Journal of Communicable Diseases
Volume 57, Issue 1 - 2025, Pg. No. 157-166
Peer Reviewed & Open Access Journal

Review Article

# Atypical Presentations of Tinea Incognito

Ravulapalli Lakshmi Sindhuja[1], Keerthana Rajasekaran[2], Navakumar Manickam[3], Seethalakshmi Ganga Vellaisamy[4], Kannan Gopalan[5]

[1]Student, [2]Assistant Professor, [3]Associate Professor, [4,5]Professor, Department of Skin & STD, Vinayaka Mission's Kirupananda Variyar Medical College & Hospitals, Vinayaka Mission's Research Foundation (DU), Salem, India
**DOI:** https://doi.org/10.24321/0019.5138.202521

## I N F O

**Corresponding Author:**
Keerthana Rajasekaran, Department of Skin & STD, Vinayaka Mission's Kirupananda Variyar Medical College & Hospitals, Vinayaka Mission's Research Foundation (DU), Salem, India
**E-mail Id:**
keerthanasekaran1991@gmail.com
**Orcid Id:**
https://orcid.org/0009-0001-2719-0938
**How to cite this article:**
Sindhuja R L, Rajasekaran K, Manickam N, Vellaisamy S G, Gopalan K. Atypical Presentations of Tinea Incognito. J Commun Dis. 2025;57(1):157-166.

Date of Submission: 2025-01-25
Date of Acceptance: 2025-02-27

## A B S T R A C T

Dermatophytosis is a prevalent superficial fungal infection involving 20–25% of the worldwide population, attributed to various species of dermatophytes, such as *Trichophyton, Microsporum* and *Epidermophyton.* However, its clinical presentations in immunocompromised individuals or those resorting to topical and systemic corticosteroids often mimic other dermatoses such as exfoliative dermatitis (ED), dermatophytosis incognito, inflammatory, or neoplastic conditions, leading to delayed or mismanagement in treatment. This review focuses on the prevalence of atypical presentations of tinea incognito and their diagnostic evaluations highlighted through relevant case reports from the year 2019 to 2024.

**Keywords:** Dermatophytosis, Tinea Incognita, Topical Corticosteroid Application, Atypical, Tinea Pseudoimbricata

## Introduction

Dermatophytosis is classified as a keratinolytic fungus predominantly affecting keratinised tissues, including the skin, nails, and hair. Worldwide epidemiological studies show the prevalence of *Trichophyton* species followed by *Microsporum* species. *T. rubrum* and *T. mentagrophytes* are more predominantly found affecting skin and nails. The emergence of resistance to antifungal agents, particularly azoles and allylamines, is being seen progressively. Recent studies in India highlight that *Trichophyton mentagrophytes* has become the predominant fungal species associated with chronic dermatophytosis. In cases of long-term infections, *Epidermophyton floccosum* and *T. mentagrophytes* are recognised as significant etiological agents.[1]

While classic presentations such as tinea corporis or tinea pedis are easy to recognise, altered presentations often induced by immunosuppression or misuse of topical corticosteroids and oral corticosteroids pose significant diagnostic challenges. Tinea incognito [TI] or dermatophytosis incognito is one such variant with modified clinical features due to misdiagnosis and inappropriate usage of corticosteroid/ calcineurin inhibitors/ immunosuppressive drugs.[2]

This review discusses rare presentations of dermatophytosis with a focus on psoriasis-like tinea incognito, eczema-like incognito, intertrigo-like, and exfoliative dermatitis-like, integrating findings from recent case reports.

## Materials and Methods

A systemic review was accomplished by extracting data utilising PubMed and Scopus databases. Search words contained "Tinea incognito", "Tinea incognita", "Tinea pseudoimbricata", and "Atypical dermatophytosis". The search strategy included a comprehensive range of study types: meta-analyses, case reports, observational studies, randomised controlled trials (RCTs), clinical trials, and

systematic reviews. The focus was on literature published globally in English within the last five years, specifically from 2019 to 2024. Furthermore, a limited number of unavailable full-text articles were incorporated into the analysis, while duplicate entries were systematically removed. The data obtained from the search results was precisely examined and analysed in detail for this review.

## Updates on the Epidemiology of Tinea Incognita

This review analysis, derived from 36 articles encompassing 163 global cases over the last five years from 2019 to 2024, demonstrated that mean age of patient was 39.3 years, with age distribution varying from 2 to 89 years as detailed in Figure 1, Table 1. A notable female predominance was observed, with females comprising 60% (n = 99) compared to 40% of males (n = 64).It is important to highlight that tinea infections predominantly affect adults. However, in this review, pediatric cases accounted for 19.4% of the total (7 out of 163), among which the primary causative agent noted were *Trichophyton mentagrophytes*, with *Microsporum canis* and *Trichophyton violaceum* following in prevalence.[3]

