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Clinical Study of Dermatophytosis Among a Sample of Patients Attending to Imamein Kadhimein Medical City

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ABSTRACT

Dermatophytosis or ringworm is a cutaneous diseases caused by dermatophytes which have ability infect keratein enrichment parts of body, such as the skin, hair, and nails. Globally, dermatophytosis is considered one of the most common skin diseases in the world. The clinical manifestations range from a scaling annular patch to severe inflammation and hair, nail loss.

The aim of this study is to determine different clinical characteristics of dermatophytosis infection patients and associated with studied variables.

A cross-sectional study was conducted at Imamein Kadhimein Medical City in Baghdad, encompassing 350 patients diagnosed with dermatophytosis at the dermatology clinic. The data collection is done by a standardized questionnaire designed to ensure sociodemographic factors, medical history, clinical manifestations of the disease, and treatment details.

The results showed that Tinea corporis was most common in females (55.6%), especially among those aged 30–39, while males showed more affected with tinea cruris (82.5%) and tinea capitis (60%). The most Body affected area included the trunk (20.6%) and groin (18.2%), with fingers being least affected (1.4%). Acute infections accounted for 76.3%, with summer had the highest rate of infection (56.6%). The majority of patients had 2–3 lesions (58.3%), and 36.6% experienced symptoms lasting 1–3 months.

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1- INTRODUCTION

Dermatophytosis is cutaneous fungal infection which are primarily caused by filamentous dermatophyte fungi and consider among the most prevalent fungal infections worldwide. dermatophytosis also called tinea or ringworm, is caused by species of the genera *Trichophyton, Microsporum*, and *Epidermophyton* [1]. Dermatophytes can cause symptoms including scaling of skin brittle hair and disintegrating nails by infecting the keratinized tissues of humans and other animals. However, due to these fungi are unable to penetrate epidermal layers of the skin, deeper tissues or organs of hosts with immune defenses, the infection limited to the keratinized layers. The keratinophilic and keratinolytic capabilities of dermatophytes are two of their main features [2].

Tinea usually appears as an annular patch with a central clearing and an approaching, elevated, and scaled edge. These characteristics may vary in intensity, causing inflammation and scaling that can cause permanent scarring or

hair loss. Severe cases of dermatophytosis are distinguished by severe inflammation and plainly recognized erythematous signs. Other mild to severe clinical indications include scaling, vesicle development, crusting, pruritus, maceration, discomfort, and erythema [3].

Dermatophyte infections can be spread through a variety of methods, including direct contact with an infected person (anthropophilic), direct contact with an infected animal (zoophilic), direct contact with contaminated soil (geophilic), or indirect contact through contaminated bedding, combs, or hair ties. The susceptibility to infection varies depending on age and the health of the exposed skin. Dermatophyte infections are notably prevalent among children, primarily due to inadequate personal hygiene practices and suboptimal environmental sanitation[4].

Dermatophytosis frequently has a chronic nature and may require years for a full cure. The extended duration of the disease substantially damages the quality of life, impacting people both psychologically and emotionally. Notably, quality of life has become an essential measure in evaluating illness progression and treatment outcomes. Additionally, the financial burden connected with the condition varies greatly among individuals, appearing as a key factor that can influence the perceived severity and length of the disease. This financial difficulty could act as a confounding variable, further complicating the assessment of disease impact [5].

2- METHOD

A cross-sectional study was conducted at the dermatology and venereology clinic Imamein Kadhimein Medical City in Baghdad, between 22th /January /2024 to 29 /July/2024. the study encompassing 350 patients diagnosed with dermatophytosis. The data collection is done by a standardized questionnaire. The association of dermatophytosis infection to the patients was investigated in terms of the following aspects: ensure sociodemographic factors, medical history, clinical manifestations of the disease, and treatment details.

3- RESULTS

This a cross-sectional study comprised 350 dermatophytosis patients, tinea corporis is high percentage in the 30-39 age group (37.9%) and the 10-19 age group (36.9%). Around 53.3% of cases are under the age of 10, and 18.5% of those in the age group 10-19 are affected with tinea capitis. tinea cruris was seen in the 30-39 age group (21.2%) and in the 40-49 age group (25%). Tinea pedis was common in the 60-69 age range, accounting for 12.5% of cases, while tinea manuum 25.0% of cases and tinea unguium most common in above 50 years age group. as table (1).

