



Infammatory Tinea Barbae – Still a Difficult Diagnostic Problem

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Clinical Image

Tinea barbae is a disease of males and almost always occurs in farmers, veterinarians and others with exposure to large animals [1,3]. It is easily recognized by dermatologists but for the other specialists it can be difficult to recognize.

A 33-year old men, farmer, was admitted to Department of Dermatology, Venerology and Allergology on June 2018. At the day of admission he presented a severe, deep folliculitis with erythema, nodular infiltrates, scales, crusts and pustules located at face and neck accompanied by lymphadenopathy (Figures 1-3). Beside this, patient was in good general condition and complained about pain localized on the face and neck .The first skin lesions appeared two weeks before admission. He was consulted by family doctor then and Amoxicillin wilt clavulonic acid in the total dose of 1.0g twice a day p.o. was prescribed. The patient observed exacerbation of skin lesions in the course of antibiotic therapy – the new inflammatory nodules with purulent discharge appeared. Additionally the elevated temperature 38.2°C was noticed so he went to Emergency Department where he was treated with cefuroxim 500mg p.o. twice a day and topical metronidazol cream twice a day together with metamisol 500mg p.o. twice a day. Despite receiving topical and systemic treatment, the progression of the disease was observed by the patient. Due to lack of improvement after following three days he was sent for dermatological consultation to Department

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Figure 1: At the admission: deep folliculitis with erythema, nodular infiltrates, scales, crusts and pustules located at face and neck accompanied by lymphadenopathy.



Figure 2: At the admission: deep folliculitis with erythema, nodular infiltrates, scales, crusts and pustules located at face and neck accompanied by lymphadenopathy.



Figure 3: At the admission: deep folliculitis with erythema, nodular infiltrates, scales, crusts and pustules located at face and neck accompanied by lymphadenopathy.



Figure 5: Clinical improvement after 4 weeks of treatment.



Figure 4: Clinical improvement after 4 weeks of treatment.



Figure 6: Clinical improvement after 4 weeks of treatment.

of Dermatology, Venerology and Allergology Medical University of Gdansk. Direct mycological examination of hair of barbe and skin scales confirmed fungal etiology of disease. The culture collected at the day of admission after 4 weeks of incubation showed *Trichophyton mentagrophytes*. Laboratory tests showed the following abnormalities: elevated CRP 81mg/l, WBC 16.0 G/l, neutrophils 11.98 G/l. The liver and kidney function were normal. Terbinafine in the dose of 250mg p.o. and topical super oxidised solution as well as cyclopirox cream were prescribed. After 4 weeks of treatment big clinical improvement and pain withdrawal were noticed (Figures 4-6). The prescribed treatment will be continued by the patient up to complete remission and negative mycological culture.

Because zoophilic organisms are the most common culprit and due to the large number of terminal hair follicles in the affected areas, the clinical presentation tends to be severe, with intense inflammation and multiple follicular pustules. Abscesses, sinus tracts, bacterial super infection and even kerion-like boggy plaques can develop. Patients may have constitutional symptoms such as malaise as well as lymphadenopathy like in presented case. The conditions that can mimic tinea barbae include bacterial folliculitis, viral infections, acne vulgaris and cervicofacial actinomycosis. Mycological examination is absolutely essential to establish the right diagnosis [1-6].

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