Patients should be informed that tinea versicolor is caused by a fungus that is normally present on the skin surface and is therefore not considered contagious. The condition does not leave any permanent scar or pigmentary changes, and any skin color alterations resolve within 1-2 months after treatment has been initiated. Recurrence is common, and prophylactic therapy may help reduce the high rate of recurrence.

Tinea versicolor can be successfully treated with various agents. [30] Effective topical agents include selenium sulfide, zinc-pyrithione, sodium sulfacetamide, ciclopirox olamine, [31] , tacrolimus, [32] as well as azole and allylamine antifungals. [33, 34, 35, 36, 37] Even if a small area of skin is involved, treating with topicals from the neck to the knees may make treatment more successful. [14] Various regimens can be used. Selenium sulfide lotion is liberally applied to affected areas of the skin daily for 2 weeks; each application is allowed to remain on the skin for at least 10 minutes prior to being washed off. In resistant cases, overnight application can be helpful. Topical azole antifungals can be applied every night for 2 weeks. Weekly application of any of the topical agents for the following few months may help prevent recurrence. In patients with widespread disease, some topical antifungal therapy can be expensive. Over-the-counter shampoo formulations of selenium sulfide, zinc-pyrithione, and ketoconazole are low-cost options that are widely available and can easily be used to cover large surface areas. Topical allylamines have been demonstrated to be clinically and mycologically effective. Tacrolimus 0.03% applied topically has been shown to provide a mycologically effective treatment; however, it is not effective in speeding the reduction in appearance of hypopigmentation associated with tinea versicolor.

While oral ketoconazole is contraindicated for the treatment of tinea versicolor, the topical foam may be useful in some patients. [38] The risk of serious liver damage, adrenal gland problems, and harmful drug interactions with use of oral ketoconazole outweighs it benefit for fungal skin infections. [39]

Oral therapy with other systemic antifungals is effective for tinea versicolor and is often preferred by patients because of convenience and oral administration is less time consuming than topical treatment. Of course, oral therapy can be used in consort with topical regimens. Fluconazole, and itraconazole are the preferred oral agents. [40, 41, 42] Various dosing regimens have been used. Fluconazole has been offered as a single 150- to 300-mg weekly dose for 2-4 weeks and is the safest oral agent. Itraconazole is usually given at 200 mg/d for 7 days. Pramiconazole and sertaconazole have also been used in the management of tinea versicolor. [43, 44] A review suggested the following dosing regimens: 200 mg/d for 5 or 7 days of itraconazole, 300 mg/wk for 2 weeks of fluconazole, and 200 mg/d for 2 days of pramiconazole. [45]