

Clinical Spectrum and Associated Factors of Dermatophytosis in a Tertiary Care Hospital: A Prospective Observational Study from Maharashtra.

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Abstract

Background: Dermatophytosis is one of the most common superficial fungal infections encountered in dermatology practice. Its clinical presentation is diverse, and recurrent and chronic infections have become increasingly important, particularly in tropical countries such as India. Environmental, behavioural and host-related factors may contribute to disease occurrence and recurrence. **Objective:** To evaluate the clinical spectrum and anatomical distribution of dermatophytosis and to assess demographic, behavioural, environmental and clinical factors associated with the infection and its recurrence. **Methods:** A prospective observational study was conducted in the Department of Dermatology, Prakash Medical College and Hospital, Islampur, Sangli, Maharashtra, from January 2024 to August 2024. Fifty consecutive patients clinically diagnosed with dermatophytosis were enrolled. Demographic characteristics, occupation, residence, clinical presentation, duration of disease, previous episodes, recurrence, behavioural and environmental factors, family/contact history and relevant comorbidities were recorded using a structured proforma. Detailed dermatological examination was performed, and potassium hydroxide examination was undertaken where indicated. Data were analysed using descriptive statistics, and associations between selected categorical variables were assessed using the Chi-square or Fisher's exact test. A p-value <0.05 was considered statistically significant. **Results:** Of the 50 patients, 29 (58.0%) were males and 21 (42.0%) were females. The 21–30-year age group was most commonly affected (28.0%), followed by 31–40 years (24.0%). Rural residents constituted 56.0% of participants. Tinea corporis was the predominant clinical presentation (34.0%), followed by tinea cruris (24.0%) and combined tinea corporis with tinea cruris (16.0%). Pruritus was the commonest clinical symptom (88.0%), followed by erythema (82.0%), annular lesions with active margins (76.0%) and scaling (72.0%). Recurrent dermatophytosis was reported by 27 (54.0%) patients. Excessive sweating (58.0%) and occlusive clothing (50.0%) were the most frequently reported environmental and behavioural factors. Diabetes mellitus was present in 16.0% of patients. Occlusive clothing was significantly associated with recurrence (63.0% vs. 34.8%; p=0.049).

Previous history of dermatophytosis showed a strong association with recurrence (77.8% vs. 26.1%; $p<0.001$), while family/contact history was also significantly associated with recurrence (33.3% vs. 8.7%; $p=0.040$). **Conclusion:** Dermatophytosis predominantly affected young and middle-aged adults and commonly presented as tinea corporis and tinea cruris. Recurrence was frequent, with previous dermatophytosis, occlusive clothing and family/contact history emerging as significant associated factors. Comprehensive management incorporating appropriate antifungal therapy, moisture control, hygienic measures, avoidance of occlusive clothing and assessment of household contacts may help reduce recurrence and reinfection.

Keywords: *Dermatophytosis; tinea corporis; tinea cruris; recurrent dermatophytosis; risk factors; superficial fungal infection; India.*

Introduction

Dermatophytosis is a superficial fungal infection caused by keratinophilic fungi collectively known as dermatophytes. These organisms primarily infect keratinized tissues, including the skin, hair, and nails, and are traditionally classified into three major genera: *Trichophyton*, *Microsporum*, and *Epidermophyton*.¹ Dermatophytosis is among the most common superficial mycoses worldwide and represents a significant proportion of patients attending dermatology outpatient departments.²

The clinical presentation of dermatophytosis is diverse and depends on the anatomical site involved, causative organism, host factors, and duration of infection. Common clinical variants include tinea corporis, tinea cruris, tinea faciei, tinea manuum, tinea pedis, tinea capitis, and onychomycosis.³ In recent years, dermatophytosis has increasingly been recognized as an important public health concern in India because of its high prevalence, frequent recurrence, prolonged treatment requirements, and considerable impact on quality of life.⁴

India provides favourable conditions for the transmission of dermatophytes because of its predominantly warm and humid climate, particularly in tropical and subtropical regions. Factors such as excessive sweating, occlusive clothing, poor personal hygiene, overcrowding, shared clothing and towels, and occupational exposure to moisture may contribute to the acquisition and persistence of infection.⁵ In addition, diabetes mellitus, obesity, immunosuppression, and other underlying conditions may predispose individuals to dermatophytosis or contribute to recurrent disease.⁶

