ONYCHOSCOPE
www.nailsocietyindia.com
Nail Society of India

Official Newsletter of NSI | Vol.4, Issue 1, January 2015

Dear Friends! So, we interact again through the 6th Issue of Onychoscope. The Nail Society of India completes three years of its existence; and how eventful these years have been, is for everyone to witness. With an impressive debut in 2012, our association has slowly and steadily increased its membership base as well as its educational activities. We have 210 active life members who regularly interact with us; as well as help and guide us. We have a 1.5 thousand member strong Facebook community, which is alive and kicking. Members from various nationalities share their problematic cases as well as take out time to give valuable inputs on other people's cases. We have regularly held our Annual Conferences from the year 2012 onwards, which in itself is no mean feat for a fledgling society like ours. And most importantly, we are enthusiastically planning and executing preparations for our next big event- the **3rd ISND (International Summit for Nail Diseases)**!

We are standing at a juncture where we bid adieu to 2014 and welcome 2015. The coming year will witness Delhi host the **3rd ISND** along with the **4th ONYCHOCON** (Annual National Conference of NSI) being organized by the department of Dermatology, University College of Medical Sciences and GTB Hospital. ISND is an international platform featuring the best brains in the field of nail research. As hosts, we are sparing no efforts in organizing this international feat which will bring together the existing international professional associations working towards promoting nail education, awareness and research. I take pleasure in inviting you all to interact with the best in India and the World. This will also be the fourth successive year for our very own ONYCHOCON. We seek the active participation of all our members in whatever capacity they would like. The interests of the residents have also been kept in mind. Apart from reduced registration rates, we also have focus sessions where they are welcome to present their research efforts. There will also be a Post graduate Quiz based on Nails. Your suggestions, comments and feedback are eagerly awaited.

This issue of Onychoscope features a very informative write-up on Nail Avulsion by our President, Prof Archana Singal. She shares with us, her experience on this very commonly done procedure, its justifiable indications and contraindications. We also feature a detailed report on the recently concluded 3rd ONYCHOCON, held in Mumbai, India compiled by your truly. The take home messages from the innovative faculty lectures are summarized for the benefit of our readers. A very interesting photo Quiz is presented by Dr Sidharth Sonthalia. He has also compiled the Nail Maze for this issue, which carries a hefty prize of free registration for the forthcoming ISND for the first two all correct responses. The same holds true for the winners of our previous nail maze whose names are being announced in this issue. I congratulate them heartily. DrPoojaArora has summarized 'What's new' in the field of nail disorders for this feature of Onychoscope. The write-up focuses on newer developments in the latter half of 2014.

So friends, as we ring in the New Year, I, on behalf of NSI Family wish you all a very **Successful and Happy New Year**. May 2015 see all your dreams and aspirations fulfilled. May we grow together and be successful in fulfilling the aspirations of our Nail patients. That's our New Year wish for all of you.

You can write to us at **nailscocietyofindia@gmail.com**Please also visit **nailsocietyindia.com** and **isnd2015india.com** for further details.

Dr Chander Grover

NAIL AVULSION

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Nail avulsion is the term meant for 'Nail Plate Avulsion' and refers to the separation of nail plate from the underlying nail bed and nail folds all around. Nail avulsion may be

1. **Traumatic**
2. **Non-traumatic or elective**

Traumatic: The patient may have had a blow to the nail; crush injury; nail gets caught in machinery; or a long hard toenail may get stuck on to some fixed object and gets pulled off the nailed. The nail plate may get avulsed completely with or without nail matrix, partially held in place by the nail folds, or adhering only to the distal nail bed. This is associated with excruciating pain. The exposed nail bed will have a whitish shiny surface with bleeding. Incomplete avulsion may be accompanied by subungual hematoma formation.

The exposed nail bed is highly sensitive due to loss of protective function of nail plate. Therefore a non-adherent dressing may be required for some time. The regrowth of nail plate takes long time, on an average 3 to 6 months for fingernails and 12 to 18 months for toenails. Management of nail matrix loss has been covered in the ONYCHOSCOPE Vol.3, Issue 1, January 2014. It is important to exclude fracture of distal phalynx on x-ray.

