slide to which a drop of potassium hydroxide is added, and examined under a microscope for the presence of hyphae. Cultures are indicated if an outbreak is suspected or the patient does not respond to therapy.

Treatment and Prognosis Dermatophyte infections usually respond to topical therapy. Lotions or sprays are easier than creams to apply to large or hairy areas. Particularly for tinea cruris, the affected area should be kept as dry as possible. When patients have extensive skin lesions, oral itraconazole or terbinafine can hasten resolution **(Table 219-3)**. Terbinafine interacts with fewer drugs than itraconazole and is generally the first-line agent.

TABLE 219-3 Suggested Oral Treatment for Extensive Tinea Infections and Onychomycosis

ANTIFUNGAL AGENT	SUGGESTED DOSAGE	COMMENTS
Extensive Tinea Infection		
Terbinafine	250 mg/d for 1–2 weeks	Adverse reactions minimal with short treatment period
Itraconazole[a]	200 mg/d for 1–2 weeks	Adverse reactions minimal with short treatment period except for drug interactions
Onychomycosis		
Terbinafine	250 mg/d for 3 months	Slightly superior to itraconazole; monitor for hepatotoxicity
Itraconazole[a]	200 mg/d for 3 months *or* 200 mg bid for 1 week each month for 3 months	Drug interactions frequent; monitor for hepatotoxicity; rarely causes hypokalemia, hypertension, edema; use with caution in patients with congestive heart failure

[a]Itraconazole capsules require food and gastric acid for absorption, whereas itraconazole solution is taken on an empty stomach.

Onychomycosis generally does not respond to topical therapy, although efinaconazole topical solution applied to the affected nail for as long as a year has been shown to be beneficial in several trials. Itraconazole and terbinafine both accumulate in the nail plate