Tinea Caused by *Trichophyton soudanense* in Non-African Subjects in Spain

M. Pereiro Jr. and J. Toribio
Department of Dermatology, Complejo Hospitalario Universitario, Faculty of Medicine, C/. San Francisco, s/n, 15782 Santiago de Compostela, Spain. E-mail: manuelpe@usc.es
Accepted January 14, 2002.

Sir,

In northwestern tropical Africa, the anthropophilic *Trichophyton soudanense* is a frequent cause of tinea capitis (1). In Europe, tinea caused by this fungus has until the present been reported almost exclusively in African immigrants (1–5). Although cases in non-Africans have been reported in France and Italy (6, 7), to our knowledge this has not been described in Spain. Here we report on 7 cases of *T. soudanense* from Galicia, a region in northwest Spain, identified among 16,968 mycological cultures performed in our Dermatology Service over the period 1985–2000. Three of these patients were African immigrants and 4 were Spanish subjects with no known history of contact with people of African origin. In all 3 African patients, the lesions were only mildly inflammatory, but in the non-immigrants noticeable post-inflammatory sequelae were seen.

CASE REPORTS

Cases 1 and 2

The first case, a male patient, aged 29 years, lived in Spain but occasionally visited Switzerland. Six weeks before consultation he developed follicular papulopustules over the lateral region of the left angle of the mandible. Under topical corticosteroid treatment, the lesions spread to the entire left side of the neck and mandible. Several days later, the patient's 9-month-old son, who had never been abroad, developed a rounded, circumscribed, erythematous, scaling plaque in the left preauricular region, which was the area that had been in contact with the father's affected side when he held the baby.

Case 3

This patient, a girl aged 15 years, resided in Galicia, had never been abroad (nor had anyone in her family), and had no contact with immigrants at home, at school or in any other context. She consulted us because of a circinate lesion with papulopustular border on the back of the hand, first noted 15 days previously, and highly pruriginous. The lesion had been treated with topical antihistamines and had grown rapidly.

Case 4

A woman, aged 67 years, presented with an intensely erythematous, pruriginous, vesiculated, exudatory lesion on the anterior surface of the leg. Her general practitioner diagnosed this condition as acute eczema, and the lesion was treated for 3 months with topical corticosteroids, resulting in a reduction in local symptoms and an increase in lesion size. She then consulted a dermatologist, who sent us material for mycological study.

Cases 6, 7 and 8

These 3 patients – a 9-year-old boy, a 5-year-old girl and a 25-year-old woman – were of African origin. Both children came from Central Africa, and were staying with Spanish families for one month, as part of a help programme organized by a Non-Governmental Organization (NGO). The woman was working as a prostitute in a low-category brothel. The children presented with pityriasis amiantacea on the scalp. The woman presented with multiple rounded scaling lesions on the inner surface of the thighs, the buttocks and the abdomen.

Mycologic analyses and treatment

In 4 cases, direct examination revealed endotrix infection in both vellus and terminal hair. In the cultures, slow-growing colonies were identified as *T. soudanense* Joyeux (Ajello & Padhye 1987) (8).

All cases were treated with oral griseofulvin (10 mg/kg/day for 30 days) and topical terbinafine. Following identification as *T. soudanense*, the patients were all asked to make a second visit: all of the Spanish patients did so, but none of the African patients complied. The longest period for cure was 2 months. The lesions healed without sequelae in 2 of the patients. One patient showed a residual purplish arcuate scar on the back of the hand, with persistently negative mycological findings followed by a permanent pigmentation. The other patients exhibited residual alopecia.

DISCUSSION

T. soudanense is detected in industrialized countries in significant numbers of immigrants, causing tinea capitis in African patients (1–9). In these patients, tinea capitis may present varying degrees of inflammation, including non-inflammatory pityriasiform infections. *T. soudanense* has also been reported as a cause of distal subungual or total dystrophic onychomycosis (2, 10, 11). One case has been described as a new form of onychomycosis, denominated "endonyx" (10). We

consider that the onychomycoses and clinically mild pityriases in patients of African origin are the principal form of introduction of *T. soudanense* into Europe (5).

Illegal immigration from North and Sub-Saharan Africa is becoming increasingly frequent in Spain. Another possible route of importation of *T. soudanense* is via the aid programmes organized by a number of organizations, under which children from regions affected by war or famine visit European families for short periods, often with the specific aim of obtaining medical attention.

The four cases of *T. soudanense* infection detected in Spanish patients showed markedly inflammatory lesions. However, in no case did we obtain any evidence of contact with African immigrants, suggesting that this pathogen is already more or less widespread in the general population of Spain. This should be borne in mind by the physicians of all countries in the European community with African immigrants.