The epidemiology and clinical pattern of dermatophytosis have changed considerably over the past decade. Indian studies have reported an increasing frequency of chronic, recurrent, and extensive dermatophytosis, with involvement of multiple body sites becoming increasingly common.⁷ The emergence of resistant or poorly responsive infections has further complicated management and has highlighted the importance of identifying associated risk factors and documenting the clinical spectrum of disease.⁸

Diagnosis is generally based on clinical examination and may be supported by direct microscopy with potassium hydroxide (KOH) preparation and fungal culture.⁹ Although clinical diagnosis is often straightforward, atypical presentations and widespread or recurrent infections can create diagnostic difficulties. Accurate characterization of the clinical patterns and associated factors is therefore important for appropriate management and prevention of recurrence.⁹

Despite the high burden of dermatophytosis in India, regional variations in clinical presentation and associated risk factors continue to exist. Local data are particularly useful for understanding the patient profile and identifying potentially modifiable factors contributing to infection. Therefore, the present study was undertaken to evaluate the **clinical spectrum and associated factors of dermatophytosis among patients attending the Department of Dermatology at Prakash Medical College and Hospital, Islampur, Sangli, Maharashtra**, over an eight-month period from January 2024 to August 2024.

Objectives

1. To study the **clinical spectrum and anatomical distribution** of dermatophytosis among patients attending the Department of Dermatology.
2. To assess the **demographic and behavioural factors** associated with dermatophytosis.
3. To study the association of dermatophytosis with selected **predisposing factors and comorbidities**.

Methodology

Study design and setting

A **prospective observational study** was conducted in the Department of Dermatology, **Prakash Medical College and Hospital, Islampur, Sangli, Maharashtra**. The study was carried out over a period of **8 months, from January 2024 to August 2024**.

Study population and sample size

The study included **50 consecutive patients** clinically diagnosed with dermatophytosis who attended the dermatology outpatient department during the study period.

Inclusion criteria

Patients were included if they:

- Had clinical features suggestive of dermatophytosis.
- Were willing to participate in the study.
- Provided informed consent.
- Belonged to either sex and any age group.

Exclusion criteria

Patients were excluded if they:

- Were unwilling to participate.
- Had received systemic antifungal treatment immediately before evaluation, where this could interfere with clinical or mycological assessment.
- Had non-dermatophytic superficial fungal infections or other dermatoses mimicking dermatophytosis.

Study procedure

After obtaining informed written consent, relevant demographic and clinical information was collected using a predesigned structured proforma. Data regarding **age, sex, occupation, residence, socioeconomic characteristics, personal hygiene practices, sweating, clothing habits, contact history, duration of disease, previous episodes, treatment history, and recurrence** were recorded. Details of relevant comorbidities such as diabetes mellitus and other predisposing conditions were also documented.

A detailed dermatological examination was performed in all participants. The **site of involvement, number of affected sites, morphology of lesions, extent of disease, and clinical type of dermatophytosis** were recorded. Cases were classified according to the anatomical site involved, including tinea corporis, tinea cruris, tinea faciei, tinea manuum, tinea pedis, tinea capitis, and other clinically relevant presentations.

Where indicated, **skin scrapings, nail clippings, or hair samples** were collected from clinically suspected lesions under aseptic precautions. Direct microscopy with **10% potassium hydroxide (KOH) preparation** was performed to demonstrate fungal elements. Fungal culture was performed where required according to institutional laboratory facilities and clinical indication.

Outcome measures

The primary outcome was the **clinical spectrum and anatomical distribution of dermatophytosis**. Secondary outcomes included the frequency of demographic, behavioural, environmental, and clinical factors associated with dermatophytosis.

Statistical analysis

The collected data were entered into a Microsoft Excel spreadsheet and analysed using appropriate statistical methods. Categorical variables were expressed as **frequencies and percentages**, while continuous variables were expressed as **mean $\pm$ standard deviation** where appropriate. Associations between categorical variables were assessed using the **Chi-square test or Fisher's exact test**, as applicable. A **p-value <0.05** was considered statistically significant.

Ethical considerations

The study was conducted after obtaining approval from the **Institutional Ethics Committee** of the institution. Written informed consent was obtained from all participants before enrolment. Patient confidentiality was maintained throughout the study, and the collected information was used exclusively for research purposes.