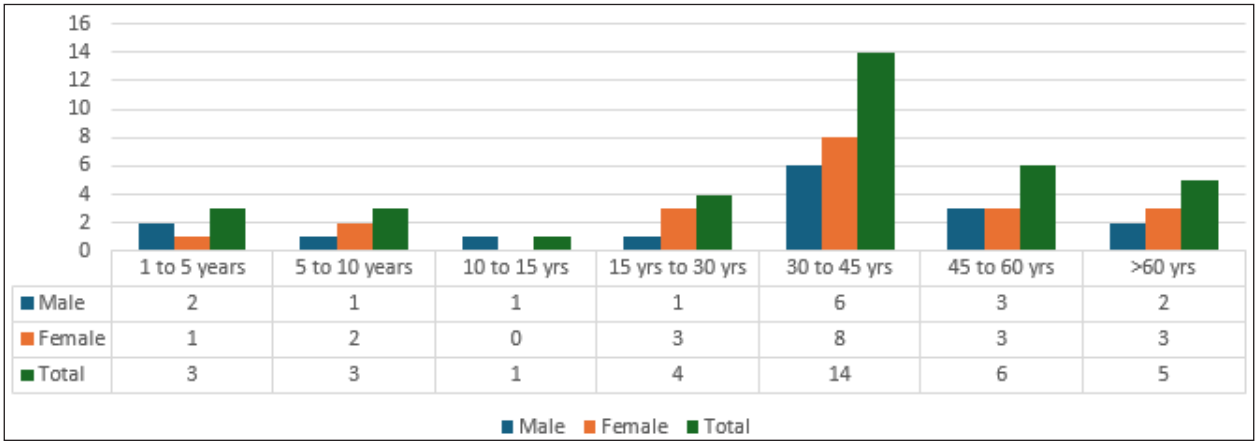


**Figure 1.Age distribution of Tinea incognito cases (Case Reports Mentioning Age were Included)**

**Table 1.Place of study and reported cases**

| Place of Study | Year | Authors | Cases |
|---|---|---|---|
| Mexico | 2024 | Diana Gallegos espadas[22] | 1 |
| India-Pune | 2024 | Divya Asnani[20] | 1 |
| India-Karnataka | 2023 | Balachandra S[24] | 1 |
| India-Maharashtra | 2022 | V.Zawar[25] | 1 |
| India-Kolkata | 2020 | Surajit Gorai[32] | 2 |
| Korea | 2023 | Hyun Bin[21] | 38 |
| China | 2023 | Sushant li[48] | 1 |
| China | 2023 | Lei chu[23] | 1 |
| China | 2023 | Wenting hu[31] | 1 |
| China | 2022 | Xiang Dong[44] | 1 |
| China | 2021 | Ya bin zhou[34] | 1 |
| China | 2020 | B. Yin[53] | 1 |
| China | 2020 | Ge Song[19] | 1 |
| Poland | 2022 | Nowowiejska[33] | 1 |

**ISSN: 0019-5138**
**DOI: https://doi.org/10.24321/0019.5138.202521**

| | | | |
|---|---|---|---|
| Italy | 2022 | Roberto russo[35] | 1 |
| Taiwan | 2022 | Yi teng[26] | 1 |
| New York | 2022 | Elizabeth J[39] | 1 |
| New York | 2022 | Cunningham[36] | 3 |
| Belgium | 2022 | Absil G[41] | 1 |
| Ireland | 2022 | Jason hynes[43] | 1 |
| USA | 2022 | Babakoohi[38] | 1 |
| USA | 2022 | Nadelman DA[37] | 1 |
| USA | 2022 | Fernandes D[40] | 1 |
| Chiba | 2021 | Tomohiro suzuki[42] | 1 |
| London | 2021 | Steele L[49] | 1 |
| Switzerland | 2021 | Emelianov[28] | 1 |
| Indonesia | 2021 | Risa[45] | 1 |
| Turkey | 2020 | Goknur kalkan[46] | 1 |
| Iraq | 2020 | Samer dhaher[14] | 90 |
| Serbia | 2020 | Sekulic J[50] | 1 |
| Georgia | 2020 | Douglas[29] | 1 |
| France | 2020 | Froidefond[27] | 1 |
| Slovenia | 2020 | Laura[30] | 1 |
| Uruguay | 2019 | Nelson turra[47] | 1 |

Atypical presentations presented mostly as eczema-like lesions (n = 82, 50%) followed by psoriasis-like (n = 28, 17%), intertrigo (n = 16, 10%), rosacea (n = 6, 3.6%), contact dermatitis like (n = 6, 3.6%), lupus erythematosus like (n = 4, 2.4%), cellulitis (n = 3, 1.8%), follicular (n = 3, 1.8%), pseudoimbricata (n = 3, 1.8%) and other case reports (n = 1, 0.6% each) presenting with rare morphology like central centrifugal cicatricial alopecia (CCCA), tinea of vellus hair, disseminated, exfoliative dermatitis, subcorneal pustular dermatosis, gyrate erythema, and cutaneous T cell lymphoma (Figure 2).

Ghaderi et al. stated that in TI, *T. mentagrophytes* is a prevalent causative agent. A review of the available case reports with the isolation of organisms from TI lesions from 2019 to 2024 (Figure 3) showed that *T. rubrum* (n = 40, 45%) and *M. canis* (n = 34, 38%) were the extensively predominant aetiological species followed by *T. mentagrophytes* (n = 6, 6.8%).[4] Other species reported were *T. interdigitale, T. violaceum, T. tonsurans, M. audouinii* and *T. erinacei*.

According to Dogra et al., an invasion of the hair follicle and shaft by *Trichophyton rubrum* species was reported by interleukin 8.[5] In this review, the prevalence of invasion of hair was noted by *T. violaceum* followed by *T. tonsurans* and *M. canis* species.

Tinea indecisiva/ tinea pseudoimbricata(Figure 4), represents a subset of tinea infections, with *Trichophyton concentricum* identified as its primary causative agent.[6,7] In this review, Absil G et al. and Suzuki et al. [41,42] found *Microsporum audouinii* and *Trichophyton tonsurans* species prevalence respectively from tinea pseudoimbricata lesions.

