

Tinea Corporis: A Comprehensive Review of Clinical Features and Homoeopathic Therapeutics

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ABSTRACT

Tinea corporis, commonly known as ringworm, is a superficial fungal infection of the glabrous skin. While once considered a manageable tropical infection, it has evolved into an epidemic-like, chronic, and difficult-to-treat condition in India over the last decade. Primarily caused by *Trichophyton rubrum*, *Trichophyton mentagrophytes* has also emerged as a major pathogen. The infection spreads through direct contact with infected individuals, animals or contaminated objects like towels and clothing. The infection typically manifests after 1-3 weeks as a well-defined, scaly, erythematous annular plaque that spreads outward with central clearing. The diagnosis of tinea corporis is usually clinical, confirmation can be done by microscopic examination of potassium hydroxide (KOH) wet-mount preparations and fungal cultures. Management centers on systemic or topical antifungals, avoiding the misuse of over-the-counter combinations and strictly maintaining personal hygiene to prevent recurrence. Additionally, this article outlines the role of Homoeopathic management utilizing individualized remedies such as *Sepia officinalis*, Tellurium, Sulphur, etc.

Keywords: Tinea corporis, Ringworm, Dermatophytosis, Annular lesion, Homoeopathic management

INTRODUCTION

Tinea corporis is a superficial dermatophyte infection characterized by either inflammatory or non-inflammatory lesions on the glabrous skin (excluding scalp, groin, palms, and soles). The most common organism worldwide is *Trichophyton rubrum* and is the source of 47% of tinea corporis cases. ^[1] Tinea corporis is characterized by pea sized, pale red, well defined, slightly raised macule which soon becomes scaly and tends to clear in the center as it spreads peripherally, developing Ring like or annular lesion so it is called as ringworm of the body. ^[2] Tinea corporis is highly contagious and may spread through direct contact with infected individuals, animals, contaminated objects, or fomites, it affects people of all ages, with higher prevalence among children and preadolescents. ^[1]

Epidemiology

The tinea infections are commonly prevalent in tropics and in geographical areas with higher humidity, overpopulation and poor hygienic living conditions. ^[3] Other factors such as increased urbanization, including the use of occlusive footwear and tight fashioned clothes etc are also linked with higher prevalence. ^[1]

According to World Health Organization (WHO), the prevalence rate of superficial mycotic infection worldwide has been found to be 20-25%. Its prevalence varies in different countries. Tinea corporis (78.1%) was the commonest clinical presentation, followed by tinea cruris (10.1%), tinea manuum (2.5%), tinea faciei (1.8%), and tinea pedis (0.7%). ^[4]

Dermatophytosis was considered as harmless and easy to treat infection of tropical and subtropical countries; mainly seen during summer and rainy seasons, has now become a perennial and difficult-to-treat in India.

According to studies, there has been increase in the incidence of this infection across the country in past decade and especially over the last 5-6 years, leading an epidemic like situation in country. ^[5] In India, dermatophytosis has a recent prevalence of 36.6–78.4%. ^[6]

Etiology:

Trichophyton rubrum, *Trichophyton tonsurans*, *Trichophyton mentagrophytes*, and *Epidermophyton floccosum* are common organisms that cause tinea corporis. Traditionally, *Trichophyton rubrum* has been regarded as the most common pathogen in the globe. Alongside *Trichophyton rubrum*, *Trichophyton mentagrophytes* has emerged as a major pathogen. ^[7]

Patho-Physiology of Tinea Corporis:

