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It is my proud privilege to present, the 3rd in series, of the biannual official newsletter of Nail Society of India (NSI) '**ONYCHOSCOPE**' that apprise you of the happenings in the world of Nail from India and across the globe.

NSI made its humble beginnings in February, 2012 and since its inception, the society has managed to carve a niche in the field of 'NAIL'. The society membership, which stands at over 150 in less than 2 years of existence, and is made up of not only the practicing dermatologists from all over India but also the plastic surgeons, physicians and pathologists, is a testimony to the dire need of such a platform to share and learn about the Nail. The **NSI Facebook page** is very vibrant with **304 members** from India and other countries. Case discussions are excellent, and it has truly emerged as a learning ground for all. We extend our heartfelt thanks to everyone for posing in us faith, belief, confidence and supporting us in all our endeavors. The society has grown hugely in stature with its global recognition during the 2nd International Summit on Nail Diseases (ISND), organized by the European Nail Society (ENS), in association with the Moroccan Society of Dermatology in Marrakesh which was attended by Dr Chander Grover, Dr Soni Nanda and myself as invited faculty. The conference was attended by 670 delegates from 17 countries. The organizing team of two extremely pleasant ladies, Dr Soumya Chiheb and Dr Hakima Benchikki, from Casablanca extended their warm hospitality in true Moroccan Style. We witnessed more of rich Moroccan culture at the Gala dinner at the magnificent and royal Chez Ali Palace. We were fortunate to interact with the pioneers in nail research, Dr R Baran, Dr Bertrand Richert, Dr Eckart Haneke, ISND founder D Rigopoulos, Dr Phoebe Rich, Dr Nathaneil Jellinek, Dr D DeBerker and more from CND (Council for Nail Disorders). They have kindly consented to be on board with us as International Advisory Members. Everyone appreciated our experiences in Onychomycosis, Glomus tumour and Nail aesthetics and was impressed by the performance of NSI. However, this is just a beginning and much more awaits learning.

Our bid to host the 3rd ISND (the 1st was held in Athens in 2010) in New Delhi, India in November 2015 was unanimously accepted by the ISND team. It was a moment of **Exhilaration for NSI and Indian dermatology** to see the logo of NSI flashing at par with the two other existing nail Societies in the world; ENS and CND. We seek your generous participation, support and best wishes in carrying out this mammoth task.

We are proud to say that NSI has gone truly GLOBAL!

Archana Singal



Taxane-Induced Onychopathy

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Fig 1: Pigmentary changes, Beau's lines and acute sterile paronychia in patient on eighth cycle of Docetaxel



Fig.2: Subungual hemorrhages and onycholysis in patient on fourth cycle of Docetaxel



Fig.3: Subungual hyperkeratosis in a patient with Taxane toxicity



Fig.4: Edema of fingers along with painful nails and subungual hemorrhage in a patient on fourth cycle of Docetaxel



Fig.5: Prominent vertical striations with Mees lines in a patient on Docetaxel



Fig.6: Multiple Beau's lines with periungual scaling in a patient on fourth cycle of Docetaxel

Introduction: Nail changes are frequent during chemotherapy of cancers. Taxanes are the chemotherapeutic agents used in the treatment of cancers of the breast, ovary and the lung. These are useful due to their ability to arrest mitosis by preventing microtubule depolymerization.

The drugs: Two most commonly used agents are Docetaxel and Paclitaxel.

Clinical features: Nail changes frequently reported after the taxanes therapy are enlisted below. The changes are generally pronounced in finger nail rather than toe nails.

Mild severity

1. Pigmentary changes and Beau's lines (**Fig 1,6**)
Roughening or brittleness of the nail plates

Moderate severity

1. Onycholysis and Subungual hemorrhages (**Figure 2**)
2. Subungual abscess (**Fig,4**)
3. Subungual hyperkeratosis (**Figure 3**)

Onycholysis and subungual hemorrhages (**Figure 4**) are the most frequent changes reported.

