

## Profile of Patients with Dermatophytosis at the Dermatology and Venereology Outpatient Clinic of RSUD Bali Mandara, 2023–2025

Made Hendra Setiawan<sup>1</sup>, I Made Birawan<sup>2</sup>  
<sup>1,2</sup>RSUD Bali Mandara, Indonesia

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### Corresponding author\*:

[madehendra96@gmail.com](mailto:madehendra96@gmail.com)

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**Abstract:** Dermatophyte infection is a superficial fungal infection that affects keratinized tissues such as the skin, hair, and nails. The warm and humid tropical climate in Indonesia contributes to the high prevalence of dermatophytosis, making it a significant dermatological health concern. **Objective:** This study aimed to describe the profile of dermatophyte infections based on age, sex, type of dermatophytosis according to infection site, and the therapies administered to patients at the Dermatology Outpatient Clinic of RSUD Bali Mandara from January 2023 to December 2025. **Methodology:** A retrospective descriptive study was conducted using medical record data of patients diagnosed with dermatophyte infections at RSUD Bali Mandara. Variables analyzed included age, sex, type of tinea, and treatment provided. **Findings:** Among 117 dermatophytosis patients, the majority were female (54.5%), and the 45–64-year age group was the most affected (33.33%). Tinea corporis was the most common type of dermatophytosis (47.32%), and topical therapy was the most frequently administered treatment (76.1%). **Implications:** These findings provide a basis for further research and support clinical decision-making and health policy development in dermatology, particularly regarding the prevention and management of dermatophytosis. **Originality:** This study presents up-to-date data on the profile of dermatophyte infections at RSUD Bali Mandara, offering specific local information for the 2023–2025 period that has been previously underreported.

**Keywords:** Dermatophyte, Tinea Corporis, Topical Therapy

## INTRODUCTION

Fungal infections represent a type of skin infection with a higher prevalence compared to other infectious agents such as bacteria or viruses (Alessandro et al., 2023; Fox & Jacoby, 2020; Gustia et al., 2020). These infections are most observed in interdigital areas, the genitalia, and skin folds. In general, cutaneous fungal infections can be classified into two main groups: dermatophytosis and non-dermatophytosis (Tan & Firmansyah, 2021). Dermatophytosis is a superficial mycosis caused by fungi capable of invading keratin-containing tissues, such as the stratum corneum of the epidermis, hair, and nails (Sahoo &

[Mahajan, 2016](#)). This condition is commonly referred to as tinea and is classified based on the body site affected. The causative agents of dermatophytosis belong to three main genera: *Trichophyton*, *Microsporum*, and *Epidermophyton* ([Bedah & Oktiana, 2024](#)). Based on the source of transmission, dermatophytes are classified as anthropophilic, zoophilic, or geophilic ([Basarang et al., 2019](#)).

Dermatophytosis is a skin infection caused by dermatophytes and affects up to 25% of the global population, with higher prevalence in Africa and Asia ([Barac et al., 2024](#); [Ortiz et al., 2024](#)). Globally, dermatophytosis cases tend to be homogeneous, with tinea pedis and tinea corporis representing the most common forms, followed by tinea unguium. The *Trichophyton rubrum* and *Trichophyton mentagrophytes* species complexes constitute the dominant infectious agents, particularly in India, Europe, Asia, and North America ([Shimoyama & Sei, 2019](#); [Verma & Madhu, 2017](#)). These regions also account for a greater number of studies compared to other parts of the world. However, this epidemiological pattern is undergoing changes, which significantly enhance the understanding of the global distribution of dermatophytosis ([Zhan & Liu, 2017](#)). In other regions, such as the Middle East and Africa, the distribution of dermatophytosis exhibits different trends. In the Middle East, tinea pedis is the most prevalent type, followed by tinea cruris and tinea corporis, with *Epidermophyton floccosum*, *T. rubrum*, and the *T. mentagrophytes* species complex serving as the dominant causative agents ([Zamani et al., 2016](#)). In South America, dermatophytosis patterns and etiological agents vary across countries. In Argentina, tinea unguium represents the principal form of dermatophytosis, followed by tinea capitis and tinea corporis, with *T. rubrum* as the main causative agent ([Mazza et al., 2018](#)). In Colombia, *T. rubrum* is most frequently isolated, followed by the *T. mentagrophytes* species complex and *E. floccosum*, with tinea pedis and tinea corporis being the most common clinical manifestations ([de Oliveira Pereira et al., 2021](#)).