TI lesions were predominantly observed on the face (n = 60, 26%),(Figure 5), which aligns with the findings of Dutta et al.,[8] particularly in the context of increased mask usage

**ISSN: 0019-5138**
**DOI: https://doi.org/10.24321/0019.5138.202521**

during the COVID-19 pandemic. Unlike Stringer et al.[9] who reported a similar prevalence of lesions on the face and trunk, our analysis revealed that lesions on the extremities (n = 42, 18%) were the second most common, followed by those on the trunk (n = 38, 16%). Ear (n = 2, 0.8%) and nail involvement (n = 2, 0.8%) were less frequently seen (Figure 6).

Forty-seven patients (79%) reported underlying systemic diseases (Figure 7) and the most common association reported was hypertension (n = 10, 16%) followed by diabetes mellitus (n = 7, 11.8%). Twelve patients (20%) reported co-existing dermatological conditions like psoriasis (n = 7, 11.8%), atopic dermatitis (n = 2, 3.3%), bullous pemphigoid (n = 1, 1.6%), prurigo nodularis (n = 1, 1.6%), and ichthyosis (n = 1, 1.6%).

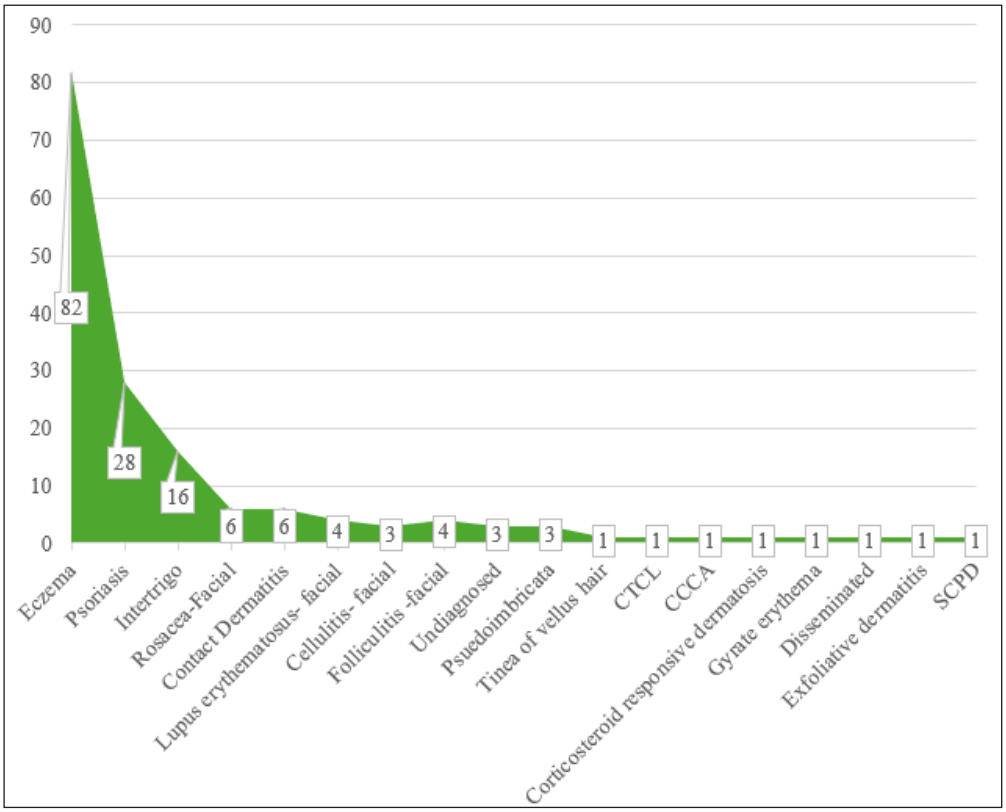


