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Original Research

A typical presentation of Tinea Faciei incidence across all the age groups

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Abstract:

Background: Tinea faciei is a superficial dermatophyte infection of the face that commonly presents as an annular erythematous scaly lesion with active margins and central clearing. However, atypical presentations are increasingly encountered due to inappropriate topical steroid use, over-the-counter medication, cosmetic application, and delayed diagnosis. Such altered morphology may mimic eczema, seborrheic dermatitis, rosacea, acneiform eruptions, photosensitive dermatoses, or lupus-like lesions, making clinical recognition difficult.

Aim: The aim of the study was to assess the atypical presentation of tinea faciei and its occurrence across different age groups among patients attending a tertiary care hospital.

Material and Methods: A hospital-based observational study was conducted among 60 patients clinically diagnosed with tinea faciei at a tertiary care hospital & private clinic. Patients of all age groups and both sexes were included. Detailed history regarding demographic profile, duration of disease, symptoms, recurrence, topical steroid use, over-the-counter medication, cosmetic use, family history, contact history, and associated dermatophytosis was recorded. Clinical examination assessed site, number, morphology, scaling, erythema, pigmentation, papules, pustules, and extent of facial involvement. Skin scrapings were examined by potassium hydroxide mount. Data were analyzed using SPSS version 27.0. Frequencies, percentages, Chi-square test, and Fisher's exact test were applied, with $p < 0.05$ considered statistically significant.

Results: Among 60 patients, atypical presentation was observed in 41 patients (68.33%), while classical annular scaly lesions were seen in 19 patients (31.67%). The highest proportion belonged to the 21–40 years age group (36.67%), followed by 41–60 years (21.67%). Males constituted 56.67% and females 43.33%. Atypical presentation was most frequent among patients aged >60 years (80.00%), followed by 21–40 years (72.73%), though age-wise association was not significant ($p = 0.777$). Steroid-modified or ill-defined erythematous plaques were the most common atypical pattern (26.67%). Visible scaling was significantly more common in classical lesions ($p = 0.025$), whereas pigmentary changes were significantly associated with atypical lesions ($p = 0.022$). Topical steroid use ($p = 0.001$) and over-the-counter medication use ($p = 0.020$) were significantly associated with atypical presentation. KOH mount was positive in 80.00% of patients.

Conclusion: Atypical tinea faciei was more common than classical presentation across all age groups. Steroid misuse and over-the-counter medication were major associated factors. Careful clinical assessment with KOH confirmation is essential for early diagnosis and appropriate treatment. lip.

Introduction

Tinea faciei is a superficial dermatophyte infection involving the glabrous, non-bearded skin of the face. It is generally considered a localized form of

dermatophytosis, but its facial location gives it special clinical importance because even small lesions are easily visible, cosmetically disturbing, and frequently confused with inflammatory facial dermatoses. The infection may involve the forehead, cheeks, nose,