Table 1: Distribution of dermatophytosis clinical types among age groups

Dermatophytosis clinical types	**Age group**													
	<10		**10-19**		**20-29**		**30-39**		**40-49**		**50-59**		**60-69**	
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Tinea corporis	10	33.3	24	36.9	21	25.0	25	37.9	15	34.1	12	32.4	6	25.0
Tinea unguium	0	.0	6	9.2	6	7.1	3	4.5	2	4.5	5	13.6	3	12.5
Tinea pedis	0	.0	0	.0	3	3.6	8	12.1	2	4.5	3	8.1	4	16.7
Tinea capitis	16	53.3	12	18.5	11	13.1	3	4.5	2	4.5	0	.0	1	4.2
Tinea faciei	4	13.3	6	9.2	8	9.5	4	6.1	4	9.1	3	8.1	1	4.2
Tinea cruris	0	.0	6	9.2	21	25.0	14	21.2	11	25.0	4	10.8	1	4.2
Tinea manuum	0	.0	5	7.7	6	7.1	5	7.6	5	11.4	6	16.2	6	25.0
Tinea barbae	0	.0	1	1.5	0	.0	0	.0	1	2.3	0	.0	0	.0
Tinea incognito	0	.0	5	7.7	8	9.5	4	6.1	2	4.5	4	10.8	2	8.3
Total	**30**	**100**	**65**	**100**	**84**	**100**	**66**	**100**	**44**	**100**	**37**	**100**	**24**	**100**
P value	0.0001*													

*Significant difference between percentages using Pearson Chi-square test (x^2-test) at 0.05 level.

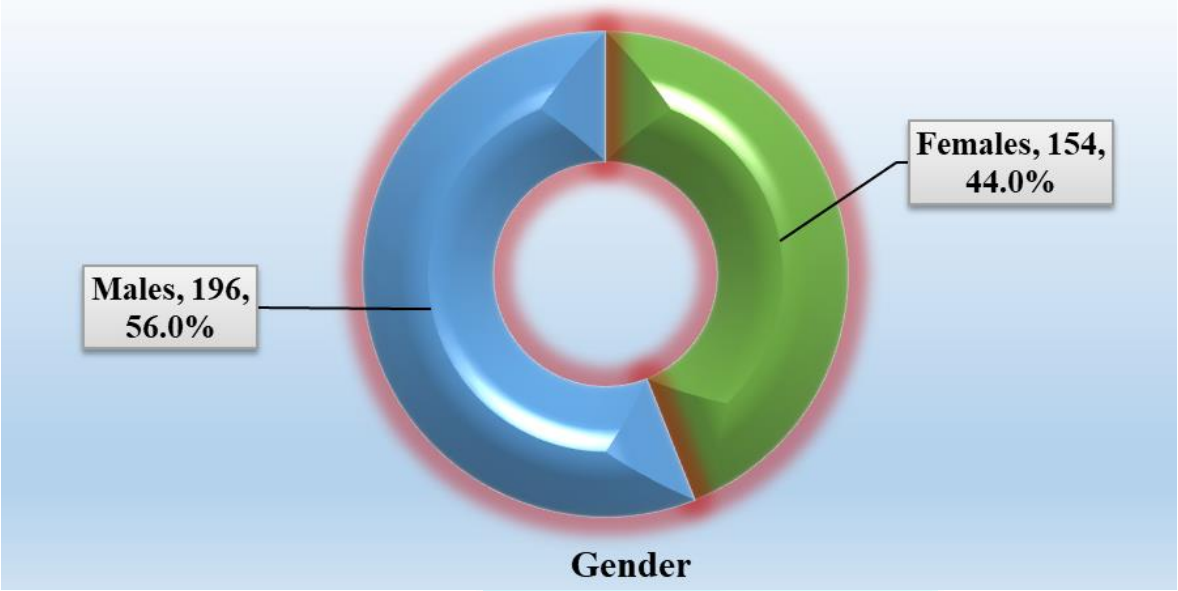

Figure1: Distribution of patient's gender

The association between the clinical types of dermatophytosis and patient sex, indicating that tinea corporis occurs more frequently in females (55.6%) compared to males. In contrast, tinea cruris is more common in males (82.5%), while tinea capitis is observed in 60 % of males, where tinea unguium and tinea manuum more in females counting 52%,59.4% respectively. As table (2)

Table 2: Association between the clinical types of dermatophytosis and the sex of patients

Clinical type of dermatophytosis	Gender			
	Male		Female	
	No.	%	No.	%
T. corporis	52	44.4	65	55.6
T. unguium	12	48.0	13	52.0
T. pedis	10	55.6	8	44.4
T. capitis	27	60.0	18	40.0
T. faciei	16	55.2	13	44.8
T. cruris	47	82.5	10	17.5
T. manuum	13	40.6	19	59.4
T. barbae	2	100	-	-
T. incognito	17	68.0	8	32.0
P value	0.0001*			
*Significant difference between percentages using Pearson Chi-square test (x^2-test) at 0.05 level.				

