

Dermatophytosis: North India.

Sangram Singh Patel¹, Nilam Kumari², Jitendra Prasad³, Anjali Agarwal⁴, Amita Arya⁵, Dilip Singh⁶

¹Associate Professor, Department of Microbiology, Hind Institute of Medical Sciences, Safedabad, Barabanki, U.P., India.

²Junior Resident, Rajendra Institute of Medical Sciences, Ranchi, Jharkhand, India.

³Senior Resident, Department of Microbiology, Hind Institute of Medical Sciences, Safedabad, Barabanki, U.P., India.

⁴Assistant Professor, Department of Microbiology, Hind Institute of Medical Sciences, Safedabad, Barabanki, U.P., India.

⁵Junior Resident, Department of Microbiology, Hind Institute of Medical Sciences, Safedabad, Barabanki, U.P., India.

⁶Tutor, Department of Microbiology, Hind Institute of Medical Sciences, Safedabad, Barabanki, U.P., India.

Received: March 2018

Accepted: April 2018

Copyright: © the author(s), publisher. It is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

Background: Skin infections are common diseases in developing countries, Skin infections due to Dermatophytes has become a significant health problem affecting children, adolescents and adults of which Dermatophytosis are of particular concern in the tropics. Dermatophytosis constitutes a group of superficial fungal infections of the epidermis, hair and nails. **Objective:** Dermatophytosis: North India. **Methods:** The study was conducted at the Department of Microbiology, Hind Institute of Medical Sciences, Barabanki, Uttar Pradesh. All samples in the form of skin and nails were collected randomly in batches under aseptically condition from both out patients & in- patients. KOH mount was done for direct exam. Culture was also done. **Results:** A total of 354 samples were collected of which majority were skin 341 (96.3%). Majority of the patients belonged to the age group of 21-30 (33.9%) and were males (81.4%). Groin lesion was the most common lesion (58.5%). KOH, culture and both tests positive was found in 78%, 79.7% and 66.7% samples respectively. The sensitivity and specificity of KOH was 88.7% and 44.4% respectively with positive predictive and negative predictive value of 85.5% and 41% respectively. **Conclusion:** In the present study, Dermatophytosis is a major problem in North Indian population & prevalence of dermatophytic infection is alarming in both rural as well as urban community in the district of Barabanki, UP.

Keywords: Dermatophytosis, Prevalence, Skin samples.

INTRODUCTION

Superficial fungal infections are the most common skin diseases affecting millions of people throughout the world. The majority of these infections are caused by dermatophytes (Rippon, 1988).

Dermatophytes are a group of closely related keratinophilic fungi, all of which produce keratinase that can invade the stratum corneum of skin or other keratinized tissues derived from epidermis such as hair and nails (Hay, 2010; Chander, 2009).

Dermatophytosis is an infection produced by a dermatophytic fungus in the keratinized tissues - hair, nails and stratum corneum of skin (Rippon, 1988). Dermatophytosis is generally called "tinea" or "ringworm". Tinea is a Latin for 'larva of small insect'. The common clinical term given to dermatophytosis is designated by appending Latin word to an anatomical site at which infection is present to the term tinea (Chander, 2009).

Trichophyton rubrum and Trichophyton tonsurans are two common dermatophytes. T. rubrum found in

face, trunk, beard area, nails, feet and groin area infection. T. tonsurans found in endothrix and black dot infection. These two species are usually transmitted from person to person. Another common dermatophyte is Microsporum canis, which is transmitted from animals such as cats and dogs to humans (Washington et al, 2006; Cheesbrough, 2005; Parija, 2011).

Dermatophytes like to live on moist areas of the skin, such as places where there are skin folds. The dermatophyte infection that affects the scalp and hair is known as tinea capitis. It is especially common among school-aged children. For reasons that are not well understood, tinea capitis does not usually occur after puberty. In recent times few cases of subcutaneous and deep fungal infections have been reported to be caused by dermatophytes. It has been noted that dermatophyte infections are more common in adolescents and adults (Parija, 2011).