perioral area, chin, jawline, and periocular region. Classically, tinea faciei presents as an annular erythematous scaly plaque with an active advancing border and central clearing; however, this typical appearance is not always present, particularly when patients have used topical corticosteroids, cosmetic preparations, or over-the-counter medications before seeking dermatological consultation.¹ Dermatophytes are keratinophilic fungi that invade keratinized tissues such as the stratum corneum, hair, and nails. The common genera include *Trichophyton*, *Microsporum*, and *Epidermophyton*. Infection is acquired through direct contact with infected humans, animals, contaminated fomites, or the patient's own infected body sites. Facial dermatophytosis may also occur due to autoinoculation from tinea corporis, tinea cruris, tinea capitis, tinea manuum, or tinea pedis. The ability of dermatophytes to adhere to keratin, release proteolytic enzymes, and adapt to the host skin environment contributes to persistence of infection. The warm and humid climate, sweating, overcrowding, sharing of towels, close family contact, and poor treatment adherence further support transmission and recurrence. ²In recent years, dermatophytosis has shown a changing clinical profile, especially in tropical countries including India. Earlier, dermatophyte infections were commonly recognized by well-defined annular lesions, scaling, and pruritus. At present, dermatologists frequently encounter extensive, recurrent, chronic, and steroid-modified cases. Tinea faciei is particularly prone to atypical presentation because the face is commonly treated with fairness creams, steroid-containing combinations, cosmetic products, and self-prescribed topical preparations. These interventions may partially suppress inflammation, reduce scaling, blur lesion margins, and produce misleading clinical features. As a result, facial tinea may resemble eczema, seborrheic dermatitis, rosacea, contact dermatitis, acneiform eruption, photosensitive dermatosis, or lupus erythematosus.³ Atypical tinea faciei is clinically important because misdiagnosis can delay correct antifungal therapy and may worsen disease spread. When a dermatophyte infection is treated as dermatitis with topical corticosteroids, symptoms may temporarily improve, but fungal growth continues. Over time, lesions become less circinate, less scaly, more diffuse, more erythematous, pustular, pigmented,

or eczematous. This steroid-modified form is commonly described under the spectrum of tinea incognito. In facial lesions, tinea incognito is especially problematic because the altered morphology can closely imitate non-infective dermatoses. Therefore, any persistent, recurrent, itchy, scaly, pigmentary, or steroid-responsive facial lesion should raise suspicion of tinea faciei, particularly when there is history of dermatophytosis elsewhere in the body or among family members. Tinea faciei can occur in all age groups, although clinical expression may vary with age, exposure pattern, hygiene practices, immunity, occupation, and treatment behaviour. In children, facial lesions may occur due to contact with infected family members, pets, schoolmates, or associated scalp infection. In adolescents and young adults, sweating, cosmetic use, shaving practices, sharing of personal items, and outdoor exposure may contribute to infection. In middle-aged adults, occupational exposure, chronic dermatophytosis at other body sites, diabetes, and repeated use of topical combinations may influence disease course. In elderly patients, atypical morphology may be more easily mistaken for eczema, seborrheic dermatitis, photosensitivity, or drug-related facial eruptions. Thus, evaluation across age groups is essential for understanding the clinical spectrum of tinea faciei. ⁵The diagnosis of tinea faciei is primarily clinical, but laboratory confirmation is valuable, especially in atypical lesions. Potassium hydroxide mount of skin scrapings from the active edge is a simple, rapid, and inexpensive method for detecting fungal hyphae. Fungal culture can help identify the causative dermatophyte species but requires more time and laboratory support. Dermoscopy may provide additional clues such as peripheral scaling, follicular involvement, broken hairs, or vascular patterns, although it does not replace mycological testing. Molecular techniques have improved diagnostic precision but are not routinely available in many resource-limited settings. Because atypical facial lesions often overlap with common inflammatory dermatoses, combining detailed history, careful examination, and mycological confirmation improves diagnostic accuracy.⁶

Material and Methods

The present study was designed as a hospital-based observational study conducted to assess the atypical clinical presentation of tinea faciei and its occurrence across different age groups among patients attending a tertiary care hospital. The study focused on identifying variations in morphology, distribution, symptomatology, predisposing factors, and clinical patterns of tinea faciei, particularly those cases that did not present with the classical annular erythematous scaly lesions. The study was carried out in the Department of Dermatology at a tertiary care hospital & my private clinic at Khosbagan, Burdwan, West Bengal, India. Patients presenting to the dermatology outpatient department with facial lesions clinically suggestive of tinea faciei were evaluated. The tertiary care hospital setting provided access to patients from different age groups, socioeconomic backgrounds, and referral sources, allowing assessment of a wide range of clinical presentations. The study population consisted of 60 patients diagnosed clinically with tinea faciei. Patients of all age groups were included in order to assess the occurrence and pattern of atypical presentation across childhood, adolescence, adulthood, and elderly age groups. Both male and female patients were included. Each patient was evaluated in detail for demographic profile, clinical features, lesion characteristics, associated symptoms, risk factors, and previous treatment history.

