Treatment of candidal intertrigo with a topical combination of isoconazole nitrate and diflucortolone valerate

Bilal Dogan and Ozlem Karabudak

GATA Teaching Hospital Department of Dermatology/GATA Haydarpasa Egitim Hastanesi, Uskudar/Kadikoy, Turkey

Key words: Isoconazole, diflucortolone, candidal intertrigo

Background

Candidal intertrigo is a relatively common infection in Turkey especially in the summer season. Fungal infections, including candidal ones, are a large part of the workload in our clinic every season. The case described here represents candidal intertrigo under the breasts, which responded well to topical therapy with an isoconazole nitrate and diflucortolone valerate combination cream followed by topical imidazole.

Case report

Patient history

A 34-year-old female presented to our clinic with candidal intertrigo and atopic dermatitis. The latter was under control with antihistamines and topical steroids. She stated that she had used different topical steroids twice daily for the candidal infection. At first she did obtain some symptomatic relief from the medication but her clinical condition had worsened afterwards while on this therapy. She admitted to our department that she had not used the topical steroids consistently as she was dissatisfied with their overall effectiveness and that the disease area had spread.

Dermatological findings

The patient had erythema and a little moist exudation starting deep in the folds of intermammary and submammary areas which had resulted in lesions initially under the left breast and that were now spread further up the chest area (Fig. 1).

Investigation and diagnosis

A native preparation with potassium hydroxide solution was prepared and a pseudohyphae pattern consistent with a diagnosis of candidal intertrigo of the intermammary and submammary area was observed. Mycological culture supported this diagnosis.

Treatment and outcome

Topical therapy with isoconazole nitrate in combination with diflucortolone valerate cream (Travocort©, Intendis, Berlin, Germany) was prescribed. This was to be applied twice a day to the affected areas of the breasts. Within a few days the patient reported that the erythema became pale and pruritus and scaling diminished rapidly. There were no side effects of the

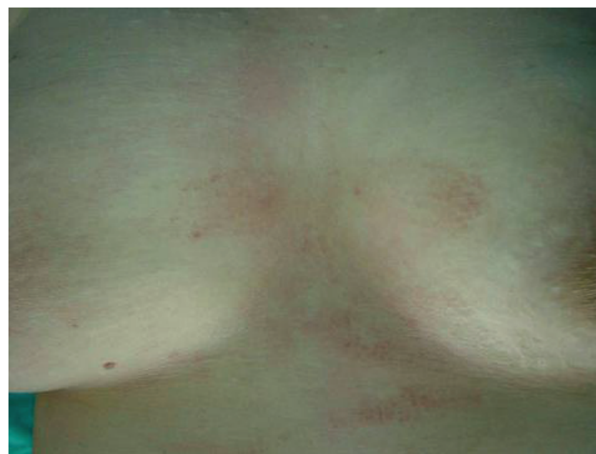

Figure 1 Pre-treatment findings, the patient had candidal intertrigo of the intermammary and submammary area.

Correspondence: Bilal Dogan, GATA Teaching Hospital Department of Dermatology/GATA Haydarpasa Egitim Hastanesi, Tibbiye Cad., 81327 Uskudar/Kadikoy, Turkey.
E-mail: gatadermdogan@yahoo.com

Accepted for publication 8 July 2008

© 2008 The Authors

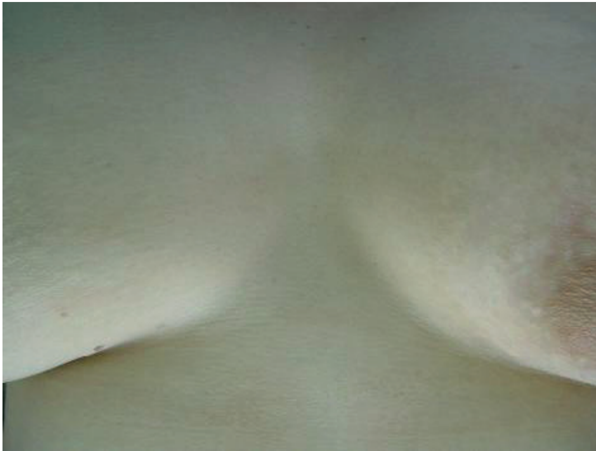

Figure 2 Findings after treatment with topical isoconazole/corticosteroid combination for 1 week followed by topical imidazole for 3 weeks.

treatment. At end of 7 days treatment with the isoconazole/diflucortolone cream, switching to topical imidazole for a further 3 weeks was recommended. At the end of this 4-week treatment period the patient's dermatological findings were negative (Fig. 2). Culture samples were also negative for *Candida* species.

Conclusion

Most cases of cutaneous candidiasis occur in skin folds where occlusion causes abnormally moist conditions as was the case in our patient. Due to pre-existing atopic dermatitis she was at risk of superficial fungal infection and she contracted a candidal infection of the skin under the breasts where the skin had become macerated. Patients with atopic dermatitis are treated mostly with topical steroids; however, these medications do not reduce the risk of superficial fungal infection, especially candidial infection in the flexural areas.

In cases with fungal infections characterised by moderate-to-severe cutaneous inflammation, as seen in our patient, topical antifungal combined with corticosteroid cream will not only ease the inflammation and decrease pruritus, but also increase patient's compliance with the treatment. Treatment of the non-inflamed superficial fungal infection should then proceed with single-agent topical antifungal preparations.

Conflict of interest

The authors have no conflict of interest.

© 2008 The Authors