**Figure 2.Atypical Presentations of Tinea Incognito**

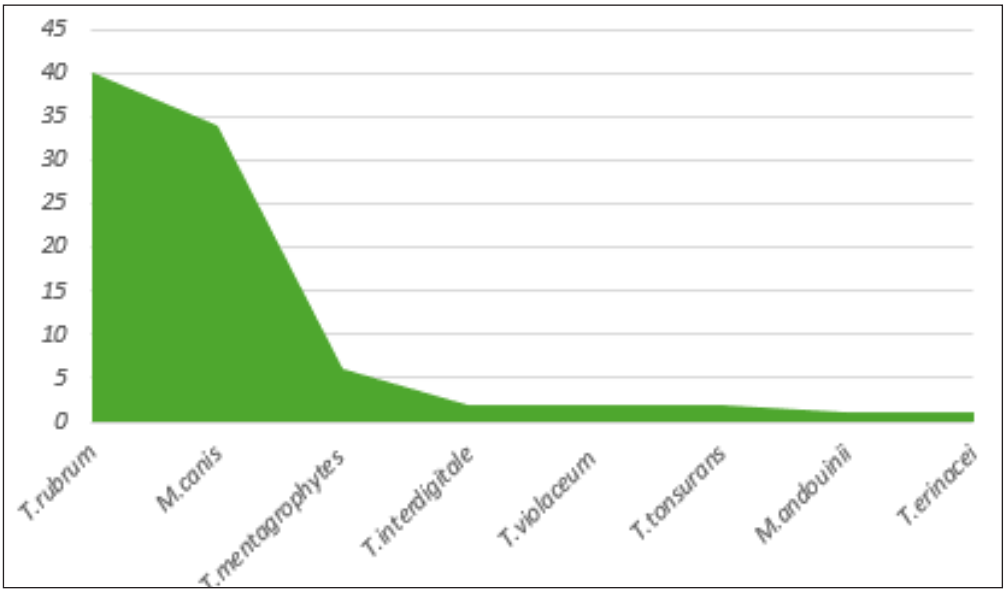


**Figure 3.Prevalence of causative organisms in Tinea incognito**

**ISSN: 0019-5138**
**DOI: https://doi.org/10.24321/0019.5138.202521**

**Figure 4.A Case of Tinea Pseudoimbricata**

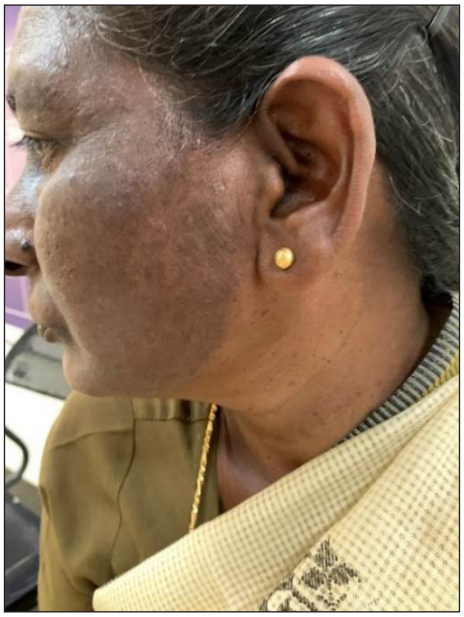

**Figure 5.A Case of Tinea Incognito-Face Region**

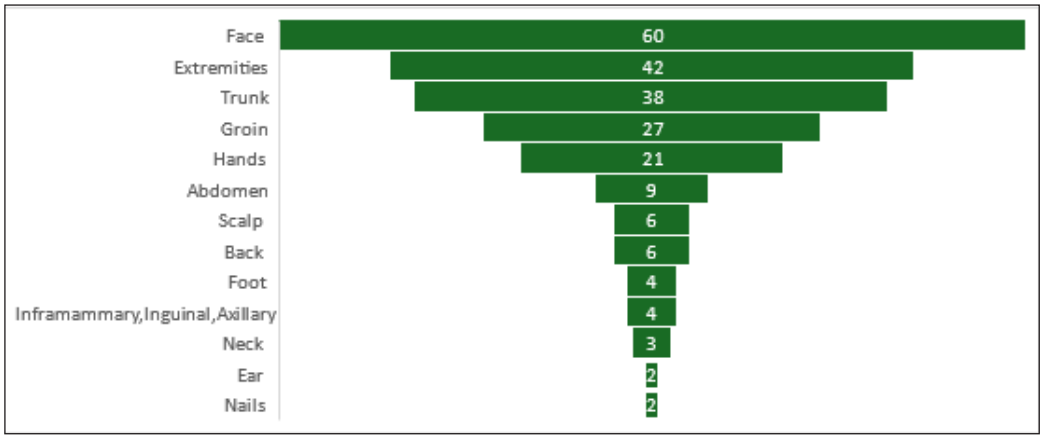


**Figure 6.Sites involved in tinea incognito cases**

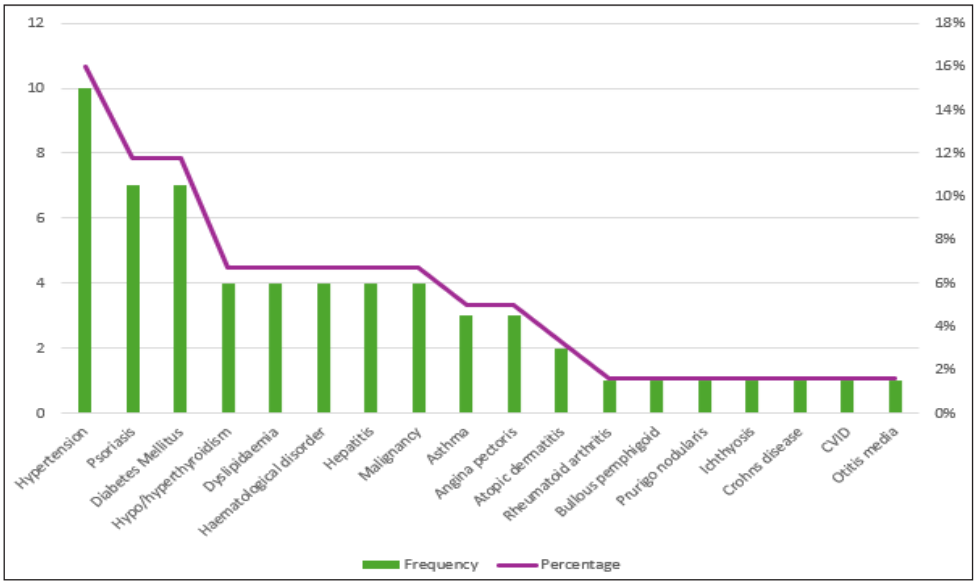


**Figure7.Associated systemic and dermatological conditions**

**ISSN: 0019-5138**
**DOI: https://doi.org/10.24321/0019.5138.202521**

Inappropriate treatment taken was also analysed as per the case reports in the past 5 years as demonstrated in Figure 8 and Table 2. Usage of topical steroids (n = 79, 44%) was the most abused drug for tinea incognito followed by fixed drug combination (n = 33, 18%). The least commonly reported drugs were minoxidil (n = 1, 0.5%), apremilast (n = 1, 0.5%), and ixekizumab (n = 1, 0.5%).

