REFERENCES

1. Haddad F, Helm TM. Wells syndrome. Cutis. 2014;93:38-9.
2. Silva CMR, Ottoni FA, Andrade-Filho JS, Pena GPM, Gontijo JRV. Do you know this syndrome? An Bras Dermatol. 2007;82:575-8.
3. Weins AB, Biedermann T, Weiss T, Weiss JM. Wells syndrome. J Dtsch Dermatol Ges. 2016;14:989-93.
4. Rajpara A, Liolios A, Fraga G, Blackmon J. Recurrent paraneoplastic wells syndrome in a patient with metastatic renal cell cancer. Dermatol Online J. 2014;20. pii: 13030/qt35w8r1g3.
5. Avelleira JCR, Viana FR, Boechat AM, Fleury RN. Well's syndrome or eosinophilic cellulitis. An Bras Dermatol. 1999:74: 53-7.

AUTHORS' CONTRIBUTIONS

Lilian Geronimo Brasileiro ORCID 0000-0002-8300-3949
Conception and planning of the study, Elaboration and writing of the manuscript, Obtaining, analyzing and interpreting the data, Intellectual participation in propaedeutic and/or therapeutic conduct of the cases studied, Critical review of the literature

Marilda Aparecida Milanez Morgado de Abreu ORCID 0000-0001-9099-6013
Approval of the final version of the manuscript, Intellectual participation in propaedeutic and/or therapeutic conduct of the cases studied, Critical review of the manuscript

Renato Soriani Paschoal ORCID 0000-0003-0493-9966
Approval of the final version of the manuscript, Critical review of the manuscript

How to cite this article: *Zanoni LGB, Morgado de breu MAM, Paschoal RS. Wells' syndrome: the importance of differential diagnosis. An Bras Dermatol. 2019;94(*3):370-2.

Follicular *tinea faciei incognito*: the perfect simulator*

Nelson Turra[1]
Jorge Navarrete[1]
Julio Magliano[1]
Carlos Bazzano[1]

DOI: http://dx.doi.org/10.1590/abd1806-4841.20197892

Dear Editor,

Tinea faciei is a relatively uncommon superficial dermatophyte infection limited to the glabrous skin of the face.[1] Studies define its classical presentation as single or multiple blemishes and circular erythematous-scaling patches with central clearing.[2] On the other hand, clinical manifestations are defined as atypical when the inflammatory component is more severe, presenting follicular papules and pustules.[2] When atypical clinical manifestations are present, the disease is known to mimic several disorders, such as cutaneous lupus erythematosus, rosacea, and granuloma annulare.[1,3,4] Additionally, treatment with corticosteroids makes its presentation incognito, becoming a great diagnostic challenge.[5] We report the case of a patient with follicular tinea faciei incognito, an atypical presentation of the disease, in which the diagnosis required a skin biopsy and successful treatment required the use of systemic antifungals.

A 31-year-old woman with no relevant medical history was referred to our university hospital with a facial dermatosis that compromised nose, cheeks, periocular region, and forehead. The lesion was characterized by an extensive erythematous and desquamative plaque of about 10 centimeters in diameter in which pustules were found in the central region and an inflammatory edge in the peripherical region (Figure 1). The lesion had appeared 4 months earlier, after the patient underwent a biopsy of a benign nasal nevus. The physical examination revealed no other remarkable findings and there was no evidence of tinea pedis or unguium. The lesion grew

Received 20 November 2017.
Accepted 04 August 2018.
* Work performed at Dermatology Department "Prof. Dr. Miguel Martínez", Clinical Hospital "Dr. Manuel Quintela", Montevideo - Uruguay.
Financial support: None.
Conflict of interest: None.