There is scanty of data about the prevalence of dermatophytes from Uttar Pradesh, hence, the present study was planned to study the prevalence of dermatophytes infection in different patients and to find the etiological agents of dermatophytes.

MATERIALS AND METHODS

This Prospective study was conducted in the Department of Microbiology, HIMS, Safedabad,

Name & Address of Corresponding Author

Dr. Jitendra Prasad,
Senior Resident,
Department of Microbiology,
Hind Institute of Medical Sciences,
Safedabad, Barabanki, U.P., India.

Barabanki, UP. The study was conducted on samples of skin scrapping, nail, hair and hair roots received to the laboratory. Identification & isolation of Dermatophytes specimens on the basis of KOH preparation, SDA and DTM.

Statistical analysis

Descriptive statistics were analysed and presented. The Chi-square test was used for comparisons. The predictive values of KOH such as sensitivity, specificity, positive & negative predictive vales (PPV & NPV) and accuracy was calculated. Analysis was carried out on SPSS 16.0 version (Chicago, Inc., USA).

RESULTS

More than one third of the patients were between 21-30 (37.9%) years followed by ≤ 20 (21.2%), 31-40 (18.9%), 41-50 (12.7%), 51-60 (6.8%) and >60 (2.5%) years. Majority of the patients were males (81.4%). More than one third of the patients were manual worker (40.1%). More than half of the patients belonged to lower middle class (52%) [Table 1].

Groin lesion was in 59.6% and abdomen was in 9.6% [Table 2].

Majority of the specimen were from skin (96%) followed by nail (3.1%) and hair (0.9%) [Figure 1].

The Dermatophytoses infection was found to be 78.8% (279/354) [Figure 2].

Dermatophytoses infection was found to be higher in the age group of 41-50 years (84.4%) and was least in the age group of >60 (55.6%). The difference was found to be statistically insignificant ($p>0.05$). Dermatophytoses infection was found to be higher in males (79.9%) than females (74.2%). The difference was found to be statistically insignificant ($p>0.05$). Dermatophytoses infection was found to be insignificantly ($p>0.05$) higher among middle class (87.2%) than lower class (79.5%), lower middle class (77.2%) and upper middle class (66.7%). Dermatophytoses infection was found to be insignificantly ($p>0.05$) higher among manual worker (81.7%) than house wife (80.5%), professional (76.9%), student (76.8%) and others (72.7%). The Dermatophytoses infection was found to be higher in skin sample (79.7%) than nail (63.5%) and hair (33.3%). The difference was found to be statistically insignificant ($p>0.05$) [Table 2].

SDA and DTM were positive in 79.7% [Table 3].

Trichophyton Rubrum (57.4%) was found to be most common organism and Trichophyton Mentagrophytes (24.1%) was the second most common organism. The percentage of other organism was less than 10% [Table 4].

The sensitivity of KOH was 84.4% and specificity was 43.1% with PPV being 85.3%. In 67.2% specimens, both DTM and KOH were found to be positive [Table 5].

Table 1: Distribution of demographic profile of patients.

Demographic profile	No. (n=354)	%
Age in years		
≤ 20	75	21.2
21-30	134	37.9
31-40	67	18.9
41-50	45	12.7
51-60	24	6.8
>60	9	2.5
Mean \pm SD (Range)	31.97 \pm 12.92 (19-75)	
Gender		
Male	288	81.4
Female	66	18.6
Occupation		
Manual worker	142	40.1
House wife	41	11.6
Student	112	31.6
Professional	26	7.3
Others	33	9.3
Socio-economic status (SES)		
Lower class	122	34.5
Lower middle class	184	52.0
Middle class	39	11.0
Upper middle class	9	2.5

Table 2: Distribution of patients according to type of lesion.