- Dermatophytes live in the non-living, cornified layers of the skin, hair, and nail, which is attractive for its warm, moist environment help to fungal proliferation. Fungi may release keratinases and other enzymes to invade deeper into the stratum corneum, although typically the depth of infection is limited to the epidermis and, at times, its appendages. They generally do not invade deeply, owing to non-specific host defense mechanisms that can include the activation of serum inhibitory factor, complement, and polymorphonuclear leukocytes.
- Following the incubation period of 1-3 weeks, dermatophytes invade peripherally in a centrifugal pattern. In its response, the active border has an increased epidermal cell proliferation with resultant scaling. This creates a partial defense by way of shedding the infected skin and leaving new, healthy skin central to the advancing lesion.
- *Trichophyton rubrum* is a common dermatophyte and, because of its cell wall, is resistant to eradication. This protective barrier contains mannan, which may inhibit cell mediated immunity, hinder the proliferation of keratinocytes, and enhance the organism's resistance to the skin's natural defenses. ^[1]

Clinical features:-

- The incubation period is 1–3 weeks.
- Tinea corporis typically presents as a well demarcated, sharply circumscribed, oval or circular, mildly erythematous, scaly patch or plaque with a raised leading edge.
- The lesion starts off as a flat scaly spot that spreads centrifugally and clears centrally to form a characteristic annular lesion giving rise to the term ‘ringworm’.
- The central area becomes hypopigmented or brown and less scaly as the active border progresses outward. The border is usually annular and irregular.
- Occasionally, the border can be papular, vesicular, or pustular. Lesions may assume other shapes such as circinate and arcuate. Mild pruritus is common. ^[8]



[Fig 1: Tinea Corporis] ^[9]

Differential diagnosis:

- A. Nummular eczema
- B. Papulosquamous lesions psoriasis^[10]
- C. Pityriasis rosea
- D. Tinea versicolor^[8]

Diagnosis:

- The diagnosis of tinea corporis is most often clinical, especially if the lesion is typical. A well-demarcated, sharply circumscribed, erythematous, annular, scaly plaque with a raised leading edge, and scaling and central clearing on the body is characteristic.
- If necessary, the diagnosis can be confirmed by microscopic examination of potassium hydroxide (KOH) wet-mount preparations of skin scrapings from the active border of the lesion.
- Fungal culture is the gold standard to diagnose Dermatophytosis, especially if the diagnosis is in doubt and results of other tests are inconclusive, or the infection is widespread, severe, or unresponsive to treatment.^[8]
- Dermascopy has emerged as a useful, rapid non –invasive diagnostic tool that helps identifying characteristic dermoscopic features such as white scales and reddish-brown globules in tinea infections.^[11]

Treatment:

- Systemic antifungal are necessary for big and extensive lesions, while topical azole, allylamine, and other kinds of antifungals can be used to treat localized small lesions.
- The majority of infections in newborns, pregnant women, lactating women, and people with hepatic or renal dysfunctions must be treated with topical antifungals alone as the initial line of treatment.
- In India, tinea corporis is complicated by a considerable number of extensive, recurrent, chronic, and steroid-modified cases, necessitating the use of systemic antifungals for longer periods of time than the standard recommendation found in older literature.

General measures:

- The patient should get counseling about the significance of following the treatment plan.
- Maintaining general hygiene is crucial to preventing infection recurrence and transmission within the family. These include of taking regular showers, changing clothes frequently, washing them, staying away from tight clothing, and not sharing mattresses, towels, or clothes. Clothes that are infected should be cleaned separately and thoroughly dried.
- Avoiding the use of over-the-counter combination creams including antibiotics, steroids, and antifungal, as well as self-medication and prescription sharing, should be prioritized. ^[10]

Homoeopathic Management:

The Homoeopathic approach to managing Tinea Corporis is based on the fundamental principles laid down by Dr. Samuel Hahnemann. In Homoeopathy, skin diseases like Dermatophytosis are not treated as merely local infections but as external expressions of an underlying internal derangement. Homoeopathy aims to treat the

patient as a whole, addressing not only local fungal infection but also the patient's susceptibility, general constitution, and possible underlying miasmatic influence. ^[12]

J. Henry Allen, in his "Diseases and Therapeutics of the skin," says that Herpes circinnatus (ringworm of the surface) is usually treated and with fair success by sepia, Rhustox, tellurium. ^[13]