[1] Dermatology Department, Clinical Hospital, School of Medicine, University of the Republic, Montevideo, Uruguay

Mailing Address:
Nelson Turra
E-mail: nelsonturra85@gmail.com

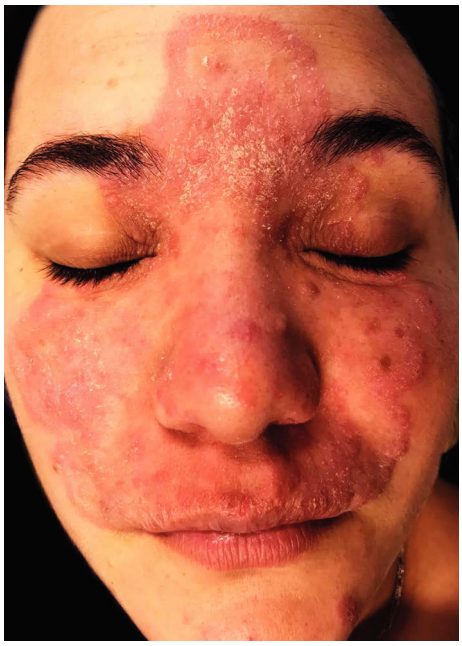

Figure 1: Follicular tinea faciei incognito. The clinical manifestation is characterized by an extensive erythematous and desquamative plaque with follicular pustules in the central region and a peripherical inflammatory edge, affecting cheeks, periocular region, and forehead

progressively until reaching the size described above. The patient received multiple topical treatments, including corticosteroids, antibiotics, and antifungal drugs without obtaining successful results. Laboratory tests showed no relevant information, and serologies for human immunodeficiency virus, hepatitis B and C viruses were non-reactive. Bacterial and fungal cultures of superficial skin were also negative. A deep surgical biopsy was performed, providing biological material for a follicular fungal culture, which was positive for *Trichophyton rubrum*. Histopathology with hematoxylin-eosin (HE) staining also supported the diagnosis, showing neutrophils within the corneal layer and an extensive inflammatory process - edema, vasodilatation, and a dense lymphohistiocytic infiltrate in the reticular dermis (Figure 2). PAS staining showed abundant septate filaments on the outer layer of the hair shaft compatible with ectothrix follicular tinea (Figure 3). According to these findings,

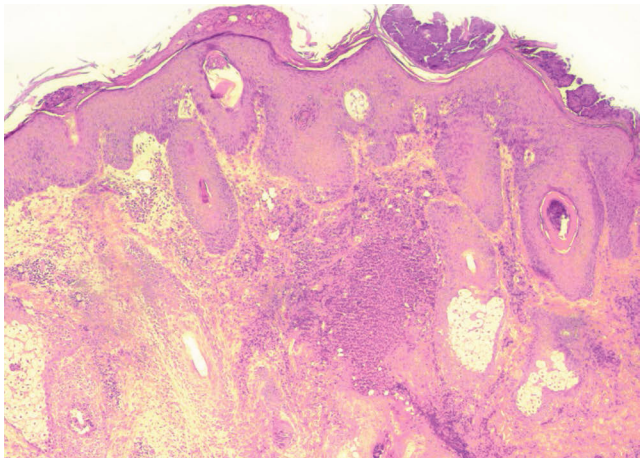

Figure 2: Follicular tinea faciei incognito. Neutrophils within the corneal layer and an extensive inflammatory process - edema, vasodilatation and a dense lymphohistiocytic infiltrate in the reticular dermis (Hematoxylin & eosin, x400)

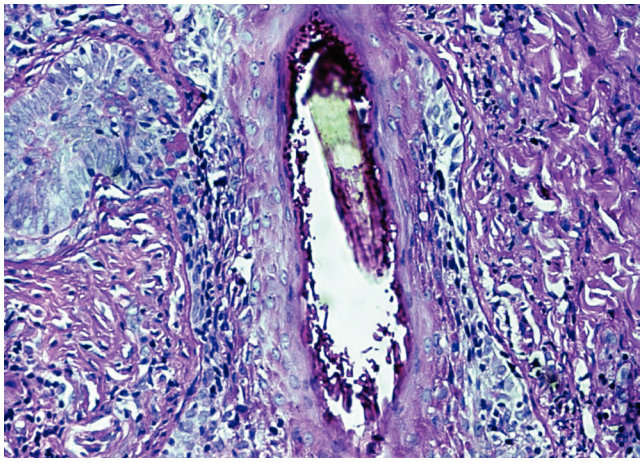

Figure 3: Follicular tinea faciei incognito. Abundant septate filaments on the outer layer of the hair shaft, compatible with ectothrix follicular tinea (PAS stain, x20)

