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Diagnosis at first sight

Painful furuncles and abscesses in the genital area associated with functional impairment☆

Forúnculos y abscesos dolorosos en el área genital asociados a impotencia funcional

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Case report

We present the case of a 30-year-old woman, with no relevant medical/surgical history, seen in the emergency department with a four-month history of lesions in her pubic region, associated with very intense pain and making it difficult for her to walk. The patient reported the onset of the condition with small pustules, located exclusively in the pubic region, with subsequent progression to both inguinal folds. She had been assessed on several previous occasions and had received treatment with corticosteroids and topical antibiotics (fusidic acid), and oral antibiotics (cloxacillin 500 mg/6 h, 7 days and amoxicillin-clavulanic acid 875/125 mg/8 h, 7 days), with no improvement. She denied contact with children, travel outside of Spain or risky sexual behaviour, but she did report close contact with horses while horseback riding.

On physical examination, the patient was afebrile, but had erythematous-scaly papules and plaques affecting the inguinal/pubic region symmetrically, with the presence of serosanguinous, meliceric crusts on the surface. Many of the lesions had follicles in the centre and felt infiltrated to the touch, but with no fluctuation on palpation (Fig. 1). There were no lesions in other intertriginous areas or in any other location.

Blood tests showed a slight increase in acute phase reactants: leukocytes 11,600/μl, with neutrophils 8,700/μl. A skin biopsy was taken for histopathological study, along with an exudate sample from the contents of a pustule and a skin biopsy for culture of bacteria, fungi, mycobacteria and viruses. After taking the samples, it was decided to admit the patient for pain control and she was started on empirical antibiotic treatment with clindamycin and ciprofloxacin and local treatment with zinc sulfate-soaked compress and topical mupirocin.

Fig. 1. Clinical image: erythematous oedematous papules, infiltrated to the touch, with follicle in the centre, with the presence of serosanguinous and, in some areas, meliceric crusts, confluent in the pubic region, extending to the labia majora and the bilateral inguinal area.

Outcome

Despite the prescribed treatment and the fact that the patient was afebrile with return to normal of inflammatory parameters, the skin lesions did not improve. The skin biopsy results 72 h after admission reported the presence of a dense inflammatory infiltrate of fragmented neutrophils located in the middle and deep dermis, with abscessing foci but no alterations in the epidermis; the stains carried out for the detection of microorganisms (PAS, Grocott, Ziehl-Neelsen and Gram) were negative.

The microbiological study identified *Microsporum canis* in the scale scraping by direct examination with calcofluor-white staining, isolation in Dermatophyte Test Medium and microscopic identification with Lactophenol Blue stain. Treatment was started with itraconazole 100 mg/day, with a spectacular improvement, and the patient completed a six-week course until the condition was completely resolved.

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Comments

Dermatophytoses are a group of fungal skin infections caused by three types of fungi: *Microsporum*, *Trichophyton* and *Epidermophyton*.[1] They are characterised by their ability to infect and invade keratinised tissues, such as skin, hair and nails.[2,3] Pubogenital *tinea* or *tinea genitalis* is an uncommon type of dermatophytosis[4], although in view of the increase in its incidence in recent years, it is probably on the rise[5]. It affects the pubis and inguinal regions, and may also affect the shaft of the penis in men and the labia majora in women.[6] It could be considered a form of *tinea cruris*, but its clinical and microbiological characteristics make it a different entity.[4]

It is a highly inflammatory form of dermatomycosis, with a high tendency towards deepening and follicular involvement,[7] which can progress to ulceration, systemic involvement (fever, elevation of acute phase reactants) and/or intense pain which causes great functional impairment and may require admission to hospital for pain control. Differential diagnosis should be made with hidradenitis suppurativa, chronic inflammatory dermatosis of the sweat glands and bacterial folliculitis. Ginter-Hanselmayer et al.[8] described a series of 30 cases of genital tinea. The most common causative dermatophyte was *M. canis*, followed by different species of *Trichophyton*. Among the predisposing factors, depilation and the concomitant presence of *tinea pedis* and onychomycosis have been reported[8]; the sexual route[5] and contact with animals have been described as forms of direct transmission. The therapeutic regimens with the best response are itraconazole and terbinafine, as has been demonstrated in studies of *M. canis* susceptibility to antifungals.[9,10] In conclusion, in patients with compatible genital skin lesions associated with intense pain and/or systemic involvement, *tinea genitalis* should be considered as a differential diagnosis. The use of suitable microbiological techniques is essential for isolation of the pathogen and optimal management and treatment.

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