Inclusion Criteria

Patients of any age group presenting with facial dermatophytic lesions suggestive of tinea faciei were included in the study. Patients with atypical morphology such as ill-defined erythematous patches, eczematous lesions, papulosquamous lesions, photosensitive-like lesions, steroid-modified lesions, seborrheic dermatitis-like lesions, or lupus-like facial lesions were also included. Patients who provided informed consent and were willing to undergo clinical evaluation and relevant investigations were enrolled.

Exclusion Criteria

Patients who were not willing to participate in the study were excluded. Patients with facial lesions due to other confirmed dermatological conditions such as psoriasis, discoid lupus erythematosus, contact dermatitis, rosacea, seborrheic dermatitis, or bacterial and viral infections were excluded after clinical evaluation.

Patients with incomplete clinical records or those who did not cooperate for examination or sample collection were also excluded from the study.

Methodology

Data were collected using a predesigned structured proforma. Detailed history was obtained from each patient regarding age, sex, residence, occupation, socioeconomic status, duration of symptoms, onset and progression of lesions, itching, burning sensation, photosensitivity-like complaints, recurrence, family history of dermatophytosis, contact with infected persons or animals, use of cosmetics, sharing of towels or personal items, and history of topical steroid or over-the-counter medication use. Special emphasis was given to previous application of steroid-containing creams, as these may modify the classical appearance of tinea faciei and lead to atypical presentation.

Clinical Examination: A thorough dermatological examination was performed in all patients. The site, number, size, shape, margin, surface changes, scaling, erythema, pigmentation, papules, pustules, central clearing, and extent of facial involvement were recorded. Lesions were examined for typical and atypical morphology. Particular attention was given to involvement of the cheeks, forehead, chin, perioral region, periorbital area, nose, and jawline. Associated dermatophytosis at other body sites such as tinea corporis, tinea cruris, tinea capitis, tinea manuum, and tinea pedis was also assessed.

Assessment of Atypical Presentation: Atypical presentation was assessed based on deviation from the classical annular, erythematous, scaly lesion with active border and central clearing. Lesions presenting as diffuse erythematous patches, eczematous plaques, seborrheic dermatitis-like lesions, acneiform lesions, rosacea-like lesions, pigmentary changes, steroid-modified tinea, photosensitive-like eruptions, or lesions with minimal scaling and poorly defined margins were categorized as atypical. The pattern of atypical presentation was recorded separately in each age group to determine its distribution across different age categories.

Age Group Classification: Patients were classified into different age groups for analysis of incidence and clinical pattern across age categories. The groups included children, adolescents, young adults, middle-aged adults, and elderly patients. This classification helped in assessing whether atypical presentation of tinea faciei was more common in any particular age group and whether the morphology of lesions varied with age.

Parameters Studied: The main parameters studied included age, sex, residence, occupation, socioeconomic status, duration of disease, site of facial involvement, number of lesions, size of lesions, morphology of lesions, presence or absence of scaling, erythema, itching, burning sensation, pigmentation, steroid-modified appearance, recurrence, family history, history of contact with infected individuals or animals, associated dermatophytosis at other body sites, previous treatment history, and use of topical steroid or antifungal medication. Clinical diagnosis and laboratory confirmation were also recorded where applicable.

Laboratory Evaluation: Skin scrapings were collected from the active margin or most representative area of the lesion after cleaning the site. The samples were subjected to potassium hydroxide mount examination for detection of fungal elements. The presence of septate branching hyphae was considered supportive of dermatophyte infection. Laboratory findings were correlated with clinical features, especially in cases with atypical presentation where diagnosis could be difficult on clinical grounds alone.