Diagnosis: Drug induced nail abnormalities are characterized by the frequent involvement of all 20 nails, a temporal correlation with drug intake, and disappearance with cessation of the offending drug.

Pathogenesis of taxane-induced onychopathy: The mechanism involved in taxane-induced onychopathy is not so clear. The affection of nail bed may result into onycholysis. Deposition of drug in matrix may directly cause pigmentation. Temporary arrest of nail matrix keratinocyte mitosis arrest may result into Beau's lines. Vascular damage may result in purpura and hemorrhage beneath the nail plate. Thrombocytopenia induced by the drugs may worsen the latter.

Involvement of multiple nails, temporally following the drug intake, and disappearance upon stoppage of the offending drug are key points in the diagnosis of drugs-induced nail changes. Toenails are involved with less severity and incidence is less. This could be ascribed to slow growth of toe nails.

Treatment: Treatment of Taxane-induced onychopathy is largely symptomatic. Appropriate antibiotics and analgesic drugs and other supportive care are generally sufficient. Reassurance plays an important role.

Prognosis: Taxane-induced nail changes, though frequent, rarely necessitate withdrawal of the drugs.

Patient should be warned beforehand as regards to the nail changes that may happen during the course of chemotherapy. This would alleviate the anxiety of patients.

Avoidance of sun exposure of the affected nail reduce the severity of nail changes

References:

1. H Uyttendaele, A Geyer, RK Scher. Drugs and nails. J EADV 2004; 18, 124-125.
2. Jacob CI, Patten SF. Nail bed dyschromia secondary to docetaxel therapy. Arch Dermatol 1998; 134: 1167-1168.
3. Flory SM, Solimando DA Jr, Webster GF et al. Onycholysis associated with weekly administration of paclitaxel. Ann Pharmacother 1999; 33: 584-586.
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5. Vanhootehem O, Richert B, Vindevooghel A. Subungual abscess: a new ungual side-effect related to docetaxel therapy. Br J Dermatol 2000; 143: 462-464.

Photo Quiz

A 52 year old uncontrolled diabetic presented with asymptomatic discoloration of nails of both hands. He complained that the discoloration had been becoming more intense since its onset about 5-6 months back. He was diagnosed to be diabetic about 10 years back and had been on oral hypoglycemic since then, although the disease was not well controlled. He also had hypertension, but was irregular with treatment. The patient was self employed and owned a grocery store. Family history of similar complaints was absent.

On examination, the involvement was symmetrical, involving all nails of both hands. There was a proximal whitish and distal brownish discoloration. The nail bed, matrix, folds and hyponychium were apparently normal and there was no associated tenderness over the nail plate. All toenails were normal in appearance. The skin and mucosae were normal on examination.

Question 1- What is this appearance known as?

Question 2- What are the likely causes for this condition?



Report on the Second International Summit on Nail Diseases, 3-5th April, 2013 at Marrakech, Morocco

Dr Soni Nanda

Consultant Dermatologist, Shine and Smile Clinic and Max Hospitals, New Delhi

The Second International Summit on Nail Diseases (ISND) was held in the beautiful city of Marrakech, Morocco, North Africa, from 3rd- 5th April 2013. It was attended by around 670 delegates from all over the world. It was organized by The Moroccan Society of Dermatology under the auspices of the European Nail Society (ENS), contemporary with the 29th Congress of Francophone Dermatology at the majestic Palais des Congres, Marrakech. ISND witnessed the presence of stalwarts in the field of nail diseases like Robert Baran, Bertrand Richert (the Conference Scientific Chair), David de Berker, Nathaneil Jellinek, Dimitris Rigopolous, Phoebe Rich and many more.

The scientific program for the summit was an appropriate mix of basics of nail in health and disease along with the latest

advancements in the field of etiopathogenesis, diagnosis, imaging and therapy of nail disorders.

