



FACIAL PITYRIASIS VERSICOLOR: A RARE PRESENTATION OF COMMON DISEASE

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ABSTRACT Pityriasis versicolor is one of the most common superficial fungal infection in the world.[1] It is caused by various species of yeast of the genus *Malassezia*. It is clinically characterized by scaly or non-scaly hypopigmented or hyperpigmented macules commonly involving upper arms, upper trunk, neck and abdomen.[2] Facial lesions in pityriasis versicolor is very rare presentation and rarely reported. In this article I have reported 4 cases of localized facial pityriasis versicolor.

KEYWORDS : Facial pityriasis versicolor, *Malassezia furfur*, Spaghetti and meatball, Zireli's sign

Introduction:

Pityriasis versicolor, also known as tinea versicolor, is a frequent, benign, superficial fungal infection of the skin. It is caused by *Malassezia*, a dimorphic lipophilic fungus, also known as *Pityriopsis* which is normal skin floral component. Out of 14 *Malassezia* species identified, pityriasis versicolor mainly caused by *Malassezia furfur*, *Malassezia globosa*, and *Malassezia sympodialis*. It presents as hyperpigmented or hypopigmented finely scaly macules. Diagnosis of pityriasis versicolor is mainly based on clinical findings. The wood's lamp examination and microscopic examination of scales soaked in potassium hydroxide may be helpful for the diagnosis.[3] I have reported 4 cases of pityriasis versicolor which is presented on face, an unusual presentation of common disease. These are as follows.

Case 1: A 12 year school going female presented with asymptomatic hypopigmented lesions over face since 10 days. On examination, multiple hypopigmented macules with fine branny scales presented over malar region, chin area and forehead. There were no such lesions over chest, back, arms or any other body parts. She denied any previous history of similar complaints. On stretching of affected skin area, positive Zireli's sign was noted. The examination of hair, nail and mucous membrane was normal. A diagnosis of facial pityriasis versicolor was made. She was treated with topical 1% clotrimazole cream applied twice daily with oral fluconazole 300 mg once a week for 2 weeks.



Figure-1: Multiple hypopigmented macular mildly scaly lesions over bilateral cheeks, nose, chin and forehead

Case 2: A 8 year school going male presented with hypopigmented lesions over cheeks since 15 days. On examination multiple mildly scaly hypopigmented macules presented over bilateral cheeks, bilateral preauricular region. No involvement of other body parts noted. Past history of one episode before 1 year over same area which was resolved by itself. On KOH scraping examination of lesions, multiple short hyphae and spores were seen. Skin biopsy was not done. He was treated with topical 1% clotrimazole cream twice daily after bath for 2 weeks.

Case 3: A 28 year housewife female of low socioeconomic class presented with whitish lesions over face since 1 month. On examination multiple hypopigmented macules with fine cranny scaling presented over forehead, bilateral cheeks and chin. No lesions noted over other body area. No past history of same lesions were noted. On 15% KOH examination of scales from the lesions, hyphae and spores were seen resembles classical spaghetti and meatball.

Histopathological examination was not done in this case. She was treated with topical 2% miconazole cream twice daily with oral fluconazole 300 mg once a week for 2 weeks. The hypopigmentation took few months to resolve in this case.



Figure-2: Multiple coalescing hypopigmented maculo-scaly lesions over left cheek.



Figure 3: Few discrete hypopigmented lesions over forehead, bilateral cheeks and chin

Case 4: A 13 year male presented with white lesions over face since 10 days. On examination multiple hypopigmented macules with mild scaling presented over bilateral cheeks. On KOH examination hyphae and spores were seen. He was treated with 1% clotrimazole cream twice daily.



Figure 4: Multiple hypopigmented macules with fine branny scaling over right cheek and preauricular region

Discussion:

Pityriasis versicolor most commonly affects the upper trunk, upper arms, neck and abdomen and less commonly affects axillae, groins, thighs and genital area.[2] Pityriasis versicolor involving face and other common body parts are commonly seen but localized facial

pityriasis versicolor is rarely seen and reported. The most common species implicated in pityriasis versicolor are *Malassezia globosa* and *Malassezia furfur*. [4] Clinically patients presents with well defined discrete or confluent macules characterized by fine branny scaling which can be made prominent by stretching the skin. [4] Pityriasis versicolor have been reported in various morphologies such as hypochromic, hyperchromic, combination of hypochromic and hyperchromic, erythematous, circinate, atrophying, follicular, acral, involving inguinocrural region etc. but localized facial type has rarely been reported. [5-7] Various mechanisms have been proposed for hypopigmentation in pityriasis versicolor. Production of dicarboxylic acid like azelaic acid by *Malassezia* species causing competitive inhibition of tyrosinase enzyme and cytotoxic effect on hyperactive melanocytes have been suggested. [2] The various treatment options for pityriasis versicolor include topical azole antifungals, 2.5% selenium sulphide, terbinafine 1% cream etc. The systemic antifungals such as fluconazole, ketoconazole, itraconazole etc. are effective. [4]

Conclusion:

Pityriasis versicolor most commonly seen over upper back, chest, upper arms. By this cases, we are able to differentiate hypopigmentary lesions over face due to pityriasis versicolor or other causes. These cases are classical presentations of facial pityriasis versicolor which are very rare and useful for academic as well as clinical practice.

Consent:

Written informed consent was obtained from the patient for publication of this article and any accompanying images.

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