A clinical study involving 147 patients with Dermatophytosis reported significant improvement following individualized Homoeopathic treatment. After 6 months of treatment, 63.3% of patients became KOH-negative. Commonly prescribed remedies included Sulphur, Natrum muriaticum, Sepia, Arsenicum album, Lycopodium clavatum, and Graphites. ^[14]

Some of the medicines which are indicated in case of Tinea Corporis are: ^[15, 16, 17, 18, 19]

1) SEPIA OFFICINALIS:

- Herpetic eruption on genitals, lips and mouth; ring-worm upon face and body, on isolated spots on upper part of the body. Ringworm like eruptions every spring

Itching, not relieved by scratching, worse in bends of elbows and knees

2) TELLURIUM:

- Ringworm covers the whole body,
- Barber's itch; Itching, pricking as from bugs, itching of hands and feet, itching aggravates at night after going to bed and also worse in cool air.
- Body thickly covered with elevated rings of herpes circinnatus. Intersecting rings over whole body

3) BACILLINUM:

- Dr. Burnett has shown that ringworm of the scalp and Pityriasis versicolor on the body or indications of tubercular diathesis. They respond to this remedy

4) CLEMATIS ERECTA:

- Red, burning, vesicular eruptions. Itches violently with profuse desquamation; worse washing in cold water. Worse on face, hands and scalp around occiput.

5) GRAPHITES:

- Itching of the skin all over the body, with or without eruptions. Itching worse at night in the warm bed; itching and burning with eruptions. Rawness in bends of limbs, groins, neck, behind ears
- Eruptions worse from heat. Moist, crusty eruptions, oozing out a sticky exudation

6) PSORINUM:

- Intolerable itching; aggravation by heat of bed; scratches raw until it bleeds

Sleepless from intolerable itching. Herpetic eruptions especially on scalp and bends of joints

- Bad effects from suppression by sulphur and zinc ointments.

7) RANUNCULUS BULBOSUS:

- Burning and intense itching worse by contact. Hard excrescences, herpetic eruptions with great itching. Vesicular and pustular eruption

8) SULPHUR:

- Eruptions almost of every kind, skin affection after local medications.
- Skin dry, rough, unhealthy, itching voluptuous; violent, aggravation at night, in bed, scratching and washing, burning when scratched
- Excoriation especially in folds, Pruritus especially from warmth, evening, often reoccur in spring time, in damp weather

9) THUJA:

- Eruptions only on covered parts, worse after scratching. Dry skin with brown spots, dirty, hairy Brown spots on hands and arms. Moist corroding eruption on occiput & temples, worse from touch, better from rubbing

10) NATRUM MURIATICUM:

- Skin oily, harsh, unhealthy or yellow
- Rash over whole body, with stinging sensation in skin, itching and pricking in skin
- Chaps of herpetic eruptions agg. Flexures, or about knuckles
- Dry eruptions on margins of hair

11) DULCAMARA:

- Ringworm in children. Eruptions scaly, thick, crusty, moist, bleeding or herpetic aggravation before menses.
- Pruritus always worse in cold, wet weather
- Tatters of different kinds, such as humid, scaly, pale tatters, oozing after having been scratched; bleeding after having been scratched; tatters with red edges painfully sensitive to touch, and to cold water. Red spots, as if caused by flea-bites.