The first day was designated as **Basic Course in Onychology**. The sessions covered the anatomy, histology and physiology of normal nail; basic nail surgery including the techniques of anaesthesia; total and partial nail avulsion; punch and elliptical biopsy of nail bed; and a discussion about the elementary lesions of nails. This was followed by Dr David de Berker's very stimulating take on history of onychology. He talked about the earliest and accurate descriptions of the origin of nail pits (from parakeratotic debris) by Alkiewicz; to the melanotic whitlow described by Hutchinson. His energy during his various lectures was infectious and highly impressive at the same time.

Second day onwards, the scientific content was more evolved and focused on latest developments from all over the world. The sessions were an interesting mix of topics like inflammatory or genetic nail disorders and common day to day problems like ingrown toe nail and nail psoriasis. Focus session on Infectious and Drug induced nail disorders included talks on the important topic of onychomycosis, diagnosis and management. Comparison of efficacy of continuous versus pulse dosing of terbinafine in toe nail onychomycosis was very well covered by Dr Archana Singal. The session on basics of nail outlined the basics like the best site for sampling direct examination, identification of culture and interpretation of results. Dr Chauvin from France also discussed newer alternative techniques like histological analysis; molecular diagnosis like the PCR; immunochromatography strip test; and MALDI-TOF mass spectrometry.

The focus session on Nail psoriasis witnessed the deliberations by stalwarts like Dr Robert Baran, Dr Bertrand Richert, Dr de Berker and Dr Rigopolous. They sessions elaborated on the clinical spectrum of nail psoriasis; clinical scoring of severity; rationale of topical treatment; systemic treatment options and intralesional injections. Relationship of nail psoriasis and arthropathy was discussed in detail. Another focus session discussed extensively the clinical spectrum of ingrown toenail; conservative treatment options; as well as the more definitive treatments like chemical cautery and surgical management approaches. Conservative treatment with nail clips (shape-memory alloy clips) and anchor and window taping – experience on 4000 cases was shared and strongly advocated by Dr Haneke, presenting on behalf of Dr H Arai.

The session on imaging of nail apparatus included naildermoscopy, matrix dermoscopy, echocardiography and intraoperative matrix confocal dermoscopy. Optical Coherence Tomography, an optical analogue of ultrasound was discussed in detail. The session was ably managed by Dr Piraccini, Thomas L. and Jemec G.

The other topics covered included genodermatosis and inflammatory disorders, nail surgery, use of systemic drugs for diseases with exclusive nail involvement. Dr Chander Grover gave an insight into the treatment of glomus tumors. The session devoted to the upcoming and controversial topic of cosmetic care of nail was well attended and generated quite a discussion. Dr Soni Nanda discussed the use of artificial nails for diseased nails; Dr Rich discussed the details of nail lacquers; Dr Haneke demonstrated some very interesting cosmetic nail surgeries; and Dr Tennstedt discussed the side effects of nail cosmetics in details.

The last session was a very interesting and interactive session "Bring your own case". Dr David de Berker enthralled the audience with a collection of very interesting cases with bizarre manifestations or difficult treatment options. The posters also made for some interesting reading with topics ranging from onychomycosis to nail involvement in pemphigus vulgaris to psoriasis, autoimmune diseases like alopecia areata, nail lichen planus, nail sarcoidosis, nail lichen sclerosis, glomus tumors, mucoid cysts, nail fibrokeratoma, verrucous lesions, ungual melanoma and many more.

The gala opening and closing ceremonies gave a good glimpse of the Moroccan culture and very well organized. The cultural Programs were an interesting mix of Moroccan and French music, conventional bridal dance and it was de3light to savour the lavish Moroccan cuisine. It was a great honor for us to share the dais with the likes of Dr Baran, Dr Richert, Dr Soumya, Dr Rigopoulos and many more. The Moroccan hospitality and the warmth of the common people was amazing. Team NSI was also successful in bringing the next (3rd) ISND to be held in 2015 to India. NSI was very well recognized and accepted.