the diagnosis of follicular tinea faciei incognito was confirmed and treatment with oral terbinafine (250 mg/day) was initiated. After eight weeks of treatment our patient showed total regression of the disease with mild post-inflammatory hyperpigmentation.

This clinical case reveals an atypical presentation of tinea faciei indicated by the large size of the lesion and the presence of pustules in the central region. The disease most likely initiated after a physical trauma that served as gateway for the pathogen. In this case, a skin biopsy was necessary to achieve proper diagnosis, as it allowed follicular samples for fungal culture, and a systemic antifungal was required to successfully treat the disease. In conclusion, tinea faciei can be a great diagnostic challenge when there are atypical clinical manifestations as it usually presents a wide variety of symptoms, especially after the application of topical corticosteroids. Thus, the authors recommend that fungal infections should always be suspected in scaly eruptions on the face. ❑

REFERENCES

1. Borges A, Brasileiro A, Galhardas C, Apetato M.Tinea faciei in a central Portuguese hospital : A 9-year survey. Mycoses. 2018;61:283-5.
2. Nicola A, Laura A, Natalia A, Monica P. A 20-year survey of tinea faciei. Mycoses. 2010;53:504-8.
3. Kye H, Kim DH, Seo SH, Ahn HH, Kye YC, Choi JE. Polycyclic annular lesion masquerading as lupus erythematosus and emerging as tinea faciei incognito. Ann Dermatol. 2015;27:322-5.
4. Dutta B, Rasul ES, Boro B. Clinico-epidemiological study of tinea incognito with microbiological correlation. Indian J Dermatol Venereol Leprol. 2017;83:326-31.
5. Salimbeni L, Delfino C. Tinea faciei incognito. G Ital Dermatol Venereol. 2017;152:390-91.

AUTHORS' CONTRIBUTIONS

Nelson Turra ORCID 0000-0002-3369-8279

Approval of the final version of the manuscript, Elaboration and writing of the manuscript, Obtaining, analyzing and interpreting the data, Effective participation in research orientation, Intellectual participation in propaedeutic and/or therapeutic conduct of the cases studied, Critical review of the literature, Critical review of the manuscript

Jorge Navarrete ORCID 0000-0002-8563-0364

Approval of the final version of the manuscript, Obtaining, analyzing and interpreting the data, Effective participation in research orientation, Intellectual participation in propaedeutic and/or therapeutic conduct of the cases studied, Critical review of the literature, Critical review of the manuscript

Julio Magliano ORCID 0000-0003-2007-9871

Approval of the final version of the manuscript, Obtaining, analyzing and interpreting the data, Effective participation in research orientation, Intellectual participation in propaedeutic and/or therapeutic conduct of the cases studied, Critical review of the literature, Critical review of the manuscript

Carlos Bazzano ORCID 0000-0003-1960-3365

Approval of the final version of the manuscript, Obtaining, analyzing and interpreting the data, Effective participation in research orientation, Intellectual participation in propaedeutic and/or therapeutic conduct of the cases studied, Critical review of the literature, Critical review of the manuscript

How to cite this article: *Turra N, Navarrete J, Magliano J, Bazzano C. Follicular tinea faciei incognito: the perfect simulator. An Bras Dermatol. 2019;94(3):372-4.*

The importance of residual tumor detection*

Luis Fernando Figueiredo Kopke[1]