Results

Table 1. Demographic characteristics of study participants (n=50)

Variable	Category	Frequency (n)	Percentage (%)
Age group (years)	≤20	6	12
	21–30	14	28
	31–40	12	24
	41–50	9	18
	51–60	6	12
	>60	3	6
Sex	Male	29	58
	Female	21	42
Residence	Urban	22	44
	Rural	28	56
Occupation	Farmer/agricultural worker	13	26
	Homemaker	10	20
	Student	8	16
	Manual worker	7	14
	Office/service	6	12
	Other	6	12

Among the 50 patients included in the study, the largest proportion belonged to the **21–30 years age group (28.0%)**, followed by 31–40 years (24.0%) and 41–50 years (18.0%). Patients aged ≤20 years constituted 12.0%, while 12.0% were aged 51–60 years and 6.0% were above 60 years. **Males predominated (58.0%)** over females (42.0%). A slightly higher proportion of participants were from **rural areas (56.0%)** compared with urban areas (44.0%). Regarding occupation, farmers/agricultural workers constituted the largest group (26.0%), followed by homemakers (20.0%), students (16.0%), manual workers (14.0%), and office/service workers (12.0%).

Table 2. Clinical spectrum and anatomical distribution of dermatophytosis (n=50)

Clinical type	Frequency (n)	Percentage (%)
Tinea corporis	17	34
Tinea cruris	12	24
Tinea corporis + cruris	8	16
Tinea faciei	4	8
Tinea pedis	3	6
Tinea manuum	2	4
Tinea unguium	2	4
Tinea capitis	1	2
Tinea corporis + other sites	1	2
Total	50	100

Tinea corporis was the most common clinical presentation, accounting for 34.0% of cases, followed by tinea cruris in 24.0%. Combined involvement of the trunk/body and groin (tinea corporis with tinea cruris) was observed in 16.0% of patients. Tinea faciei accounted for 8.0%, while tinea pedis and tinea manuum were observed in 6.0% and 4.0%, respectively. Tinea unguium constituted 4.0% of cases, whereas tinea capitis and tinea corporis with involvement of another site were each seen in 2.0%. Overall, **truncal and groin involvement constituted the predominant clinical spectrum.**

Table 3. Clinical characteristics of dermatophytosis (n=50)

Clinical characteristic	Frequency (n)	Percentage (%)
Pruritus	44	88
Erythematous lesions	41	82
Annular lesions with active margins	38	76
Scaling	36	72
Multiple lesions	31	62
Extensive/multisite involvement	18	36
History of recurrence	27	54
Duration >3 months	23	46
Family/contact history	11	22

Pruritus was the most frequent symptom, reported by 88.0% of patients, followed by erythematous lesions in 82.0%. Annular lesions with active margins were present in 76.0% of cases, while scaling was noted in 72.0%. Multiple lesions were observed in 62.0% of patients. A history of **recurrent dermatophytosis was present in 54.0%**, and 46.0% had disease duration exceeding three months. Multisite or extensive involvement was documented in 36.0% of patients. A history of similar infection among family members or close contacts was reported by 22.0% of participants.

Table 4. Behavioural and environmental factors associated with dermatophytosis (n=50)

Associated factor	Present n (%)	Absent n (%)
Excessive sweating	29 (58.0)	21 (42.0)
Frequent use of occlusive clothing	25 (50.0)	25 (50.0)
Sharing of clothes/towels	18 (36.0)	32 (64.0)

Inadequate drying after bathing	21 (42.0)	29 (58.0)
Regular exposure to water/moisture	20 (40.0)	30 (60.0)
Similar infection among family members	11 (22.0)	39 (78.0)
Previous dermatophytosis	27 (54.0)	23 (46.0)

Among the assessed behavioural and environmental factors, excessive sweating was the most frequently reported factor (58.0%). Frequent use of occlusive clothing was reported by 50.0% of participants. Inadequate drying after bathing was reported by 42.0%, while 40.0% had regular exposure to water or moisture. Sharing of clothes or towels was reported by 36.0% of patients. A similar infection among family members was reported in 22.0%. More than half of the participants (54.0%) reported a previous history of dermatophytosis, suggesting a substantial burden of recurrent or repeated infection.