Excerpts from Nail Literature

Dr Suruchi Vohra, MD
Senior Resident, Department of Dermatology and
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WHAT'S NEW IN THE FIELD OF NAIL FOLD CAPILLAROSCOPY?

The long term effects of endothelin receptor antagonist treatment on microvascular damage in patients with systemic sclerosis.

Cutolo M et al. J Rheumatol. 2013 Jan.

Systemic sclerosis (SSc) is characterized by microvascular injury, fibrosis, and hypoxia of involved tissues. The vasoactive peptide endothelin-1 (ET-1) seems to be implicated in these events. In this study, the long term effect of ET-1 antagonist treatment (bosentan 125 mg twice a day for 3 years) on nailfold microvascular damage in patients with SSc was evaluated using nailfold videocapillaroscopy (NVC). During follow up, a statistically significant increase of capillary number was observed in these patients indicating angiogenesis. Thus, the study concluded that **long term treatment with bosentan may improve and stabilise the microvasculature in SSc by modulating the structural changes in the blood vessels.**

Nailfold capillaroscopy in systemic sclerosis: Data from the EULAR scleroderma trials and research (EUSTAR) database.

Ingegnoli F et al. Microvasc Res. 2013 Jun 1 (Epub ahead of print)

The aim of this study was to obtain cross-sectional data on capillaroscopy in an international multi-centre cohort of Systemic Sclerosis (SSc) and to investigate the frequency of the capillaroscopic patterns and their disease-phenotype associations. Four major patient's profiles were identified characterized by a progressive severity for skin involvement, as well as an increased number of systemic manifestations. The **"early"** and **"active"** scleroderma patterns were generally observed in patients with mild/moderate skin involvement and a low number of disease manifestations, while the **"late"** scleroderma pattern was found more frequently in the more severe forms of the disease. These data indicate that **capillaroscopic patterns are directly related to the extent of organ involvement.**

The capillaroscopic findings in idiopathic pernio: is it a microvascular disease?

Ozmen M et al. Mod Rheumatol. 2012 Sep 24. (Epub ahead of print)

Pernio is a disorder that affects the unprotected skin regions of individuals who are exposed to non-freezing, damp cold. The study aimed to examine nailfold capillaries by video capillaroscopy and evaluated the vascular involvement in patients with idiopathic pernio. This study found **increased nailfold capillary diameter and increased apical capillary diameter in patients with pernio** regardless of the disease activity as compared to controls. These findings suggest organic damage of the microcirculation.

Periungual capillaroscopy in psoriasis.

Ribeiro CF et al. *An Bras Dermatol*. 2012 Jul-Aug.

Nailfold capillaroscopy was performed in 46 psoriatic patients and 50 controls to assess microscopic morphological changes, capillary density and the presence of areas with devascularisation. **Patients with psoriasis had lower capillary density, increased avascular areas and an increased number of morphologically abnormal capillaries (coiled) compared to controls.** However, no association was found between capillary density and the duration of the disease or the extent of skin involvement, as measured by the psoriasis area and severity index (PASI) score. The presence of avascular areas was more common in psoriatic individuals whose nails were affected by the condition.

WHAT'S NEW IN THE DIAGNOSIS AND MANAGEMENT OF ONYCHOMYCOSIS?

Nail digital dermoscopy (onychoscopy) in the diagnosis of onychomycosis.

Piraccini BM, et al. *J Eur Acad Dermatol Venereol*. 2013 Apr.

