Tinea cruris treated with a combined topical therapy containing isoconazole and a corticosteroid

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Key words: Tinea cruris, isoconazole, corticosteroid

Background

In South Africa, tinea is the fifth most common cutaneous manifestation of HIV and AIDS, with other opportunistic fungal infections such as candidiasis being the 11th most frequent cause of skin complaints in immunocompromised patients.[1] The overall incidence of tinea in Sub-Saharan Africa was reportedly 78 million in 2005.[2]

Case report

Patient history

A 44-year-old male presented with a rash between the legs of 3 months' duration. The rash was itchy, red, scaling and inflamed and had not been treated previously.

The patient was a store manager and stated he had no regular contact with animals at work or at home. He was diagnosed with type 2 diabetes mellitus in 2001 and was being treated via diet and exercise. His blood glucose reading was 13.5 mmol l^{-1} and his body mass index amounted to 36.3 kg/m^2.

Dermatological findings

The rash is erythematous and approximately 7 cm by 4 cm in size. There are signs of skin scaling and inflammation (Fig. 1).

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Investigation and diagnosis

The dermatological findings were indicative of a tinea dermatomycosis and therefore microscopic and culture studies were not deemed necessary. A diagnosis of tinea cruris was made.

Treatment and outcome

The patient was treated with a twice-daily application of a combined antifungal and corticosteroid cream containing isoconazole nitrate and diflucortolone valerate (Travocort®; Indendis, Berlin, Germany). The patient also began treatment with metformin 850 mg twice a day to bring his diabetes under better control.

At his first follow-up visit 1 week later, the patient reported that he was suffering from less pruritus and

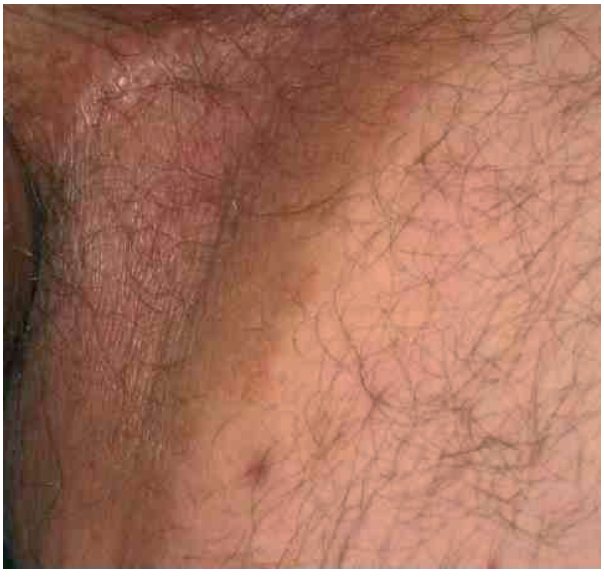

Figure 1 Dermatological findings at presentation.

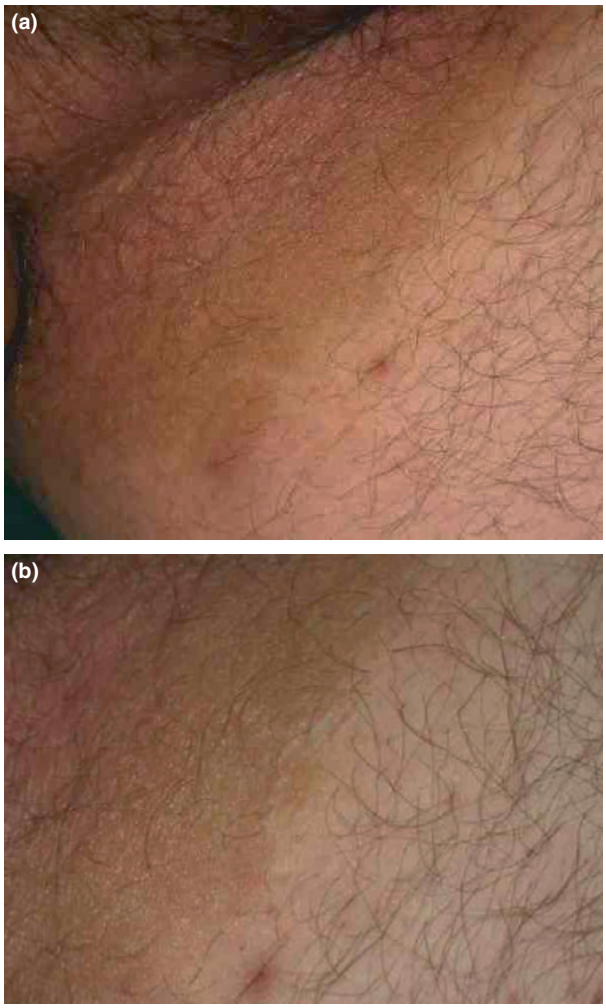

Figure 2 Dermatological findings at (a) 1 week and (b) 2 weeks follow-up.

upon examination the rash and scaling had subsided. The affected area was less erythematous and less inflamed (Fig. 2a). The patient's blood glucose level had improved and was 11.5 mmol l^{-1}. The patient was satisfied with the results obtained and experienced no adverse effects due to the topical cream.

By the following week, 2 weeks after the cream was first applied, the skin lesion was noticeably improved (Fig. 2b). The patient experienced less itching, erythema and scaling. Although not related to the isoconazole/diflucortolone cream, the patient developed a mild folliculitis on the thighs and this was treated with an antibiotic (amoxicillin/clavulanate potassium at a dose of 1 g applied twice a day).

Conclusion

This case highlights the successful use of a combined antifungal/corticosteroid cream in treating tinea of the inner thigh in an obese, diabetic patient. Although mycological examination was not performed, the patient's symptoms were most likely due to tinea cruris and rather than delaying therapy it was decided to treat immediately with the topical cream. The therapy chosen is active against a range of fungi that are known to cause tinea and therefore the patient was able to obtain fast relief of his discomforting symptoms. The patient is more susceptible to fungal infections due to diabetes. Irrespective of this drawback the Travocort® combination drug did clear the fungal infection.

Conflict of interest

The author has no conflict of interest.

References

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