Statistical Analysis

The collected data were entered into Microsoft Excel and analyzed using Statistical Package for the Social Sciences software, SPSS version 27.0. Descriptive statistics were used to summarize demographic and clinical variables. Categorical variables such as sex, age group, clinical pattern, site of involvement, steroid use, associated dermatophytosis, and KOH positivity were expressed as frequency and percentage. Continuous variables such as age and duration of symptoms were expressed as mean and standard deviation. Association between atypical presentation and selected variables such as age group, sex, steroid

use, duration of disease, and associated dermatophytosis was assessed using chi-square test or Fisher's exact test where applicable. A p-value of less than 0.05 was considered statistically significant.

Results

A total of 60 patients with clinically diagnosed tinea faciei were included in the present study. The demographic characteristics, clinical presentation, atypical morphological patterns, associated clinical features, predisposing factors, and laboratory findings were evaluated. Overall, atypical presentation was observed in 41 patients (68.33%), whereas the classical annular scaly presentation was identified in 19 patients (31.67%), indicating that atypical manifestations constituted the predominant mode of presentation in the study population.

Table 1 presents the demographic profile of the study participants. Among the 60 patients, the highest proportion belonged to the 21–40 years age group (22 patients; 36.67%), followed by the 41–60 years age group (13 patients; 21.67%) and the 11–20 years age group (12 patients; 20.00%). Children aged ≤ 10 years accounted for 8 patients (13.33%), while only 5 patients (8.33%) were older than 60 years. With respect to gender distribution, males constituted the majority of the study population with 34 patients (56.67%), whereas females accounted for 26 patients (43.33%), suggesting a slight male predominance. Based on residence, most participants were from urban areas (37 patients; 61.67%), while 23 patients (38.33%) were from rural regions, reflecting a relatively higher burden among the urban population attending the tertiary care hospital. Regarding socioeconomic status, more than half of the participants belonged to the middle socioeconomic class (32 patients; 53.33%), followed by the lower socioeconomic class (18 patients; 30.00%), whereas only 10 patients (16.67%) belonged to the upper socioeconomic group. Occupational analysis revealed that students formed the largest occupational category (17 patients; 28.33%), followed by homemakers (14 patients; 23.33%), outdoor workers (12 patients; 20.00%), indoor or office workers (11 patients; 18.33%), and retired or elderly dependent individuals (6 patients; 10.00%).

Table 2 illustrates the distribution of typical and atypical presentations across different age groups.

Overall, atypical presentation was observed in 41 patients (68.33%), whereas classical presentation was found in only 19 patients (31.67%). In children aged ≤ 10 years, equal proportions of patients exhibited typical and atypical lesions (50.00% each). Among adolescents aged 11–20 years, atypical presentation was observed in 8 patients (66.67%), compared with only 4 patients (33.33%) showing the classical pattern. Similarly, in the 21–40 years age group, which represented the largest study population, atypical presentation was identified in 16 of 22 patients (72.73%), while only 6 patients (27.27%) demonstrated the classical annular morphology. In the 41–60 years age group, 9 patients (69.23%) had atypical lesions compared with 4 patients (30.77%) having classical lesions. The highest proportion of atypical presentation was observed among patients older than 60 years, where 4 out of 5 patients (80.00%) showed atypical morphology, while only one patient (20.00%) had the classical presentation. Although atypical lesions predominated across almost all age groups, statistical analysis using the Chi-square test demonstrated no significant association between age group and type of clinical presentation ($p = 0.777$).

