Sir,
Dermatophyte infection of the penis and scrotum is rare. It is difficult to explain why the penile shaft is generally not involved in patients affected by tinea cruris. Glans penis involvement is considered even rarer,[1] whereas dermatophytosis of the prepuce has not been reported in the literature. Here we report a patient who presented with scaly lesion on the prepuce, which on investigation was found to be due to *Trichophyton rubrum*.

A 29-year-old male presented with itching and burning sensation of the preputial sac since the last ten days. He was married and denied history of any extramarital sexual exposure in the recent or remote past. On further enquiry he gave the history that his wife had got ringworm infection of the groin and anterior abdomen but did not have any history of vaginal discharge. On examination, the uncircumcised prepuce showed an erythematous, moist lesion with raised margins (Figure 1). The border of the lesion revealed the presence of moist scales. There was no scaling or any other lesion on the glans, or on the shaft of the penis, scrotum, intertriginous area or elsewhere on the body. The patient was otherwise in normal health.

On investigation, routine examination of blood, serum glucose, VDRL and HIV status could reveal no abnormality. A 10% potassium hydroxide smear prepared from the scaly area of the lesion showed the presence of fungal hyphae. Culture on Sabouraud’s dextrose agar media with gentamicin grew *Trichophyton rubrum*. He was treated with 1% clotrimazole gel and started improving in a few days; a repeat culture after contamination or delay in processing the specimen in the laboratory. *Trichophyton rubrum* was the commonest organism, isolated in 17.3% of the cases. Most Indian and western studies have also proved *T. rubrum* as the commonest offending agent.[3,4]

Hence, the factors found responsible for chronicity were (1) onychomycosis (2) body surface area of involvement (3) prolonged sun exposure and (4) diabetes mellitus.

REFERENCES


---

**Trichophyton rubrum Infection of the prepuce**

Figure 1: *Trichophyton rubrum* infection on the prepuce
two weeks failed to show growth of any fungus.

Dermatophyte infection from the inguinal area may extend to the scrotum and uncommonly to the penis, but rarely occurs on the glans or prepuce.\textsuperscript{[2-4]} In the present case the provisional clinical diagnosis was Candida infection of the prepuce, however a ring-like configuration with central clearing and mild scaling at the border prompted the 10% KOH smear and subsequent culture, which proved the infection to be of T. rubrum.

It is widely accepted that dermatophytes are keratinophilic in nature and they invade their host by enzymatic digestion of the keratin. However, many workers have been unable to demonstrate enzymes produced by dermatophytes with keratin-specific proteinase activity. In vitro, non-keratin substances extracted from keratinized tissues will support the growth of dermatophytes much better than the keratin.\textsuperscript{[5]} This may be true for the present case, since anatomically the glans penis and inner surface of the prepuce are covered with non-keratinized epithelium. Also the uncircumcised preputial surface is continually moist and may accumulate smegma, which is an excellent medium for the growth of pathogens. Tropical climate also plays an important role in the pathogenesis of dermatophytosis of the genitalia.\textsuperscript{[6]} In the present patient, probably all these factors led to dermatophyte infection in a rare site, perhaps from contact with the spouse’s ringworm infection during sexual activity.

There have been some reports of extensive and persistent cases of tinea corporis in which dermal and subcutaneous involvement has been a feature. A few cases of deep dermatophytoses affecting bone, the central nervous system and lymph nodes, have been reported, but no satisfactory explanation for this highly unusual behavior of the dermatophytes is yet available.\textsuperscript{[9]}

\textbf{Amiya Kumar Mukhopadhyay}

Consultant Dermatologist, Asansol, Kolkata, India

Address for correspondence: ‘Pranab’, Ismile (near Dharmaraj Mandir), Asansol - 713301, Dist. Burdwan, West Bengal, India.

E-mail: dramiyaurmi@yahoo.co.in

\section*{REFERENCES}


\section*{Familial speckled acral hypopigmentation: A new variant of reticulate acropigmentation?}

\textbf{Sir,}

Reticulate acropigmentation disorders include reticulate acropigmentation of Kitamura (RAPK), Dowling Degos disease (DDD), acropigmentation of Dohi and dyschromatosis universalis heredetaria (DUH). While RAPK and DDD are characterized by hyperpigmentation, acropigmentation of Dohi and DUH have both hyper and hypopigmentation. Herein we report a case who has hypopigmentation in a speckled fashion on the sides of the dorsa of both the hands and feet.

A girl aged 14 years presented with speckled hypopigmentation on the sides of the dorsa of the hands and feet (Figures 1 and 2). On enquiry she informed that her elder sister and cousin had similar lesions. Unlike other reticulate hypopigmentations they were confined only to the sides rather than the whole dorsa of feet and/or hands. Atrophy or pits on the dorsa and/or palms were absent. The pattern looked speckled due to hypopigmented macules of more or less uniform size (2-4 mm) on a background of normal colored skin.