Non-traumatic or elective: This type of nail avulsion may be surgical or non-surgical. **- Non-surgical (Chemical):** Chemical nail avulsion is occasionally undertaken to avulse highly dystrophic nail in the treatment of onychogryphosis, onychomycosis (non-responsive to oral antifungal therapy alone), psoriasis or candida infection or when surgical nail avulsion is contraindicated. 40% urea ointment under occlusion is used with care to protect surrounding nail-folds for weeks (2-6 weeks). It is almost always a painless procedure.

Surgical nail avulsion: It is undoubtedly the most common surgical procedures undertaken on nail unit for various diagnostics and therapeutic purposes.

Indications:

Diagnostic: Exploration of the nail bed, nail matrix, nail folds and in some cases before contemplating a biopsy on the nail bed

Therapeutic: As for onychocryptosis/ ingrown toenail (most common indication), warts, onychomycosis, chronic paronychia, nail tumors, matricectomy, retronychia and pincer nail deformity.

Pre-requisites: Following pre-requisite must be taken into consideration before embarking on the procedure:

• It is imperative for the surgeon to be well versed with the applied anatomy and histology of the nail unit including nerve innervation and vascular supply.

• A good medical history of the patient is another pre-requisite with special attention to diabetes and peripheral vascular disease.

• Instruments required are shown in Figure 1.

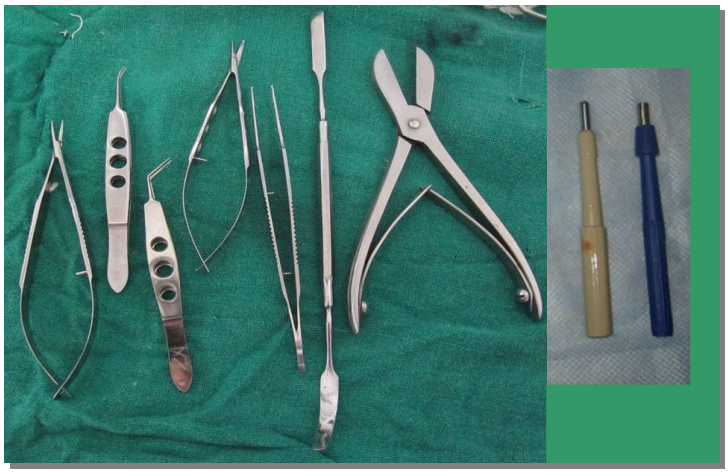


Figure 1

• The procedure is performed under local anaesthesia with 2% lidocaine injection with epinephrine; using either proximal digital block or distal digital block depending upon the surgeon's personal preferences. Transthecal digital block is not very popular among dermatologist.

Methods:

• Distal approach: Most commonly used procedure.

• Proximal approach: used only when it is difficult to find a cleavage plane distally due to severely hyperkeratotic nail plate or when the nail plate is firmly adherent to the nail bed as in cases with retronychia.

Types:

I. Total nail avulsion: seldom used except in removal of dermatophytoma in a total dystrophic onychomycosis (TDO) as it is frequently associated with post-operative morbidity.

☐ After the administration of LA, with the help of elevator, proximal nail fold (PNF) is detached from the underlying nail plate.

☐ This is followed by insertion of elevator under the free edge of nail plate and gradually separating the nail plate from nail bed along the entire width. It is important to detach the lateral horns of the plate.

☐ The separated nail plate is then grasped by a hemostat forceps and an upward rotatory motion avulses the nail plate.

☐ A bulky dressing is then done using large amount of antiseptic ointment.

Complications: Loss of counter pressure of the removed nail plate can result in distal embedding of the newly regrowing nail plate (impacted nail). The distal nail bed may also get damaged during the procedure due to injury to the hyponychium by the elevator

II. Total nail avulsion with plate replacement (Trap door avulsion):
Proximal part of the nail bed and/or matrix is allowed to remain attached to the ventral aspect of avulsed nail plate. Hyponychium, nail bed and distal matrix can be visualized and explored, and lesion may be biopsied/ removed. Trap door technique is used as follows

☐ Nail avulsions begins from the free edge using elevator and avoiding trauma to the hyponychium and progressing proximally stopping short at the matrix region when the elevator gives way.