Table 5. Predisposing factors and comorbidities among study participants (n=50)

Predisposing factor/comorbidity	Frequency (n)	Percentage (%)
No significant comorbidity	31	62
Diabetes mellitus	8	16
Obesity/overweight	7	14
Immunosuppressive condition/therapy	2	4
Atopic tendency	3	6
Other chronic illness	4	8

Of the 50 participants, 31 (62.0%) had no significant documented comorbidity or predisposing medical condition. Diabetes mellitus was the most frequent comorbidity, present in 16.0% of

patients, followed by overweight/obesity in 14.0%. Atopic tendency was noted in 6.0%, immunosuppressive conditions or therapy in 4.0%, and other chronic illnesses in 8.0%. Since some patients had more than one predisposing factor, the percentages were not mutually exclusive.

Table 6. Association of selected factors with recurrent dermatophytosis (n=50)

Factor	Recurrent n (%)	Non-recurrent n (%)	p-value
Excessive sweating			
Present	19 (70.4)	10 (43.5)	0.054
Absent	8 (29.6)	13 (56.5)	
Occlusive clothing			
Present	17 (63.0)	8 (34.8)	0.049*
Absent	10 (37.0)	15 (65.2)	
Previous history of dermatophytosis			
Present	21 (77.8)	6 (26.1)	<0.001*
Absent	6 (22.2)	17 (73.9)	
Diabetes mellitus			
Present	6 (22.2)	2 (8.7)	0.194
Absent	21 (77.8)	21 (91.3)	
Family/contact history			
Present	9 (33.3)	2 (8.7)	0.040*
Absent	18 (66.7)	21 (91.3)	

Among the 50 participants, **27 (54.0%) had recurrent dermatophytosis**, while 23 (46.0%) had no history of recurrence. Excessive sweating was more frequent among patients with recurrent disease than those without recurrence (70.4% vs. 43.5%), although the association did not reach statistical significance (**p=0.054**). Occlusive clothing was significantly more common among recurrent cases (63.0% vs. 34.8%; **p=0.049**). A previous history of dermatophytosis showed a **strong statistically significant association with recurrence**, being

present in 77.8% of recurrent cases compared with 26.1% of non-recurrent cases ($p<0.001$). Diabetes mellitus was more frequent among recurrent cases, but the association was not statistically significant ($p=0.194$). Similarly, a positive family/contact history was significantly associated with recurrence (33.3% vs. 8.7%; $p=0.040$). Overall, **previous dermatophytosis, occlusive clothing, and family/contact history emerged as significant factors associated with recurrent disease.**

Discussion

Dermatophytosis remains one of the most frequently encountered superficial fungal infections in dermatology practice. In India, the disease has assumed considerable clinical importance because of the increasing frequency of chronic, recurrent, extensive and multisite infections. Verma et al. described the recent Indian scenario as being characterized by a disproportionate increase in tinea corporis and tinea cruris, extensive disease and recurrent presentations.¹ The present prospective study of 50 patients from a tertiary care dermatology department provides a local perspective on the clinical spectrum and factors associated with dermatophytosis.

In the present study, **young and middle-aged adults constituted the majority of patients**, with the 21–30-year age group being the most commonly affected (28.0%), followed by 31–40 years (24.0%). This finding is consistent with previous Indian studies reporting a predominance of dermatophytosis among young adults. A multicentric Indian study found that patients aged 18–30 years constituted the largest age group, while an earlier Indian study also reported the 20–40-year age group as being particularly affected.^{2,3} The higher occurrence in this age group may be related to greater outdoor activity, occupational exposure, sweating, occlusive clothing and increased opportunities for interpersonal transmission.

A **male predominance (58.0%)** was observed in the present study. Similar male predominance has been documented in several Indian studies. In a multicentric study involving 395 patients, males constituted 63.8% of cases.² However, sex distribution varies between studies depending on the population studied and local occupational and behavioural factors. The predominance of males in the current study may partly reflect greater occupational exposure to heat, sweating and outdoor environments.

The **rural population accounted for 56.0%** of participants, with farmers/agricultural workers forming the largest occupational group. This observation may be explained by increased exposure to soil, moisture, heat and sweating among agricultural workers. However, residence

and occupation should be interpreted as contextual rather than independent risk factors, as dermatophytosis is common in both rural and urban populations.

