Primary onychomycosis with granulomatous *Tinea faciei*

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**TO THE EDITOR**

We report a 67-year-old male who was referred to us due to subfebrile temperatures, nocturnal diaphoresis and painful lesions on his left cheek. His past medical history revealed that he has severe type 1 diabetes mellitus, hypertension, hepatitis A and pulmonary tuberculosis. The patient was under topical therapy with ciclopirox olamine lacquer for onychomycosis of the toenails of both feet.

Clinical examination disclosed violet to dark red confluent plaques involving the left cheek and neck (Figure 1). Previous therapy with doxycycline and flucloxacillin was ineffective. Due to lack of response to therapy and associated problems, clinical investigations were performed in order to exclude systemic tuberculosis and other systemic disorders, to arrive at the diagnosis and start appropriate therapy.

Direct microscopic examination of scrapings obtained from the left cheek revealed the presence of fungal elements, while those from the toenails and beard were negative. Fungal cultures demonstrated *Trichophyton rubrum* from the left cheek, beard and toenails. Histological sections showed multinucleate giant cells with fungal elements within the cytoplasm.

There were no abnormalities in lymphocyte subpopulations, and serum or urine protein electrophoresis was normal. HIV, p-ANCA, c-ANCA and ANA were all negative. PCR in lesional skin revealed no *Mycobacterium tuberculosis* DNA, and Ziehl-Neelsen staining was also negative. After similar microbiologic investigations from sputum sample, as well as pulmonary imaging studies, the possibility of active tuberculosis was ruled out.

After starting systemic therapy with itraconazole 100 mg twice a day for 14 days (4 cycles) and local therapy with solution of 3% brilliant green in combination with octenidine dihydrochloride solution, full remission was achieved.

**Figure 1:** Hemorrhagic, confluent plaques and papules in the area of the left cheek and neck present over 2 months.
**REFERENCES**