BC Centre for Disease Control
Provincial Health Services Authority

TMVII: *Trichophyton mentagrophytes type VII*
What Providers Need to Know

This resource is to assist providers with key information about Trichophyton mentagrophytes type VII (TMVII)

- TMVII is a rare, emerging fungal infection typically transmitted by skin-to-skin and sexual contact
- Providers are recommended to test individuals with history of persistent ringworm rash that has not responded to topical creams or explained by other etiology
- Most cases have been reported among gbMSM, but anyone can be affected
- Definitive diagnosis requires fungal / dermatophyte culture testing
- Suspected cases are recommended to be treated based on epidemiologic and clinical assessment without awaiting fungal results

Key Information

- *Trichophyton mentagrophytes* genotype VII (TMVII) is a rare fungal infection typically transmitted by skin-to-skin and sexual contact.
    - TMVII is considered an emerging STI that has been circulating in Europe for a few years, and more recently in North America.
    - Recent cases have been noted particularly among gay and bisexual men who have sex with men (gbMSM).
- The first case of TMVII in Canada was reported in 2025 in a man returning from travel to Mexico. Cases have previously been reported in New York, Minnesota and Washington.
    - To our knowledge, there have been no cases of TMVII reported in British Columbia; however, due to its non-reportable nature and low provider awareness, it is possible that cases could be missed.
- Lesions can appear on the genitals, buttocks, face, trunk, arms/hands, and legs. A fungal rash resembling tinea or ringworm can develop, marked by a circular, red, and scaly appearance.
- Currently, there is no vaccine available for TMVII.

Clinical Management

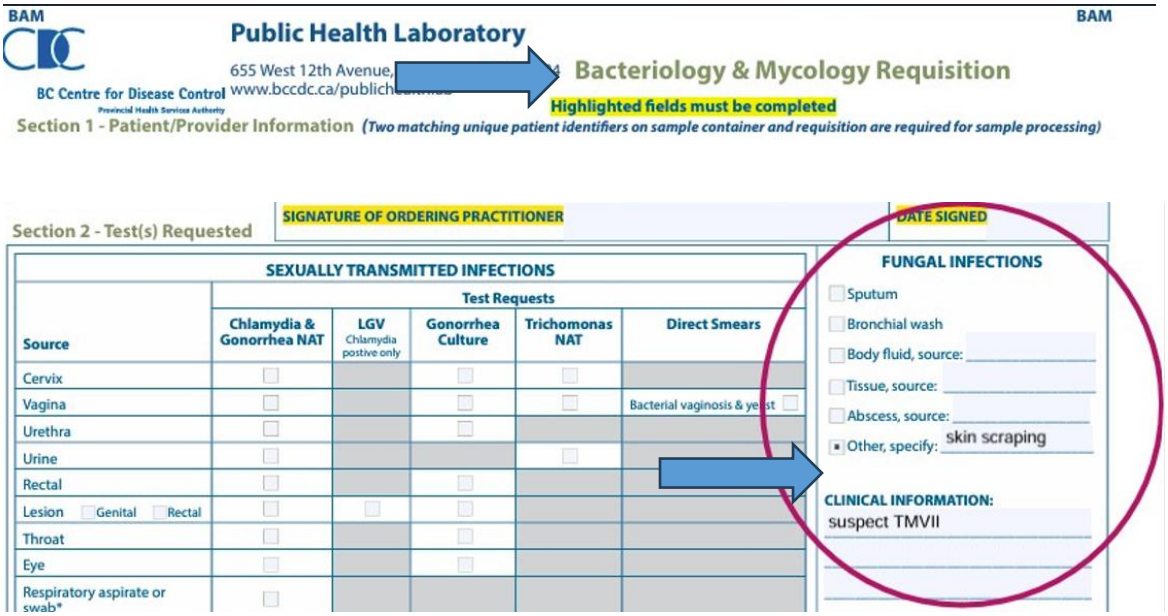
Consider TMVII in individuals with persistent or atypical dermatophyte presentation, particularly when not responding to standard topical or oral antifungal therapy

Presentation

- Lesions involving the genital, perianal, or facial regions
- Lesions may also occur on the trunk, arms, legs or other body sites
- Rash is often pruritic, painful, and persistent
- May resemble other tinea (i.e. ringworm) infections but tends to be more inflammatory
- Infection may not respond to standard topical antifungal treatments
- Consider consultation with Dermatology or BCCDC STI Clinic for complex or severe cases

Testing

- Collect skin scrapings for fungal culture
    - Submit with Bacteriology & Mycology Requisition indicate 'suspect TMVII' in clinical information


BAM

Public Health Laboratory

655 West 12th Avenue, www.bccdc.ca/publich

BC Centre for Disease Control

Bacteriology & Mycology Requisition

Highlighted fields must be completed

Section 1 - Patient/Provider Information (Two matching unique patient identifiers on sample container and requisition are required for sample processing)

Section 2 - Test(s) Requested

SIGNATURE OF ORDERING PRACTITIONER

DATE SIGNED

SEXUALLY TRANSMITTED INFECTIONS

Source	Test Requests: Chlamydia & Gonorrhea NAT	LGV (Chlamydia postive only)	Gonorrhea Culture	Trichomonas NAT	Direct Smears
Cervix	☐		☐	☐	
Vagina	☐		☐	☐	Bacterial vaginosis & yeast ☐
Urethra	☐		☐		
Urine	☐			☐	
Rectal	☐		☐		
Lesion ☐ Genital ☐ Rectal	☐	☐	☐		
Throat	☐		☐		
Eye	☐		☐		
Respiratory aspirate or swab*	☐				

FUNGAL INFECTIONS

☐ Sputum

☐ Bronchial wash

☐ Body fluid, source:

☐ Tissue, source:

☐ Abscess, source:

☒ Other, specify: skin scraping

CLINICAL INFORMATION:

suspect TMVII

    - For details on collecting skin scrapings refer to LifeLab's Dermatophyte/KOH Collection Instructions
    - If *Trichophyton mentagrophytes* complex is isolated on culture, consult medical microbiologist to discuss potential for further testing (e.g. molecular typing)

- Conduct a sexual health assessment and screen for other sexually transmitted infections, based on exposure history
    - Refer to BCCDC Quick Reference STI Screening and Testing Guide

Treatment

- Oral antifungal therapy is recommended. Consult with Infectious Disease to review treatment plan and duration as extended treatment time may be required
    - Terbinafine is the preferred treatment:
        - Terbinafine 250 mg orally once daily for 4-8 weeks
    - Alternate:
        - Itraconazole 100 mg orally once daily for 4 weeks
    - Fluconazole is generally ineffective and is not recommended
- Do not delay treatment when awaiting culture results where clinical suspicion is high, based on clinical presentation and epidemiologic risk factors

Education

Advise individuals with confirmed or suspected with TMVII to:

- Avoid direct skin-to-skin contact with affected areas, including during sex, until treated
- Not share personal items (e.g., razors, towels, clothing, bedding)
- Maintain good skin hygiene, including washing hands after touching rashes
- Consider full STI testing
- See Standard Education for STBBI for further resources