In Indonesia, approximately 52% of dermatophytosis cases consist of tinea corporis and tinea cruris ([Amukty & Puspasari, 2024](#)). Overall, dermatophytosis ranks second in prevalence after pityriasis versicolor among skin diseases ([Sondakh et al., 2016](#)). According to a study by ([Sondakh et al., 2016](#)) at RSUP Prof. Dr. R. D. Kandou, Manado, tinea cruris was the most common type, accounting for 35.3% of cases. Conversely, research conducted by at RSUD Dr. Soetomo, Surabaya, during 2014–2016 indicated that tinea corporis was the dominant type, reaching 56.1%. Another study by ([Nurwulan et al.,](#)

2019) at RSI Aisiyah, Malang, in 2017 reported that tinea incognita accounted for 26% of cases, followed by tinea corporis and tinea unguium at 21% each (Surekha et al., 2015).

Other studies across different regions in Indonesia also demonstrate variations in the characteristics of dermatophytosis patients. A study conducted in Jambi City in 2023 reported that the majority of patients were male and belonged to the productive age group of 17–25 years. In that study, tinea corporis was the most frequently observed type, followed by tinea cruris and tinea capitis. The high incidence of dermatophytosis in the productive age group is thought to be associated with high levels of physical activity, increased sweat production, and suboptimal personal hygiene practices (Arif et al., 2025).

In addition to individual factors, environmental and social determinants play a critical role in dermatophytosis occurrence (Segal & Frenkel, 2015). Humid environments, warm temperatures, and poor sanitation can facilitate the growth and transmission of dermatophytes (Akhoundi et al., 2022; Al-Khikani, 2020; Jain & Sharma, 2022). Hygienic behaviors, such as infrequent clothing changes, prolonged use of tight or damp clothing, and sharing personal items like towels, garments, or footwear, can increase the risk of fungal transmission. Moreover, high-intensity physical activity leading to excessive sweating can create moist skin conditions that favor fungal growth.

RSUD Bali Mandara is a referral hospital in Bali Province, housing a Dermatology and Venereology Outpatient Clinic that manages a variety of skin diseases and sexually transmitted infections, including dermatophytosis. The hospital serves patients from diverse regions in Bali with varying social and demographic backgrounds, positioning RSUD Bali Mandara as a key healthcare facility for managing dermatological conditions in the region.

The high patient volume presenting with skin complaints at the Dermatology and Venereology Outpatient Clinic of RSUD Bali Mandara makes it a suitable site for characterizing dermatophytosis patients. However, to date, data on the profile of dermatophytosis patients at this clinic remain limited and have not been comprehensively documented. This study aims to characterize dermatophytosis patients at the Dermatology and Venereology Outpatient Clinic of RSUD Bali Mandara during 2023–2025.

## RESEARCH METHOD

The unit of analysis in this study consisted of patients diagnosed with dermatophytosis who attended the Dermatology and Venereology Outpatient Clinic of RSUD Bali Mandara

during the period from January 2023 to December 2025. The focus of the study was the patient profile, particularly sex, age group, type of dermatophytosis, and treatment modality documented in the medical records. Thus, the study did not examine causality or therapeutic effectiveness but rather described the characteristics of dermatophytosis cases managed at the clinic during the study period.

This study employed a quantitative descriptive design with a cross-sectional approach. This design was selected because the objective of the study was to provide a systematic description of the characteristics of dermatophytosis patients based on available clinical data within a defined period. A descriptive quantitative approach is considered appropriate when the purpose of the research is to summarize frequencies, proportions, and distributions of variables without testing causal relationships. The cross-sectional approach was used because all variables were observed from existing records at one point of review, allowing the researchers to describe the overall pattern of cases efficiently.

