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Efficacy and Safety of Terbinafine in the Treatment of Tinea Corporis: A Clinical Knowledge Review

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Abstract

Case: *A male in his late 20s presented with well-demarcated erythematous plaques, pruritus, and scaling on the trunk, clinically diagnosed as tinea corporis. The patient had a history of similar infections and had been unsuccessfully treated with topical antifungals.*

Treatment and outcome: *The patient was administered oral terbinafine, 250 mg twice daily, for a duration of four weeks. Adjunctive topical antifungal agents (Myconazole ointment) were also used. Regular follow-up was conducted to assess clinical response and monitor for potential adverse effects on liver function. Treatment resulted in complete resolution of lesions, with no recurrence observed during the follow-up period. The patient did not report any side effects or concerns regarding the treatment.*

Discussion: *This case highlights the efficacy of terbinafine in managing tinea corporis at the prescribed dose. The twice-daily 250 mg regimen proved effective in achieving favorable outcomes within a short treatment period. This case supports terbinafine as a first-line treatment for tinea corporis, particularly in cases requiring systemic therapy.*

Conclusion: *Oral terbinafine remains a cornerstone in the management of tinea corporis, providing high efficacy with excellent tolerability. This case underscores the importance of individualized treatment regimens to optimize outcomes in dermatophyte infections.*

Keywords: Metabolic Dysfunction–associated Steatotic Liver Disease (MASLD), Hepatic Steatosis.

Introduction

Dermatophytoses, also referred to as tinea, are fungal infections of keratinized tissues (skin, hair, nails) caused by dermatophytes of the genera Trichophyton, Microsporum, and Epidermophyton. Clinically, they present as erythematous, scaly, pruritic lesions with a well-defined border. Misdiagnosis is not uncommon in this condition. They can closely resemble lesions of other etiologies (e.g., psoriasis, discoid eczema) or appear atypically due to prior use of topical steroid preparations (e.g., tinea incognito). It is well known that potent corticosteroids increase the number of fungal hyphae on the skin surface due to a suppressed immune response, while all give the impression that the patient's lesions are improving.

Mechanism of Infection

Dermatophytes are primarily acquired from three sources: an infected person (via fomites rather than direct skin contact), domestic animals, or soil. Environmental factors such as sweating, occlusion, occupational exposure, and high humidity also play a role. The clinical course of the infection also depends on the species-specific pathogenicity, host factors, and the anatomical site involved. Predisposing host factors include cell-mediated immunodeficiency, atopy, ichthyosis, collagen vascular disease, and use of topical or systemic glucocorticosteroids [1].

Tinea corporis is an infection of the trunk, arms, legs, or neck, and Trichophyton rubrum is the most common causative fungal species. When infection is localized to the scalp, it is called tin-

ea capitis and most often presents with pruritic, scaly patches with alopecia. Microsporum species are the main cause of tinea capitis, usually transmitted from domestic animals, and occur more frequently in children. Failure to provide prompt treatment of tinea capitis may result in progression of the infection. It can evolve into deep folliculitis and develop into a kerion or Majocchi granuloma. Kerion is an inflammatory form of tinea capitis resulting from a T-cell mediated hypersensitivity reaction to a dermatophyte infection. Early diagnosis is crucial to prevent unnecessary outcomes such as surgical intervention. There is also a special type of tinea that is masked by the use of topical steroids, called tinea incognito. It presents as a poorly defined lesion that spreads slowly at the periphery and characteristically lacks the typical raised, scaly margin.

Case

A male in his late 20s presented to the Family Medicine Center in Prishtina with a history of pruritus, scaling on the trunk, and well-demarcated erythematous plaques. The patient reported a history of similar infections previously, which had been unsuccessfully treated with topical antifungals. The patient was instructed to start oral terbinafine therapy, 250 mg twice daily, for a duration of four weeks. He was also concurrently treated with topical antifungal agents (Myconazole). During the four-week treatment, the patient was under continuous monitoring for potential adverse effects on liver function. Treatment resulted in complete resolution of lesions, with no recurrence observed during follow-up. The patient reported no side effects or concerns regarding the treatment during and after therapy.

14 February

Figure 1: Primary lesions observed at the initial presentation, manifested as annular erythematous lesions with peripheral activity, marginal scaling, and central clearing, characteristic of tinea corporis.

