A woman in her 70s presented with a skin eruption on the left dorsal foot that had developed spontaneously 2 weeks before. The rash initially appeared with pruritic papules that evolved to fluid-filled blisters and persisted despite self-treatment with topical hydrocortisone 1% cream and antibiotic ointment. Examination revealed an erythematous plaque with tense and denuded bullae (Figure 1). She received oral cephalexin for presumed bullous impetigo. Bacterial culture and herpes simplex virus and varicella zoster virus polymerase chain reaction (PCR) swab results were negative. Over the ensuing 6 weeks, she continued to experience new bullae. She presented to the dermatology clinic, where examination showed an expanding annular plaque with peripheral scale (Figure 2).

Thirty percent potassium hydroxide (KOH) preparation demonstrated hyphae, confirming bullous tinea pedis. Fungal culture grew *Trichophyton rubrum*. The patient responded well to terbinafine cream and dilute acetic acid soaks.

Bullous tinea, seen in adults and children, and most often affecting the feet, presents with an erythematous scaly rash with serous fluid-filled bullae, as opposed to the pus-filled blisters of bullous impetigo.\(^1\)\(^-\)\(^3\) Misdiagnosis and treatment delays are common.\(^4\) Differential diagnoses include bullous impetigo, bullous allergic contact dermatitis, thermal injury, edema-related bullae, or localized bullous pemphigoid.\(^5\) Clues to diagnosis include unilateral, localized distribution; expanding annular scaling; concomitant onychomycosis; and a lack of response to topical corticosteroids. Thorough history, examination, and KOH preparation aid diagnosis. Topical terbinafine is effective against most culprit dermatophytes. Bullous tinea should be considered in the differential diagnosis of unilateral blistering dermatoses,
especially when on the foot, to hasten diagnosis and effective treatment.

POTENTIAL COMPETING INTERESTS
The authors report no competing interests.

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