The source of data in this study was secondary data derived from hospital medical records. The study was conducted at RSUD Bali Mandara, particularly at the Dermatology and Venereology Outpatient Clinic and the Medical Records Unit. The population consisted of all patients visiting the clinic during the study period, while the sample included all patients with a diagnosis of dermatophytosis recorded in the medical records from January 2023 to December 2025. Sampling was conducted using a total sampling technique, in which all eligible medical records meeting the inclusion criteria were included in the study. The inclusion criteria were patients diagnosed with dermatophytosis during the study period, while incomplete medical records, particularly those lacking information on sex, age, diagnosis, or treatment, were excluded.

Data were collected after obtaining permission from RSUD Bali Mandara. The researchers then accessed the medical records of eligible patients and extracted the required information using a data extraction form prepared for the study. The variables collected included sex, age group, clinical type of dermatophytosis, and treatment received. In this study, the medical record served as the main research instrument because it contained the clinical and demographic information required for analysis. The use of secondary data from medical records was chosen because it allowed the researchers to obtain factual clinical information efficiently and to describe the profile of dermatophytosis patients based on routine service data.

The data were analyzed using descriptive statistical analysis. After collection, the data were checked, classified, and tabulated according to the study variables. Frequencies and percentages were then calculated for each variable to describe the distribution of cases. The analyzed data were presented in tables and explained narratively to highlight the main findings. This analytical technique was considered appropriate because the purpose of the study was to describe the profile of dermatophytosis patients rather than to test associations or causal relationships between variables.

## RESULT

### Profile of Dermatophytosis Patients Based on Sex

The profile of dermatophytosis patients according to sex at the Dermatology and Venereology Outpatient Clinic of RSUD Bali Mandara from 2023 to 2025 is presented in Table 1.

**Table 1.** Distribution of Dermatophytosis Patients by Sex at RSUD Bali Mandara, 2023–2025

Years	Male		Female		Total	
	N	%	N	%	N	%
2023	18	15.38	20	17.09	38	32.48
2024	17	14.53	12	10.26	29	24.79
2025	21	17.95	29	24.79	50	42.74
<b>Total</b>	<b>56</b>	<b>45.5</b>	<b>61</b>	<b>54.5</b>	<b>117</b>	<b>100</b>

As shown in Table 1, of the total 117 dermatophytosis cases over three years, females accounted for a higher proportion than males, with 61 cases (54.5%) and 56 cases (45.5%), respectively. In 2023, there were 18 cases in males (15.38%) and 20 cases in females (17.09%) of the total 38 cases. In 2024, the number of cases decreased to 17 males (14.53%) and 12 females (10.26%) out of 29 cases. In 2025, the number of patients increased, with 21 cases in males (17.95%) and 29 cases in females (24.79%), totaling 50 cases.

### Profile of Dermatophytosis Patients Based on Age

The age distribution of dermatophytosis patients at RSUD Bali Mandara during 2023–2025 is presented in Table 2.

**Table 2.** Age Distribution of Dermatophytosis Patients at RSUD Bali Mandara, 2023–2025

Age group	N	%
1-14 tahun	12	10.26
15-24 tahun	22	18.8
25-44 tahun	28	23.93

45-64 tahun	39	33.33
> 65 tahun	16	13.68
<b>Total</b>	<b>117</b>	<b>100</b>

Based on the data, the majority of dermatophytosis patients were aged 45–64 years, with 39 cases (33.33% of 117 cases). The 25–44-year age group ranked second with 28 cases (23.93%), followed by 15–24 years with 22 cases (18.80%). Patients over 65 years accounted for 16 cases (13.68%), while the 1–14-year group had the lowest number of cases, with 12 cases (10.26%). These findings suggest that dermatophytosis is more common in adults and middle-aged individuals (25–64 years), likely due to high physical activity, increased sweat production, and environmental and personal hygiene risk factors.