Distal subungual onychomycosis and traumatic onycholysis are the most common causes of toenail abnormalities, and differential diagnosis is often impossible without mycology. Dermoscopic digital images of 57 consecutive patients who underwent global photography, videodermoscopy and mycological examination for onycholysis of a single toenail were evaluated and compared. The presumptive dermoscopic diagnosis was compared with results of mycology. Evaluation of videodermoscopic images identified three recurring peculiar dermoscopic features, two of which were present only in distal subungual onychomycosis (jagged proximal edge with spikes of the onycholytic area and longitudinal striae) and one only in traumatic onycholysis (linear edge - without spikes - of the onycholytic area). Detection of these signs is simple and can, in selected cases, help to avoid mycology.

Successful identification of clinical dermatophyte and *Neoscytalidium* species by matrix-assisted laser desorption ionization-time of flight mass spectrometry.

Alshawa K, et al. *J Clin Microbiol*. 2012 Jul.

This article highlighted matrix-assisted laser desorption ionization-time of flight mass spectrometry (MALDI-TOF MS) as a useful technique for routine and fast identification of dermatophytes and *Neoscytalidium* spp. in clinical mycology laboratories.

Oral albaconazole in patients with distal subungual onychomycosis: A phase II, randomized, double-blind, placebo-controlled trial.

Sigurðsson B, et al. *J Am Acad Dermatol*. 2013 May 22. (Epub ahead of print)

Onychomycosis is effectively treated with terbinafine and itraconazole. However, frequent repeated dosing is required, and hepatic and cardiac adverse events may occur.

This double-blind, phase II study randomized 584 patients to receive either albaconazole 100 to 400 mg or placebo weekly for 24 or 36 weeks. Effective treatment was measured as mycologic cure and clear or almost clear nail at week 52. Albaconazole group achieved greater effective treatment rates compared to placebo at week 52. Most adverse events were mild or moderate. No treatment-related hepatic or cardiac serious adverse events were observed. Thus, **Albaconazole can be used as an alternative to terbinafine and itraconazole.**

Meta-analysis comparing long-term recurrences of toenail onychomycosis after successful treatment with terbinafine versus itraconazole.

Yin Z, et al. *J Dermatolog Treat*. 2012 Dec.

This meta-analysis highlighted that itraconazole therapy is more likely to produce mycological recurrence compared with terbinafine therapy.

Efficacy of 4 weeks topical bifonazole treatment for onychomycosis after nail ablation with 40% urea: a double-blind, randomized, placebo-controlled multicenter study.

Tietz HJ, et al. *Mycoses*. 2013 Jul.

This placebo controlled study evaluated the efficacy of bifonazole 1% cream for 4 weeks following non-surgical nail ablation with urea 40% paste over 2-4 weeks in 692 subjects with mild-to-moderate onychomycosis. Efficacy of the two phase treatment was evaluated by overall cure of the target nail comprising clinical and mycological cure at 2 weeks, 3 and 6 months after end of treatment. **Higher early overall cure rate with 4 weeks topical bifonazole was observed as compared to placebo after removal of infected nail parts with urea.** This two stage treatment was well tolerated and offers an additional option in topical onychomycosis therapy.

Laser and light therapy for onychomycosis: a systematic review.

Ledon JA, et al. *Lasers Med Sci*. 2012 Nov 20. (Epub ahead of print)

Many treatment modalities for the treatment of onychomycosis have been studied, including topical lacquers and ointments, oral antifungals, surgical and chemical nail avulsion, and lasers. Due to their minimally invasive nature and potential to restore clear nail growth with relatively few sessions, lasers have become a popular option in the treatment of onychomycosis for both physicians and patients. Laser or light systems that have been investigated for this indication include the carbon dioxide, neodymium-doped yttrium aluminum garnet, 870/930-nm combination, and femtosecond infrared 800-nm lasers, in addition to photodynamic and ultraviolet light therapy.

MAGNETIC RESONANCE IMAGING OF THE NAIL UNIT IN PSORIASIS PATIENTS.

Soscia E, et al. *J Rheumatol Suppl*. 2012 Jul.