Type of lesion*	No. (n=354)	%
Groin lesion	211	59.6
Back	5	1.4
Finger	6	1.7
Thumb	5	1.4
Abdomen	34	9.6
Legs	40	11.3
Hands	44	12.4
Scalp	3	0.8
Generalized	24	6.8

*Multiple response

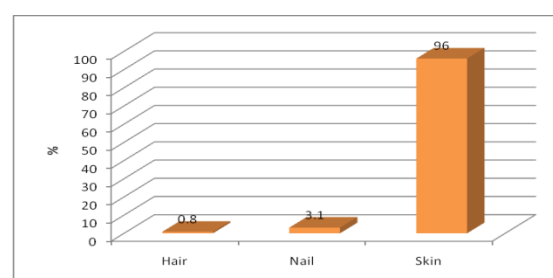


Figure 1: Distribution of patients according to site of specimen

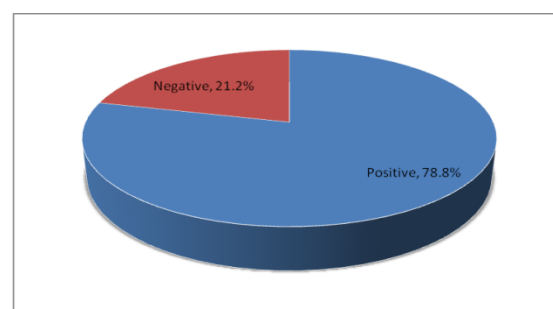


Figure 2: Distribution of patients according to Dermatophytoses infection

Table 2: Dermatophytoses infection according to demographic profile

Demographic profile	No. of patients	With Dermatophytoses		Without Dermatophytoses		p-value ¹
		No.	%	No.	%	
Age in years						
≤20	75	60	80.0	15	20.0	0.54
21-30	134	105	78.4	29	21.6	
31-40	67	53	79.1	14	20.9	
41-50	45	38	84.4	7	15.6	
51-60	24	18	75.0	6	25.0	
>60	9	5	55.6	4	44.4	
Gender						
Male	288	230	79.9	58	20.1	0.31
Female	66	49	74.2	17	25.8	
SES						
Lower class	122	97	79.5	25	20.5	0.43
Lower middle class	184	142	77.2	42	22.8	
Middle class	39	34	87.2	5	12.8	
Upper middle class	9	6	66.7	3	33.3	
Occupation						
Manual worker	142	116	81.7	26	18.3	0.76
House wife	41	33	80.5	8	19.5	
Student	112	86	76.8	26	23.2	
Professional	26	20	76.9	6	23.1	
Others	33	24	72.7	9	27.3	
Type of specimen						
Hair	3	1	33.3	2	66.7	0.06
Nail	11	7	63.6	4	36.4	
Skin	340	271	79.7	69	20.3	

¹Chi-square test**Table 3: Distribution of patients according to culture.**

Culture	No. (n=354)	%
Sabouraud's Dextrose Agar (SDA)		
Positive	282	79.7
Negative	72	20.3
Dermatophyte Test Medium (DTM)		
Positive	282	79.7
Negative	72	20.3

Table 4: Distribution of patients according to isolates

Organism	No. (n=282)	%
Epidermophyton Floccosum	16	5.7
Microsporum audouini	6	2.1
Microsporum canis	6	2.1
Microsporum gypseum	9	3.2
Trichophyton Mentagrophytes	68	24.1
Trichophyton Rubrum	162	57.4
Trichophyton Schaeleinii	1	0.4
Trichophyton Tonsurans	12	4.3
Trichophyton Violaceum	2	0.7

Table 5: Predictive value of KOH test

KOH test		DTM test		Total
		Positive	Negative	
KOH test	Positive	238 (67.2%)	41 (11.6%)	279 (78.8%)
	Negative	44 (12.4%)	31 (8.8%)	75 (21.2%)
	Total	282 (79.7%)	72 (20.3%)	354 (100%)
Sensitivity	84.4			
Specificity	43.1			
PPV	85.3			
NPV	41.3			
Accuracy	76.0			

