

2020/21 Welcome Message

A very happy new year to all and a warm welcome from the British Hair and Nail society.

Looking back on last year, 2020 was turbulent for all. With COVID dominating the news for most of the year, as health professionals' majority would have gone through challenging times in striking a balance between work and health concerns about family and friends. Additionally, the pressures felt in the department, mine included were palpable when we were requested/ deployed to help in the COVID wards. With priorities rightly being maintained for emergencies and cancer treatments, our hair patients have also struggled with many having to endure even longer waits to be seen face to face. Unfortunately, hair referrals are not very amenable to telephone or video consultations. though we can appreciate the psychological impact of the problems it is not easy to give a definite diagnosis or monitor response to treatment. COVID had its own link with Telogen Effluvium which caught the attention of the media.

We are currently in a new wave and stricter measures which does mean our hair patients may need to wait a little longer. There is optimism in the air with vaccinations in full swing.

I am pleased though with the progress we made at the BHNS- we have welcomed a new team and are continuing to increase our membership. Our website is going through a major revamp. We have discussed exciting new projects for the coming year with a New BHNS Registrar training day. The Nail and Hair educational days are scheduled for this year- We are delighted to welcome Prof Rodney Sinclair and Dr Michela Stearace for expert talks at the SIG meeting at virtual BAD annual meeting. The BHNS project of standardising medical photography for hair loss disorders has been tasked to Emily Arthur, the senior medical photography manager. Nekma Meah has got a ACE project which she discusses in detail.

We have four excellent educational articles in this edition- submitted by Ivan Bristow, Greg Williams, Dhruv Laheru and Matthew Wynne. We are always looking for interesting educational articles/ case reports for the newsletter so do keep sending them to Rose Wilmot at rose.wilmot@nhs.net.

Lets look for a more normal but exciting 2021!



By Dr Anita Takwale
(BHNS President)

UPCOMING BHNS EVENTS

BHNS Education Update Day

We are pleased to announce that our ever-popular **Nail Education Update Day** will be making a (Virtual) comeback this year in May 2021. This is an event usually held on an alternate yearly basis, aimed at Consultants, featuring national and international experts in Nail disease and surgery. We focus on increasing breadth and depth of your knowledge in Nails and improving confidence in the independent treatment of disease.



Event Organiser Dr Dhruv Laheru
(BHNS Clinical Nail Lead)

BHNS Registrar Hair & Nail Training Day

Following on from the above established course, we are looking forward to hosting our first **BHNS Registrar Hair & Nail Training Day** in September 2021. This will be aimed at our Junior colleagues, to obtain a good grounding in the new JRCPTB Dermatology Curriculum requirements being introduced in 2021. We aim to cover common diseases of hair and nail, use of dermoscopy, genetics of hair and nail disorders and lots of other useful topics. Trainees will find this event very helpful for their clinical practice but also to support their preparation for the SCE.



Event Organisers Dr Leila Asfour (BHNS Member) and
Dr Rona Applewaite (SAS Representative)

BHNS Grand Round

As ever, we continue to accept your challenging hair and nail cases monthly in our Hair and Nail (Virtual) Grand Round. Our Expert panel then go through your submission and photos and provide feedback through the members section of our website. We encourage all members from the society to consider submitting.

To make a submission please email rose.wilmot@nhs.net or upload directly onto the website by going to Community > Case Discussions.

UPCOMING EXTERNAL EVENTS

WCHR in Melbourne, Australia, 22-25 April 2022
EHRS in St Petersburg, Russia, 16-18 June 2022
EHRS in Sheffield, England, 15-17 June 2023

Website Update - You may have noticed that the BHNS website has gone through a recent update. Not all of the pages have been converted to the new style but we will be working on update them all over the next year.

We hope you'll agree that the changes represent a much needed improvement and make the information we're trying to get across a lot easier to access.

Journal Club - We are looking for any contributions to the BHNS Journal Club. The Journal Club takes place monthly and any member can contribute.

To get involved email rose.wilmot@nhs.net.

Standardising Medical Photography for Hair Disorders

The BHNS has agreed on an exciting project to standardise medical photography for hair disorders. Emily Arthur, Medical Photography Manager from Gloucestershire Hospitals will be taking the lead for this project. She will be looking to collaborate with other Hair Centres and Medical Photography departments around the UK to produce the National Guidelines for Hair Loss Photography.

