

Sexually Transmitted Psoriasis-like Kerion of the Pubis and Vulva

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Fungal infections of the pubis and vulva may be divided into 2 different clinical presentations: tinea pubis and kerion (1–21). Tinea pubis, also named pubic tinea (4), tinea genitalis (11, 13, 19), tinea in the genital area (13), and pubogenital tinea (13, 18, 19), is characterized clinically by roundish lesions, with well-defined, erythematous, vesicular borders and an inner area with mild erythema, scales and crusts. Kerion, or kerion celsi, also named trichophytic granuloma (1), Majocchi's granuloma (2, 12, 15), cystic tinea profunda (3), and tinea profunda (3, 5, 12), is characterized by inflammatory, infiltrated plaques, with follicular pustules. A case of sexually transmitted psoriasis-like kerion of the pubis and vulva is reported here.

CASE REPORT

A 29-year-old Caucasian woman was admitted with a clinical diagnosis of psoriasis located on the pubis and vulva. The patient stated that she was in good general health and that she was not on therapy with systemic drugs. She also declared that her dermatitis had appeared 4 months earlier. It was treated at another dermatological centre with topical calcipotriol and corticosteroids; however, both drugs caused a worsening of the dermatitis.

Dermatological examination showed the presence of 2 lesions: the first lesion was located in the centre of the pubis: it was erythematous-squamous, infiltrated, roundish, 1.5 cm in diameter; the second lesion involved the mons veneris and labia majora and was erythematous-squamous, infiltrated, with tiny follicular pustules. Pubic hairs were of different lengths (**Fig. 1**). The patient complained of mild itching. No other lesions were observed elsewhere.

General physical examination did not reveal anything pathological; in particular, no inguinal lymphadenopathy was detected.



Fig. 1. Psoriasis-like kerion of the pubis and vulva.

Laboratory tests were within normal ranges. The patient refused a biopsy. Bacteriological examinations were negative. Mycological cultures were positive for *T. mentagrophytes* from pubic and vulval lesions, and negative from inguinal and intergluteal folds.

A thorough medical history revealed that the patient's boyfriend, who worked as a veterinarian, had been suffering from tinea inguinalis for months. We therefore decided to carry out in our patient laboratory tests for syphilis, HIV, and hepatitis C (negative results), swabs for Herpes Simplex Virus types 1 and 2 (negative results), urethral swabs for real-time PCR for *C. trachomatis*, *M. genitalium*, and *N. gonorrhoeae* (negative results) and microscopical examinations and cultures for *N. gonorrhoeae* (negative results). Vaginal swabs for fungi and bacteria were also negative.

Mycological examinations of the inguinal folds of the patient's boyfriend were positive for *T. mentagrophytes*. It is likely that he was infected by cats or dogs he repeatedly touched in his job.

Final diagnosis was sexually transmitted psoriasis-like kerion of the pubis and vulva. The patient was treated with itraconazole (200 mg/day for 3 weeks) and isoconazole cream (1 application/day for 3 weeks). No side effects were reported or observed. Complete clinical remission was observed 18 days after the beginning of the therapy. Mycological examinations were negative at day 21 of therapy. Follow up (4 months) was negative.

DISCUSSION

Kerion of the pubis and vulva is often caused by *T. mentagrophytes* (3, 6–10, 12, 17, 20, 21) (also *T. interdigitale* [11, 13, 19] and *Arthroderma/T. benhamiae* [13, 14, 18, 21]). Other involved species are *T. erinacei* (7), *T. rubrum* (3, 13, 15, 19, 21), *T. tonsurans* (13), *T. verrucosum* (5, 13), and *M. canis* (1, 13). Mixed fungal/bacterial infections have also been reported: *T. mentagrophytes* + *E. coli* + *P. aeruginosa* (4) and *T. mentagrophytes* + *P. aeruginosa* + *Klebsiella* sp. (20).

Predisposing factors include contacts with animals such as mice (13), rats (13, 14), guinea pigs (18), cats (5, 13) and dogs (2); travels in endemic areas (11, 13); sexual intercourse, as in our patient (11, 15, 17–19, 21); poor personal hygiene (19); hyperhidrosis (19); sharing clothes (underwear, bed linens, towels) (19); shaving (13, 15, 17, 18, 20); waxing (12); and autoinoculation from other infected areas (19). Chronic use of topical (2, 15, 19) and oral (3) corticosteroids is also considered as a predisposing factor. Except for very rare cases in children (6, 8), kerion in the pubic and genital area occurs much more frequently in women (13).

The clinical picture of kerion of the pubis and vulva is characterized by alopecia (5, 6, 10–12), lymphadenopathy (1, 6, 8, 15), pain (11, 21) and fever (15).

Itraconazole (2, 4, 7, 10, 11, 13, 15) and terbinafine (9, 12, 13, 15, 17) are the 2 most frequently used antifungals. As previously mentioned, we successfully used itraconazole. Other drugs used are fluconazole (3, 13) griseofulvin (1, 6, 8), and amphotericin B (3). Some authors have added systemic corticosteroids (2, 6, 11).

In conclusion, we have described a case of kerion located on the pubis and vulva. The infection was acquired by the patient through intercourse with her boyfriend, who in turn had been infected by cats or dogs during his work as a veterinarian. The case we have reported is in our opinion interesting for several reasons: (a) the atypical clinical presentation of kerion; (b) the confirmation that kerion of the pubis and vulva can be considered as a true sexually transmitted infection, and (c) once again, the great adaptive capacity of an originally zoophilic species, such as *T. mentagrophytes*.

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