☐ The lateral horns of the nail plate are detached carefully

☐ Nail is grasped with the hemostat and lifted upward like a trap door.

☐ There are instances when examination of proximal nail bed and distal matrix is vital. In this situation, in order to have better exposure of proximal nail bed and distal matrix, two oblique incisions may be given at proximal nail fold and stay sutures put.

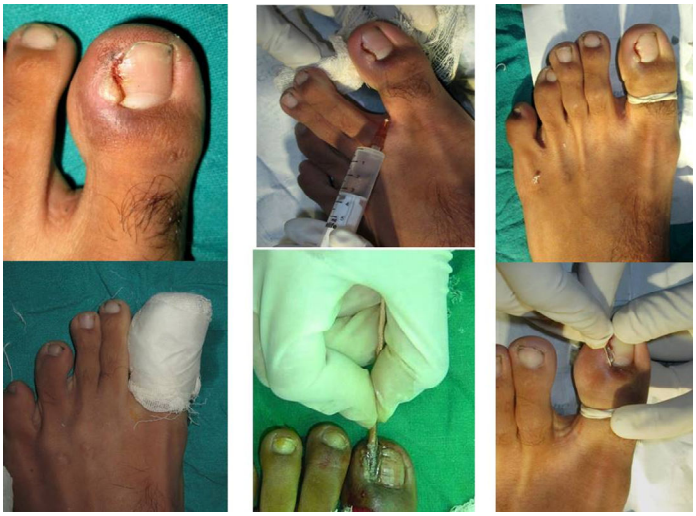
☐ After exploration, biopsy or removal of tumor, the reflected nail plate is put back in place and sutured to the lateral nail folds.

☐ 3mm punch holes may be made in the nail plate for drainage to prevent sub-ungual hematoma collection followed by a greasy and bulky dressing.

III. Partial nail avulsion:
Most commonly performed procedure.

Indications: Sometimes in the treatment of some onychomycosis caused by moulds, removal of tumor/ longitudinal melanonychia and as a part of partial matricectomies in the treatment of ingrown toenails (onychocryptosis). Conventionally, the lateral chemical matricectomy is performed by rigorous application (for I min; 3 sessions each of 20 seconds) of either 88% Phenol or 10% NaOH by a fine cotton tipped applicator. Alternatively Co2 LASER or RF ablation may also be done.

The steps are depicted in **Figure 2**. The procedure of digital anesthesia, tourniquet lateral nail avulsion and phenolisation is depicted. The dressing should be bulky with non-adhesive ointment, highly absorbant and have antibiotic/ antiseptic property. **Patient is advised to wear open footwear.**



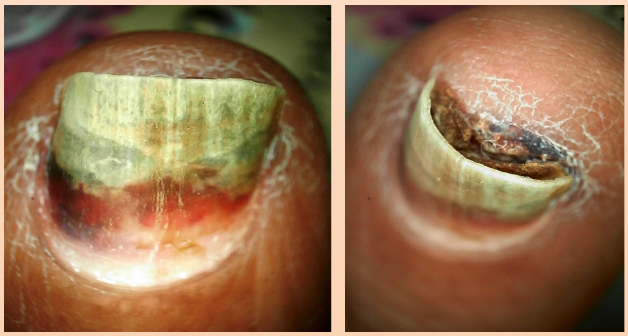
Nail Quiz

A 41-year old lady with advanced metastatic Breast Carcinoma was planned for 6 cycles of docetaxel-based chemotherapy, one cycle given over a week once every 3 weeks. The treatment was being given as neoadjuvant chemotherapy to shrink the metastatic deposits and make her amenable to surgery. Two weeks after her fourth chemocycle, she started complaining about swelling and tenderness of digits of both hands. Within 4 days, subungual pus and blood deposition and surrounding desquamation were noted by the patient. On clinical examination, all the twenty nails were involved showing varying degrees of dystrophic changes. While orange-brown discoloration of nail plate along with orangish-red Beau's lines and onychomadesis were seen in almost all nails, multiple nails also showed prominent acute Subungual puncture revealed free flowing pus and blood. On histopathology, nail plate revealed mounds of parakeratosis alternating vertically and horizontally with zones of orthokeratosis in tiered pattern accompanied by numerous neutrophils, eosinophils and lymphocytes within the mounds of parakeratosis. Fungi were ruled out on PAS staining.

