Tinea guide

Assess patient's needs

A. Patient characteristics

The age and pregnancy status (if female and of child-bearing age) of the patient should be determined because these will affect the advice provided.

B. Symptoms

The location, appearance and severity of the lesions will help with deciding on the appropriate recommendation. Different presentations of tinea include:

- *Tinea pedis* (athlete's foot)[1–3]
  - interdigital—the most common form; starts with fissuring, maceration, erythema, scaling and itching between the fourth and fifth toes. It may eventually extend to the plantar surface (sole) of the foot
  - chronic hyperkeratotic—known as 'moccasin' *tinea pedis*. The soles, heels and sides of the feet become scaly and thickened. Itching, pain and inflammation may be slight or severe
  - vesiculobullous—characterised by painful, itchy vesicles, usually on the soles, with persistent redness and scaling after the vesicles rupture
  - ulcerative—rapidly spreading vesiculopustular lesions, ulcers and erosions, typically in the web spaces. Usually accompanied by a secondary bacterial infection. Occasionally large areas, even the entire sole, can be sloughed. Commonly seen in immuno-compromised and diabetic patients.
- *Tinea corporis* (ringworm)—single or multiple annular, scaly lesions with central clearing, a slightly elevated, reddened edge and sharp margination on the trunk, extremities or face. The border of the lesion may contain pustules or follicular papules. Itching is variable.[1]
- *Tinea cruris*—presents in the groin area as large patches of erythema with central clearing and pustules and vesicles at the active edge of the infected area. In acute infections, the rash may be moist and exudative, whereas chronic infections are usually dry. Patients complain initially of intense itching, but if maceration and superinfection occur, the lesions will become painful. May spread to the buttocks or lower thighs. The scrotum and penis are generally not affected, unlike candidal infections in this area.[1,3]
- *Tinea unguium* (onychomycosis)—a dermatophyte infection of the nails, which thicken and become chalky and dull. Brownish-yellow debris forms beneath the nail, causing it to separate from its bed. About half of those affected experience pain.[3]
- *Tinea capitis*—the most common dermatophytosis in children. Characterised by patches of alopecia and scaling on the scalp. An immune response termed a 'kerion', which is a boggy, sterile, inflammatory scalp mass, may also occur.[1,3]

C. Medical and lifestyle history

The presence of other medical conditions and other medications being taken will affect the advice provided. Risk factors for developing tinea include[2,4,5]:

- prolonged use of occlusive footwear
- a hot, humid, tropical environment
- hyperhidrosis (excessive perspiration)
- activities such as swimming and communal bathing
- contact with infected animals (e.g. cats, cattle)
- diabetes
- HIV or other conditions affecting the immune system
- medications affecting the immune system, (e.g. cyclosporin, azathioprine)
- occupation (e.g. farm worker, zookeeper, lab worker, vet)
- sports and hobbies (e.g. gardening, contact sports, use of sports facilities, animals).

D. Prior treatment

Prior use of, and the patient's response to, tinea medications will help determine either the need for referral or the type of treatment recommended.