DISCUSSION

Dermatophytoses are superficial infections of keratinised tissue, the skin, hair and nails, caused by dermatophytes. The prevalence of dermatophytosis is determined by environmental conditions, personal

hygiene and individuals' susceptibility. The variation in clinical presentation is related to the species of the fungus, size of the inoculum, the involved sites, and the immune status of the host. The higher incidence of superficial mycoses is seen in month of July to September due to rainy season &

humid atmosphere which is also correlating well with other studies (Humera et al, 2014, Mayr, 1989, Rippon, 1988).

In the present study, 354 clinically suspected cases of dermatophytoses attending Skin and Venereal disease outpatient Department of HIMS, Barabanki were studied.

In the present study, most common age group affected was 41-50 years with 84.4% followed by ≤ 20 years (80%), 31-40 years (79.1%). Overall, most of the cases of dermatophytoses are in 21-60 years age group while it is least common at extremes of age.

Most of the studies from different parts of India reported commonest age group affected to be 21-30 years (Patwardhan and Dave, 1999; Peerapur et al, 2004; Sen and Rasul, 2006; Kumar et al, 2014; Najotra et al, 2015).

The present study was correlated with other studies done by Patwardhan and Dave (1999) Aurangabad, Peerapur et al. (2004) at Bijapur, Sen and Rasul. (2006) at Assam, Kumar et al. (2014) at Mangalore, Najotra et al. (2015) at Jammu and Kashmir.

High infection of dermatophytosis in this age group (21-60 years) might be due to increased physical activity, high chances of exposure and hormonal factors. In the present study, males (79.9%) were more affected than females (74.2%). Male to female ratio was 4.7:1. The higher percentage of males might be due that females much lower enrolled in this study.

The present study was correlated with studies done by Sen et al (2006) at Assam, Bindu et al (2002) at Calicut, Patwardhan et al. (1999) Aurangabad, Singh and Beena (2003) at Baroda all of which reported male preponderance.

Male preponderance might be due to more involvement of them in physical and outdoor activities thereby increasing chance of exposure. Male: Female ratio of 4.7:1 (higher as compared to other studies), may be due to increasing involvement of females nowadays in outdoor activities and increasing health awareness among them.

In the present study, Dermatophytoses infection was found to be insignificantly ($p > 0.05$) higher among middle class (87.2%) than lower class (79.5%), lower middle class (77.2%) and upper middle class (66.7%). This was in agreement to the study done by Sarada et al (2015) at Vijayawada which states that 73.6% cases are from low socio-economic status. This may be due to poor hygienic conditions, overcrowding, sharing of linen, towels etc., poor nutrition. These all factors are frequently associated with lower economic classes of society (Gupta et al, 2014).

Dermatophytoses infection was found to be insignificantly ($p > 0.05$) higher among manual worker (81.7%) than house wife (80.5%), professional (76.9%), student (76.8%) and others (72.7%). This was in agreement to the study done by

Veer et al. (2007). This may be due to more involvement of manual workers in physical activities and thereby increased chance of exposure (Chander, 2009).

Direct microscopy, although false negative in 5 to 15% of cases in ordinary practice (Rippon, 1988), is a highly efficient screening technique. Scrapings and hairs may be mounted for direct examination in 25% KOH or NaOH mixed with 5% glycerol, heated (e.g., for 1 h at 51 to 54°C) to emulsify lipids, and examined under 3400 magnification for fungal structures. Another formulation is 20% KOH-36% dimethyl sulfoxide ((Rippon, 1988)), and two techniques for fluorescence microscopy, the calcofluor white technique (Robinson, and. Padhye, 1988) and the Congo red technique (Slifkin, and Cumbie, 1988), may be used.