Table 3 summarizes the various clinical patterns of tinea faciei observed among different age groups. Classical annular scaly lesions were present in 19 patients (31.67%), whereas atypical clinical morphology was observed in 41 patients (68.33%), confirming that atypical presentation was considerably more common than the classical form. Among atypical lesions, steroid-modified or ill-defined erythematous plaques represented the most common pattern, occurring in 16 patients (26.67%). These lesions were most frequently observed among patients aged 21–40 years (7 patients; 31.82%), followed by those aged 41–60 years (3 patients; 23.08%) and those older than 60 years (2 patients; 40.00%). This finding highlights the influence of inappropriate topical corticosteroid use in altering the classical morphology of tinea faciei. Eczematous plaque-like lesions were identified in 9 patients (15.00%), with relatively uniform distribution across different age groups. Seborrheic dermatitis-like lesions were noted in 6 patients (10.00%), predominantly among adults aged 21–60 years. Photosensitive or lupus-like eruptions were documented in 5 patients (8.33%), occurring mainly in adult and elderly patients. Pigmentary or acneiform

presentations were also observed in 5 patients (8.33%), particularly among younger and middle-aged adults. Table 4 compares the clinical characteristics between patients with classical and atypical presentation. Cheek involvement was the most frequent anatomical site, affecting 38 patients (63.33%). It was observed in 68.42% of patients with classical lesions and 60.98% of those with atypical lesions; however, this difference was not statistically significant ($p = 0.578$). Likewise, forehead involvement was present in 25 patients (41.67%) and showed nearly identical distribution between the two groups ($p = 0.963$). Perioral or chin involvement was documented in 18 patients (30.00%), being relatively more frequent in atypical cases (34.15%) than classical cases (21.05%), although this difference was not statistically significant ($p = 0.303$). Multiple facial areas were involved in 36 patients (60.00%), with a higher frequency among atypical presentations (68.29%) compared with classical lesions (42.11%). This association approached statistical significance ($p = 0.054$), suggesting a tendency for atypical lesions to involve larger facial areas. Itching was the predominant symptom, affecting 54 patients (90.00%), and occurred equally in both groups without significant difference ($p = 1.000$). Burning sensation was present in 29 patients (48.33%) and was more frequently reported among atypical cases (56.10%) than classical cases (31.58%), although this did not reach statistical significance ($p = 0.077$). Visible scaling was observed in 42 patients (70.00%) and was significantly more common among classical lesions (89.47%) than atypical lesions (60.98%) ($p = 0.025$). Conversely, pigmentary changes were identified in 22 patients (36.67%) and occurred significantly more often in atypical presentation (46.34%) compared with classical presentation (15.79%) ($p = 0.022$). Papules or pustules and recurrent lesions were relatively more frequent in atypical cases; however, these differences were not statistically significant ($p = 0.112$ and $p = 0.515$, respectively).

Table 5 describes the distribution of predisposing factors and laboratory findings according to the type of clinical presentation. A history of topical steroid use was reported by 31 patients (51.67%). Among these, steroid exposure was significantly more frequent in patients with atypical presentation (65.85%) than in those with classical presentation (21.05%), demonstrating a highly significant association ($p =$

0.001). Similarly, previous over-the-counter medication use was recorded in 38 patients (63.33%) and was significantly higher among atypical cases (73.17%) compared with classical cases (42.11%) ($p = 0.020$). Cosmetic use on the face was noted in 20 patients (33.33%), while sharing of towels or personal items was reported by 25 patients (41.67%). Although both factors were more common among atypical cases, the differences were not statistically significant ($p = 0.432$ and $p = 0.281$, respectively). A family history of dermatophytosis was present in 17 patients (28.33%), and contact with infected persons or animals was documented in 15 patients (25.00%). Both variables were relatively more frequent among atypical

presentations but failed to achieve statistical significance ($p = 0.394$ and $p = 0.112$, respectively). Associated dermatophytosis involving other body sites was observed in 28 patients (46.67%), with greater occurrence in atypical cases (53.66%) than classical cases (31.58%); however, the difference remained statistically non-significant ($p = 0.111$). Laboratory confirmation by potassium hydroxide (KOH) mount was positive in 48 patients (80.00%), confirming dermatophyte infection in the majority of cases. KOH positivity was observed in 89.47% of classical cases and 75.61% of atypical cases, but the difference was not statistically significant ($p = 0.306$).