The trunk, groin area, and upper limbs exhibited most affected body area, at approximately 20.6%, 18.2%, 16.6% respectively, while the fingers accounted for the lowest percentage, representing 1.4% of cases. In terms of lesions, 2–3 lesions are associated with a high percentage of 58.3%, while the presence of more than 10 lesions corresponds to the lowest percentage of 4.6% of patients. As table (3)

Table 3: Distribution of site and numbers of lesions

		No.	%
Site of lesion	Scalp	50	14.3
	Face	37	10.6
	Upper limbs	58	16.6
	Fingers	5	1.4
	Finger nails	14	4.0
	Trunk	72	20.6
	Toe	16	4.6
	Lower limbs	22	6.3
	Toe nails	12	3.4
	Groin areas	64	18.2
Number of lesions	1	117	33.4
	2--5	204	58.3
	6--10	16	4.6
	=>10 lesions	13	3.7

Table (4) presents the clinical manifestations of dermatophytosis. A total of 95.7% of patients experienced itching, redness, and scaling in the affected areas. Additionally, 90% reported pain or discomfort, 55.4% exhibited pus-filled blisters, oozing, or crusting, and 19.4% experienced changes in the appearance of nails or hair.

Table (4): Clinical manifestation of dermatophytosis

Clinical manifestations	No.	%
The affected areas itchy, red, or scaly	335	95.7
Experience any pain or discomfort in affected areas	315	90.0
Changes in the appearance of your nails or hair	68	19.4
Note pus-filled blisters, oozing, or crusting in the affected areas	194	55.4
Worsening of symptoms after exposure to certain triggers	334	95.4

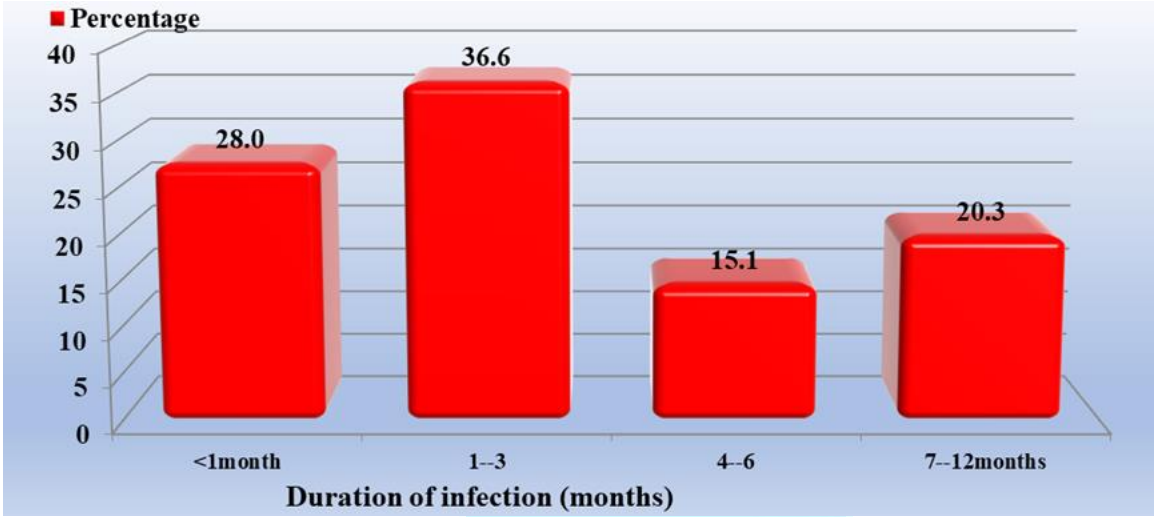

Figure (2): Duration of infection

The duration of illness is shown in Figure 4.4 The highest frequency was 36.6% for the duration of 1-3 months, 28% for less than a month, and 15.1% for the duration of 7-12 months