Diagnostic challenges increase in TI cases as repeated KOH and culture show negative results, urging demand for other advanced diagnostic techniques like dermoscopy, reverse transcription polymerase chain reaction (RT-PCR), MALDI-TOFMS (matrix-assisted laser desorption ionisation-time of flight mass spectrometry) and reflectance confocal microscopy. In this study, as illustrated in Figure 8, 40% of the cases were identified using potassium hydroxide (KOH) preparation, while 35% were diagnosed via culture methods. The remaining cases were diagnosed through various techniques, including periodic acid-Schiff (PAS) staining, calcofluor white (CW) staining, histopathological examination, RT-PCR, and dermoscopy.[10] Limitations of biopsy and confocal microscopy were that such tests couldn't specify the species or genus of the fungus.

Table 3 delineates the various treatment interventions administered in these cases.It is noted that in about 67% of patients griseofulvin showed a significant cure both microscopically and clinically.[14] Terbinafine obtained a complete recovery in a patient not responding to oral itraconazole as reported by Sushan et al. in contrast to Yamada et al. and Sardana et al.[11,12,13] who reported terbinafine resistance due to squalene epoxide gene mutation and higher minimum inhibitory concentration (MIC). Itraconazole was found effective in 6.6% of patients followed by fluconazole 0.7%.

Topical treatment is considered first-line treatment in mild cases. In this comprehensive five-year evaluation (Table 4)terbinafine cream was found effective in 20% of cases followed by, isoconazole in 19%.

In India, case studies have demonstrated effective management of TI lesions through the administration of itraconazole, complemented by the topical application of luliconazole cream for about 4–6 weeks.

## Literature Review of Atypical Presentation of Steroid Treated Tinea Cases

Topical corticosteroids are known to disrupt local immune responses, consequently allowing for the potential dissemination of the infection. The process commences with steroid hormones binding to cytoplasmic receptors in keratinocytes, which subsequently triggers the synthesis of lipocortins. These lipocortins play a crucial role in interfering with the action of inflammatory mediators and regulating arachidonic acid metabolism. This mechanism results inhibit polymorphonuclear leukocyte migration, causing the anti-inflammatory effects of steroids. Additionally, lipocortins may enhance vasoconstriction and reduce vascular permeability, resulting in diminished oedema and erythema increasing the incidence of coinfections.[4]

In TI there is immune dysfunction and repression of inflammatory response causing the spread of fungal infection. Corticosteroids act on antigen-presenting cells, dendritic cells, and macrophages altering the cytokine expression. Shift in immune response from Th1 to Th2. Th2 is activated by steroid-induced dendritic cells-TRL2 release, as well as by the release of IL-6, IL-10, TNF-ALPHA, and a decrease in IL-23, IL6, IL-17, and TGF BETA. Glucocorticoids induce APCs to cause suppression of MHC-2 and loss of inhibition of IL 12, releasing IFNG, and IL-4. Downregulates IL-12 receptors on natural killer and T cells, IL-1, IFN-GAMMA.Concomitantly reduced oxygenation, nutrient availability, and antimicrobial peptide dysfunction also prompt discrepancies in the morphological appearance of Tinea lesions and their progression.[15, 16, 17,18]

## Diagnostic Updates of Tinea Incognito

Dermoscopy at the lesional site aids in diagnosis well as assessment of progression of the disease. Characteristic fungal infection findings noted were brown spots with white-yellowish halos and follicular micropustules. The earliest finding is micropustules around 2 weeks, perifollicular scaling, 4 weeks. Misusage of steroids shows dotted vessels, atrophy and telangiectasia. Also, broken hair, bent, morse code, and corkscrew hairs were seen. [50,51,] In Yadav et al., the most common dermoscopic findings were translucent hair and broken hair.[11]

DendrisCHIP®DP technology is beneficial in culture-negative dermatophyte infections, processed by RT-PCR or sequencing. It is a semi-automated rapid diagnostic technique which processes up to 192 sample sizes/day with higher sensitivity.[10]

Chu et al.[22] conducted DNA analysis using ITS1/ITS4 PCR sequencing, which identified the organism as *Trichophyton interdigitale* based on BLAST comparison results. The corresponding nucleotide sequence has been submitted to GenBank and is available under accession number ON778572. In a case report by Suzuki et al.[41], the causative agent of tinea pseudoimbricata was identified as *Trichophyton tonsurans* through sequencing of the internal transcribed spacer (ITS) regions of the ribosomal RNA gene. Similarly, a case described by Song et al[18], which was diagnosed as tinea affecting vellus hair, revealed via genomic sequencing a 99% homology with *T. violaceum* (CBS 374.92).

**ISSN: 0019-5138**
**DOI: https://doi.org/10.24321/0019.5138.202521**

## Critical Analysis

In multiple cases, age-related data was absent, which hindered the capacity to assess the prevalence of age-specific incidence effectively.

The association between animal exposure and skin conditions is often overlooked in case reports, which is a significant omission given the recent incidence of tinea incognito linked to *Trichophyton erinacei* from pet hedgehogs and *M. canis* by pet cats.[25,52] It is essential to incorporate pet ownership history when evaluating cases of tinea.