Table 1: Demographic distribution of study participants

Variable	Category	Frequency (n=60)	Percentage (%)
Age group	≤10 years	8	13.33
	11–20 years	12	20.00
	21–40 years	22	36.67
	41–60 years	13	21.67
	>60 years	5	8.33
Sex	Male	34	56.67
	Female	26	43.33
Residence	Urban	37	61.67
	Rural	23	38.33
Socioeconomic status	Lower	18	30.00
	Middle	32	53.33
	Upper	10	16.67
Occupational status	Student	17	28.33
	Homemaker	14	23.33
	Outdoor worker	12	20.00
	Indoor/office worker	11	18.33
	Retired/elderly dependent	6	10.00

Table 2: Distribution of typical and atypical presentation across age groups

Age group	Total n (%)	Typical presentation n (%)	Atypical presentation n (%)	p-value
≤10 years	8 (13.33)	4 (50.00)	4 (50.00)	
11–20 years	12 (20.00)	4 (33.33)	8 (66.67)	
21–40 years	22 (36.67)	6 (27.27)	16 (72.73)	
41–60 years	13 (21.67)	4 (30.77)	9 (69.23)	
>60 years	5 (8.33)	1 (20.00)	4 (80.00)	
Total	60 (100.00)	19 (31.67)	41 (68.33)	0.777

Table 3: Clinical pattern of tinea faciei according to age groups

Clinical pattern	Total n (%)	≤10 years n (%)	11–20 years n (%)	21–40 years n (%)	41–60 years n (%)	>60 years n (%)
Classical annular scaly lesion	19 (31.67)	4 (50.00)	4 (33.33)	6 (27.27)	4 (30.77)	1 (20.00)
Total atypical presentation	41 (68.33)	4 (50.00)	8 (66.67)	16 (72.73)	9 (69.23)	4 (80.00)
Steroid-modified/ill-defined erythematous plaque	16 (26.67)	1 (12.50)	3 (25.00)	7 (31.82)	3 (23.08)	2 (40.00)
Eczematous plaque-like lesion	9 (15.00)	1 (12.50)	2 (16.67)	3 (13.64)	2 (15.38)	1 (20.00)
Seborrheic dermatitis-like lesion	6 (10.00)	1 (12.50)	1 (8.33)	2 (9.09)	2 (15.38)	0 (0.00)
Photosensitive/lupus-like eruption	5 (8.33)	0 (0.00)	1 (8.33)	2 (9.09)	1 (7.69)	1 (20.00)
Pigmentary/acneiform presentation	5 (8.33)	1 (12.50)	1 (8.33)	2 (9.09)	1 (7.69)	0 (0.00)

Table 4: Clinical features according to type of presentation

Clinical feature	Total n (%)	Typical presentation n=19 n (%)	Atypical presentation n=41 n (%)	p-value
Cheek involvement	38 (63.33)	13 (68.42)	25 (60.98)	0.578
Forehead involvement	25 (41.67)	8 (42.11)	17 (41.46)	0.963
Perioral/chin involvement	18 (30.00)	4 (21.05)	14 (34.15)	0.303
Multiple facial areas involved	36 (60.00)	8 (42.11)	28 (68.29)	0.054
Itching	54 (90.00)	17 (89.47)	37 (90.24)	1.000
Burning sensation	29 (48.33)	6 (31.58)	23 (56.10)	0.077
Visible scaling	42 (70.00)	17 (89.47)	25 (60.98)	0.025
Pigmentary changes	22 (36.67)	3 (15.79)	19 (46.34)	0.022
Papules/pustules	15 (25.00)	2 (10.53)	13 (31.71)	0.112
Recurrent lesions	14 (23.33)	3 (15.79)	11 (26.83)	0.515

Table 5: Predisposing factors and laboratory findings according to type of presentation