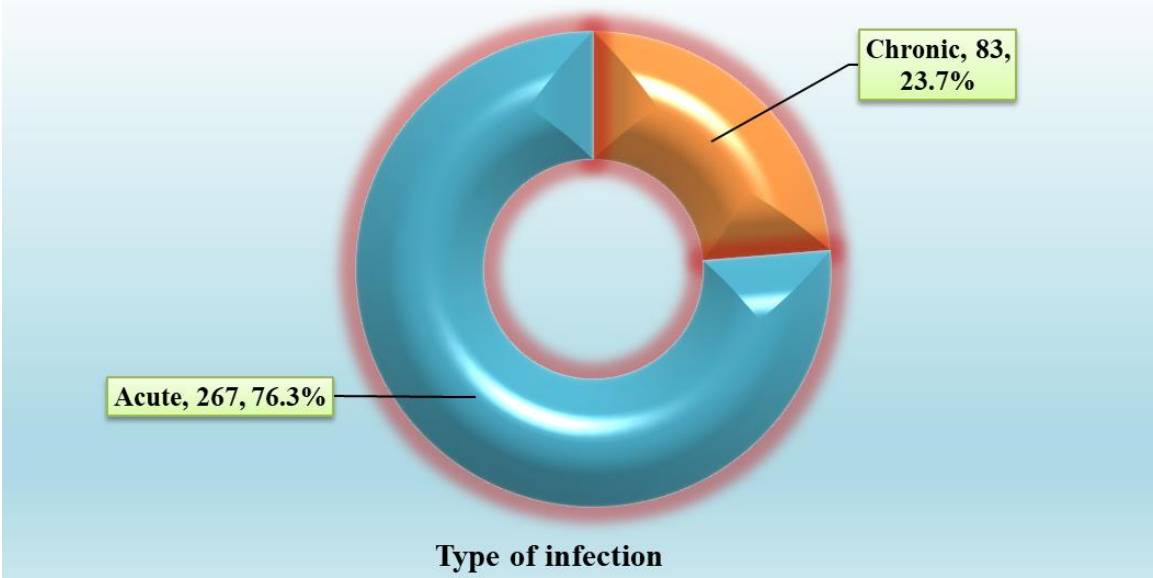

Figure (3) Type of infection

Figure3 shows that 76.3% of dermatophytosis patients had acute infection, while 23.7% of cases had chronic infection.

Figure 4: (A) Tinea corporis (B) Tinea unguium (C) Tinea barbae

Figure 4 : presents clinical manifestation of dermatophytosis where an rings-like patch with a central clearing and an approaching, elevated, and scaled edge and yellowish and brittle nails in tinea unguium case.

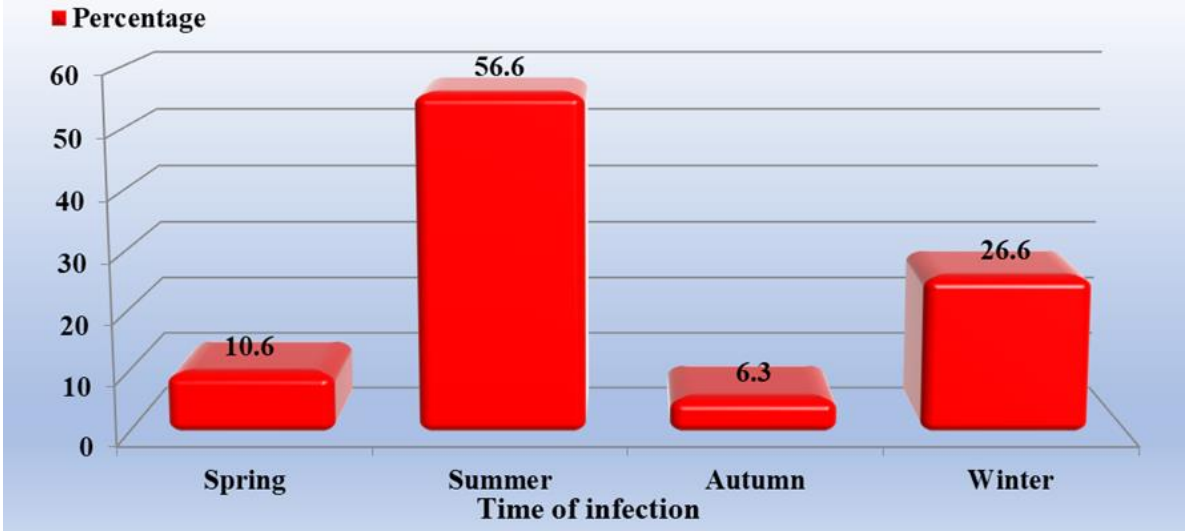

Figure (5): Time of infection

According to this figure, dermatophytes infection is more common in the summer (56.6%), followed by winter (26.6%), then springs (10.6%), and low frequency in the autumn (6.3%).