Emily has worked closely alongside Dr Anita Takwale to trial and produce standardised protocols for Hair Loss Photography for Gloucestershire Hospitals. The 3 protocols designed cover 13 diagnoses and provide objective and comparative results. In 2019, Emily presented her findings at the Institute of Medical Illustrators conference in Belfast and hopes to take the project further by producing National Guidance.

Emily would be looking for volunteers to form a working group to collaborate on this project. Those in the group will be asked to share their current practice in Hair Loss Photography and to offer comment towards the National Guidance. Can those interested in being part of the working group please contact Rose Wilmot (rose.wilmot@nhs.net) our BHNS admin for further details.



By Emily Arthur
Senior Medical Photography Manager

Alopecia Areata Consensus

We are very delighted to present a summary of the findings from part 1 of The Alopecia Areata Consensus of Experts (ACE) study published in the Journal of American Academy of Dermatology in July 2020. The ACE Study is a large-scale international consensus document which explored the use and utility of different treatments for alopecia areata (AA) (1). Leading hair experts from across the globe were involved in a three step Delphi process and expert consensus achieved for 134 (32%) questions relating to treatment, prognosis and registry development. Below are some of the key findings.

Topical agents:

- **Corticosteroids:**
For the treatment of scalp AA, a potent topical corticosteroid should be applied daily for at least 6 to 12 weeks and, at most, 3 to 6 months. Topical corticosteroids should be first-line treatment, irrespective of disease severity, in children up to 12 years of age. Complete regrowth should be considered the clinical indication for cessation of topical corticosteroids.
- **Minoxidil:**
Topical minoxidil is believed to accelerate the linear growth rate of hair regrowing within a patch of AA. It can be prescribed in conjunction with other topical or systemic agents, but does not need to be used for all patients with AA.
- **Immunotherapy:**
Children with alopecia universalis/alopecia totalis/ophiasis should be offered contact immunotherapy before systemic therapy is considered.

Intralesional corticosteroids (ILC):

- A solitary patch of scalp AA is best initially treated with 2.5 to 5 mg/mL of triamcinolone acetonide. ILC are more effective than ultrapotent/potent topical steroids for inducing regrowth and a more durable remission

Systemic agents:

- **Corticosteroids:**
Prednisolone (or prednisone) is the preferred choice of systemic corticosteroid, and daily administration is optimal. In adolescents with severe AA, the initial dose of prednisolone may be 0.4 to 0.6 mg/kg/day. Gradual taper of systemic corticosteroids over more than 12 weeks will help to achieve durable remission.
- **Cyclosporin:**
In adults with severe AA, the target dose of cyclosporine should be 3 to 5 mg/kg/day.
- **Methotrexate:**
In adults with severe AA, the target dose of methotrexate should be 15 to 20 mg weekly. Efficacy of systemic treatment in combination with systemic corticosteroids:

Methotrexate, cyclosporine, or JAK inhibitors are

effective.

- Preferred second line agent:
JAK inhibitors would be the ideal choice of systemic therapy in adults
- Indications for discontinuation of systemic treatment include:
Full coverage of scalp with terminal hair.
- International AA registry:

There was consensus agreement on its development. Whilst there were potential limitations to the study (not all therapies were included and all special patient groups not considered), this is first large-scale consensus paper on alopecia areata. Part II ACE is also available online ahead of print (2).

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By Dr Nekma Meah (BHNS Secretary) and Dr Dmitri Wall (BHNS Member)

What has 2020 taught us about patient perspectives in Alopecia areata?

Alopecia areata (AA) is a frequently encountered diagnosis in clinic. It is common, occurring in 2% (1) of the population and associated with significant psychological comorbidity (2). Not only are treatment options limited by efficacy, but in our current times, instigating immunosuppressants for non-life-threatening diseases, is a challenging call to make. 2020 and its medical literature, has been dominated by COVID.

In this short letter, I aim to highlight two important publications (3,4) which address how we as Dermatologists, can better serve the needs of our patients with AA. Whilst new treatment options jostle for position on the horizon, now more than ever, it seems pertinent for Dermatologists to gain insight into patient perspectives in this often chronic, recurrent and recalcitrant condition.

The Severity of Alopecia Tool (SALT) is a widely used standardised scoring system in the assessment of extent (0-100%) of scalp hair loss. Whilst guidelines have described 50% as a definable measure of treatment success (5) and clinical trials point to 50% (6) and 90% (7) baseline improvements, patient perceived treatment success has only recently been defined.

