



“What are these white patches?”

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A 26-year-old otherwise healthy female presents with areas of hypopigmentation on her back. Her uncle has vitiligo, so she is quite worried. She is on no medications and has no drug allergies.

1. What is the most likely diagnosis?

- Vitiligo
- Tuberous sclerosis
- Tinea versicolour
- Pityriasis alba
- Mild dermatitis

2. When does this condition become most evident?

- Fall
- Winter
- Spring
- Summer
- Christmas holidays

3. How might you manage these lesions?

- Oral azole antifungals
- Topical selenium sulphide
- Topical azole antifungals
- Topical ciclopiroxolamine
- All of the above

Tinea versicolour is a fungal infection common in young healthy individuals, though it is not considered to be contagious, as it is part of the body's normal microbial flora.

Tinea versicolour normally affects the chest, back and upper arms. Lesions can be hypopigmented which can mimic vitiligo, or can be hyperpigmented (brown), but the discolouration is not permanent.




Figure 1. White lesions on back.

Heat and humidity seem to precipitate this condition.

The treatment of tinea versicolour consists of using topical agents, such as:

- selenium sulfide,
- ciclopiroxolamine and
- azole or allylamine antifungals.

Various regimens can be used. Selenium sulfide lotion can be liberally applied to the affected areas of the skin daily for two weeks; each application is allowed to remain on the skin for at least 10 minutes prior to being washed off. For resistant cases, overnight applications can be helpful. Topical azole antifungals can be applied every night for two weeks. Oral antifungal therapy is beneficial for widespread involvement, when patients cannot reach or have no assistance applying topicals, or for resistant cases. I typically use 100 mg of itraconazole b.i.d. for seven days.

The recurrence of tinea versicolor is not uncommon. 

Answers: 1-c; 2-d; 3-e

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