A thorough documentation of the body surface area impacted by tinea incognito is crucial for assessing treatment efficacy and outcomes. As in a case of exfoliative dermatitis secondary to tinea incognito, clinical resolution is earned by the 29th day of treatment and culture was observed to return negative by the 64th day, as reported by Hidayah et al.[44]

Occupational history was ignored in many case reports, which is a critical risk factor, including occlusive clothing and excessive sweating as there is an incidence of mask tinea due to the occlusive effect of the mask.[34]

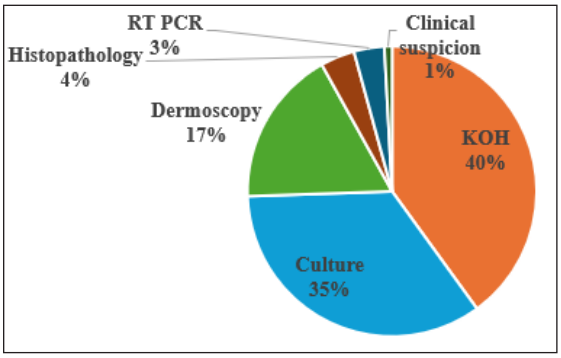


**Figure 8.Diagnostic evaluation of Tinea incognito**

**Table 2.Misuse of drugs in Tinea incognito**

| Drugs Prescribed/ Self-Treated/ OTC Usage | Frequency | Percentage |
|---|---|---|
| Topical steroid | 79 | 43.80 |
| Fixed drug combination | 33 | 18.30 |
| Topical steroid/ calcineurin inhibitors | 21 | 11.60 |
| Systemic steroid | 8 | 4.40 |
| Both topical and systemic steroid | 7 | 3.80 |
| Calcineurin inhibitors | 7 | 3.80 |
| Calcipotriol/ betamethasone | 6 | 3.30 |
| Mupirocin/ gentamicin/ clindamycin/ azithromycin | 4 | 2.20 |
| NBUVB | 4 | 2.20 |
| Triamcinolone acetonide cream/ inj | 3 | 1.60 |
| Methotrexate | 3 | 1.60 |
| Amoxiclav/ doxycycline | 2 | 1.10 |
| Minoxidil | 1 | 0.50 |
| Ixekizumab | 1 | 0.50 |
| Apremilast | 1 | 0.50 |

**Table 3.Treatment taken in Tinea incognito cases**

| Systemic Treatment taken | IADVL Textbook-Dose* | n | Rooks Textbook-Dose* | n | Fitzpatrick Textbook-Dose* | n |
|---|---|---|---|---|---|---|
| Griseofulvin | 500 mg/day x 4–8 weeks | 2 | 1g/day x 4–6 weeks | 90 | - | - |
| Terbinafine | 250 mg/day x 2 weeks | 4 | - | - | 250 mg/day x 2–4weeks | 29 |
| Itraconazole | 200–400 mg/day x 1 week | 9 | 100mg/day x 2–4 weeks | 1 | - | - |
| Fluconazole | 150–300 mg/ week x 4–6 weeks | 1 | - | - | - | - |

Dose*-standard dosage regimen according to Indian textbook

ISSN: 0019-5138
DOI: https://doi.org/10.24321/0019.5138.202521

**Table 4.Topical treatment taken in Tinea incognito**

| Topical Treatment Taken | N |
|---|---|
| Terbinafine cream | 18 |
| Isoconazole | 17 |
| Luliconazole 1% | 3 (with benzoyl peroxide -1) |
| Ciclopirlox cream 1% | 2 |
| Econozole | 1 |
| Luriconozole | 1 |
| Clotrimazole | 1 |
| Sertaconazole 1% | 1 |
| Bifonazole | 1 |
| Ketoconozole 2 % | 1 (with 10% urea) |
| Butenafine hydrochloride | 1 |

## Conclusion

The analysis revealed that atypical presentations of tinea incognito in the past 5 years predominantly exhibited eczema-like lesions followed by psoriasis-like and intertrigo-like lesions. The aetiological prevalence shows *Trichophyton rubrum* followed by *Microsporum canis* and *Trichophyton mentagrophytes*, mostly affecting the face, extremities and trunk region. The most abused drug is topical steroids followed by fixed drug combinations. In instances of negative KOH and culture results, PAS stain, histopathological evaluation followed by dermoscopic assessment and molecular analysis exerts a critical influence in the diagnosis of tinea incognito. Prolonged systemic antifungal therapies are often required for effective management. In cases of tinea incognito lesions, an expert evaluation is essential, as these conditions are frequently misdiagnosed and may not receive appropriate treatment.

**Conflict of Interest:** None

**Source of Funding:** None

**Authors' Contribution:** All authors collaborated in formulating the conceptual framework for the review, selecting relevant studies, extracting data, interpreting findings, and drafting the manuscript. Each author has reviewed and endorsed the final version of the manuscript.