ACKNOWLEDGEMENT

This study was partly supported by grant XUGA20819B96 from the Local Government of Galicia, Spain.

REFERENCES

1. Rubben A, Krause H. Tinea superficialis capitis due to Trichophyton soudanense in African immigrants. Mycoses 1996; 39: 397–398.
2. Ricci C, Monod M, Baudraz-Rosselet F. Onychomycosis due to Trichophyton soudanense in Switzerland. Dermatology 1998; 197: 297–298.
3. Cremer G, Bousseloua N, Roudot-Thoraval F, Houin R, Revuz J. Teignes du cuir chevelu à Créteil. Évolution sur 10 ans. Ann Dermatol Venereol 1998; 125: 171–173.
4. Cuetara MS, del Palacio A, Pereiro M, Amor E, Alvarez C, Noriega AR. Prevalence of undetected tinea capitis in a school survey in Spain. Mycoses 1997; 40: 131–137.
5. Schwinn A, Ebert J, Wever S, Brocker EB. Trichophyton soudanense als Erreger der Tinea corporis et capitits. Hautarzt 1995; 46: 854–857.
6. Mathieu P, Adam MN, Giacomini T. Trichophyton soudanense contracte par des sujets non africains: a propos de quatre cas survenus en France. Ann Biol Clin (Paris) 1996; 54: 215–217.
7. Albanese G, Di Cintio R, Crippa D, Galbiati G. Trichophyton soudanense in Italy. Mycoses 1995; 38: 229–230.
8. De Hoog GS, Guarro J, Tan CS, Wintermans RGF, Gene J. Pathogenic fungi and common opportunists. In: de Hoog GS, Guarro J, eds. Atlas of clinical fungi. Baarn: Centraalbureau voor Schimmelcultures, 1995: 117.
9. Pereiro Miguens M, Pereiro M, Pereiro M. Review of dermatophytoses in Galicia from 1951 to 1987, and comparison with other areas of Spain. Mycopathologia 1991; 113: 65–78.
10. Tosti A, Baran R, Piraccini BM, Fanti PA. "Endonyx" onychomycosis: a new modality of nail invasion by dermatophytes. Acta Derm Venereol 1999; 79: 52–53.
11. Kalter DC, Hay RJ. Onychomycosis due to Trichophyton soudanense. Clin Exp Dermatol 1988; 13: 221–227.
12. Maleville J, Moulinier C, Boineau D, Marc-Antoine H, Mollard S, Guillet G, et al. Teignes du cuir chevelu. 73 cas observes a Bordeaux. Ann Dermatol Venereol 1979; 106: 869–872.

Sporotrichoid Spread of *Mycobacterium Chelonae* in a Presumably Immunocompetent Patient

Elena Rosón, Ignacio García-Doval, Carlos de la Torre, Antonio Losada, Carlos Feal and Manuel Cruces
Department of Dermatology, Complejo Hospitalario de Pontevedra, C/Loureiro Crespo n° 2 Pontevedra, Galicia, Spain
Accepted January 15, 2002.

Sir,

Mycobacterium chelonae is an unusual human pathogen. Cutaneous dissemination with a sporotrichoid pattern has been described mainly in immunocompromised patients. We present here a case of infection by *Mycobacterium chelonae* with a linear cutaneous distribution in a healthy immunocompetent woman. Minocycline was an effective treatment.

CASE REPORT

A 42-year-old, healthy woman presented with one-month old erythematous-violet papular lesions on her left arm. Initially, only one lesion was present, on the proximal phalanx of the fourth finger (Fig. 1*a*). Over the next few days, new lesions developed on the dorsum of the hand (Fig. 1*b*) and forearm, in a linear distribution. Occasionally, some of these lesions ulcerated and drained. The patient did not have a history of trauma in this area. A small axillary adenopathy was present.

Haemogram, biochemical screening, immunoglobulin levels, human immunodeficiency virus serology and chest X-ray were all normal. A skin biopsy showed suppurative granulomas without evidence of microorganism (negative PAS and Ziehl-Neelsen techniques). Because of the sporotrichoid spread of the lesions, our initial clinical suspicion was lymphocutaneous syndrome by *Sporothrix schenckii*, so potassium iodide treatment was started. Mycobacterium sp. grew on a tissue culture. Thus, infection by *Mycobacterium marinum* was considered and the previous treatment was changed to minocycline (200 mg/day). Later, *Mycobacterium chelonae* was identified. The lesions healed satisfactorily and the treatment was continued for 2 months until the lesions disappeared.