Q A. Question - What is the diagnosis?

Figure 1: Paronychia with subungual abscess formation and varying degrees of onycholysis

Figure 2: Painful subungual haemorrhages and crusts were prominent in few hand nails.



Report on 3rd ONYCHOCON

National Conference of Nail Society of India held in 2014 at Mumbai, India.

ONYCHOCON-2014 was organized at Asia Heart Institute, Mumbai, India, under the able guidance and leadership of **Dr Sushil Tahilainai,** Organising Chairperson and **Dr Nina Madnani**, Organizing Secretary. It was heartening to see that the attendance and the level of interest of the delegates going up every passing year. The 3 day long program went literally without any glitches. **Dr Nisha Tahiliani** deserves special applaud for being the force behind the event. **Dr Nina Madnani,** was looking closely at onstage management and taking personal care of all the sessions. **Dr Ashok Shah, Dr Harsh, DrNishant** and the postgraduates from DY Patil ensured a smooth conduct of the events. The Scientific chairperson **Dr Vijay Zawar** had planned a truly academic feast by roping in speakers on varied topics like the History of Onychology, Radiology of nail, Forensic importance of nails etc. This event was unique in more ways than one.

Day 1: Pre-Conference workshop

The workshop saw participation by young and enthusiastic learners. The keenness to ask questions, seek answers and give their own inputs was distinctly visible. **Dr Nitin Nadkarni** was the opening batsman, who successfully knocked a huge score by discussing relevant anatomy of the nail unit in his own impeccable style. **Dr Sheetal Poojary** discussed the various techniques of anesthesia with representative diagrams, facilitating and easy assimilation by us all. **Dr Raghunath Reddy** then demonstrated the various indications, techniques and extents of nail involvement. His video presentations showed the whole gamut of procedures possible. Most interesting was the use his demonstration of finger glove tourniquet, which he prepares beforehand and keeps it pre-sterilized. **Dr Sushil Pande** demonstrated few cases in which he has used the CO2 laser. **Dr Chander Grover** demonstrated the various techniques of nail biopsy and the indications for the same. She placed special emphasis on choosing and appropriate site for the biopsy. The video demonstrations were appreciated as they enhance the understanding of the delegates. Her technique of use of Gauze strip tourniquet was also appreciated. The Organizing Chairperson **Dr Tahiliani** then presented very useful tricks and tips for nail surgery highlighting important small innovations useful in improving the postoperative outcome. **Dr Nirmal B,** Assistant Professor, CMC, Vellore demonstrated the use of bleomycin in nail warts. Of particular mention was the use of his red LED Light which outlines the complete extent of the wart in this acral area, thus helping in lower recurrences.

There were good number of high quality **e-posters available** for delegates on all three days.

Day 2:

The "no-frills" nature of the conference was an essential highlight.

The conference was blessed by the continuous presence and creative inputs of our seniors like **Dr Hema Jerajani, Dr Chetan Oberoi, and Dr Rui Fernandez. Dr Jerajani,** who is also the esteemed patron of NSI was present both days, encouraging and appreciating liberally, all presenters and faculty.

Dr Vidya Kharkar outlined the approach to diagnosing any nail disorder. **Dr Sharmila Patil** threw light on the Laboratory diagnosis of common nail conditions, outlining algorithmic approach for the same. **Dr Uday Khopkar** discussed the rising clout of Dermoscopy/ Onychoscopy in the early diagnosis, especially of nail psoriasis along with other disorders.

Dr Vasudha Belgaumkar's interesting talk on radiological signs in nail disease made us realize the value of this seemingly small and cheap investigational modality. **Dr Kalpana Bhat**, a radiologist who has had extensive experience in ultrasonographic examination of nails showed us interesting pictures of Ultrasound Biomicrospic examination of nail unit.