**Declaration of Generative AI and AI-Assisted Technologies in the Writing Process:** None

## References

1. Gupta AK, Ryder JE, Chow M, Cooper EA. Dermatophytosis: the management of fungal infections. Skinmed. 2005;4(5):305-10. [PubMed] [Google Scholar]
2. Kokandi AA. Tinea incognito. Clin Cosmet Investig Dermatol. 2024;17:993-8. [PubMed] [Google Scholar]
3. del Boz J, Crespo V, de Troya M. Pediatric tinea faciei in southern Spain: a 30-year survey. Pediatr Dermatol. 2012;29(3):249-53. [PubMed] [Google Scholar]
4. Ghaderi A, Tamimi P, Firooz A, Fattahi M, Ghazanfari M, Fattahi Mahsa. Updates on tinea incognito: literature review. J Dermatol. 2023;50(2):123-30. https://doi.org/10.22034/cmm.2023.345069.1425
5. Dogra S, Narang T. Emerging atypical presentations of dermatophytosis in India. Clin. Dermatol. Rev. 2017;1:S12-S18. https://doi.org/10.4103/CDR.CDR_39_17
6. Batta K, Ramlogan D, Smith AG, Garrido MC, Moss C. 'Tinea indecisiva' may mimic the concentric rings of tinea imbricata. Br J Dermatol. 2002;147(2):384. [PubMed] [Google Scholar]
7. Bhagyashree M, Shilpashree P. A clinico mycological study of tinea pseudoimbricata. Indian Dermatol Online J. 2022;13(1):73. [PubMed] [Google Scholar]
8. Dutta B, Rasul ES, Boro B. Clinico-epidemiological study of tinea incognito with microbiological correlation. Indian J Dermatol Venereol Leprol. 2017;83(3):326-31. [PubMed] [Google Scholar]
9. Stringer T, Gittler JK, Orlow SJ. Tinea incognito in an urban pediatric population. Cutis. 2018;102(5):370-2. [PubMed] [Google Scholar]
10. Zacharopoulou A, Tsiogka A, Tsimpidakis A, Lamia A, Koumaki D, Gregoriou S. Tinea incognito: challenges in diagnosis and management. J Clin Med. 2024;13(11):3267. [PubMed] [Google Scholar]
11. Yamada T, Maeda M, Alshahni MM, Tanaka R, Yaguchi T, Bontems O, Salamin K, Fratti M, Monod M. Terbinafine resistance of *Trichophyton* clinical isolates caused by specific point mutations in the squalene epoxidase gene. Antimicrob Agents Chemother. 2017;61(1):e00115-17. [PubMed] [Google Scholar]
12. Sardana K, Kaur R, Arora P, Goyal R, Ghunawat S. Is antifungal resistance a cause for treatment failure in dermatophytosis: a study focused on tinea corporis and cruris from a tertiary centre? Indian Dermatol Online J. 2018;9(2):90-5. [PubMed] [Google Scholar]
13. Dhaher S. Tinea incognito: clinical perspectives of a new imitator. Dermatol Reports. 2020;12(1):8323. [PubMed] [Google Scholar]
14. Solomon BA, Glass AT, Rabbin PE. Tinea incognito and "over-the-counter" potent topical steroids. Cutis. 1996;58(4):295-6. [PubMed] [Google Scholar]

15. Atzori L, Pau M, Aste N, Aste N. Dermatophyte infections mimicking other skin diseases: a 154-person case survey of tinea atypica in the district of Cagliari (Italy). Int J Dermatol. 2012;51:410-5. https://doi.org/10.1111/j.1365-4632.2011.05049.x
16. Crawford KM, Bostrom P, Russ B, Boyd J. Pimecrolimus-induced tinea incognito. Skinmed. 2004;3(6):352-3. [PubMed] [Google Scholar]
17. Abed Ali FA, Al-Janabi JK, Alhattab MK. Prevalence of dermatophyte fungal infection in Hillah, Iraq. Int J ChemTech Res. 2017;10:827-37. [Google Scholar]
18. Song G, Liang GZ, Liu WD. Tinea of vellus hair caused by *Trichophyton violaceum* in a child: a case report. Int J Dermatol Venereol. 2024;7(1):58-9. [Google Scholar]
19. Asnani D, Singh S, Gupta A. Addressing diagnostic and therapeutic challenges in a case of concurrent tinea and plaque psoriasis. Case Rep Dermatol. 2024;16(1):254-8. [PubMed] [Google Scholar]
20. Kwak HB, Lee SH, Yoo HH, Lee IJ, Lee GJ, Nam KH, Yun SK, Park J. Facial tinea incognito: a clinical, dermoscopic and mycological study of 38 cases. Eur J Dermatol. 2023;33(2):101-8. [PubMed] [Google Scholar]
21. Espadas DG, Martínez-Ortega JI, Hernandez DA, Mendieta CP, Fernandez-Reyna I. Unmasking tinea incognito: case study, insights into the pathogenesis, and recommendations. Cureus. 2024;16(10):e72042. [PubMed] [Google Scholar]
22. Chu L, Jiang X, Ke Y, Liu J, Zhang C, Zhou X, Gao R, Ran Y. Generalized tinea incognito masquerading as psoriasis via *Trichophyton interdigitale.* Mycopathologia. 2023;188(3):291-3. [PubMed] [Google Scholar]
23. Ankad BS, Dhananjaya S. Recognition of superadded tinea incognito in erythrodermic psoriasis: diagnostic excellence by dermoscopy. Indian Dermatol Online J. 2024;15(2):303-4. [PubMed] [Google Scholar]
24. Zawar V, Kumavat S, Rathi S. Dermatophytosis mimicking psoriasis: a classic presentation of steroid treated tinea. Actas Dermosifiliogr. 2022;113(6):622-3. [PubMed] [Google Scholar]
25. Hung YT, Huang YH, Sun PL. Tinea incognito with intrafamilial outbreak caused by *Microsporum canis.* J Pediatr. 2022;244:242-3. [PubMed] [Google Scholar]
26. Froidefond M, Dudouet P, Ranque S, Cassir N. Tinea incognito: primum non nocere. Int J Infect Dis. 2021;103:597-8. [PubMed] [Google Scholar]
27. Emelianov V, Feldmeyer L, Yawalkar N, Heidemeyer K. Tinea Corporis with Trichophyton Rubrum Mimicking a Flare-Up of Psoriasis UnderTreatment with IL17-Inhibitor Ixekizumab. Case Rep Dermatol. 2021 Jul 9;13(2):347-351. https://doi.org/10.1159/000515702
28. Diruggiero D. Successful management of psoriasis and treatment-induced tinea incognito: a case report. J Clin Aesthet Dermatol. 2020;13(9 Suppl 1):S21-5. [PubMed] [Google Scholar]
29. Betetto LD, Žgavec B, Suhodolčan AB. Psoriasis-like tinea incognita: a case report and literature review. Acta Dermatovenerol Alp Pannonica Adriat. 2020;29(1):43-5. [PubMed] [Google Scholar]
30. Hu W, Xia X, Ma Y, Xu AE. A typical but rare case of solitary tinea auricularis. Infect Drug Resist. 2023;16:239-41. [PubMed] [Google Scholar]
31. Itraconazole/steroids/triamcinolone. Reactions Weekly. 2021 Mar 1;1848(1):228. https://doi.org/10.1007/s40278-021-93230-9
32. Nowowiejska J, Baran A, Flisiak I. Tinea incognito—a great physician pitfall. J Fungi (Basel). 2022;8(3):312. [PubMed] [Google Scholar]
33. Zhou YB, Ma L, Xiao YY. A boy with annular erythema on the nose. BMJ. 2021;374:n1952. [PubMed] [Google Scholar]
34. Russo R, Trave I, Cozzani E, Parodi A. Generalized tinea incognito developing from "mask tinea". Mycopathologia. 2023;188(3):263-6. [PubMed] [Google Scholar]
35. Cunningham EP, Carter NF. Tinea incognito "mask"erading as allergic contact dermatitis due to COVID-19 facial covering in children. Pediatr Dermatol. 2022;39(2):326-27. https://doi.org/10.1111/pde.14911
36. Nadelman DA. Tinea incognita with secondary bacterial infection. J Dermatol Dermatol Surg. 2022;26(Suppl 1):S26-8. [Google Scholar]
37. Babakoohi S, McCall CM. Dermatophytosis incognito mimicking cutaneous T-cell lymphoma. Cureus. 2022;14(6):e25809. [PubMed] [Google Scholar]
38. Klein EJ, Karim M, Kushner CJ, Marji JS, Adotama P, Sicco KL, Shapiro J. Enlarging alopecic patch in an African American woman with central centrifugal cicatricial alopecia: a case of concomitant tinea incognito. JAAD Case Rep. 2022;23:67-9. [PubMed] [Google Scholar]
39. Fernandes D, Kwan E, Lenz B. A worsening abdominal rash. J Fam Pract. 2022;71(10):439-41. [PubMed] [Google Scholar]
40. Absil G, Sabatiello M, Nikkels A. Tinea pseudoimbricata. JAMA Dermatol. 2022;158(5):574. [PubMed] [Google Scholar]
41. Suzuki T, Sato T, Horikawa H, Kasuya A, Yaguchi T. A case of tinea pseudoimbricata due to *Trichophyton tonsurans* induced by topical steroid application. Med Mycol J. 2021;62(2):67-70. [PubMed] [Google Scholar]
42. Hynes J, Laing M, Ridge A, Ready K. Tinea incognito mimicking a gyrate erythema in the setting of common variable immunodeficiency. Br J Dermatol. 2022;187(Suppl 1):113.
43. Wang XD, Liu ZH. Disseminated tinea incognito due

