Dermatology Reports
https://www.pagepress.org/journals/index.php/dr/index

eISSN 2036-7406

Please cite this article as:

Licata G, Franzese P, Giorgio CM. A trichromatic diagnostic pattern in inverse pityriasis versicolor: clinical, dermoscopic, and Wood's lamp correlation. *Dermatol Rep 2026 [Epub Ahead of Print] doi: 10.4081/dr.2026.10737*

Submitted 06/12/25 - Accepted 29/12/25

A trichromatic diagnostic pattern in inverse pityriasis versicolor: clinical, dermoscopic, and Wood's lamp correlation

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Key words: trichromatic diagnostic pattern; inverse pityriasis versicolor; dermoscopy; Wood's lamp.

Conflict of interest: the authors have no conflict of interest to declare.

Ethics approval and consent to participate: no ethical committee approval was required for this case report by the Department, because this article does not contain any studies with human participants or animals. Informed consent was obtained from the patient included in this study.

Consent for publication: the patient gave her written consent to use her personal data for the publication of this case report and any accompanying images.

Availability of data and materials: not applicable.

Dear Editor,

Pityriasis versicolor (PV) is a superficial mycosis caused by *Malassezia* species and most often affects the trunk and upper limbs. Flexural or inverse variants, however, may differ markedly from classical morphology due to the influence of moisture, temperature, and friction.[1,2] These atypical presentations frequently mimic erythrasma, candidal intertrigo, tinea cruris, seborrheic dermatitis, and pigmentary disorders. Although dermoscopy and Wood's lamp examination are recognized diagnostic tools for PV, their combined relevance in inverse cases has been insufficiently explored. We present a case demonstrating how the integration of clinical inspection, dermoscopy, and ultraviolet-induced fluorescence reveals a distinctive trichromatic diagnostic pattern that aids in identifying inverse PV.

A patient presented with sharply demarcated hypochromic macules distributed symmetrically along both inguinal folds (Figure 1 a,b). The surface exhibited delicate, powdery scaling that became more evident after gentle scraping. Light-brown reticulated macules contributed to a heterogeneous background, while faint erythematous undertones indicated minimal inflammation. This combination of hypopigmented, light-brown, and erythematous components is consistent with atypical PV arising in occluded environments.[1,2] Dermoscopy revealed fine white superficial scale arranged in irregular polygonal or reticulated patterns with mild perifollicular accentuation (Figure 1c). The surface appeared dry rather than macerated, differentiating it from candidiasis and dermatophytosis. The background ranged from off-white to pale pink, and vascular structures such as dotted or glomerular vessels were absent. These findings align with dermoscopic features described in PV, including polygonal scaling and uniform pigment dilution.[3,4]

Wood's lamp examination showed bright green fluorescence, either homogeneous or perifollicular (Figure 1d). Although not universally present across all *Malassezia* species, this green emission is a recognized supportive sign of PV.[5] It contrasts with the coral-red fluorescence of erythrasma, the absence of fluorescence in candidiasis, and the chalk-white appearance typical of vitiligo.

The correlation of clinical, dermoscopic, and fluorescent findings provided a cohesive diagnostic framework. The integration of clinical morphology, dermoscopy, and Wood's lamp fluorescence revealed a reproducible trichromatic diagnostic pattern in this case of inverse PV.

The coexistence of hypochromic macules, light-brown pigmentation, and mild erythema produces a heterogeneous appearance that may otherwise suggest competing inflammatory or infectious conditions common in flexural regions. Dermoscopy contributed important discriminatory features by demonstrating polygonal white scaling without vascular structures, distinguishing PV from inverse psoriasis and seborrheic dermatitis, where characteristic vascular morphology is expected.[3,4] Wood's

lamp examination further refined the diagnosis by demonstrating bright green fluorescence, a feature supportive of PV and absent in several key differential diagnoses.[5]

To our knowledge, no published reports have synthesized these three modalities into a unified diagnostic triad for inverse PV. Recognizing this trichromatic pattern may facilitate earlier and more confident diagnosis, particularly in anatomical regions where occlusion and friction obscure classical morphology. Multimodal assessment may therefore reduce diagnostic uncertainty and guide appropriate management in atypical presentations.[1,3] This case illustrates the diagnostic value of combining clinical inspection, dermoscopy, and Wood's lamp examination when evaluating inverse PV. The identification of a trichromatic pattern – expressed clinically, dermoscopically, and through ultraviolet-induced fluorescence – offers a structured approach particularly suited to flexural areas where morphology may be misleading. Although based on a single case, this integrated diagnostic perspective highlights a potentially useful framework deserving further study.

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Figure 1. Clinical, dermoscopic, and Wood's lamp features of tinea inversicolor (inverse pityriasis versicolor). **a**) Clinical overview of the inguinal region showing multiple well-defined hypochromic macules of variable size along both inguinal folds. The dry, powdery surface scale becomes more evident in areas of friction, producing the heterogeneous trichromatic appearance characteristic of inverse presentations. **b**) Closer clinical detail highlighting intermixed hypopigmented and light-brown macules, with subtle erythematous undertones. The heterogeneous color distribution reflects the combined influence of occlusion, humidity, and subclinical inflammation in flexural sites. **c**) Dermoscopic image demonstrating fine white superficial scale arranged in irregular polygonal or cracked configurations with mild perifollicular accentuation. The background appears off-white to pale pink and lacks vascular structures, consistent with dermoscopic features of pityriasis versicolor and useful in differentiating it from inverse psoriasis, candidiasis, and dermatophytosis. **d**) Wood's lamp examination revealing bright green fluorescence, either homogeneous or perifollicular, corresponding to *Malassezia*-associated fluorophores. This finding strongly supports the diagnosis of pityriasis versicolor and contrasts with the coral-red fluorescence of erythrasma and the absence of fluorescence typical of candidal intertrigo and pigmentary disorders.