In January 2020, the British Journal of Dermatology published, "The Alopecia Areata Investigator Global Assessment scale: a measure for evaluating clinically meaningful success in clinical trials" (3). This funded study attempted to develop an Investigator Global Assessment for Alopecia Areata (AA-IGA), having determined both patient and clinician perspectives on treatment success and defining treatment success for those with $\geq 50\%$ hair loss.

Investigators conducted qualitative interviews with 10 US Dermatologists and 30 patients with AA and $\geq 50\%$ hair loss. Scalp hair loss was the key feature for patients, due to cosmetic and also functional issues, such as concern over wigs being dislodged during activities. This was also the main outcome measure for all Dermatologists in determining treatment success. This concordance between patient and clinician was also demonstrated in the perception of clinically meaningful treatment success, where short of 100%, patients considered a 70-90% (median 80%) re-growth a success and 75-90% (median 80%) a success for Dermatologists. The AA-IGA describes 5 graduations of hair loss: None (0%); Limited (1-20%); Moderate (21-49%); Severe (50-94%); and Very Severe (95-100%). Therefore, of nearly all those interviewed, for patients with $\geq 50\%$ hair loss, an improvement to 'Limited' ($\leq 20\%$) hair loss was agreed as treatment success.

Accepted for publication in the British Journal of Dermatology as of October 2020, is the article, "A qualitative exploration of the experiences of adolescents with alopecia areata and their messages for healthcare professionals" (4). De Vere Hunt et al analysed 21 semi-structured interviews with young people suffering with AA (mean age 21.5 years).

Common themes included: feelings of isolation due to alopecia being 'a hidden problem'; loss of identity and not just loss of hair; self-consciousness and worry about being 'stared at'; and 'living in fear' about the unpredictable nature of their condition. Interviewed patients gave two clear and consistent messages for healthcare professionals:

1. "Give more information"
"I think most of the explanation was, "Look on Alopecia UK, they have a section about what alopecia is. Get your information from there. Am I ill then? Am I sick? Am I okay? Do I have a disease? Like what's going on?"
2. "Address the emotional impact"
"Doctors-wise, like I said, it would be nice to have someone just be like, 'How's your hair doing?' 'How are you feeling about it?' And just talk about it."

The authors postulated that 'time constraints' were likely to be the main reason for healthcare professionals failing to address this emotional impact and highlighted the significance of being diagnosed with an incurable illness with effects on identity, during adolescence.

Finding the time to address emotional issues in busy and often over-booked clinics can be a challenge. But for conditions which have no cure, have limited treatment efficacy and have significant psychological consequences, clear and empathetic communication may one of the few things we can offer and is a standard we should all strive for. In current times of heightened stress, providing clear information, enquiring about treatment expectations and addressing emotional well-being are of paramount importance in consultations for those suffering with AA.

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By Dr Matthew Wynne
(BHNS Member)

Introduction to Morphea

Morphea, also known as localized scleroderma, is a rare disease seen in both adults and children. Most pediatric patients have the linear subtype, which can extend deeply into the subcutaneous tissue, muscle, and bone. Linear morphea on the head and neck, called en coup de sabre (ECDS), and Parry-Romberg syndrome (PRS), also called progressive hemifacial atrophy, are felt to be related variants within the morphea spectrum of disease.

Case Presentation

An 18 year old female presented to the Farjo Hair Institute with linear morphea en coup de sabre (ECDS) lesion left parieto-occipital scalp (Figure 1). The condition had presented in childhood and had been stable for many years. There were no extracutaneous stigmata and although there was some fat atrophy, there was no overt bony abnormality.

Procedure

The patient opted for a Linear Strip Excision method of donor hair harvesting and had 1903 follicular unit grafts implanted using forceps (Figure 2). Implantation density was conservative given the scarring nature of linear morphea. Post-operative healing was uneventful. The patient was reviewed at 10 months and was pleased with the results achieved (Figure 3) but wanted to increase density by repeating the procedure.

Discussion

Surgical excision was offered as an option to the patient but would still have left a non-bearing surgical scar and was declined by the patient. Successful hair transplant in LM ECDS has been published in the medical literature. A variety of neurologic symptoms have been reported, most commonly seizures and headaches. In addition, computed tomography (CT) and magnetic resonance imaging (MRI) can reveal calvarial and intracranial abnormalities, even in asymptomatic

patients and hair transplant surgeons should be aware of this when planning hair transplant procedures.

In this case, funding was sought from the National Health Service and granted so there were no surgical costs to the patient.