REFERENCES

1. Dr. Seema Gupta, Dr. Pooja Jain, Role of homoeopathic medicines in tinea corporis: A case study, International Journal of Homoeopathic Sciences 2019; 3(4): 01-04
2. Dr. Shrishail M Murgod. Tinea corporis and homoeopathic management. Int J Hom Sci 2021;5 (4):123-126.
3. Uttamchandani, Piyu & Patil, Aditya. (2019). Homoeopathy an Alternative Therapy for Dermatophyte Infections.
4. Gupta, Yogeshwari & Tuteja, Sonia & Acharya, Ankita & Tripathi, Vikrant. (2021). Effectiveness of Homoeopathy in Tinea corporis and Tinea cruris – A Prospective, Longitudinal Observational Study. International Journal of Advanced Ayurveda, Yoga, Unani, Siddha and Homeopathy. 10. 618-627.
5. Verma SB, Panda S, Nenoff P, et al. The unprecedented epidemic-like scenario of dermatophytosis in India: I. Epidemiology, risk factors and clinical features. Indian J Dermatol Venereol Leprol. 2021;87(2):154-175. doi:10.25259/IJDVL_301_20
6. Rajagopalan, M., Inamadar, A., Mittal, A., Miskeen, A. K., Srinivas, C. R., Sardana, K., Godse, K., Patel, K., Rengasamy, M., Rudramurthy, S., & Dogra, S. (2018). Expert consensus on the management of dermatophytosis in India (ECTODERM India). BMC Dermatology, 18, 6.

7. Tahiliani, S., Saraswat, A., Lahiri, A. K., Shah, A., Hawelia, D., Shah, G. K., Girdhar, M., Rao, P. N., Raghav, P. A., Agarwal, P., Kharkar, R. D., Gupta, R. P., Udare, S., Hegde, S., & Haldar, S. (2021). Etiological prevalence and antifungal sensitivity patterns of dermatophytosis in India - A multicentric study. *Indian journal of dermatology, venereology and leprology*, 87(6), 800–806.
8. Leung AKC, Lam JM, Leong KF, Hon KL. Tinea corporis: an updated review. *Drugs in Context* 2020; 9: 2020-5-6. DOI: 10.7573/dic.2020-5-6]
9. Miao, V.Y., Saunderson, R. B. (2024). A polycyclic scaly eruption on the trunk and shoulders. *Medicine Today*, 25(8), 57-59.
10. Devinder M Thappa, *Essentials In Dermatology*, 2nd edition. Jaypee Brothers Medical Publisher Ltd. New Delhi, 2009, 57-58.
11. Sablok, A., Singhal, R., Choudhary, V., Rathoriya, S. G., & Tandon, M. (2023). Role of dermoscopy in assisting the diagnosis of KOH positive dermatophytosis: A prospective study. *Journal of Cardiovascular Disease Research*, 14(2).
12. Dr. Hahnemann S., *Organon of Medicine*, Translated by Dr. William Boericke, 6th Edition, New Delhi, India, B. Jain Publishers (P) Ltd, 2002.
13. Allen JH. *Diseases and therapeutics of the skin* Reprinted edition, B. Jain Publishers Pvt. Ltd. New Delhi 1998, 182-184.
14. Mittal, R., Kaushik, S., Prusty, A. K., Shivadikar, A. P., Rajashekhar, B., Mahajan, N., Taneja, D., Singh, S., Barod, N., & Khurana, A. (2025). Homeopathic Treatment Outcomes in Tinea Corporis and Tinea Cruris-A Multicentric, Open-Label, Prospective, Observational Study. *Alternative therapies in health and medicine*, AT11599. Advance online publication.
15. Dr. Boerick William, *Pocket Manual of Homoeopathic Materia Medica*, New Delhi, India, B. Jain Publishers (P) Ltd, 2002.
16. Dr. Phatak SR, *Materia Medica of Homoeopathic Medicines*, 2nd Revised and Enlarged Edition, New Delhi, India, B. Jain Publications (P) Ltd, 1999.
17. Dr. Clark JH., *A Dictionary of Practical Materia Medica*, Volume I, II & III, New Delhi, India, B. Jain Publishers (P) Ltd, 1999.
18. Dr. Kent, James Tyler. *Lectures on Homoeopathic Materia Medica*, B. Jain Publishers, 1986.
19. Allen, H. C. *Keynotes and Characteristics with Comparisons of Some of the Leading Remedies of the Materia Medica*, B. Jain publishers, 2008