CASE FOR DIAGNOSIS

Inflammatory Tinea Faciei Mimicking Sweet’s Syndrome

Tinea faciei inflamatoria que simula un síndrome de Sweet

Medical history

A 53-year-old female with a 2-month history of a painful pruritic eruption on the face. The patient had previously presented with abrupt onset of multiple edematous pseudovesicular papules on the face and shoulders preceded by a febrile upper respiratory infection (Fig. 1A and B). A diagnosis of Sweet’s syndrome had been presumed pending pathologic confirmation. Initially, the condition was treated empirically with triamcinolone 0.1% cream twice daily and prednisone starting with 60 mg daily and gradual tapering. No improvement was observed and new lesions developed. Therefore, and after receipt of the pathology report (see below), hydroxychloroquine 200 mg twice daily was added to the corticosteroid regimen with suspicion of either Jessner lymphocytic infiltrate, lupus tumidus, or polymorphous light eruption. No response was observed after one-month of treatment.

Physical examination

Physical examination revealed multiple well-defined edematous pseudovesicular papules and plaques symmetrically distributed on the chin and both cheeks with underlying erythema and a few scattered lesions on the shoulders.

Microscopic examination

Microscopic examination revealed perivascular and periadnexal lymphocytic infiltrate with papillary edema. A biopsy from lesional skin was submitted for direct-immunofluorescence with negative results. Examination of a biopsy obtained 1 month later revealed the above-mentioned changes, together with a mixed inflammatory infiltrate containing neutrophils in the hair follicle (Fig. 2).

What is Your Diagnosis?

reported 3 patients with tinea faciei simulating discoid lupus erythematosus.\textsuperscript{7} Dermatophytosis usually follows a chronic non-inflammatory clinical course and is mostly limited to the superficial keratin structures. Subcutaneous involvement is rare and involves atypical clinical manifestations such as pustular psoriasiform trichophytia, trichophytosis mimicking pseudolymphoma or Sweet’s syndrome, and impetiginized herpetiform trichophytosis in which a definitive diagnosis is generally confirmed by biopsy. Exceptional cases have been reported of tinea corporis bullosa caused by \textit{M. canis} in which the clinical presentation was characterized by multiple annular bullous lesions.

In the present case, the clinical picture resembled Sweet’s syndrome, but subsequent treatment with oral and topical corticosteroids only worsened the condition. Despite repeated biopsies, diagnosis was challenging, and only appropriate histopathological examination with special stains and tissue cultures allowed the diagnosis to be confirmed, isolating \textit{M. canis} as the pathogenic organism. The lesions resolved completely after 1 month of treatment with griseofulvin.

This case illustrates the need to consider an infectious etiology in what would otherwise be presumed to be cases of reactive dermatitis refractory to corticosteroid therapy.

**Conflicts of interest**

The authors declare that they have no conflicts of interest.

**References**


M.H. Viera\textsuperscript{a}, S.M. Costales\textsuperscript{b}, J. Regalado\textsuperscript{b}, J. Alonso-Llamazares\textsuperscript{b}

\textsuperscript{a} University of Miami, Miller School of Medicine, Department of Dermatology and Cutaneous Surgery, 1600 NW 10th Ave, RMSB, Room 2023A (R250), Miami, FL 33136, United States
\textsuperscript{b} Veterans Affairs Medical Center Miami (VAMC), University of Miami, Miller School of Medicine, Department of Dermatology and Cutaneous Surgery, United States

\textsuperscript{c} Corresponding author.
E-mail address: mviera2@med.miami.edu (M.H. Viera).