4- DISCUSSION

The present study identifies dermatophytosis is more common in the 30-39 age group, underscoring middle-aged people, susceptibility to fungal infections. This age group had the highest percentage of tinea corporis (37.9%) and tinea cruris (21.2%), these findings agreement with Bhatt [6], Ali [7], and Kannan [8] studies. The tinea capitis was widespread in children under 10 years of age, including 53.3%; this agreement with Mohammed [9] in Baghdad. These results underscore the considerable burden of this disease among people of younger ages, especially school-aged children, who are more vulnerable due to contact with peers, the sharing of personal things,

and many hygiene-related issues prevalent in school environments. Similarly, Raju [10] and Hibstu [11] studies marked that, tinea capitis widespread among children at the ages under 10 years. Tinea cruris is the most common among middle-aged people (25%). This finding agreement with Bhatia [12] and Gupta [13] who found that tinea cruris affected about a quarter of people with dermatophytosis in the same age group. Several factors, such as occupational exposure, increased sweating, wearing tight-fitting clothing, and extended exposure to warm, humid environments, can be attributed to the elevated occurrence. Tinea unguium is more affected in people over 50, according to other studies like Balamuruganvelu [14] and Pang [15]. This could lead to a decreased ungual plate growth rate, an increase in trauma rates, poor peripheral circulation, and an inability to maintain proper foot care [16, 17].

There is a significant gender imbalance in dermatophytosis cases, with 56% of patients being male and 44% female, similarly, in Hilla [7], Anbar [18, 19]. While this study disagrees with Al-garawyi [20] and Al-Masoudi [21] studies. Differences between sexes in dermatophytosis infection rates appear from varying exposure to risk factors and behaviors, males are more affected due to activities like sports, work dangers, and occlusive footwear, which enhance exposure. Conversely, they found higher percentages in females, perhaps due to geographical and socioeconomic characteristics. These variations reflect the complex interaction of lifestyle, environment, and healthcare availability. Based on the distribution of clinical forms of dermatophytosis, tinea corporis is more common in females than in males. It was accounted for in 55.6% of cases in females, as reported by Novita [22], a result compatible with subsequent findings from Tanriati [23], which found female infection rates of 58% and 58.1%, respectively. The higher occurrence of dermatophytosis in females compared to males may be attributed to females' increased exposure to water during activities at home, resulting in a greater susceptibility to humidity that promotes dermatophyte growth. Additional factors, including lifestyle, physiological differences between males and females, and variations in social behavior or vocational activities, significantly contributed to the occurrence of dermatophytosis [24].

Tinea cruris more affected males compared to females, accounting for 82% of cases. This result is agreement with the study conducted by Sharquie and Jabbar [25] which found that tinea cruris was roughly 78.5% for men. Tinea cruris was more common in males because the scrotum creates a warm and damp environment conducive to dermatophyte growth, Other research has shown similar patterns, with studies by, Aref [26] and Nagaral [27]. Tinea capitis occurs more frequently in males, accounting for around 60% of cases. This result agree with numerous studies, including those by Mohammed [9], Ahmed [28], Ramanath [29] and who reported high percentages of tinea capitis in males, about 62%, 66.6%, 57%, and 61% respectively. Males are more likely than females to get tinea capitis, which is frequently linked to overcrowding and the sharing of personal hygiene products like combs, towels, and shaving equipment that can spread the infection [30]. Tinea pedis in males was found to be 55.4%, which is agreement with the findings of Ramanath [29], who reported 52%, as well as Aref [26], who documented 66%.