The evolution of dedicated magnetic resonance imaging (MRI) musculoskeletal equipment allows new sequences and better images of the nail unit. In the case of psoriatic arthritis (PsA), the MRI study of the nail unit identifies nail involvement, which appears as an initial lesion for the induction of distal phalanx damage and consequently of distal interphalangeal joint arthritis. All patients with psoriasis, even in the absence of a clinically evident onychopathy, show characteristic MRI changes in the nail. This evidence could have a practical diagnostic value, because **MRI study of the nail could document diagnosis in patients with undifferentiated spondyloarthropathies who have a barely evident psoriasis.**

TRANSILLUMINATION: A SIMPLE TOOL TO ASSESS SUBUNGUAL EXTENSION IN PERIUNGUAL WARTS.

Ashique KT, et al. Indian Dermatol Online J. 2013 Apr.

Transillumination is the technique of illumination by transmission of light through the sample. **Transillumination can be used as a simple tool to assess the subungual extent of periungual warts.** This is especially useful in patients who have a very thick nail plate making visualization of the deeper extent of the wart difficult under normal light. The dermatologist has to at times resort to invasive procedures like nail avulsion to treat the warts effectively. Transillumination would ensure that nail avulsion surgery, which is an unwelcome and traumatic procedure for most of the patients, is avoided. The technique also helps in winning the confidence of the patients who can visualize the problems themselves and therefore understand the rationale for surgical treatment if necessary.

WHAT'S NEW IN NAIL LICHEN PLANUS?

Dermatoscopy of nail lichen planus.

Nakamura R, et al. Int J Dermatol. 2013 Jun.

Nail lichen planus is a severe disease that may lead to destruction of the nail plate. Thus, early diagnosis is important due to its aggressive behaviour. Histopathology in many occasions it is not enough to come to a conclusive diagnosis. In this study dermatoscopic photographic data of 11 patients with histopathologically proven nail lichen planus were analyzed. Dermatoscopy showed abnormalities of the nail matrix, like trachyonychia and pitting. As to nail bed anomalies, there was chromonychia, fragmentation of body of nail, splinter hemorrhage, onycholysis, and subungual keratosis. Concerning anomalies that involved nail matrix, bed, and perionychial region altogether, there were longitudinal streaks and anonychia. Thus, **dermatoscopy may act as a diagnostic tool for the early diagnosis of nail lichen planus.**

Close association between metal allergy and nail lichen planus: detection of causative metals in nail lesions.

Nishizawa A, et al. J Eur Acad Dermatol Venereol. 2013 Feb

This article elucidated the link between metal allergy and nail lichen planus (NLP). Of the 79 patients that received a metal patch test, 24 (30%) were positive for at least one of the metal compounds tested. Notably, the prevalence of positive

reactions to metals in the NLP patients was significantly higher as compared with the OLP patients. **The causative metals in the dental fillings/braces were detected in the involved nail tissues.**

THE USE OF IMMUNOHISTOCHEMISTRY IN THE EVALUATION OF THE NAIL MATRIX IN BIOPSIES OF INGROWN TOENAILS.

Fernandez-Flores A, et al. Rom J Morphol Embryol. 2013.

The success of surgical approaches to ingrown toenails depends on the extraction (either partial or total) of the nail matrix. The identification of the nail matrix in specimens taken from ingrown toenails is not always easy because of the fragmentation of the biopsies, difficulties in matrix orientations and the heavy inflammatory infiltrate. This article concluded that **CD10 and CD34 immunohistochemical markers can be useful in fragmented specimens taken from surgeries for ingrown toenails, in order to confirm the removal of the nail matrix.**