Parameter	Total n (%)	Typical presentation n=19 n (%)	Atypical presentation n=41 n (%)	p-value
History of topical steroid use	31 (51.67)	4 (21.05)	27 (65.85)	0.001
Over-the-counter medication use	38 (63.33)	8 (42.11)	30 (73.17)	0.020
Cosmetic use on face	20 (33.33)	5 (26.32)	15 (36.59)	0.432
Sharing of towels/personal items	25 (41.67)	6 (31.58)	19 (46.34)	0.281
Family history of dermatophytosis	17 (28.33)	4 (21.05)	13 (31.71)	0.394
Contact with infected person/animal	15 (25.00)	2 (10.53)	13 (31.71)	0.112

Associated dermatophytosis at other body sites	28 (46.67)	6 (31.58)	22 (53.66)	0.111
KOH mount positive	48 (80.00)	17 (89.47)	31 (75.61)	0.306



Figure 1



Figure 2



Figure 3



Figure 4



Figure 5



Figure 6



Figure 7



Figure 8



Figure 9



Figure 10

Discussion

In the present study, atypical presentation was the predominant pattern of tinea faciei, being observed in 41 patients (68.33%), while classical annular scaly lesions were seen in 19 patients (31.67%). This finding is comparable with Suganita et al. (2025), who studied 75 patients with tinea faciei and reported multiple atypical morphologies such as ill-defined margins, absence of scaling, incomplete circular lesions, pustular lesions, psoriasiform lesions, and erosions. In their study, steroid abuse was observed in 73 patients (97.30%), which was higher than the present study where topical steroid use was noted in 31 patients (51.67%). However, both studies support the observation that atypical morphology is common in tinea faciei and is strongly influenced by steroid misuse. In the present study, steroid-modified or ill-defined erythematous plaque was the most common atypical pattern, seen in 16 patients (26.67%), which is in agreement with the atypical morphological spectrum described by Suganita et al. (2025).⁷In the present study, the highest proportion of patients belonged to the 21–40 years age group (36.67%), followed by 41–60

years (21.67%) and 11–20 years (20.00%). A slight male predominance was observed, with 34 males (56.67%) and 26 females (43.33%). Similar age-related findings were reported by Paul et al. (2023) in a tertiary care hospital-based study of 111 patients with dermatophytosis, where the mean age was 32.8 years and the majority of adult cases belonged to the 21–30 years age group (34.20%), followed by 31–40 years (27.00%). Their study also showed male predominance (76.60%), which was higher than the male proportion in the present study. The similarity in young adult predominance may be explained by greater outdoor exposure, sweating, cosmetic use, social contact, and health-seeking behaviour in this age group.⁸In the present study, atypical presentation was observed across all age groups, with the highest proportion among patients older than 60 years (80.00%), followed by 21–40 years (72.73%) and 41–60 years (69.23%). However, the association between age group and type of presentation was statistically non-significant ($p = 0.777$). Romano et al. (2005), in a retrospective study of 84 tinea faciei cases, reported classical tinea in 54 patients (64.30%) and tinea incognito due to inappropriate therapy in 30 patients (35.70%). They