Highlight of the event was an interesting recount of the history of Onychology by **Dr Amiya Myukhopadhyay.** He brought out interesting references to nail diseases in out earliest known Vedas and the fact that nail avulsion was used and described by Sushruta, thousands of years ago. The mention and demonstration of **"Nakh Chitra"** was also intriguing and inspiring at the same time. **Dr Roman Novicki,** Professor of Dermatology from the historic town of Gdansk, Poland, highlighted the involvement and importance of nail in Occupational and Contact dermatitis. His interesting collection of cases inspired new perspectives. **Dr Manjunath Shenoy** demonstrated the common pitfalls in clinically diagnosis onychomycosis and **Dr Autar Miskeen** highlighted the laboratory pitfalls. Overall, the session highlighted that not every nail dystrophy is onychomycosis and specialized perspective and approach is required. The ensuing panel discussion with Dermatology stalwarts like **Dr Archana, Dr Kiran Godse, Dr Madnani, Dr Novicki and Dr Kura** highlighted practical problems and their solutions in onychomycosis management.

Post lunch, the post prandial sleepiness was counteracted effectively by **Dr Sharad Mutalik** who presented Nail in a lighter vein. The numerous references to nail and hilarious anecdotes were shared. His parodies of Hindi film songs, based on "khujli" and "nails" left the audience in peals of laughter**. Dr Bela Shah** outlined nail manifestations of systemic disease and **Dr Chitra Nayak** did the same for drug reactions. An interesting panel discussion on management of inflammatory nail diseases succeeded in giving useful tips to practicing dermatologists. The last two sessions by **Dr Rajiv Joshi,** highlighting histological surprises in nail biopsies and **Dr Nilendu Sarma,** highlighting the pigmentary abnormalities of nails were eye openers for many. The meeting successfully concluded with the AGBM of NSI.

Day 3:

This day the sessions were conducted by **Dr Chetan Oberoi, Dr Sacchidanand and Dr Ameet Valia.** The Award paper session and Free paper sessions witnessed enthusiastic and astounding research efforts by our young members who came up with innovative studies and fresh answers.

The subsequent session on Behavioral disorders of nails by **Dr Archana Singal,** gave the listeners a fresh view of how to recognize and deal with these nail problems. **Dr Chander Grover** showed various common nail tumors but emphasized on the nail unit warts and glomus tumors as these are the most common nail tumors. Col **Dr Rajesh Verma's "murder mystery"** showed us how nail examination and evidence derived from nails has solved so many cases in the past and continues to do so. The cosmetic side of the nail was well illustrated by **Dr Soni Nanda.** She showed us what all can be done to help our patients and how to do this best. **Dr Vijay Zawar's** collection of interesting nail cases were total bouncers which evoked the Sherlockian spirit of "observing, not just seeing" in the panelists and the delegates alike. This session was well appreciated for highlighting how we need to think "out of the box" to solve not so common cases. This session was well appreciated for highlighting how we need to think "out of the box" to solve not so common cases.

Dr Biju Vasudevan conducted the **"Nail Quiz"** where 12 teams participated in the prelims and 4 teams qualified for the finals. The winners were **ESI Hospital, Basaidarapur, Delhi and First Runners-up were UCMS and GTB Hospital, Delhi.** The other two finalists were **Dr DY Patil Hospital, Mumbai and INHS Ashvini, Mumbai.** This was followed by an interesting session on "What's new in ONYCHOLOGY" by **Dr RD Kharkar,** which brought us abreast with the latest in the field the world over.

The concluding Valedictory function was brief and simple with huge cash prizes being distributed to the winners. The pharma support and the support of Team ONYCHOCON-2014 was graciously acknowledged by all the organizers. I do not have a complete list of the winners in each category. This conference succeeded in bringing out yet new perspectives and approaches in the field of nail.

Though the curtains have come down on this effort, the preparations are in full swing for the next event- 4th ONYCHOCON which shall be clubbed with 3rd ISND (International Summit on Nail Diseases) on 20-22 November, 2015 at Delhi. See you all there!!

