from this textbook picture. These unusual morphologies not only challenge diagnostic acumen but can also mimic a wide range of dermatologic and systemic conditions, from psoriasis and eczema to lupus erythematosus and cutaneous lymphoma. This paper explores the enigmatic and often deceptive manifestations of tinea corporis that lead to diagnostic delays and inappropriate management. Through a series of illustrative cases and a review of current literature, we aim to highlight the importance of maintaining a high index of suspicion, particularly in regions with a high prevalence of dermatophytosis or in patients with modified presentations due to prior corticosteroid use or immunosuppression. Recognizing these masqueraders is essential for timely and effective treatment and for avoiding unnecessary investigations and interventions [1].

Description

Tinea corporis is generally considered a straightforward clinical diagnosis, especially when it presents with its classical annular configuration and scaling border. However, a growing body of clinical evidence reveals that the presentation is far from uniform, particularly in populations exposed to inappropriate topical corticosteroids, immunosuppressive therapy, or antifungal misuse. These altered presentations often collectively referred to as tinea incognito can obscure the typical features and result in confusing morphologies. Eczematous, psoriasiform, granulomatous, or even vesiculobullous appearances have all been documented, frequently leading to misdiagnosis and improper treatment. One of the major clinical challenges is the resemblance of atypical tinea lesions to common inflammatory dermatoses. Psoriasis-like plaques with well-defined erythema and silvery scales can easily be mistaken for chronic plaque psoriasis, especially when localized to atypical areas like the trunk or limbs. In other cases, lesions may appear as lichenified plaques with minimal scaling, closely resembling eczema or lichen simplex chronicus. When corticosteroids are applied—often without proper antifungal cover lesions may temporarily improve, further masking the fungal etiology before rebounding more aggressively, sometimes spreading to new areas. Another concerning presentation involves tinea mimicking autoimmune or neoplastic dermatoses. Annular lesions with central hypopigmentation and peripheral hyperpigmentation may be mistaken for cutaneous lupus erythematosus, particularly in sun-exposed areas [2].

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Similarly, granulomatous variants of tinea corporis can resemble cutaneous sarcoidosis or even mycosis fungoides, prompting extensive investigations. In such cases, only a high index of suspicion combined with appropriate mycological testing such as KOH preparation, fungal culture, or histopathology can confirm the correct diagnosis. The emergence of resistant and recalcitrant dermatophyte infections, especially in South Asia and parts of the Middle East, adds another layer of complexity. These strains often require systemic antifungal therapy and longer treatment durations, yet are frequently mismanaged due to their misleading appearance. Furthermore, the proliferation of over-the-counter combination creams containing corticosteroids, antifungals and antibacterials has led to the widespread misuse of topical treatments, exacerbating diagnostic confusion and promoting fungal resistance. In light of these challenges, clinicians must adopt a broad differential diagnosis when evaluating atypical skin lesions and avoid premature labeling based solely on morphology. Careful history taking ; particularly regarding previous treatments, hygiene practices and close contacts along with judicious use of laboratory testing, is crucial in arriving at the correct diagnosis. In regions where dermatophytosis is endemic, it is especially important to consider tinea corporis as a potential masquerader, even when lesions deviate from the norm [3].

As with many other diseases, personalized medicine is becoming an essential aspect of dermatological care. Genetic profiling of patients to identify individuals who are more predisposed to developing unusual Tinea Corporis presentations or recurrent infections could lead to tailored treatment plans. This approach might involve adjusting antifungal choices or combining them with lifestyle interventions based on genetic susceptibility, immune response and even gut microbiome composition. With the rise of Artificial Intelligence (AI), dermatology stands to benefit from automated diagnostic tools. AI-powered systems that analyze photographs of skin lesions could help clinicians differentiate Tinea Corporis from its mimics, especially in the context of unusual presentations. AI algorithms are already being developed to evaluate and classify skin conditions and their increasing accuracy could lead to faster, more accurate diagnoses in clinical settings. The pathogenesis of Tinea Corporis is still not fully understood, particularly when it manifests in unusual ways. Future research focusing on how environmental, genetic and microbial factors interact to influence the development of atypical presentations of dermatophyte infections will be crucial. This will help in identifying at-risk populations and understanding why certain individuals develop more severe or resistant forms of the infection. In addition, more research into the interaction between dermatophytes and the skin microbiome may uncover new therapeutic approaches, such as manipulating the skin microbiome to inhibit fungal colonization or using probiotics to restore a healthy microbial balance.Tinea Corporis remains a global public health issue, particularly in tropical regions where environmental conditions promote fungal growth. As global travel increases, the spread of unusual strains of dermatophytes and multi-drug-resistant species could lead to more complex clinical scenarios [4].

The future will require a global approach to epidemiological surveillance and the development of universal guidelines for the management of atypical Tinea Corporis, especially in immunocompromised patients and those with coexisting conditions like diabetes or HIV. In the coming years, public health

campaigns will likely focus on improving patient education regarding the prevention, early recognition and treatment of Tinea Corporis. Greater awareness will help reduce stigma, improve hygiene practices and promote earlier intervention, especially in communities where fungal infections are underdiagnosed or misdiagnosed. With the rapid advancement of telemedicine, teledermatology could become a powerful tool in diagnosing unusual or atypical skin conditions. Patients living in remote areas or those without access to specialized care could benefit from online consultations with dermatologists who can assess images and provide treatment recommendations for Tinea Corporis. Teledermatology could facilitate early diagnosis and reduce the burden on healthcare systems by providing more efficient and accessible care. The future of diagnosing and managing Tinea Corporis with unusual or atypical presentations holds much promise. With advancements in molecular diagnostics, more effective antifungal treatments, personalized approaches and the application of artificial intelligence, dermatologists will be better equipped to handle the complexities of this common yet often misunderstood condition. Ongoing research, combined with greater patient education and global collaboration, will ensure that Tinea Corporis is better understood and treated in the years to come [5].

Conclusion

The evolving clinical spectrum of tinea corporis underscores the need for heightened diagnostic vigilance, especially in cases where skin lesions deviate from classical descriptions. Atypical presentations can easily mislead even experienced clinicians, resulting in delayed or inappropriate therapy. Misuse of topical corticosteroids, emergence of resistant strains and patient-driven self-medication further complicate the clinical picture, leading to what is often referred to as a “dermatophytosis epidemic” in certain regions. Ultimately, restoring antifungal stewardship and curbing the misuse of steroid-containing formulations are key steps in preventing further masquerades. By keeping tinea corporis on the differential especially when lesions appear uncharacteristic clinicians can improve patient outcomes, reduce misdiagnosis and mitigate the growing challenge of chronic and resistant dermatophyte infections.

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Conflict of Interest

None.

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