also observed that patients with typical tinea were younger, while tinea incognito was more common in older patients. Compared with their study, the present study showed a higher proportion of atypical cases (68.33% versus 35.70%), possibly due to greater topical steroid and over-the-counter medication use in the current population. In the present study, cheek involvement was the most common site, affecting 38 patients (63.33%), followed by forehead involvement in 25 patients (41.67%) and perioral/chin involvement in 18 patients (30.00%). Multiple facial areas were involved in 36 patients (60.00%), with higher frequency among atypical cases (68.29%) than classical cases (42.11%), although the association was not statistically significant ($p = 0.054$). Khiewplueang et al. (2024), in a retrospective study of 151 tinea faciei cases in Thailand, also reported that clinical presentations commonly involved plaques and scales on the cheeks. Their study found female predominance (64.90%) and pet exposure in 54.60% of patients, whereas the present study showed male predominance (56.67%) and did not record pets as a major demographic variable. The common cheek involvement in both studies highlights the importance of careful examination of facial plaques, especially when scaling is minimal or morphology is atypical.¹⁰In the present study, itching was the most common symptom, present in 54 patients (90.00%), while burning sensation was noted in 29 patients (48.33%). Visible scaling was significantly more common in classical cases (89.47%) than atypical cases (60.98%) ($p = 0.025$), while pigmentary changes were significantly more common in atypical cases (46.34%) than classical cases (15.79%) ($p = 0.022$). Dutta et al. (2017), in a study of 100 cases of tinea incognito, reported that eczema-like lesions were the most common manifestation, followed by inflammatory, autoimmune, and infective mimics. They also found face involvement in 51 cases and two or more body areas involved in 70 cases. These findings support the present observation that atypical tinea faciei may show reduced scaling, pigmentary alteration, burning, and wider facial involvement, making it difficult to distinguish from eczema, lupus-like eruptions, seborrheic dermatitis, or rosacea-like lesions.¹¹Topical steroid use emerged as an important factor in the present study. A history of topical steroid application was present in 31 patients (51.67%) and was

significantly higher among atypical cases (65.85%) than classical cases (21.05%) ($p = 0.001$). Similarly, over-the-counter medication use was present in 38 patients (63.33%) and was significantly associated with atypical presentation ($p = 0.020$). Saraswat et al. (2011), in a prospective multicenter Indian study on topical corticosteroid abuse on the face, reported that almost 15.00% of dermatology outpatients with facial dermatoses were already using topical corticosteroids when they consulted a specialist, and more than 93.00% of such use was inappropriate. They also found that 59.30% of patients received topical corticosteroid advice from non-physician sources. These findings closely support the present study, where unsupervised steroid and over-the-counter medication use were major contributors to atypical tinea faciei.¹²Laboratory confirmation by KOH mount was positive in 48 patients (80.00%) in the present study. KOH positivity was slightly higher among classical cases (89.47%) than atypical cases (75.61%), but the difference was statistically non-significant ($p = 0.306$). Poluri et al. (2015), in a clinicomycological study of 110 dermatophytosis samples from South India, reported KOH positivity in 58.18% and culture positivity in 56.36% of cases. Their KOH positivity was lower than that observed in the present study, possibly because the present study focused only on clinically suspected facial dermatophytosis and included active-margin scraping. The present finding confirms that KOH mount remains a useful and rapid diagnostic tool, especially in atypical facial lesions where clinical diagnosis alone may be misleading.¹³In the present study, associated dermatophytosis at other body sites was observed in 28 patients (46.67%), and recurrent lesions were recorded in 14 patients (23.33%). Although associated dermatophytosis was more common among atypical cases (53.66%) than classical cases (31.58%), the difference was statistically non-significant ($p = 0.111$). Vineetha et al. (2018) reported chronic dermatophytosis in 68.00% of patients and topical steroid application in 63.00% of cases in a tertiary care center study, supporting the role of steroid exposure, chronicity, and involvement of multiple body sites in the changing pattern of dermatophytosis. Compared with their study, the present study showed lower recurrence (23.33%) and lower steroid use (51.67%), but still demonstrated a significant association between steroid use and atypical

presentation. Overall, the findings emphasize that tinea faciei should be suspected in persistent, recurrent, pigmentary, eczematous, or steroid-modified facial lesions.¹⁴

Conclusion

The present study concluded that atypical presentation of tinea faciei was more common than the classical annular scaly form across all age groups. Young adults were most frequently affected, with slight male predominance. Topical steroid use and over-the-counter medication were significantly associated with atypical clinical morphology. KOH mount remained a useful diagnostic tool, especially in atypical facial lesions where clinical diagnosis may be difficult. Early recognition, avoidance of steroid misuse, and appropriate antifungal treatment are essential to prevent recurrence and diagnostic delay.

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