**Materials and Methods**

All medical records of patients affected by a dermatophytosis due to *Trichophyton violaceum* between January 2007 and December 2018 were collected. Patients attended the Department of Dermatologyof the Cantonal Multisite Hospital and the outpatient consultation clinic specialized in hair and nail disorders, both localized in Bellinzona (Ticino, Switzerland). All mycological data were collected from the Department of Laboratory Medicine, Microbiology Division, Cantonal Multisite Hospital (Bellinzona, Ticino, Switzerland).

Year of diagnosis, age, sex, place of origin, type of dermatophytosis, predisposing factors, and treatment prescribed were analyzed for each patient (Tables 1–3).

As predisposing factors, we considered refugee status, contact with people from endemic areas or travel to endemic countries, comorbidities, and postmenopausal status (Table 2).

Hair samples, skin scrapings, and subungual scales (nail plates were excluded since they frequently contain contaminants) were collected for each corresponding dermatophytosis and submitted first to direct microscopy after being placed on a glass slide with a drop of 40% potassium hydroxide. All cases were also submitted for culture which is mandatory to identify the fungal species: samples were inoculated in tubes with slant agar with Sabouraud Glucose Agar with 0.05% chloramphenicol at 30 and 35°C (bioMérieux, Marcy-l’Etoile) and Mycosel Agar with 0.05% chloramphenicol and 0.04% cycloheximide at 30°C (Becton Dickinson, Franklin Lakes, NJ, USA). These particular media permit the growth of dermatophytes and inhibit the growth of moulds and yeasts. When growth was observed mycelium was transferred on agar plates for further characterization. In particular, for plates the growth media used were Glucose Pepton Agar, Potatoe Dextrose Agar (Oxoid; Thermo Fisher Scientific, Perth, UK), and Sabouraud Glucose Agar at 30°C, and Sabouraud Glucose Agar at 35°C. Original tubes and plates were incubated at the indicated temperatures for 28 days.

Diagnosis of *T. violaceum* was based on macroscopic and microscopic characteristics of the colonies [3]. Fungal identification in 25/44 cases was confirmed by molecular methods, because morphology of the colonies and microscopic characteristics were not conclusive. The molecular method used to confirm identification of the species was PCR. During this procedure the fungal DNA was extracted and the internal transcribed spatter regions 1 and 2 of the rRNA gene were amplified and sequenced according to the method of Hendolin et al. [4].

As a treatment terbinafine tablets 250 mg/day have been mainly prescribed. In children between 20 and 40 kg of body weight terbinafine tablets 125 mg/day were prescribed. In children who refused, or whose parents refused, oral terbinafine even chopped and mixed with food, we prescribed griseofulvin suspension 20 mg/Kg/day.

No topical treatment has been proposed for tinea capitis and it has been explained to all patients and parents that systemic treatment was mandatory to prevent the spread of the infection [5]. We treated only the cases of tinea corporis with terbinafine or imidazole cream, both prescribed twice a day. In all patients, we also prescribed washing with an imidazolic detergent once a day.