

PRACTICAL DERMATOLOGY

Diagnosis and Management of Nail Psoriasis

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Abstract. Nail psoriasis has traditionally been considered as one of the most difficult forms of psoriasis to treat. The most recent studies have found a higher prevalence of fungal infections in psoriatic nails and therefore cultures before and during treatment are necessary. Over the last few years, novel psoriatic therapies have been developed, some of which are effective for both skin and nail lesions (cyclosporine and biologic agents). Of the topical agents, vitamin D and A derivatives as well as nail lacquer containing 8% clobetasol propionate can help improve lesions of both the nail bed and matrix.

Key words: psoriasis, nails, diagnosis, management.

ASPECTOS DIAGNÓSTICOS Y TERAPÉUTICOS DE LA PSORIASIS UNGUEAL

Resumen. La psoriasis ungueal ha sido considerada clásicamente una de las manifestaciones más difíciles de tratar de la enfermedad. Los últimos estudios han evidenciado una mayor prevalencia de infecciones fúngicas en las uñas psoriásicas, por lo que debemos practicar cultivos al inicio y durante el tratamiento. En los últimos años han aparecido numerosas novedades terapéuticas en la psoriasis; algunas son eficaces tanto para las lesiones cutáneas como para las ungueales (ciclosporina y biológicos). A nivel tópico, los derivados de la vitamina D y A, así como la laca de clobetasol propionato al 8% pueden conseguir mejorar tanto las lesiones del lecho como las de la matriz ungueal.

Palabras clave: psoriasis, uñas, diagnóstico, tratamiento.

Introduction

For many years, the nails have been one of the most frustrating anatomical locations for the treatment of psoriasis, both for patients and dermatologists. While, unsurprisingly, many patients with psoriasis have made use of specific novel and not-so-novel treatments for the rest of the body, the nails have been neglected, since, except for painful infiltrations of corticosteroids, no new treatments had been developed. Furthermore, patients often report associated pain and for many it is yet another change in their physical appearance that is often very noticeable. Thus, it is clearly a health care problem that has not received the attention it deserves.

Currently, the development of new drugs and vehicles that allow nail penetration mean that the situation has

changed substantially. For diagnosis, quantitative methods similar to the psoriasis area and severity index (PASI) have been developed to allow assessment of the severity of the lesions and thereby facilitate greater reproducibility of studies.

Epidemiologic Features

Nail involvement is very common in the course of psoriasis, with between 10% and 78% of patients affected.¹ In our own experience, we have observed nail involvement in 53% of our patients (n=164).² The fingernails are affected more often than the toenails, and more than 1 nail is usually involved. In fact, psoriasis is one of the diseases that most often involves the nails. It is also well known that there is an association between psoriatic arthritis and nail psoriasis (70% of patients have nail lesions)³ (Figure 1), which often precedes the disease rather than just accompanying it. Patients are sometimes referred by rheumatology departments during assessment of arthritis, and it is not surprising for a patient with psoriatic arthritis to only have lesions of the nails, or at most, in the gluteal cleft (Figure 2) or scalp (Figure 3).

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Figure 1. Patient with psoriatic arthritis (presenting as dactylitis) and nail psoriasis (onycholysis and oil spots).



Figure 2. Psoriasis of the gluteal cleft, which usually accompanies nail psoriasis and psoriatic arthritis, especially in men.

Nail psoriasis in young children is rare,³ and on occasions, when it occurs, it may form part of the syndrome known as 20-nail dystrophy, which can itself have various causes.

It has recently been shown that patients with nail psoriasis are negative for the HLA-Cw*0602 allele on chromosome 6, as well as being late-onset cases of psoriasis that display a severe course.⁴

In recent years, numerous studies have addressed the psychosocial impact of psoriasis and the effect of the disease on patients' quality of life. In a study published by our group in 2003, we reported that 38.8% of our patients had not been to public swimming pools in the last month and stress was the triggering factor for outbreaks in 43% of those surveyed (n=1500).⁵ Clearly, those lesions that affect the appearance of the hands and nails have a major psychosocial impact. In addition, we should not forget that many patients also report painful nails, as indicated in a study undertaken in 1728 patients, of whom 51.8% reported pain in the affected nails and 58.9% were restricted in their daily activities.¹

There is an association between the duration of cutaneous lesions and the frequency of nail involvement.⁶

As in other anatomical sites, when the patient has an outbreak we must evaluate the presence of one or more triggering factors. In addition to stress, which tends to be the most important, we should not forget repeated trauma (Koebner phenomenon), which accounts for the more frequent involvement of the fingernails than the toenails, particularly in manual workers.⁴ The appearance of nail psoriasis has also been described in response to lithium,⁷ β -blockers, and interferon.⁴

It was traditionally thought that onychomycosis was very rare in psoriatic nails⁸; however, this view has changed since the recent study published by Gupta et al,⁹ who analyzed a series of 561 patients with psoriasis and found that when there were psoriatic lesions of the toenails the frequency of



Figure 3. Psoriasis of the scalp, particularly associated with nail psoriasis.

onychomycosis increased by up to 27%, the risk increased with age, and the fungi responsible were the same as in the healthy population. In our experience, in a series of 20 patients with nail psoriasis, 6 (30%) had positive cultures for dermatophytes, yeasts, and moulds, and interestingly, 2 of those patients had positive cultures for *Epidermophyton floccosum*, a rare pathogen in tinea unguium.¹⁰ Finally, an important factor to take into account is that the use of artificial nails can increase the risk of bacterial and fungal secondary infection of psoriatic nails. We should recommend that patients do not manipulate or chew their nails, and that they avoid excessive manicure. An important conclusion to draw from the study is that we should always perform a direct examination (potassium hydroxide) and fungal culture prior to initiation of treatment, particularly if we plan to use corticosteroids, and of course, if the patient reports pain in the nail at the beginning or during treatment. A practical

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