Tinea pedis may be more common among men due to their employment, and prolonged periods of time in enclosed footwear sometimes result in infections. Non-breathable materials used to make closed shoes are especially hazardous. Additionally, high humidity and temperature are risk factors for tinea pedis and Shoes that are too tight can harm superficial veins and increase the risk of foot disease [31], [32]. In contrast, females are more affected by tinea unguium, accounting for 52% of cases. This conclusion agrees with other studies such as Aghamirian [33], Akcaglar [34], and Ramanath [29] who reported that 54%, 58%, and 51%, respectively, of females were affected by tinea unguium.

Approximately, 28.0% of dermatophytosis patients had symptoms lasting less than a month and 36.6% had lasting one to three months. While (20.3%) had persistent symptoms last for 7 to 12 months. These results are also supported by Shivam [35], which found that the majority of cases occurred within the first six months of onset and that a significant percentage of chronic cases lasted longer than six months. This pattern demonstrates the growing difficulty in treating persistent infections, which are frequently linked to resistance and recurrence. In contrast, Ghuse study [36] represents a previous clinical pattern in which the majority of cases occurred in the early stages of disease, primarily within the first three months. Approximately, 23.7% of cases had chronicity, which is agreement with Sooriya study [37] who reported 29.4%, and closely aligns with the findings of Saha [38] and Mahajan [39] studies who reported 34.2% and 35.8%, respectively. This chronicity may be caused by topical corticosteroids, which only relieve inflammation and itching but aid in the growth of fungi by altering their microenvironment, insufficient dosages of antifungal medicine, and poor adherence to treatment [40].

Approximately 56.6% of dermatophytosis cases were occurred in the summer, consistent with earlier research's by Siddiqui [41]and Janardhan [42] who similarly identified summer as the season with the highest infection rates. This

seasonal variation is largely attributed to warm and humid conditions that promote fungal growth, as demonstrated by Balamuruganvelu [14], which reported that one-third of cases occurred between April and June. Behavioral factors, including increased sweating and activities such as swimming, contribute to the elevated prevalence observed during the summer [41]. Contrasting findings have been reported, including an Iranian studies [43],[44] that noted a peak in dermatophytosis cases during winter, possibly attributed to dry skin and environmental factors such as low humidity and temperature fluctuations.

5- CONCLUSION

Tinea corporis is more common among females and the 30-39 age group, where tinea capitis widespread in under 10 years of age; most dermatophytosis cases ware an acute infection and had occurred in summer months.

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دراسة سريرية لفطريات الجلد لدى عينة من المرضى المراجعين لمدينة الإمامين الكاظمين الطبية

الخلاصة

فطريات الجلد أو القوباء الحلقية هي مرض جلدي تسببه الفطريات جلدية التي لها القدرة على إصابة الأجزاء الغنية بالكيراتين في الجسم، مثل الجلد والشعر والأظافر. عالميا، تعتبر فطريات الجلد واحدة من أكثر أمراض الجلدية شيوعًا في العالم. تتراوح المظاهر السريرية من بقعة حلقية متقشرة إلى التهاب شديد وفقدان الشعر والأظافر.

يهدف هذا البحث الى تحديد الخصائص السريرية المختلفة لمرضى الفطار الجلدي والمرتبطة بالمتغيرات المدروسة.

أجريت دراسة مقطعية في مدينة الإمامين الكاظمين الطبية في بغداد، شملت ٣٥٠ مريضًا تم تشخيص إصابتهم بفطريات الجلد في عيادة الأمراض الجلدية. تم جمع البيانات من خلال استبيان موحد مصمم لضمان العوامل الاجتماعية والديموغرافية والتاريخ الطبي والمظاهر السريرية للمرض وتفاصيل العلاج.

أظهرت النتائج أن سعفة الجسم أكثر شيوعًا عند الإناث (٥٥,٦٪)، وخاصة بين أولئك الذين تتراوح أعمارهم بين ٣٠ و ٣٩ عامًا، بينما أظهر الذكور تأثرًا أكبر بسعفة الفخذ (٨٢,٥٪) وسعفة الرأس (٦٠٪). وشملت أكثر مناطق الجسم تأثرًا الجذع (٢٠,٦٪) والفخذ (١٨,٢٪)، وكانت الأصابع أقل تأثرًا (١,٤٪). شكلت الالتهابات الحادة ٧٦,٣٪، وكان الصيف أعلى معدل للإصابة (٥٦,٦٪). كان لدى غالبية المرضى ٢-٣ آفات (٥٨,٣٪)، و٣٦,٦٪ عانوا من أعراض استمرت لمدة ١-٣ أشهر.