**ISSN: 0019-5138**
**DOI: https://doi.org/10.24321/0019.5138.202521**

to *Trichophyton violaceum* in a healthy child. Int J Infect Dis. 2022;122:368-72. https://doi.org/10.1016/j.ijid.2022.06.018
44. Hidayah RM, Anjani AD, Ramali LM, Suwarsa O, Gunawan H. Exfoliative dermatitis due to dermatophytosis. J Infect Dev Ctries. 2021;15(2):306-9. [PubMed] [Google Scholar]
45. Kalkan G, Demirseren DD, Güney CA, Aktas A. A case of tinea incognito mimicking subcorneal pustular dermatosis. Dermatol Online J. 2020;26(2):13030/qt46g9x55w. [PubMed] [Google Scholar]
46. Turra N, Navarrete J, Magliano J, Bazzano C. Follicular tinea faciei incognito: the perfect simulator. An Bras Dermatol. 2019;94(3):372-4. [PubMed] [Google Scholar]
47. Li S, Tang Z, Liu T, Liu Z, Yang S, Li F. Tinea incognito caused by *Trichophyton interdigitale*. Mycopathologia. 2023;188(3):283-5. [PubMed] [Google Scholar]
48. Steele L, Hong A, Balogh P , O'Toole, E. A., Harwood, C. A., & Maruthappu, T. Disseminated tinea incognito in a patient with ichthyosis vulgaris and eczema. Clin Exp Dermatol. 2021;46(1):210-2. https://doi.org/10.1111/ced.14406
49. Sekulic J, et al. Tinea incognito manuum—a case report. J Dermatol Nurses Assoc. 2020;12(2):85-7. https://doi.org/10.1097/JDN.0000000000000526
50. Dell'Antonia M, Mugheddu C, Ala L, Lai D, Pilloni L, Ferreli C, Atzori L. Dermoscopy of tinea incognito. Mycopathologia. 2023;188(4):417-8. [PubMed] [Google Scholar]
51. Lim SS, Shin K, Mun JH. Dermoscopy for cutaneous fungal infections: A brief review. Health Sci Rep. 2022;5(1):e464. https://doi.org/10.1002/hsr2.464
52. Yin B, Ran X, Zhang C, Xie Z, Ran Y, Fu L, Pradhan S. Tinea incognito infection with *Trichophyton erinacei* from a pet hedgehog. Br J Dermatol. 2020;183(4):e92. [PubMed] [Google Scholar]

**ISSN: 0019-5138**
**DOI: https://doi.org/10.24321/0019.5138.202521**