

Editorial

Fungal skin diseases and seborrheic dermatitis

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Description

Seborrhoeic dermatitis (SD) is a chronic relapsing inflammatory skin disease with erythematous lesions and desquamation as basic features. The prevalence of SD in the general population is high (USA 11.6%) [1]. However, in some groups, the incidence of SD can be over 80%, such as in elderly patients with parkinsonism [2] or HIV+ persons (from 34% to 83%) [3,4]. The most important factors for the development of SD are: genetic predisposition, hyperhidrosis, malnutrition, immunodeficiency [4], pregnancy, use of systemic corticosteroids or contraceptives, as well as environmental conditions such as high temperature, humidity and *Malassezia* yeast [5].

These yeasts are part of the microbial flora of the human skin, but under certain conditions can become pathogenic and lead to the development or worsening of certain skin diseases and rarely, to the development fungaemia [6]. Correlation of SD flares with proliferation of *Malassezia* species and clinical response of SD to antifungal agents (ketoconazole, ciclopirox) have led many researchers and clinicians to believe that *Malassezia*. Genus *Malassezia* includes 14 species: *M. globosa*, *M. restricta*, *M. furfur*, *M. slooffiae*, *M. obtusa*, *M. sympodialis*, *M. japonica*, *M. nana*, *M. dermatis*, *M. cuniculi*, *M. equina*, *M. caprae*, *M. yamatoensis* (lipophilic) and *M. pachydermatis* (non-lipophilic) [7]. There are data about the difference in the distribution of certain species of *Malassezia* in relation to the patient's gender or localisation of skin changes [8], geographic location of patients [7], also in the applied method of sampling, improving and identification of *Malassezia* [9]. There is not enough data about distribution, species and density of *Malassezia* in patients with SD in Serbia, except for patients with Parkinson's disease [10]. Some newer studies tried to determinate *Malassezia* presence and density on lesional skin

(LS) and nonlesional skin (NLS) in patients with SD, as well as to examine the differences in presence and density of identified species on LS and NLS in patients with SD and healthy control (HC) and found out higher presence and density of *Malassezia* spp. on LS of SD patients than on NLS of SD patients and HC. *M. slooffiae* was identified as the most prevalent species in SD patients (Serbia) [11].

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