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A Case of Persistent Beard Folliculitis

To the Editor:

A 48-year-old agronomist with no history of comorbidities or medication intake consulted with a 2-month history of progressive swelling on his upper lip. He did not complain of any symptoms, and the lesion was refractory to oral antibiotic and antiviral treatments. He denied any recent contact with animals. On physical examination, he had a boggy erythematous plaque consisting of pustules and crusts on the upper left lip (Figure 1A). Hair was easily pluckable, causing less density. Tinea barbae was suspected; crusts and pustules were taken for microbiological tests. Direct mycological examination showed hyaline septate hyphae, and mycological culture revealed the growth of *Trichophyton rubrum*. The patient was treated with terbinafine 250 mg/d for 8 weeks. At 2-months control, there was complete resolution of the lesion with partial hair regrowth (Figure 1B).

Tinea barbae is a mycotic infection that affects the beard, mustache, and neck area. It is almost exclusively seen in young male adults.[1] Frequently, animals are the main source of infection, but also autoinoculation from fingernails or tinea pedis has been reported.[2] It can be caused by various types of dermatophytes; *Trichophyton rubrum* is the most commonly isolated agent. Other reported species include *Microsporum canis* and *Trichophyton mentagrophytes*.[2] Diagnosis can often be challenging because the clinical presentation is usually misdiagnosed as bacterial or viral infections. Tinea barbae may present as an acute pustular folliculitis, or it can develop as a red, tender, inflammatory boggy plaque called *kerion*.[3] Microbiological tests (KOH mount and culture) are essential for establishing the diagnosis and making therapeutic decisions. Treatment includes the same therapeutic regimens as in the fungal infection of the scalp (i.e. terbinafine 250 mg/d for 4-6 weeks or itraconazole 200 mg every 12 hours for 7 days). Shaving could be a predisposing factor, so single-use shaving machines are recommended.[4]

Figure 1 **(A)** Boggy plaque with crusts and pustules. **(B)** Complete resolution at 8 weeks of treatment.

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