### Profile of Dermatophytosis Types

The distribution of dermatophytosis types at RSUD Bali Mandara from 2023 to 2025 is presented in Table 3.

**Table 3.** Distribution of Dermatophytosis Types at RSUD Bali Mandara, 2023–2025

Years	Diagnosis															
	Capitis		Barbae		Manus		Cruris		Pedis		Unguinum		Korporis		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
2023	3	2.56	0	0,0	0	0.00	8	6.84	3	2.56	3	2.56	21	17.95	38	32.48
2024	1	0.85	0	0,0	0	0.00	12	10.26	2	1.71	3	2.56	11	9.40	29	24.79
2025	3	2.56	0	0,0	1	0.85	14	11.97	5	4.27	1	0.85	26	22.22	50	42.74
<b>Total</b>	<b>4</b>	<b>3.57</b>	<b>0</b>	<b>0,0</b>	<b>1</b>	<b>0.89</b>	<b>34</b>	<b>30.36</b>	<b>10</b>	<b>8.93</b>	<b>7</b>	<b>6.25</b>	<b>53</b>	<b>47.32</b>	<b>117</b>	<b>100</b>

Tinea corporis was the most frequently observed type, with 53 cases (47.32%). Tinea cruris ranked second with 34 cases (30.36%), followed by tinea pedis with 10 cases (8.93%) and tinea unguium with 7 cases (6.25%). Tinea capitis was reported in 4 cases (3.57%), tinea manus in 1 case (0.89%), and tinea barbae was not observed during the study period (0%).

Yearly analysis revealed that tinea cruris cases increased from 8 (6.84%) in 2023 to 14 (11.97%) in 2025. Tinea corporis also showed a significant increase from 21 cases (17.95%) in 2023 to 26 cases (22.22%) in 2025. Other types, including tinea pedis, tinea unguium, and tinea capitis, exhibited relatively minor fluctuations.

### Profile of Dermatophytosis Treatment

The distribution of dermatophytosis treatment at RSUD Bali Mandara from 2023 to 2025 is presented in Table 4.

**Table 4.** Distribution of Dermatophytosis Treatment at RSUD Bali Mandara, 2023–2025

Years	Topical		Systemic		Combination		Total	
	N	%	N	%	N	%	N	%
2023	29	24,8	1	0,9	8	6,84	38	32,48
2024	22	18,8	1	0,9	6	5,13	29	24,79
2025	37	31,6	3	2,6	10	8,55	50	42,74
<b>Total</b>	<b>88</b>	<b>76,1</b>	<b>5</b>	<b>4,3</b>	<b>24</b>	<b>20,5</b>	<b>117</b>	<b>100</b>

The majority of patients received topical therapy, accounting for 88 cases (76.1%). Combination therapy of topical and systemic agents was administered in 24 cases (20.5%), while systemic monotherapy was relatively rare, with only 5 cases (4.3%). Annual analysis showed an increase in the use of topical therapy from 29 cases (24.8%) in 2023 to 37 cases (31.6%) in 2025. The use of systemic monotherapy remained low (1–3 cases per year), while combination therapy fluctuated from 8 cases (6.84%) in 2023 to 10 cases (8.55%) in 2025. These results indicate that dermatophytosis management at RSUD Bali Mandara primarily relies on topical therapy, either as monotherapy or in combination with systemic therapy, consistent with standard guidelines for superficial dermatophytosis treatment.

## DISCUSSION

### Profile of Dermatophytosis Patients Based on Sex

Based on the results presented in Table 1, dermatophytosis patients at the Dermatology and Venereology Outpatient Clinic of RSUD Bali Mandara during the 2023–2025 period were predominantly female. The high proportion of female dermatophytosis patients during this period may be attributed to the characteristics of female skin, which tends to retain more moisture in certain areas due to wearing more enclosed or layered clothing, thereby creating an environment conducive to dermatophyte growth. Moisture is a key factor in the pathogenesis of dermatophytosis. In addition, females are more frequently exposed to risk factors such as wearing tight clothing, prolonged use of closed footwear, and sharing personal items (e.g., towels or clothing), which can facilitate fungal transmission. Domestic activities that involve prolonged contact with water also contribute to excessive skin moisture.