Clinical spectrum

In the present study, **tinea corporis was the most common clinical presentation (34.0%)**, followed by tinea cruris (24.0%) and combined tinea corporis with tinea cruris (16.0%). Thus, involvement of the trunk and groin accounted for the major proportion of cases. These findings are broadly consistent with the contemporary Indian literature. Verma et al. reported a disproportionate increase in tinea corporis and tinea cruris in India.¹ A multicentric study also identified tinea corporis and tinea cruris as the most common clinical types, occurring in 71.4% and 62.0% of patients, respectively.²

The present findings are also comparable with a study from eastern India in which tinea corporis et cruris was the predominant presentation, followed by tinea corporis and tinea cruris.⁴ Similarly, a western Indian study reported tinea corporis et cruris as the commonest clinical presentation.⁵ The variation in the exact frequency of individual clinical types between studies may reflect differences in geographic location, climate, referral patterns and the proportion of treatment-naïve versus chronic/recurrent cases.

Pruritus was the commonest symptom (88.0%) in the present study, followed by erythema (82.0%), annular lesions with active margins (76.0%) and scaling (72.0%). These findings are compatible with the classical clinical morphology of dermatophytosis. However, the contemporary Indian epidemic has also been associated with atypical morphology and extensive disease, particularly among chronic and recurrent cases.¹

Chronicity and recurrence

An important finding of the present study was the relatively high frequency of **previous dermatophytosis (54.0%)**, with 54.0% of participants reporting recurrent disease. Chronic and recurrent dermatophytosis has become a major clinical concern in India. In a large multicentric study of chronic and recurrent dermatophytosis, 27.86% of patients with glabrous dermatophytosis fulfilled criteria for chronic or recurrent disease.³ The authors also reported frequent multiple-site involvement and a high prevalence of family history and fomite sharing.

The relatively high recurrence observed in the present study may be related to incomplete treatment, reinfection from family members, environmental exposure, occlusive clothing,

excessive sweating and persistence of predisposing factors. Pathania et al. emphasized that recurrent dermatophytosis often follows a protracted course with repeated exacerbations and remissions.⁶

Behavioural and environmental factors

Excessive sweating (58.0%) was the most frequently reported behavioural/environmental factor, followed by the use of occlusive clothing (50.0%). Heat, humidity, sweating and occlusion create favourable conditions for fungal proliferation and are particularly relevant in tropical climates. The association with occlusive clothing was statistically significant in relation to recurrence in the present study ($p=0.049$).

This observation is supported by previous Indian research. In an institution-based study from eastern India, patients with tinea cruris and tinea corporis reported worsening with tightly fitting clothing.⁴ Similarly, a multicentric study of chronic and recurrent dermatophytosis found that 43.47% of patients wore synthetic tight clothes.³ These findings emphasize the importance of counselling patients regarding loose, breathable clothing and measures to reduce excessive moisture.

Sharing of clothes or towels was reported by **36.0%** of participants in the present study. Although the association with recurrence was not directly tested in the same manner as in larger studies, this finding is clinically relevant because fomites can contribute to transmission and reinfection. In the multicentric Indian study, fomite sharing was reported in approximately half of patients with chronic/recurrent dermatophytosis and was identified as an important associated factor.³

A **family/contact history was present in 22.0%** of the present participants and was significantly associated with recurrence ($p=0.040$). This finding supports the importance of household transmission and reinfection. The eastern Indian study similarly demonstrated a significantly greater frequency of family history and sharing of fomites among chronic and recurrent cases.⁴

Comorbidities

In the present study, **diabetes mellitus was identified in 16.0%** of patients, while overweight/obesity was documented in 14.0%. Although diabetes was more frequent among recurrent cases, the association did not reach statistical significance ($p=0.194$). Diabetes has

traditionally been recognized as a predisposing systemic condition for superficial fungal infections. Earlier Indian literature has also reported diabetes mellitus and atopy among common systemic associations in chronic dermatophytosis.⁷

The absence of a statistically significant association in the present study should, however, be interpreted cautiously because of the **small sample size of 50 patients**. A larger study would be required to determine whether diabetes and metabolic factors independently contribute to recurrence.

Factors associated with recurrence

The most important finding of the present study was the strong association between **previous history of dermatophytosis and recurrent disease**. A previous history was present in 77.8% of recurrent cases compared with only 26.1% of non-recurrent cases ($p<0.001$). This finding indicates that patients who have experienced dermatophytosis previously may be particularly susceptible to repeated episodes, whether because of persistent predisposing factors, inadequate treatment, reinfection or behavioural/environmental exposure.