In the present study, out of 354 clinically suspected cases of dermatophytoses, fungal elements was demonstrated in 67.2% were positive by both microscopy and DTH, 11.6% were positive by microscopy but were negative by DTH, 12.4 cases were negative by microscopy but DTH positive, 8.8% were negative both by microscopy and DTH. This was comparable with the other studies done by Singh et al (2003) Baroda, Yadav et al. (2013), Navi Mumbai.

Considering DTH as gold standard sensitivity of KOH was found to be 84.4% and specificity was 43.1%, Positive predictive value (PPV) was 85.3% and Negative predictive value (NPV) was 41.3%. Sensitivity of direct microscopy was comparable to the study done by Gupta et al (2014). In this study, as sensitivity of direct microscopy was high it appears to be good screening test for diagnosing and starting early treatment in suspected cases of dermatophytoses as DTH report often take time.

Culture is generally considered gold standard for diagnosis of dermatophytoses. But culture also have drawback of high false negativity as suggested by various studies (Lacaz et al, 2002; Sidirm, 2004). This high false negativity can be due to presence of nonviable hyphae in specimens, insufficient and improper collection of specimen. But as all the sample collection was done by me, last two variables - insufficient and improper collection of specimen was largely addressed in this study.

In the present study, *Trichophyton Rubrum* (57.4%) was found to be most common organism and *Trichophyton Mentagrophytes* (24.1%) was the second most common organism. The percentage of other organism was less than 10%. This was comparable to the findings of studies done by Najotra et al. (2015) at J&K (*T. rubrum*: 41.8%, *T. mentagrophytes*: 22.4%), Ranganathan et al. (1995) at Madras (*T. rubrum*: 52.2%, *T. mentagrophytes*: 29.35%).

In contrast, Karmakar et al. (1995) Rajasthan reported *T. violaceum* (55.76%) as most common isolate followed by *T. rubrum* (42.3%). Bhatia and

Sharma (2014) at Himachal Pradesh reported *T. mentagrophytes* (63.5%) as most common isolate followed by *T. rubrum* (34.6%).

This shows wide variation in isolation of various dermatophyte species across different geographical area.

CONCLUSION

Dermatophytoses are quite common in India because of hot and humid climate along with poor hygienic conditions, both playing important role in growth of these fungi. There is varying difference in isolation of different species of dermatophytes from different regions of India.

