

**HIV/STD Program  
STD Clinic**

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**Public Health**   
Seattle & King County



**Health Advisory: *Trichophyton mentagrophytes* genotype VII (TMVII) – March 30, 2026**

*Trichophyton mentagrophytes* genotype VII (TMVII) has caused several outbreaks among gay, bisexual and other men who have sex with men (GBMSM), including a 2024 outbreak with 5 confirmed cases in New York City (1) and a 2025 outbreak in Minnesota with 30 confirmed or suspected cases (2). Public health is aware of a single confirmed case of TMVII in WA State in 2026, though clinicians have treated other presumptive cases.

**Actions Requested:**

- **Medical providers should be aware that *Trichophyton mentagrophytes* genotype VII (TMVII) is a dermatophyte fungus that can be transmitted through skin-to-skin contact, including through sexual contact.** TMVII can cause a tinea infection (ringworm) which typically presents with pruritic, well-demarcated, annular scaly lesions on the genitals, buttocks, face, trunk or extremities. These are sometimes mistaken for eczema or psoriasis.
- **Clinicians evaluating patients for possible TMVII should obtain skin scrapping for fungal culture and/or polymerase chain reaction (PCR) testing if that testing is available.** The definitive diagnosis of TMVII requires fungal culture with molecular sequencing of the fungal isolate or PCR testing. PCR testing and culture with molecular sequencing for TMVII can be performed at the University of Washington Microbiology Laboratory but is not currently available through local commercial laboratories. Insofar as testing is available, Public Health recommends that clinicians test patients for TMVII if they present with anogenital ringworm or have ringworm at another anatomic site and have a sex partner with anogenital ringworm or confirmed TMVII. PCR is the preferred test for TMVII since it is more sensitive and provides results more quickly than fungal culture, though it is also more expensive and does not provide fungal susceptibility information. Persons with possible TMVII can be evaluated and tested at the Public Health – Seattle & King County Sexual Health Clinic at Harborview Medical Center.
- **Confirmed or suspected cases of TMVII should be treated with oral terbinafine (250mg daily).** Topical treatments are not consistently effective against TMVII. Medical providers should initiate terbinafine therapy in suspected cases without awaiting fungal culture or PCR results. Treatment should typically be continued for 6-8 weeks but may be required for up to 12 weeks. Patients should continue therapy until 2 weeks after resolution of symptoms (e.g., pruritus, pain).
- **Medical providers should ask patients with possible or confirmed TMVII about recent sexual exposures and symptoms in their sex partners and should advise patients with suspected TMVII to avoid skin-to-skin contact with affected areas (including during sex) or sharing of personal items (e.g., razors, towels, bedding, cloths) until their symptoms have resolved.** Providers should advise patients that their symptomatic sex partners should seek medical evaluation. People with TMVII should wash their hands after touching TMVII rashes and be aware that TMVII can affect pets, leading to localized hair loss or irritated skin in the infected animal; potentially affected pets should be evaluated by a veterinarian.

- **Medical providers should test patients with possible or confirmed TMVII for syphilis and HIV (if not already known to be HIV positive) and offer them HIV pre-exposure prophylaxis (PrEP) (if HIV negative) and doxyPEP.**

### **Background:**

TMVII was first identified as a cause of genital area tinea infections in two heterosexual partners in 2010, with a subsequent report of 7 cases among European travelers to southeast Asia (3). Thirteen cases were identified among GBMSM in France in 2021-2022 (4), with the first cases in the US identified among GBMSM in NYC in 2024 (1). More recently, the infection was identified among GBMSM in Minnesota (2), and at least one confirmed case has been diagnosed in King County, WA. Because TMVII does not consistently respond to topical antifungal therapy, clinicians should have a low threshold for initiating oral terbinafine therapy when they suspect TMVII infection. Additional information about TMVII, including images of rashes associated with the infection, are available through the National Coalition of STD Directors (NCSD) and Centers for Disease Control and Prevention (5, 6).

Clinicians seeking medical consultations related to TMVII should call the PHSKC Sexual Health Clinic at (206) 744-3954. Patients with rashes concerning for TMVII can be referred to the clinic for TMVII testing.

### **Resources**

1. Zucker J, Caplan AS, Gunaratne SH, Gallitano SM, Zampella JG, Otto C, et al. [Notes from the Field: Trichophyton mentagrophytes Genotype VII - New York City, April-July 2024. MMWR Morb Mortal Wkly Rep. 2024;73\(43\):985-8.](#)
2. [Minnesota Department of Health. About TMVII 2026.](#)
3. Luchsinger I, Bosshard PP, Kasper RS, Reinhardt D, Lautenschlager S. Tinea genitalis: a new entity of sexually transmitted infection? Case series and review of the literature. Sex Transm Infect. 2015;91(7):493-6.
4. Jabet A, Delliere S, Seang S, Chermak A, Schneider L, Chiarabini T, et al. [Sexually Transmitted Trichophyton mentagrophytes Genotype VII Infection among Men Who Have Sex with Men. Emerg Infect Dis. 2023;29\(7\):1411-4.](#)
5. [NCSD. Recent dermatophyte \(ringworm\) cases associated with sexual contact 2026 .](#)
6. [CDC. Clinician Brief: Emerging Ringworm 2026.](#)