Compiled by,

Dr.Chander Grover

Update from the Realm of Nails

Novel treatment of nail psoriasis using the intense pulsed light: a one-year follow-up study.
TawfikAA .Dermatol Surg 2014 Jul;40(7):763-8

Pulsed dye laser has been used successfully in the treatment of nail psoriasis. Intense pulsed light (IPL) has been used in the treatment of plaque psoriasis using a 550-nm filter. This study evaluated the efficacy of IPL in the treatment of nail psoriasis.

Twenty patients with finger and toe nail psoriasis were treated by IPL. Sessions were performed every 2 weeks for a maximum of 6 months. The Nail Psoriasis Severity Index (NAPSI) score was calculated at baseline and 1 month after the last treatment session. Follow-up was performed at 1, 6, and 12 months.

The authors conclude that **intense pulsed light is a promising effective modality of treatment of nail psoriasis, which is easy to use, safe, and provide a long period of remission.** This was confirmed by the elicited clinical improvement, NAPSI, and patient satisfaction.

Combined Oral Terbinafine and Long-Pulsed 1,064-nm Nd: YAG Laser Treatment Is More Effective for Onychomycosis Than Either Treatment Alone.
Xu Y, Miao X, Zhou B et al.DermatolSurg 2014 Nov; 40 (11):1201-7.

Onychomycosis is difficult to cure. Systemic and topical treatments, including the 1,064-nm Nd: YAG laser, are not very effective when used individually. This study compared the efficacy and safety of combined treatment with a long-pulsed 1,064-nm Nd: YAG laser and oral terbinafine with those of either treatment alone.

53 patients with a total of 90 infected nails were randomly divided into 3 treatment groups: the T group received oral terbinafine, the L group received long-pulsed Nd: YAG laser treatment, and the T + L group received both treatments. The mycological clearance rate (MCR) and the clinical clearance rate (CCR) of the 3 groups were evaluated at weeks 4, 8, 12, 16, and 24.

The MCR and CCR increased in all 3 groups in a time-dependent manner. **The MCR and CCR of the T + L group were significantly higher than those of the T group and the L group** at Weeks 8, 12, 16, and 24 ($p < .05$).

The study concluded that 12 weeks of **combined treatment with a long-pulsed Nd: YAG laser and oral terbinafine produce more rapid and effective mycological and clinical clearance in patients with onychomycosis** than either treatment alone, without any obvious side effects.
The biological and physical effects of laser treatment on dermatophytes have been discussed in several studies but remain uncertain. Some researchers have proposed that the effectiveness of laser treatment results from the photothermolytic effect of heating both the nail and the fungus. Other hypotheses are that nonspecific heating of tissues results in vasodilatation and an increase in circulation, which stimulates immunological processes and that the laser induces the formation of free radicals and influences cellular metabolic reactions. In this study, the **laser treatment was more effective on nails with a black color than nails with thick white scales.** This result may be explained by the selective photothermolytic effect of the long-pulsed Nd: YAG laser on the black chromophores produced by some fungi.

Nail Surgery Is a Risk Factor for Recurrence of Ingrown Nails.

Erdogan FG, Guven M, Erdogan BD, et al.DermatolSurg 2014 Oct; 40 (10):1152-4.

Few **risk factors** defined for ingrown nails include hyperhidrosis, ill-fitting shoes, inappropriate trimming of the nail side, weight gain, pregnancy, and over- curvature of the nail. The aim of this article was to determine the recurrence rate after a course of successful conservative treatment and to define the risk factors associated with recurrence.

88 patients with 123 ingrown nails that were successfully treated with braces were followed up. Recurrence was the ultimate end point of the study; otherwise, all patients were under control for at least 18 months.

The authors concluded that ingrown nail may be considered as a relatively benign condition that might not have a tendency to recur in most patients. Therefore, ceasing the edema and inflammation of the skin under the nail may be tried before removing the nail plate indefinitely because operations lead to resistance to conservative treatments. If all ingrown nails are treated using this method, there may be fewer recurrences given that the number of operated cases would also decrease.

