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BEYOND THE USUAL CAT: TRICHOPHYTON BENHAMIAE KERION CELSI IN A CHILD WITH CHINCHILLA-ASSOCIATED HOUSEHOLD OUTBREAK**T. Galeotti¹, D. Tesauri¹, P. Caposciutti¹, L. Bianchi¹, S. Crotti², D. Cruciani², K. Hansel¹, L. Stingeni¹**¹Dermatology Unit, Department of Medicine and Surgery, University of Perugia, Perugia, Italy; ²Istituto Zooprofilattico Sperimentale dell'Umbria e delle Marche "Togo Rosati", Perugia, Italy**Keywords:** *Trichophyton Benhamiae*, *Kerion Celsi*.

Introduction. *Trichophyton benhamiae* is an emerging zoophilic dermatophyte increasingly reported as a cause of inflammatory tinea in children, including kerion celsi. Due to its variable epidemiological sources and often misleading exposure history, accurate identification of the infection source may be challenging and may require molecular confirmation.

Materials and Methods. We report a pediatric case of extensive dermatophytosis initially managed in the outpatient setting and subsequently hospitalized due to clinical worsening. Clinical evaluation, laboratory testing, mycological examination, and epidemiological reconstruction were performed. Definitive species identification was obtained through molecular sequencing.

Results. A 5-year-old boy presented with multiple erythematous, scaly papulo-squamous lesions involving the face, trunk, gluteal region, and scalp. Initial outpatient management by a community dermatologist included topical antifungal therapy for suspected tinea corporis, with partial improvement. Over the following weeks, scalp involvement progressed to a large inflammatory alopecic plaque with pustulation, crusting, and associated retroauricular and laterocervical lymphadenopathy, consistent with kerion celsi. The patient was therefore referred for hospital admission. On admission, laboratory tests showed mild neutrophilic leukocytosis and elevated inflammatory markers. Systemic therapy with griseofulvin was initiated, together with ampicillin/sulbactam for suspected bacterial superinfection and topical antiseptic/antibacterial treatment (fusidic acid and aqueous fuchsin). Bacterial and yeast cultures from skin swabs were negative. During hospitalization and subsequent follow-up visits, progressive clinical improvement was observed, with crusting of lesions, reduction of the pustular component, and normalization of inflammatory markers. Species identification as *Trichophyton benhamiae* was achieved by fungal culture and confirmed by molecular sequencing. Epidemiological re-evaluation revealed a household zoonotic out-

break. A sibling presented with concomitant tinea corporis of the trunk, successfully treated with topical terbinafine. Domestic chinchillas showed alopecia and pruritus and were subsequently treated, strongly suggesting an animal reservoir as the source of infection. Initial exposure hypotheses, including animal contact during a travel in India and rural accommodation, were considered less relevant. At follow-up, the patient showed marked clinical improvement under systemic antifungal therapy, with resolution of inflammatory signs and residual patchy alopecia of the scalp.

Conclusions. This case highlights a household outbreak of *Trichophyton benhamiae* infection presenting with extensive tinea corporis and kerion celsi in a child, confirmed by molecular identification. It emphasizes the importance of repeated and dynamic epidemiological assessment and awareness of atypical zoonotic reservoirs, such as chinchillas and guinea pigs. Molecular diagnostics can be crucial for confirming emerging dermatophyte species and for accurate outbreak tracing.

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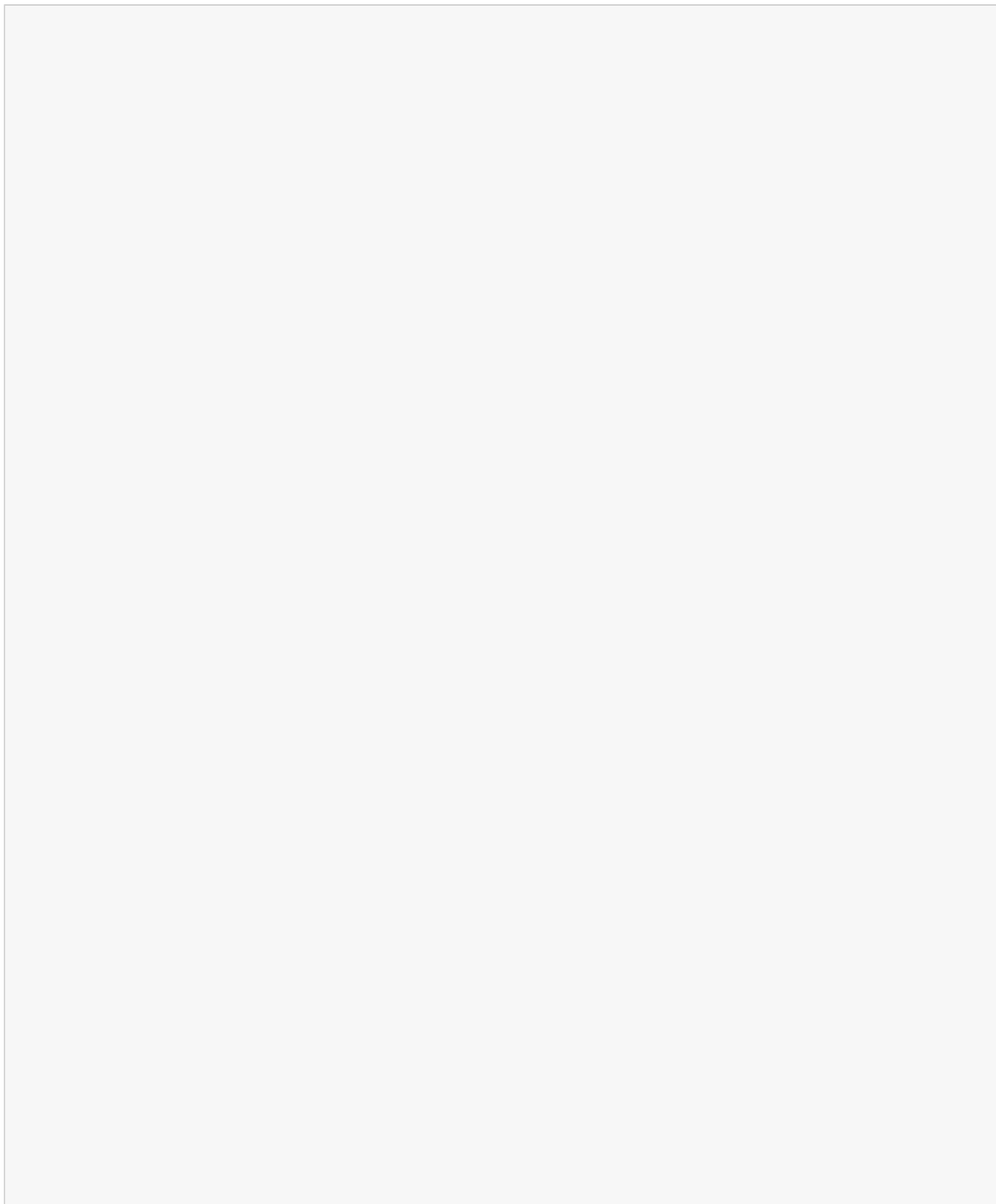
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