CASE FOR DIAGNOSIS
Inflammatory Tinea Faciei Mimicking Sweet’s Syndrome

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 polymorphic 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?

Figure 1 Facial lesions (A-Lateral; B-Inferior) multiple symmetrically distributed edematous papules on bilateral cheeks and chin.

Figure 2 Hematoxylin and Eosin Stain (HE), 4 X magnifications. Superficial and deep dense perivascular and periappendageal mixed inflammatory infiltrate with the presence of neutrophils within the hair follicles.
In Dermatophytosis

The initial presentation of tinea faciei is mostly with inflammatory eruptions mimicking Sweet’s syndrome, which is characterized by the presence of 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 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 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 dermatosis refractory to corticosteroidtherapy.

Conflicts of interest

The authors declare that they have no conflicts of interest.

References


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