Figure 2: Clinical evolution of tinea corporis lesions after antifungal treatment. a. The same lesion on 6 March (post-treatment), demonstrating significant regression of clinical signs. b. Lesion documented on 14 February (pre-treatment).

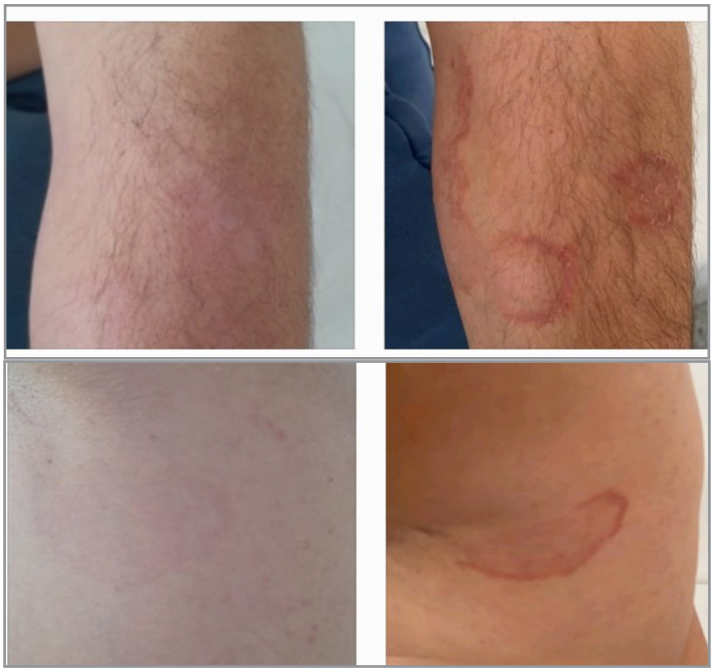

Figure 3: Images before and after terbinafine treatment illustrating full recovery of areas affected by tinea corporis.

Discussion

The major challenges today include recognition and management of dermatophyte infections. These are the most common causes of skin, hair, and nail infections, often referred to as ringworm, tinea, or dermatophytosis in humans. They are frequently encountered in primary care and dermatology clinics. Diagnosis in primary care centers is usually based on clinical presentation, whereas dermatologists often require direct microscopic examination using KOH to identify septate hyphae from scrapings of the affected area to more accurately confirm dermatophyte involvement [2, 3].

The presented case in the Primary Care Center highlights the efficacy of terbinafine in managing tinea corporis at the prescribed dose. The twice-daily 250 mg regimen proved effective in achieving favorable outcomes within a short treatment period. This case supports terbinafine as a first-line treatment for tinea corporis, particularly in cases requiring systemic therapy.

Conclusion

The treatment of dermatophytosis of the skin has become increasingly challenging for both dermatologists and family physicians, who are compelled to think beyond conventional approaches to combat this threat. Although there is sufficient evidence demonstrating the efficacy of topical antifungals in limited disease, data on relapse rates after discontinuation of monotherapy are scarce. Among the various options, topical terbinafine for four weeks appears to be the treatment of choice for limited disease (tinea corporis/cruris/pedis). However, an appropriate dose of oral terbinafine and duration of administration can achieve mycological cure and prevent fungal recurrence [4].

At the end of our patient's treatment, we conclude that oral terbinafine remains a cornerstone in the management of tinea corporis, providing high efficacy with excellent tolerability. This case underscores the importance of individualized treatment regimens to optimize outcomes in fungal infections, particularly dermatophyte infections.

References

1. Havlickova, B., Czaika, V. A., & Friedrich, M. (2008). Epidemiological trends in skin mycoses worldwide. Mycoses, 51(Suppl. 4), 2–15. https://doi.org/10.1111/j.1439-0507.2008.01606.x
2. Moriarty, B., Hay, R., & Morris-Jones, R. (2012). The diagnosis and management of tinea. BMJ, 345, e4380. https://doi.org/10.1136/bmj.e4380
3. High, W. A., & Fitzpatrick, J. E. (2012). Topical antifungal agents. In Fitzpatrick's dermatology in general medicine (8th ed., pp. 2116–2121). Tata McGraw Hill.
4. El-Gohary, M., van Zuuren, E. J., Fedorowicz, Z., Burgess, H., Doney, L., Stuart, B., Moore, M., & Little, P. (2014). Topical antifungal treatments for tinea cruris and tinea corporis. The Cochrane database of systematic reviews, 2014(8), CD009992. https://doi.org/10.1002/14651858.CD009992.pub2