Emerging Topical Onychomycosis Therapies - Quo Vadis?
Elkeeb R, Hui X, Murthy N, et al. Expert OpinEmerg Drug 2014 Dec; 19(4); 489-95.
Topical drug delivery to the nail is highly desirable in treating nail disorders. However, efficacy of topical therapies is low due to their limited permeability across the nail plate. Advances have especially been made by the development of new therapeutic options including new drug entities, new formulations and reformulations. This overview updates emerging topical treatments for onychomycosis, research progress and future perspectives.

Hay and Baran revised clinical classification to include new subtypes of fungal nail plate invasion and if onychomycosis is a primary or secondary. This revised classification has been mentioned in detain in this article. The article focuses on the present status of emerging topical antifungal: **Luliconazole** (Phase III stage), **Tavaborole** (AN-2690, FDA approved in July 2014), An 2718 (completed Phase I), **Terbinafine nail lacquer** (completed Phase III), **TDT-067** (ongoing Phase III) and **NB002** (completed Phase II). If increasing evidence from extensive studies supports their efficacy, it is imminent that they would provide a highly effective and safe treatment for onychomycosis. The authors encourage well-controlled long-term clinical trials that gauge response, side effects and compliance of the current approved topical over a longer period since initial clinical studies simply measure preliminary outcome.

Compiled by:

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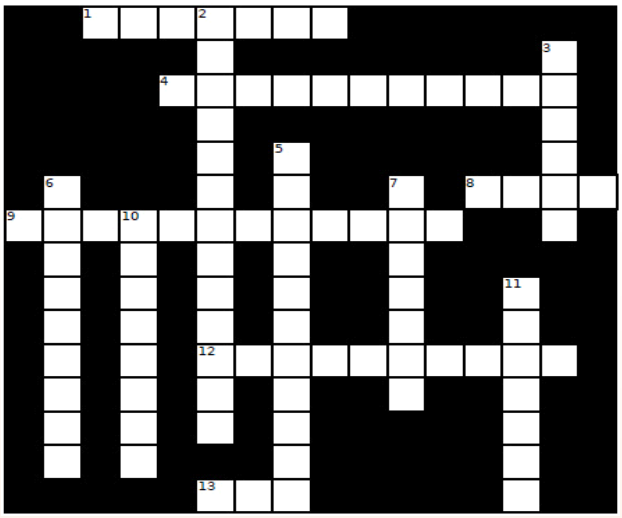
Nail Maze



Across

1 If you detect Mee's Lines, in a patient suspected of heavy metal poisoning, don't forget to test the patient's blood for

4 Acne patient on treatment develops blue nails. Whats he being given?

8 Syndrome characterized by poorly developed fingernails, toenails, and patellae, iliac horns and proteinuria

9 Syphilitic stigmata of periodic shedding ofnails is known as!

12 Simple thickening ofthe nail without deformity often seen in psoriasis, PRP or Darier's disease.

13 Go in for acrylic nails, but never use the one containing.

Down

2 The Latest anti-fungal on the block, used as 10% solution for onychomycosis

3 Primery lymphadema and concomitant pleural effusion with Bronchiectasis may paint your nails..

5 Chronic paronychia, with disruption ofthe linear nail growth resulting from incarnation of the nail plate in the proximal nail fold is better known as!

6 Thinning of nails in lichen planus is popular as.....deformity

7 Nails seen in chronic kidney patients, especially on a Freaky Friday

10 The "floating nail" sign and the "Profile" sign indicate early stages of!

11 Acronym for the nails of a patient trying to cutdown on tobacco: but nicotine staining still leaving its mark behind

Compiled by:
Dr. Sidharth Sonthalia
Consultant Dermatologists
Director, SKINNOCENCE: THE SKIN CLINIC Gurgaon.
Please mail your answers to
nailsocietyofindia@gmail.com
Names of the first two winners will be published in the Next issue of the newsletter.