The findings of this study are consistent, who reported that dermatophytosis cases occur more frequently in females. Similarly, the study by (Ali Al-garawyi & Al-Hamadani, 2021) indicated a higher incidence of dermatophytosis in females compared to males across various age groups. This pattern is suspected to be related to exposure to specific social

and behavioral risk factors, such as household work, which increases contact with dermatophyte infection sources.

Higher prevalence in females is further supported by epidemiological studies in Iran, which demonstrated that although most global reports show sex-based variation, certain populations report a higher incidence among women. Contributing factors include environmental conditions, clothing habits that increase skin moisture, and biological differences in immune defense potential (Fallahi et al., 2017). However, not all studies indicate female predominance. Some epidemiological reports, including clinical analyses at teaching hospitals in India, recorded a higher prevalence among males, although the differences were not always statistically significant (Al-Dafay et al., 2024). These variations suggest that the gender distribution of dermatophytosis can be influenced by demographic factors, climate, lifestyle habits, and access to healthcare, highlighting the importance of local population characteristics in epidemiological outcomes.

Furthermore, studies from dermatology and venereology clinics in Indonesia, such as RSUP Prof. Dr. R. D. Kandou, have also reported female dominance in dermatophytosis cases, accounting for more than 60% of total patients (Sondakh et al., 2016). These findings reinforce the observation that females are often more frequently diagnosed or referred for dermatophytosis treatment in clinical settings. Regionally, these studies suggest that the gender distribution of cases is not random but is related to personal care behavior, occupational exposure, and socio-cultural factors that differentiate the roles and activities of men and women in society.

### **Profile of Dermatophytosis Patients Based on Age**

The results of the study at the Dermatology and Venereology Outpatient Clinic of RSUD Bali Mandara during the 2023–2025 period indicated that the 45–64-year age group constituted the largest proportion of dermatophytosis cases, accounting for 33.33% of the total 117 cases (primary data). This finding may be attributed to the aging process within this age range, characterized by a decline in skin barrier function, reduced cellular regeneration, and alterations in skin lipid composition. These changes render the skin more susceptible to infections, including dermatophyte infections. In addition, individuals aged 45–64 years tend to have a higher prevalence of comorbid conditions such as diabetes mellitus, obesity, or peripheral circulation disorders. Several studies suggest that conditions like diabetes can impair immune responses and increase glucose levels in tissues, thereby

creating an environment more conducive to fungal growth. A decline in immunity, whether due to natural aging or chronic disease, also contributes to increased vulnerability to dermatophytosis.

Biologically, immune function and skin integrity change with age, facilitating the growth of dermatophytes in older adults. This observation aligns with epidemiological studies of dermatophytosis, which indicate that most forms of non-capitis dermatophytosis occur more frequently in post-pubertal age groups compared to children or adolescents ([Drakensjö & Chryssanthou, 2011](#)).

Other studies in adult populations report slightly different dominant age patterns but remain within the adult spectrum. A clinical study in Tehran, Iran, found that individuals aged 25–44 years were most frequently diagnosed with dermatophytosis from over a thousand patients examined over a ten-year period. These results suggest that dermatophytosis can be prevalent among the socially and professionally active population, who are exposed to environments that favor fungal transmission ([Aref et al., 2022](#)). Although the peak age ranges differ (25–44 years vs. 45–64 years), both findings emphasize that dermatophytosis predominantly affects adults, likely influenced by environmental factors and personal hygiene behaviors that increase infection risk.