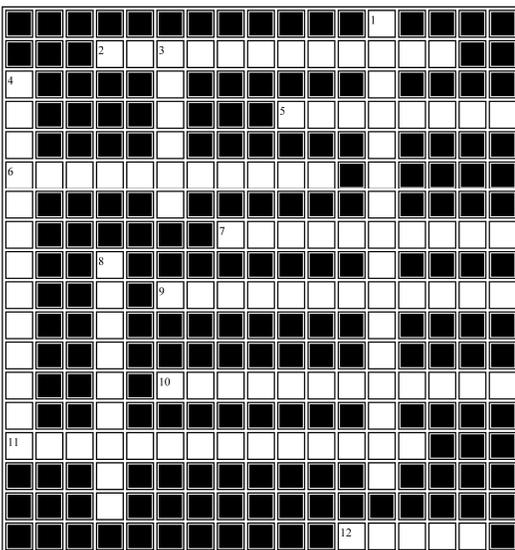
3rd International Summit on Nail Diseases & 4th Onychoccon
(National Conference of Nail Society of India)
November, 2015 at Delhi, India
Organized by :
Nail Society of India & Department of Dermatology & STD, University College of Medical Sciences & Guru Teg Bahadur Hospital, Delhi

Visit website for updates: nailsocietyindia.com



Nail Maze

Dr Shikha Bansal, Specialist, Dermatology, VMMC and Safdarjung Hospital, Delhi



Nail Maze

Please mail your answers to nailsocietyofindia@gmail.com
 Names of the first three winners will be published in the next issue of the newsletter. Exciting prizes to be won!

Down

1. A characteristic nail side effect of tetracyclines, taxanes and psoralens
3. Proximal subungual onychomycosis is commonly due to Trichophyton.....
4. A condition seen mainly in young women after repeated manicures, associated with nail brittleness
8. A window seen on apposing dorsal aspects of two fingers from opposite hands, revealing a window of light, bordered laterally by the Lovibond angles

Across

2. An abnormality in color of the substance or surface of the nail plate or subungual tissues
5. During nail plate formation ,cells may retain their nuclei until more distal in the nail plate. These retained nuclei are called as bodies
6. A slow-growing, locally destructive tumour, histologically related to squamous cell carcinoma, known as Epithelioma
7. A nail condition associated with pyogenic granuloma formation in patients receiving anti- EGF receptor agents (as chemotherapeutic drugs)
9. Another term for nail biting
10. Palmoplantar keratoderma with severe nail bed hyperkeratosis is a feature of
11. A form of psoriasis producing destructive pustulation of the nail unit
12. A nail which is white proximally and normal distally. Attributed to cirrhosis, congestive cardiac failure and adult-onset diabetes mellitus

Deadline for Early bird Registration and Abstract Submission extended till 31st August, 2013.

Answer to Photo Quiz

Diagnosis: The picture is suggestive of Half and Half Nails.

First, any whitish discoloration of nail needs to be characterized as being either True or Pseudoleukonychia. **True leukonychia** occurs as a result of matrix dysfunction e.g. punctate leukonychia seen in alopecia areata and Mee's lines seen in systemic illness, chemotherapy etc. **Pseudoleukonychia** occurs due to conditions of the nail bed. **Half-and-half nail**, also known as **Brown Arcs** or **Lindsay nails**, is a form of pseudoleukonychia. It needs to be differentiated from other forms of pseudoleukonychia like Muehrcke's paired white bands (white bands running parallel to the lunula in the nail bed, with pink between two white lines) and Terry's nails (quite a similar appearance with white discoloration proximally and normal looking plate distally). Each of these have been associated with different systemic disorders.

Common Associations: Half and Half nails may occur in patients with chronic kidney disease (CKD), Kawasaki disease, cirrhosis, Crohn's disease or Zinc deficiency. Association with Behcet's disease, yellow nail syndrome, citrullinaemia and pellagra has also been reported. The condition may also be seen in patients without any demonstrable systemic abnormality. The presence of these nail changes warrants evaluation to rule out azotemia.

