



Counter-reply

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Dear authors

In answer to your previous letter:

1- The author quoted by you - Tchernev G - says in his article that possible agents involved in perifolliculitis capitis abscedens et suffodiens are various *Malassezia* yeast species. For your verification, provided below is the original quote from the author.

"Folliculitis et perifolliculitis capitis abscedens et suffodiens is a rare disease of unknown etiology... The cause of scalp folliculitis is not well understood. It is generally considered to be an inflammatory reaction to components of the hair follicle, particularly the micro-organisms. These include: bacteria (especially Propionibacterium acnes, but in severe cases, also Staphylococcus aureus), Yeasts (Malassezia species) and mites (Demodex folliculorum)."

The same author highlights that this is an entity of unknown cause. Therefore, despite the many etiopathogenic hypotheses, we cannot include or exclude with accuracy any known or unknown nosological agent. The literature is rich in multidrug treatments. The paper by Tchernev that you quoted includes metronidazole, an agent used for the treatment of rosacea, for *Demodex folliculorum*. This microorganism is cited by Tchernev as a possible participant agent in the disease. In a recent publication, Mihic et al used fluconazole to treat the aforementioned entity.

Provided below is the original quote from the article by Mihic et al:

..." The patient received systemic antibiotics (azithromycin and amoxicillin-clavulanate) and oral antimycotic therapy (fluconazole), followed by a long period of oral isotretinoin with local skin care, which led to resolution and thus inhibited the evolution to scarring and nodular stage of the disease..."

Mihic et al reinforce the need for the performance of repeated mycological tests in patients with the disease, and this is exactly the point that our paper wishes to emphasize.

Our paper does not attribute the fungal etiology to *Folliculitis et perifolliculitis abscedens et suffodiens capitis*. Nor is the purpose of our article to deny or question well-established publications and authors who correlate dissecting cellulitis with the participation of the bacteria *Staphylococcus aureus* and with the alteration of keratinization of the pilosebaceous follicle. This is an indisputable fact. What we want is to draw attention to the necessity of performing mycological examination in cystic and fistulous lesions of the scalp with pus formation in adults and in children, because in our hospital we often see misdiagnosed cases resulting in scarring alopecia secondary to fungi, which could have been avoided with early treatment. Our paper is not a review of the pathogenesis of alopecias but rather a therapeutic review of mycoses, among them tinea capitis.

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2- " Black dots are undoubtedly seen in patients with tinea capitis and correspond to the tonsure of the hair caused by endothrix parasitism (initially endothrix or ectothrix). The works of Nilam, Koch and Rudnika highlight the black dots as important features of tinea capitis. In their paper, Nilam et al published figure number 6 and chart number 1 to highlight the presence of black dots in this entity.

Provided below are the original quotes from the article by Nilam et al:

"Trichoscopy features vary in inflammatory and non-inflammatory variants. A specific finding of tinea capitis is comma hair, seen as stubs of hair close to the skin surface. Non-inflammatory variant of black dot tinea is characterized by numerous broken hair shafts seen as black dots over the scalp. These represent shafts that break due to destruction caused by fungal elements. Scaling usually accompanies these findings." Fig 6 (Tinea capitis: Black dots with scaling and blotchy pigmentation pattern are visible) (chart1)

"Black dots had greater sensitivity and diagnostic value (LR > 1) for the contact mode that is they were better appreciated in contact mode, but were not statistically correlated. They were seen in alopecia areata (71.8%), tinea capitis (73%) and trichotillomania (100%) patients."

Koch *et al* named it "black dot" tinea capitis.

"Black dot" tinea capitis is a common cause of alopecia in young patients. It is most commonly caused by a dermatophyte infection with Trichophyton tonsurans."

Several scalp disorders other than alopecia areata may show black dots in dermoscopy images, such as, for example, trichotillomania or chemotherapy-induced alopecia. This is a sign that represents the dystrophic anagen hair, which has not emerged from the skin. This may be caused by several factors. The so-called "broken hairs", which correspond to the tonsured anagen hairs, are frequently seen in the dermoscopy of tinea, and represent the chief feature of the clinical examination: the tonsure. In tinea capitis

there may be narrowing of the proximal portion of the hair shaft, with "exclamation mark" appearance (the term "tapered hair" is used in many articles as a synonymous of exclamation mark hair), which is seen in alopecia areata, as reported in Nilam's study, quoted below:

"Other hallmark features for alopecia areata included tapered hair, black dots and broken hair which can also be observed to a degree in trichotillomania and tinea capitis."

Likewise, the "exclamation mark" appearance can also be seen in trichotillomania, in which the hair is broken by physical forces. In alopecia areata and tinea capitis the peribulbar inflammatory process may be responsible for reducing the diameter of the hair shaft in the area close to the scalp. Electronic microscopy will certainly show different aspects of the shaft, despite similar dermoscopy. Of chief importance is the characterization of the image of the tonsured (pigmented) anagen hair. There are other dermoscopic aspects, such as comma hair and corkscrew hair, which also represent the tonsured hair shaft and are not pathognomonic, but very characteristic. These details would be much better highlighted in a review article on dermoscopy than in a therapeutic update on mycoses.

It is important to emphasize the fact that the gold standard for diagnosis of tinea capitis is not dermoscopy, but mycological examination. Dermoscopy, when available, is a complementary auxiliary tool. It does not replace direct mycological examination and culture, which are also important for epidemiological purposes.

3- There really was a misprint ON THE TABLE, which has been well identified by you. Instead of "griseofulvin", it should read "amphotericin". Fortunately, the text is correct. Furthermore, griseofulvin is not available for IV use.

Conclusion:

We would like to thank the experts in alopecias for the great contribution of their letter to this update article on the treatment of superficial mycoses.

REFERENCE

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