Figure 1



Figure 2



Figure 3



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By Dr Greg Williams
(BHNS Member)

Pilonidal sinus of the foot – a common condition in an unusual location

Introduction

Pilonidal sinus is a commonly reported condition, which occurs when hair penetrates and enters the skin creating a chronic sinus or fistula. This paper describes an unusual case arising interdigitally on the foot of a 57-year-old woman.

Case Report

A 57-year-old woman presented in clinic for her routine podiatry treatment. Her medical history included ulcerative colitis and spina bifida, which has resulted in peripheral neuropathy in both her feet. Upon examination by the podiatrist, hairs were noted to be 'sprouting' from her third and fourth interdigital space (Figure 1) of her right foot. Closer examination revealed a pilonidal sinus (See Figure 2) with numerous hairs evident protruding from the lesion. The hairs were carefully extracted by the clinician (Figure 3) and dressed. Healing was uneventful.

The patient owns five dogs. While at home, she admitted to just wearing socks. Dog hairs subsequently became embedded in the material, which presumably was the source of the problem. Due to the lack of sensation, the patient was unaware of itching or other symptoms as the hairs penetrated her skin. Subsequent to this episode, similar lesions have developed on the patient's feet, (Figure 4) some with accompanying infection. These have been managed with wound care, monitoring and flucloxacillin 500mg QDS.

Background

A pilonidal sinus (PNS) is a condition that most commonly occurs on hair bearing areas - typically the sacrococcygeal area, but they have also been reported to affect other hair bearing areas such as the umbilicus (1), chest (2), anal canal (3), ear (4), nose (5), penis (6) and scalp (7). The term translates from Latin, literally meaning 'hair nest' (8). Recognised by British Surgeon Herbert Mayo in 1833, it was named by Hodges in 1880 (9). Typically, growing hairs may become embedded into the surrounding skin. However, a PNS can develop in non-hair bearing areas too. The only difference in these cases is that the embedding hair does not come from the patient.

Lesions arising in non-hair bearing areas have been reported to arise in specific occupations such as hairdressing (10), dog grooming (11), milking (12) and sheep shearing (13). This has led to the term 'occupational PNS' being used. The typical areas for developing this type of PNS are the interdigital areas of the hands and fingers. Less commonly, cases also occur on the breasts, under the nails and in the popliteal fossa (14).

However, cases such as this one, involving the feet and

web spaces have rarely been noted in medical literature (15-18).

The feet are most vulnerable when going bare foot or in open footwear, as reported in a case of a hairdresser with recurrent PNS who consistently wore sandals (16).

In occupational PNS with barbers, it is thought that cutting of the hair creates a sharp end to the hair shaft that can easily penetrate the epidermis. Barbers who cut men's hair are thought to be most at risk, as men's hair tends to be shorter also, penetration is also more likely when the skin is damp (19). The hair may then penetrate the epidermis and dermis. From here, the clinical picture can be very varied, ranging from an asymptomatic sinus with or without protruding hairs to large, painful and infected nodules as the embedded hair invokes a foreign body reaction. The picture can be complicated by recurrent bacterial or fungal infections (11) with inflammation and purulent discharge from the sinus. Osteomyelitis of the affected digit has also been observed (14) and in one case, a hairdresser with PNS that affected her feet over a 30-year period, developed a verrucous carcinoma within the fistula (20). This was successfully treated with excision and a skin graft.

Diagnosis and Treatment

Diagnosis, depending on the clinical presentation can be difficult, particularly if hairs are not visually evident on examination. Dermatoscopic examination has been found to be useful (21). The typical features of recurrent infection and purulence in an interdigital area should raise suspicion of the condition. Although, other conditions such as splinters, insect bites, mycobacterial infection and pyoderma should be ruled out. Ultrasonography has been found to be beneficial in assessing lesions (22). In minor cases, often the offending hair can be extracted if protruding from the sinus, however, deeply embedded hairs with significant tissue involvement may require complete surgical excision to ensure healing.

Full consent was obtained from the patient prior to publication of this case study.

Figure 1



Figure 2



Figure 3



Figure 4



Figures

Figure 1: Interdigital Lesion showing hair between the digits

Figure 2: Close up of the pilonidal sinus

Figure 3: Dog hair extracted from the lesion

Figure 4: Further lesion evident on left foot

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By Dr Ivan Bristow (BHNS Member) and Andrew Boyle

Nailing a Diagnosis

A 72 year old gentleman of Asian ethnicity presented with acute-on-chronic dystrophy of the right hallux nail plate. Of relevance, he had previously presented to dermatology with a rash on the natal cleft which occurred following haemorrhoidectomy & anal wall repair which was managed as lichen simplex chronicus. He had a background history of ulcerative proctitis and essential hypertension.