Additionally, a clinical study in Belém, Brazil, reported the highest prevalence of dermatophytosis among individuals aged 51–60 years, with the majority of cases presenting as onychomycosis and tinea pedis forms of dermatophytosis often associated with age-related skin changes ([Pires et al., 2014](#)). Minor differences in dominant age ranges between populations (e.g., 45–64 years vs. 51–60 years) may reflect demographic, geographic, and local behavioral variations. Nevertheless, the consistency across studies indicates that middle-aged and older adults are at high risk of dermatophyte infections.

Studies in several clinics in Indonesia and other tropical countries frequently report the highest prevalence among the productive adult age group, ranging from 19–59 years or 40–59 years. This pattern suggests that tropical environments and active lifestyles are key drivers of dermatophytosis occurrence among middle-aged adults.

### **Distribution of Dermatophytosis Types at the Dermatology and Venereology Outpatient Clinic of RSUD Bali Mandara, 2023–2025**

Based on the results presented in Table 3, tinea corporis was the most frequently observed type of dermatophytosis, accounting for 47.32% of cases. The high proportion of

tinea corporis in this study indicates that dermatophyte infections of the body skin represent the dominant clinical manifestation among the patient population examined.

Tinea corporis is a dermatophyte infection affecting extensive areas of glabrous skin, which increases the likelihood of occurrence compared to other types of dermatophytosis that are confined to specific areas such as the scalp or nails. From an anatomical perspective, the body skin is the area most frequently exposed to external factors such as heat, moisture, friction, and direct contact with infectious sources, whether from humans, animals, or contaminated objects (fomites). Additionally, tinea corporis has a broader transmission pattern. Infection can occur through direct skin-to-skin contact, sharing personal items, or exposure to contaminated environments. Daily activities such as work, sports, or social interactions increase the probability of such contact, thereby raising the incidence rate.

The findings of this study are consistent with various epidemiological studies of dermatophytosis worldwide, which also report that tinea corporis is often the most common clinical form, although prevalence varies depending on population characteristics, environmental conditions, and diagnostic methods used. A microbiological clinic study conducted at a hospital in northern India reported that tinea corporis was the most frequent clinical presentation, albeit at a lower proportion of approximately 24.7% of all dermatophytosis cases examined ([Noronha et al., 2016](#)).

Similarly, a multicenter study in India demonstrated that tinea corporis was the dominant clinical type of dermatophytosis, accounting for more than 70% of cases in the sample. The predominance of tinea corporis in these studies is thought to be closely related to environmental factors, particularly in tropical and subtropical regions characterized by warm temperatures and high humidity. Such conditions promote the growth and spread of dermatophytes on the skin surface, thereby increasing the risk of infection on large areas of the body compared to other forms of dermatophytosis, such as tinea cruris or tinea pedis ([Tahiliani et al., 2021](#)).

However, not all epidemiological studies report tinea corporis as the most common type of dermatophytosis. Some studies in other regions show different distribution patterns. For example, an epidemiological survey conducted in Spain found that tinea unguium (onychomycosis) was the most frequently observed type, accounting for 39.1% of cases, whereas tinea corporis ranked second at approximately 25.1% of all reported cases. These variations indicate that the distribution of dermatophytosis types is strongly influenced by

geographic location, population characteristics, and behavioral factors related to lifestyle and personal hygiene (Cuenca-Estrella & Rodríguez-Tudela, 2003).

In Indonesia, several local studies also report similar trends to those found in this study, with tinea corporis being the most frequently observed type of dermatophytosis. A study conducted at a hospital in Medan reported that tinea corporis accounted for 55.7% of all cases examined. These findings support the results of the present study, although slight differences in percentages may be attributed to variations in study periods, sample sizes, or patient inclusion criteria in each study (Najwa et al., 2026).

The differences observed across studies indicate that the distribution of dermatophytosis types is not uniform across populations. Variations may be influenced by factors such as age, sex, socioeconomic status, personal hygiene practices, residential density, and local climate and environmental conditions. Therefore, the finding that tinea corporis was the most frequently observed type of dermatophytosis in this study, accounting for 47.32% of cases, can be understood as part of a broader epidemiological pattern in which tinea corporis often emerges as the dominant clinical form, as reported in multiple previous epidemiological studies.

