Editorial

The Changing Landscape of Dermatophytosis in Bangladesh: Emergence of Trichophyton indotineae and Therapeutic Challenges

Treating superficial fungal infections, especially dermatophytosis, has become increasingly challenging in Bangladesh and other South Asian countries over the last decade due to the increasing frequency of chronic, resistant and recurrent cases. As a result, a significantly higher proportion of patients attending dermatological outpatient departments (OPDs) present with fungal infections, creating an epidemic-like clinical scenario. The cause of this changing epidemiological and clinical scenario has been attributed to the emergence of a new dermatophyte species, Trichophyton indotineae, formerly classified as T. mentagrophytes ITS genotype VIII.[1-3] In fact, T. indotineae is a distinct species that was previously classified within the T. mentagrophytes species complex. It has emerged as a dominant dermatophyte variant, accounting for more than 94% of the study population with chronic, recalcitrant and resistant superficial fungal infections in selected patient populations in Bangladesh and other South Asian countries.[1,2] Clinically, patients present with various atypical features, including intense itching and burning sensations, involvement of extensive and unusual anatomical sites (ears, face and genitalia), and uncommon morphological patterns (polycyclic, arcuate, double-edged, dumbbell-shaped and bizarre geographic shapes). Other presentations include eczematous, steroid-modified, pustular, intensely inflammatory and erythroderma-like lesions.[2-4] A major therapeutic challenge in the management of dermatophytosis is the increasing frequency of terbinafine resistance, which is frequently associated with mutations in the squalene epoxidase (SQLE) gene.[1,5] In Bangladesh, nearly 64% of culture-positive isolates demonstrated terbinafine resistance, with SQLE mutations including L393S, L393F, F397L and F397I.[1-5] Oral itraconazole has become an important systemic treatment option, particularly for terbinafine-resistant dermatophytosis, often requiring prolonged treatment and careful clinical monitoring.[1],4-5 In this context, the use of oral voriconazole for dermatophytosis has also been reported with increasing clinical interest in Bangladesh.[6]

This unprecedented scenario underscores the need for continuous epidemiological surveillance, improved diagnostic capacity, and further research into novel therapeutic options and effective non-pharmacological preventive strategies.

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