REFERENCES

- Rippon JW. Medical mycology- The pathogenic fungi and the pathogenic actinomycetes. 3rd edition. Philadelphia: WB Saunders company; 1988.
- Hay RJ. Dermatophytosis and other superficial mycoses. In: Mandell, Douglas, and Bennett's Principles and practice of infectious diseases. Mandell GL, Bennett JE, Dolin R. (eds) 1x edition Vol 2. Philadelphia: Churchill Livingstone Elsevier; 2010.p.3345-63.
- Chander J. Textbook of medical mycology. 3rd edition. New Delhi: Mehta Publishers; 2009.
- Washington C, Winn, Stephen D, Allen, William M, Janda, Koneman W, Elmer, Gary W, Procop, Paul C, Schreckenberger, Gail L, Woods. Identification of dermatophytes. Koneman's Color Atlas and Textbook of Diagnostic Microbiology, 6th edition. Baltimore: Lippincott Williams & Wilkins; 2006 page no. 1187-1195.
- Cheesbrough Monica. Dermatophytes. District laboratory practice in tropical countries. Part 2, 2nd edition. United Kingdom: Cambridge University Press; 2005, page no. 234-238.
- Parija SC. Mycology. Textbook of Practical Microbiology, 1st edition. New Delhi, India: Aph Ahuja Publishing House; 2011. Page no. 211-237.
- Milne LJR, Fungi. In: Mackie and McCartney, Practical Medical Microbiology. Collee JG, Fraser AG, Marmion BP, Simmons A (eds.) 14th edition New Delhi: Elsevier; 2011.p.695-717.
- Ansari HQF, Patel MB, Juwairriyyah AW. Epidemiology and In-Vitro Antifungal Susceptibility Testing of Dermatophytes; Int J Adv Res. 2014;2:553-560.
- Mayr A. Infections which humans in the household transmit to dogs and cats. Zentralbl. Bakteriell. Mikrobiol. Hyg. Ser. B 1989;187:508-526.
- Patwardhan N, Dave R. Dermatophytosis in and around Aurangabad. Indian J Pathol Microbiol 1999; 42:455-462.
- Peerapur BV, Inamdar AC, Pushpa PV, Srikant B. Clinicomycological Study of Dermatophytosis in Bijapur. Indian J Med Microbiol. 2004;22 (4):273-274.
- Sen SS, Rasul ES. Dermatophytosis in Assam. Indian J Med Microbiol 2006;24:77-8.
- Kumar S, Mallya PS, Kumari P. Clinico-Mycological study of dermatophytosis in a tertiary care hospital. Int J Sci Study 2014;1(6):27-32.
- Najotra DK, Choudhary V, Sahni B, Choudhary A. Clinico-epidemiological profile of dermatophytosis in district of Samba: a cross sectional study from the state of Jammu and Kashmir. India. Med Sci 2015;3(1): 183-9.
- Bindu V. Clinico-mycological study of dermatophytosis in Calicut. Indian J Dermatol Venerol Leprol 2002;68:259-61.
- Singh S, Beena PM. Profile of dermatophyte infections in Baroda. Indian J Dermatol Venerol Leprol 2003;69:281-3.
- Sarada D, Kumari PR. A study of Dermatophytoses. International journal of advanced research 2015;3(1):582-8.
- Gupta S, Agrawal P, Rajawat R, Gupta S. Prevalence of dermatophytic infection and determining sensitivity of diagnostic procedures. Int J Pharm Pharm Sci 2014;6(3):35-8.
- Veer P, Patwardhan NS, Damle AS. Study of onychomycosis: Prevailing fungi and pattern of infection. Indian J Med Microbiol 2007;25:53-6.
- Robinson, B. E., and A. A. Padhye. 1988. Collection, transport and processing of clinical specimens, p. 11–32. In B. B. Wentworth (ed.), Diagnostic procedures for mycotic and parasitic infections. American Public Health Association, Washington, D.C.
- Slifkin M, Cumbie R. Congo red as a fluorochrome for the rapid detection of fungi. J. Clin. Microbiol. 1998;26:827–830.
- Yadav A, Urhekar AD, Mane V, Danu MS, Goel N, Ajit KG. Optimization and isolation of dermatophytes from clinical samples and in vitro antifungal susceptibility testing by disc diffusion method. RRJMB 2013;2(3): 19-34.
- Lacaz CS, Porto E, Martins JEC, Heins-Vaccari EM, Melo TN. Tratado de Micologia Médica, 9th ed. Prefácio: Bertrand Dupont. São Paulo: Sarvier, 2002. 44(5): 297-298.
- Sidirm J. Micologia médica à luz de autores contemporâneos. Rio de Janeiro: Guanabara Koogan. 2004.
- Karmakar S, Kalla G, Joshi KR. Dermatophytosis in a desert district of Western Rajasthan. Indian J Dermatol Venerol Leprol. 1995; 61:280-3.
- Bhatia VK, Sharma PC. Epidemiological studies on Dermatophytosis in human patients in Himachal Pradesh. India. Springer Plus 2014;3:134-38.

How to cite this article: Patel SS, Kumari N, Prasad J, Agarwal A, Arya A, Singh D. Dermatophytosis: North India. Ann. Int. Med. Den. Res. 2018; 4(4): MB01-MB05.

Source of Support: Nil, **Conflict of Interest:** None declared