Efficacy of acitretin and topical clobetasol in trachyonychia involving all twenty nails

Sir,
Trachyonychia is primarily an inflammatory disease of the nail matrix that manifests as brittle, thin nails with excessive longitudinal ridging. It may present either as an idiopathic disorder or may be associated with other dermatological conditions such as alopecia areata, psoriasis, lichen planus, atopic dermatitis and vitiligo.\(^1\) Besides being a cosmetic concern, it may also impair daily activities. Here, we describe a case of trachyonychia that was successfully treated with a combination of oral acitretin and topical clobetasol.

A 45-year-old woman with hypothyroidism presented with changes affecting all finger and toe nails for 2 years. During the past year, she was treated with a course of oral terbinafine for suspected onychomycosis but with no response. On physical examination, all twenty nail plates showed dystrophic changes with hyperkeratosis, longitudinal ridges, onychorrhexis, distal onycholysis and thinning [Figure 1]. There was no evidence of any skin or mucosal involvement. Complete blood count, liver function tests, thyroid hormones and hepatitis B and C virus serology were unremarkable. Mycological cultures were negative. A biopsy was not performed considering the risk of iatrogenic damage to the nail matrix. Therefore, a clinical diagnosis of idiopathic trachyonychia was made. After baseline investigations, the patient was initiated on treatment with oral acitretin (Neotigason) at a daily dose of 0.4 mg/kg (25 mg). After 2 months of treatment, the nail dystrophy improved significantly and the dose of acitretin was tapered to 25 mg every 2 days (0.2 mg/kg daily). Topical clobetasol 8% nail lacquer was initiated once a day. Nail dystrophy continued to improve [Figure 2] and the patient did not develop any retinoid-induced complications other than a mild hypercholesterolemia (total cholesterol level rose to 245 mg/dl from a baseline of 170 mg/dl) that required initiation of statins. Treatment was continued for 10 months with slow tapering, achieving excellent results finally.
Though trachyonychia is not an uncommon condition, a comprehensive review of the literature reveals that there is no clear evidence-based treatment for trachyonychia. We found less than 20 published articles describing the different therapeutic approaches for trachyonychia. Case reports and series have mentioned the use of oral and intramatricial injections of corticosteroids, topical and systemic retinoids, antimalarials, psoralen plus ultraviolet A and cyclosporine, albeit with heterogeneous results. Topically applied psoralen plus ultraviolet A exposure, intralesional triamcinolone acetonide injection and oral cyclosporine have demonstrated some clinical improvement.

Acitretin has been commonly used in the treatment of keratinization disorders due to its anti-inflammatory and anti-proliferative properties. It has been proven to be beneficial in patients with trachyonychia secondary to psoriasis and nail lichen planus at doses of 0.3 and 0.5 mg/kg daily. The use of clobetasol 8% nail lacquer has been reported in nail psoriasis with enough evidence to support its use and safety. This case provides evidence that supports the use of acitretin in combination with a high potency topical corticosteroid in the treatment of trachyonychia.

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Pagetoid Bowen’s disease of vulva: Excellent response to imiquimod

Sir,

Bowen’s disease is a form of intraepidermal squamous cell carcinoma with a small chance of progression to invasive malignancy. Pagetoid Bowen’s disease is a histological variant of Bowen’s disease which simulates the pattern of Paget’s disease, especially extramammary Paget’s disease.

A 28-year-old married woman presented with an itchy erosion on the vulva for the past 3 years. It started as a small, itchy, red macule which developed erosions over time. She had received multiple treatments including topical corticosteroids, calcineurin inhibitors, oral antibiotics, oral dapsone, antivirals and systemic steroids with no improvement.

Examination revealed an erythematous to violaceous, minimally indurated, non-tender plaque measuring 3 cm × 2.5 cm on the upper one-third of the left labia majora. The surface of plaque had a single, well-defined, clean looking, brightly erythematous erosion with irregular margins [Figure 1]. Regional lymph nodes were not enlarged. Investigations including hematological workup, anti-nuclear antibodies and herpes simplex virus serology were within normal limits. Serological tests for human immunodeficiency virus and syphilis were negative.

Biopsy revealed a partly eroded epidermis with single and nested atypical cells in a scattered distribution occupying the full thickness of the epidermis [Figure 2]. A dense inflammatory infiltrate was noted around eccrine glands in the deeper dermis. A differential diagnosis of pagetoid Bowen’s disease and extramammary Paget’s disease was considered and immunohistochemistry with p63 and carcinoembryonic antigen was undertaken.

Immunohistochemistry results showed strong diffuse positivity for p63 [Figure 3a] and all the tumor cells were negative for carcinoembryonic antigen [Figure 3b]. This confirmed the diagnosis of pagetoid Bowen’s disease and the patient was started on imiquimod (5%) cream. After 6 weeks of therapy, the patient showed significant improvement [Figure 4] and the lesion completely resolved with 12 weeks of treatment [Figure 5]. There was no relapse after 1 year of follow-up. Further screening for internal malignancy was normal.

Pagetoid Bowen’s disease is a histological variant of Bowen’s disease which simulates Paget’s disease. There have been many case reports of extragenital pagetoid Bowen’s disease but cases involving the genitalia, especially the vulva, have been rarely reported.

Both pagetoid Bowen’s disease and extramammary Paget’s disease present as well-defined superficial erosions on the vulva associated with itching. These usually present with a long history and can be...