DISCUSSION

The patient shown had increased blood urea levels on further investigations and had high levels of urinary protein. First described by Bean and subsequently by Lindsay, half-and-half nail involves a nail-bed modification in which the proximal half is white and the distal half red to brown; 20–40% of the nail surface is generally affected. Many authors sustain that if the distal band is <20% of total nail length, the patient has Terry nail syndrome. The frequency of this nail change in CKD ranges between 15% and 50.6%.

The exact pathogenesis is not known. The histology of distal part suggests an increase of vessel wall thickness and melanin deposition. Some authors have postulated that the whiteness of this disorder is caused by excessive development of connective tissue between the nail and the bone, reducing the quantity of blood in the subcapillary plexus. It was originally considered a specific nail change that is pathognomonic of uremic patients and disappears rapidly after renal transplantation. Half-and-half nails have no relation with

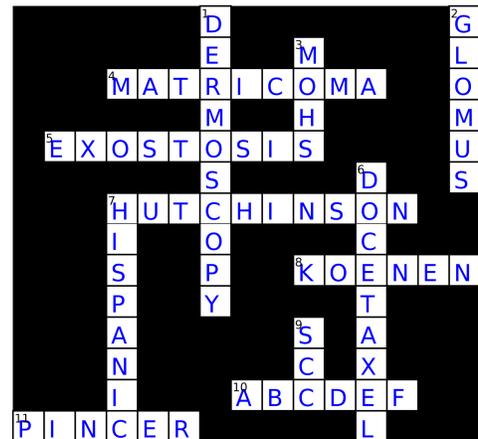
severity of CKD. Its frequency does not change with dialysis duration and the condition is probably related to long-term uraemia.



Contributed by
Dr Ananta Khurana

Solution to Nail Maze from Onychoscope Vol 2 Issue 1 (Jan 2012)

Dr Sidharth Sonthalia, Consultant Dermatologist, Gurgaon



Down

1. New non-invasive technique for diagnosis of nail lesions
2. Tender papule over the nail fold
3. Treatment of choice for squamous cell carcinoma of the nail apparatus
6. The chemotherapeutic agent with high incidence of nail toxicity
7. The race with a very high incidence of benign longitudinal melanonychia
9. Suspect it in a case of recalcitrant disruptive verrucous lesion of lateral nail groove (acronym)

Across

4. Rare subungual tumor presenting as thickened yellowish nail, transverse over-curvature, riding and dystrophy
5. Hard subungual tumor with nail plate deformity, digital pain and easily diagnosed on digital X-ray
7. Alarming sign with perionychial hyperpigmentation
8. Periungual fibroma characteristic of a genodermatoses
10. Acronym for clinical presentation of suspected nail melanoma
11. Often benign, this nail deformity may arise out of a nail neoplasm

NO CORRECT ENTRY WAS RECEIVED



Nail Society of India (NSI)
Welcomes you to

ONYCHOCON-2013

2nd National Conference
ON

NAIL DISORDERS

Date: 9th-10th November, 2013
Venue :
Auditorium, PGIMER Block
Dr. Ram Manohar Lohia Hospital
New Delhi

Pre-conference surgical workshop

Date : Friday, 8th November 2013
Time : 2:00 pm - 5:00pm
Venue : Conference hall,
University College of Medical
Sciences, Delhi

Registration Fees

	Early Bird Registration (Upto 31 Aug.)	Late Registration (Upto 31 st Oct.)	Spot Registration (1 st Nov. 2013 onwards)
NSI Member	₹ 1,500+200*	₹ 2,000+250*	₹ 2,500+300*
Non-Member	₹ 2,500+300*	₹ 3,000+350*	₹ 3,500+400*
Pre Conference Workshop (For members)	₹ 1,500+200*	₹ 2,000+250*	₹ 2,500+300*

* 12.5% additional tax as per GOI Regulations

** Please add Rs. 80/- for Outstation Cheques

Please note: there will be no refund of registration fee

For queries contact : onychocon2013@gmail.com

Registration Form

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NSI Member: Yes No

Membership No.

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Telephone: 9968604408

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