### **Profile of Dermatophytosis Treatment at the Dermatology and Venereology Outpatient Clinic of RSUD Bali Mandara, 2023–2025**

Based on the data presented in Table 4, the majority of dermatophytosis patients receiving treatment at the Dermatology and Venereology Outpatient Clinic of RSUD Bali Mandara during the 2023–2025 period were managed primarily with topical therapy, accounting for 89 cases (76.1%). Combination therapy, involving both topical and systemic agents, was administered in 24 cases (20.5%), whereas systemic therapy as a sole treatment was relatively uncommon, reported in only 5 cases (4.3%). This distribution pattern indicates that the therapeutic approach in this healthcare facility prioritizes the use of topical antifungal agents as the first-line management for dermatophytosis. This practice aligns with the superficial nature of dermatophyte infections, which are generally confined to the stratum corneum of the skin, making topical therapy often sufficient as an initial treatment before considering systemic agents.

The predominance of topical therapy in managing dermatophytosis has also been reported in other national and international studies. A study conducted at RSUP Dr. Hasan Sadikin found that topical antifungal administration was the most frequently used therapy,

accounting for approximately 69.6% of cases. These findings reinforce the perspective that topical therapy remains the mainstay of clinical practice for dermatophytosis, particularly in cases with limited skin involvement and without complications.

However, patterns of dermatophytosis treatment may vary significantly between healthcare facilities. For instance, a study conducted at RSUP Sanglah reported that combination therapy with topical and systemic agents was more commonly used, representing 54.1% of all dermatophytosis cases treated ([Gopal et al., 2019](#)). This variation suggests that therapy selection is strongly influenced by clinical factors such as lesion size, anatomical location, severity of infection, and history of previous treatment failure.

In addition to patient-related clinical factors, variations in therapy patterns may also reflect local clinical practice habits. The high proportion of combination therapy reported in Denpasar may indicate a greater prevalence of complex or chronic dermatophytosis cases that require a more aggressive therapeutic approach compared to cases confined to the superficial skin layers. Consistent with these findings, studies conducted in Brazil also reported that combination therapy is often chosen by clinicians to manage dermatophytosis with extensive lesions or chronic disease progression ([Pires et al., 2014](#))

## CONCLUSION

The findings of this study indicate that dermatophytosis at the Dermatology and Venereology Outpatient Clinic of RSUD Bali Mandara during 2023–2025 was more frequently observed in female patients, with the highest proportion found in the 45–64-year age group. Tinea corporis was identified as the most common clinical type, accounting for 47.32% of cases, while topical antifungal therapy was the most frequently administered treatment modality, representing 76.1% of all cases. These findings suggest that dermatophytosis in this clinical setting was predominantly encountered among middle-aged adults and generally presented as a superficial fungal infection that could be managed primarily with topical therapy.

This study contributes scientifically by providing a descriptive epidemiological overview of dermatophytosis cases in a referral hospital setting in Bali. The study adds local empirical data regarding patient characteristics, distribution of dermatophytosis types, and treatment patterns, which remain limited in this setting. These findings may serve as an important reference for clinicians, hospital managers, and future researchers in

understanding the local burden of dermatophytosis and in supporting the development of more context-specific preventive and management strategies.

However, this study has several limitations. The use of a descriptive cross-sectional design and secondary data from medical records restricted the analysis to case profiles only and did not allow further exploration of causal relationships, risk factors, microbiological confirmation, disease severity, or treatment outcomes. In addition, the quality of the findings depended on the completeness and accuracy of the medical record documentation. Therefore, future studies are recommended to apply more comprehensive analytical designs, incorporate laboratory confirmation, and examine additional clinical and behavioral variables in order to generate a deeper and more comprehensive understanding of dermatophytosis.

### **Ethical Statement**

This study was conducted in accordance with the research ethics approval issued by the Health Office of RSUD Bali Mandara no. B.44.000/11093/KEP/RSBM.

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