DOI: http://dx.doi.org/10.1590/abd1806-4841.20198074

Dear Editor,

Reports indicating "absence of residual neoplasm" are not uncommon in cases of reoperation of patients where the initial resection was incomplete. This usually leads to the conclusion that the tumor had been completely removed, which can be misleading and could be complicated to prove that the operation was not performed on the wrong site.[1] This case exemplifies this situation and points out the importance of demonstrating the residual tumor. In 2012, a 75-year-old female patient was referred to the clinic with a suspected recurrence of a basal cell carcinoma located in the nasolabial sulcus next to the right nasal ala that had been operated in 2009 (Figure 1A). In 2009, a punch biopsy was performed and the histopathology report revealed an adenoid basal cell carcinoma (Figure 1B). The patient was referred to a plastic surgeon in 2009. The surgery report revealed "solar keratosis and a small focus suggestive of basaloid proliferation" (Figure 2). The plastic surgeon considered the case "closed". In 2012, a new punch biopsy at the same site showed the same histopathological findings as the first biopsy in 2009, demonstrating the persistence of the tumor (Figure 1C). A micrographic surgery using the three-dimensional method was able to detect a small amount of residual basal cell carcinoma, which was located eccentrically in the surgical specimen and showed tumor-free surgical margins after the first stage, the same histological pattern found in 2009 (Figure 3). Therefore, it was possible to demonstrate that the tumor was recurrent and it was totally excised. It could be misleading to claim a case as "solved" after a surgery report that indicates tumor-free margins as one must be aware of how relative histopathology reports can be, especially when less than 1% of the total surgical margin is examined.[2] Effectiveness of surgeries that remove neoplasms can only be properly tested by the absence of further clinical manifestations. However, if clinical symptoms arise, it is difficult to determine if they represent a new tumor or if they are related to the previous tumor. Finding the residual tumor with actual tumor-free margins in the final, definitive surgery is a good sign that the surgery was effective. Failure to detect the residual tumor is quite unexpected and some will mistakenly interpret it as a sign of spontaneous regression or as the surgeon's incredible ability to have cauterized the proper vessel and accurately electrocoagula

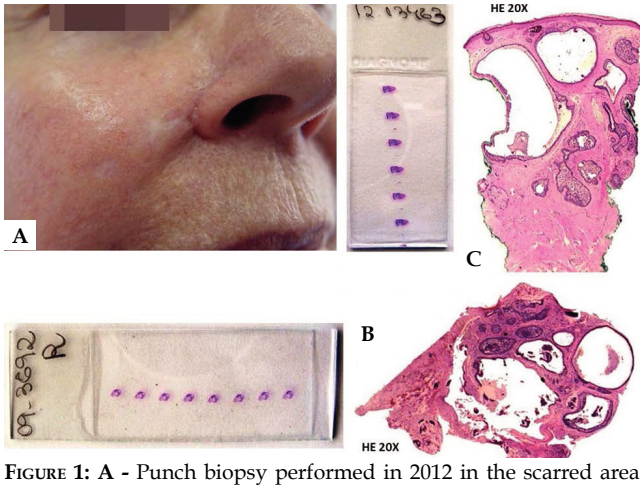

Figure 1: A - Punch biopsy performed in 2012 in the scarred area located near the right nasal ala. Patient had been biopsied and operated on the same site in 2009, when the problem was allegedly solved. **B -** Slide and corresponding histology of the punch biopsy performed in 2009 in the area located near the right nasal ala (Hematoxylin & eosin, x20). **C -** Slide and corresponding histology of the punch biopsy performed in 2012 in the same region. Histopathological findings are identical and confirm the persistence of the tumor (Hematoxylin & eosin, x20)

Received 11 January 2018.
Accepted 26 July 2018.
* Work conducted at Clínica Dapele Dermatologia, Florianópolis (SC), Brazil.
Financial support: None.
Conflict of interest: None.

[1] Outpatient Surgery Division, Dermatology Service, Hospital Universitário Polydoro Ernani de São Thiago, Universidade Federal de Santa Catarina, Florianópolis (SC), Brazil.

Mailing Address:
Luis Fernando Figueiredo Kopke
E-mail: luiskopke@uol.com.br