Answer to Photo Quiz

TAXANE-INDUCED ONYCHOPATHY

A large number of chemotherapeutic drugs including taxanes, 5-Flourouracil, bleomycin, doxorubicin, etoposide, and vinca alkaloids etc. have been associated with nail changes; however, nail toxicity is strikingly more common with taxanes, particularly docetaxel, as compared to any other agent. Although nail toxicity is typical of weekly regimes of chemotherapy, it has been reported with almost all therapeutic schedules. The onset of dystrophy has varied from as early as the 1st cycle to as late as the 7th cycle of chemotherapy.

Taxanes, typically docetaxel and paclitaxel are an essential component of modern day chemotherapy, especially for advanced metastatic breast malignancy, ovarian and lung carcinoma. The incidence of nail involvement has been reported to range from 0-44% in different studies. Typical features of taxane onychopathy include - orange-brown discoloration of nail plate, red or orange Beau's lines, onychomadesis, acute paronychia, subungual abscess, and subungual hemorrhages with onycholysis. Toxicity to the nail matrix can lead to nail plate changes including Beau's lines; whereas, toxicity to nail bed epithelium leads to onycholysis and damage to proximal nail fold results in paronychia. Hemorrhagic onycholysis and subungual hematoma and abscess formation are rare but serious manifestations.

Docetaxel and other taxanes act via inhibition of microtubule formation. Thus taxane onychopathy may be the result of direct toxicity to the proliferating cells in the nail matrix epithelium, anti angiogenic activity or possibly additional neurogenic mechanisms.

Differential diagnoses for such a presentation can include nail psoriasis, onychomycosis, trauma with secondary infection, and the recently described PRIDE complex. In our case, the typical chronology; a history of chemotherapy; and prominence of features like an orange colored plate, with subungual hemorrhages and abscess, were pointers towards taxane-onychopathy, which was confirmed on histopathology. Lack of other clinical features of PRIDE complex ruled it out.

The response to conservative management is satisfactory in these cases. Our patient recovered on oral and topical antibiotics and oral anti-inflammatory drugs given for a week. Severe cases may require drainage of subungual hematoma and abscess. Preventive measures described include application of opaque nail hardeners (photo protective action) and the use of frozen hand glove or foot sleeper (cold induced vasoconstriction reducing the diffusion and penetration of agent); however, their efficacy needs further evaluation.Compiled by,

Dr.Sidharth Sonthalia
Consultant Dermatologist
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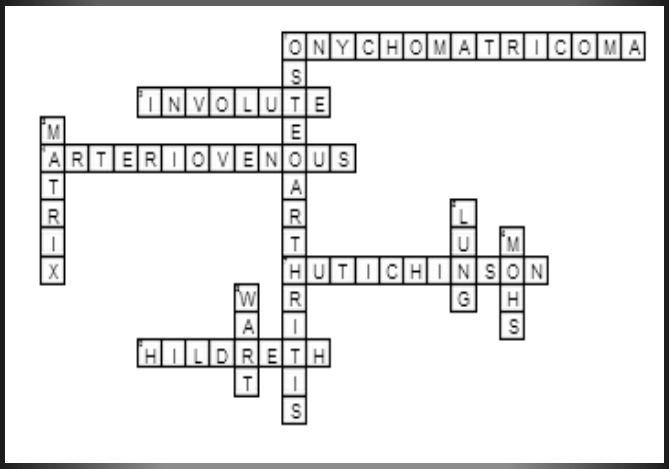
THE SKIN CLINIC Gurgaon

Solution to Nail maze from Onychoscope Vol 3, Issue 2, July 2014



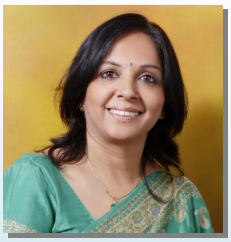
The winners are:

- Dr.Urmi Khanna
- Dr.Nirmal B

Congratulations!!

Both these winners as well as winners for the current issue of Onychoscope Nail maze would be awarded Registration for the upcoming 3rd International Summit on Nail Diseases (ISND) and 4th ONYCHOCON to be held from 20-22nd November, 2015, at Hotel Holiday Inn, MayurVihar, Delhi, India.

Editorial Board Members



Dr Archana Singal

Dr Chander Grover

Dr Shikha Bansal

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