Over 2 years there was a gradual change to his nail with clinical onychomycosis-like appearances for which he was treated with antifungals in the community. Two months prior to presentation, this changed dramatically to the figure seen and a florid warty appearance of the right hallux nail plate was evident on examination

(Figure A). A diagnostic biopsy and nail plate avulsion was performed, which was representative of a benign wart-like process and there was no evidence of dysplasia or malignancy. This sample was re-examined three times at local and regional meetings for clinicopathological correlation and repeatedly the consensus was that there was no evidence of malignancy. Our working diagnosis at this time was an infective peri-ungual viral wart process +/- benign inflammatory change (atypical psoriasis, acrodermatitis continua of Hallopeau or lichen planus). Over this time course, the patient's digital tip continued to evolve with a dystrophic flat nail growing in place of the old avulsed one and other digits and finger nails also showing signs of irregular nail plate thickening and hyperchromia. Topical salicylic acid preparation use over four months did not provide any improvement.

Repeated opinions amongst nail-specialist dermatologists came with warnings of Verrucous Carcinoma. However, the patient remained keen to avoid mutilating surgery and sought repeated other opinions. Given that two diagnostic biopsies (nail bed and matrix) and repeated examinations of the histology had failed to demonstrate malignancy, we compromised on treating him a systemic retinoid (acitretin) to assist with our initial working diagnosis of an infective peri-ungual viral wart process +/- benign inflammatory change (atypical psoriasis, acrodermatitis continua of Hallopeau or lichen planus).

Within 3 months of initiation of acitretin, there was a significant improvement of the skin and nails throughout his body. The evolution and clinical appearance of the digits through his improvement permitted us to revisit his diagnosis and settle on Acrodermatitis continua of Hallopeau (Figure B). He continues to demonstrate stable appearances in all areas and we have lowered the dose of his medication to 10mg OD (Figure C).

Acrodermatitis continua of Hallopeau (ACH) is a rare acropustular condition often follows a recalcitrant treatment course and indeed has been described as the most difficult type of pustular psoriasis of the nail unit to treat (1).

Clinically visible pustules can be seen on the nail bed of isolated fingers and toes with surrounding erythematous atrophic skin. Onychodystrophy may be a presenting feature. Resultant anonychia can occur and it is important to note that osteolysis of the distal phalanges can later ensue.

As described in our patient's case, treatment with acitretin has proven successful. Methotrexate has been described as beneficial in some cases in the literature. However, conventional systemic treatment should be used in conjunction with application of topical calcipotriol and/or supra-potent topical corticosteroids to the nail bed.

Intralesional triamcinolone injected directly into the

nail bed and matrix under regional anaesthesia has been shown to provide a beneficial and sustained response (2).

However, the advent of biologic therapy has changed our management of some of these cases, these results predominantly arising from large case series. Guselkumab, Secukinumab and Adalimumab have proven the most efficacious, with Guselkumab showing the most promising response rates (3).

Verrucous Carcinomas are slow-growing, well-differentiated variants of squamous cell carcinomas. They are locally destructive and have known to have low/absent metastatic potential. All the cases in the reported literature demonstrate a > two year delay to diagnosis as the clinical mimic of viral wart/other inflammatory conditions is prominent. There is no set histopathological diagnostic feature and diagnosis relies on a constellation of clinical suspicion, biopsy and histology, viral typing & radiographs (if available) (4). There is no reported trial or outcome of verrucous carcinomas improving with acitretin.

This case demonstrates multiple aspects in the diagnosis of nail disease: the importance of other cutaneous sites/signs, history of evolution, questioning the nail histopathology and cross-examination for correlation, trusting the histopathology report and not avoiding dogmatic perusal of a clinical suspicion, and the importance of time following an initial treatment path. It also reminds us of the importance of revisiting the diagnosis in the setting of poor response to treatment to avoid unnecessary procedures for the patient, and indeed strengthens the case for a multidisciplinary discussion and approach to these patients. Going forward, we propose a watchful eye and time will have the final say with regards to the diagnosis.

Figure A



Figure B



Figure C



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By Dr Dhruv Laheru (BHNS Clinical Nail Lead)
and Dr Laura Nestor