The significant association between **occlusive clothing and recurrence** ($p=0.049$) further supports the role of modifiable environmental factors. Similarly, the significant association between **family/contact history and recurrence** ($p=0.040$) suggests that reinfection from close contacts may contribute to persistent disease. These findings are in agreement with larger Indian studies in which family history, fomite sharing, tight clothing and multiple-site involvement were prominent among chronic or recurrent cases.^{3,4}

An important limitation in interpreting the present findings is that the study was conducted at a single tertiary care centre and included only 50 patients. Therefore, the findings may not be generalizable to the wider population. Furthermore, although KOH examination was included in the methodology, the present analysis primarily focused on clinical characteristics and associated factors rather than species-level mycological identification. Larger multicentric studies incorporating culture, species identification and antifungal susceptibility testing would provide additional information, particularly given the increasing concern regarding recalcitrant dermatophytosis and antifungal resistance in India.⁵

Overall, the present study demonstrates that dermatophytosis predominantly affected young and middle-aged adults and was characterized mainly by **tinea corporis and tinea cruris**, with a substantial burden of recurrent disease. **Previous dermatophytosis, occlusive clothing and**

family/contact history were significantly associated with recurrence. These findings highlight the importance of early diagnosis, adequate treatment, avoidance of inappropriate topical therapies, attention to personal hygiene and moisture control, and simultaneous identification and management of infected household contacts.

The findings of the present study are also comparable with a recent prospective observational study from South India by Balasubramanian et al., which evaluated 420 patients with dermatophytic mycoses in a tertiary care hospital. Tinea corporis was the most common classical clinical manifestation (17.38%), followed by tinea cruris (16.43%), although tinea incognita accounted for a substantial proportion of cases. The study further demonstrated that dermatophytosis affected patients across different age groups, emphasizing the continuing clinical burden of dermatophytosis in tertiary care settings.⁸

The high frequency of recurrent disease observed in the present study is particularly relevant in the context of the changing epidemiology of dermatophytosis in India. Recent literature has highlighted the emergence of chronic, recurrent and extensive dermatophytosis, with *Trichophyton indotineae* increasingly implicated in difficult-to-treat infections. This organism is notable for frequent terbinafine resistance and has been associated with chronic or recurrent widespread infections involving the groin, trunk, gluteal region and face.⁹ Therefore, persistent or recurrent disease should not be attributed solely to poor compliance or reinfection; mycological evaluation and consideration of antifungal resistance may be warranted in selected recalcitrant cases.

The issue of antifungal resistance is particularly important in the Indian context. Shah et al., in a clinical-mycological study from Western India, emphasized that antifungal resistance contributes to recalcitrant dermatophytosis, although resistance alone does not explain the changing epidemiology of the disease.¹⁰ Similarly, multicentric Indian data have demonstrated differences in antifungal susceptibility among dermatophyte species.¹¹ These observations support the need for rational antifungal prescribing, avoidance of inappropriate combination or corticosteroid-containing preparations, and culture or susceptibility testing in patients with persistent or treatment-resistant disease.

Conclusion

The present prospective observational study demonstrated that dermatophytosis constituted a clinically diverse superficial fungal infection, predominantly affecting **young and middle-**

aged adults, with a slight male predominance. **Tinea corporis was the most common clinical presentation**, followed by tinea cruris and combined corporis-cruris involvement. Pruritus, erythema, annular lesions with active margins, and scaling were the predominant clinical features.

A substantial proportion of patients had **recurrent disease and a previous history of dermatophytosis**, indicating the persistent nature of the condition. Excessive sweating, occlusive clothing, inadequate drying, moisture exposure, and sharing of clothes or towels were frequently reported behavioural and environmental factors. **Previous dermatophytosis, use of occlusive clothing, and family/contact history were significantly associated with recurrence**, highlighting the importance of both individual and household factors in disease persistence.

The findings emphasize that management of dermatophytosis should extend beyond antifungal therapy and include **patient education regarding personal hygiene, moisture control, appropriate clothing, avoidance of shared fomites, adequate treatment adherence, and evaluation of symptomatic household contacts**. Early recognition of recurrent disease and identification of modifiable risk factors may help reduce treatment failure and reinfection. Larger multicentric studies with detailed mycological identification and antifungal susceptibility testing are warranted to further characterize the changing epidemiology and treatment challenges of dermatophytosis in India.

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