BHNS Summer Newsletter 2022

Summer 2022
Welcome message

Hello to all! Welcome to our second newsletter for this year.

First and foremost, hope all are keeping well in the extreme heat, we need rains soon! We have had a great summer with the Lionesses bringing the Euros home, a successful Commonwealth games and a Eurovision contest to look forward in 2023 with multiple cities bidding to host this event. The most exciting news for us has been the recent approvals of JAK inhibitor Baricitinib for alopecia areata by the U.S. Food and Drug Administration, the European Medicines Agency and the Committee for Medicinal Products for Human Use. This is just the first step of hopefully many more JAK inhibitors for alopecia areata. NICE is currently undergoing a technology appraisal for Baricitinib for severe alopecia areata – so watch this space!

Alopecia UK has also published the Charter for wigs, included in this newsletter. We applaud their work in bringing this very important topic to the forefront .The best practice is to recommend up to 4x synthetic fiber wigs per year, or one human hair wig per year, with an absolute minimum level of provision of 2x synthetic wigs per year. Please share this Charter with your trusts. The Charter also discusses opening a dialogue between primary and secondary care for provision of wigs before patients are referred to secondary care and also highlights the psychological impact of alopecia.

We have had a successful BAD SIG session with excellent speakers Prof Bianca Maria Piraccini and Dr David de Berker, thank you so much to both! Watch out for some great events lined up for next year including co-badged events with BSPD.

Do remember we have a great platform to seek expert opinion within two weeks on your difficult hair and nail cases. Sonia Sharma has detailed the discussions on two such nail cases which were presented to the BHNS grand round. You can send your cases to Rose Wilmot (rose.wilmot@nhs.net) who can load these on the website for you.

As always, we have great clinical articles in the newsletter relevant to everyday practice, enjoy reading!

Thank you

Dr Anita Takewale
BHNS President

ARTICLES

An Update on Recent Approvals for Baricitinib for Alopecia Areata

Alopecia areata (AA) is a common autoimmune non-scarring hair loss condition which can have adverse emotional and psychosocial impact. It has a broad range of severity from isolated patchy hair loss, which has a good prognosis of 80% spontaneous remission within one year, to more chronic and extensive disease, which carries a poorer prognosis (1). The point prevalence of this disease was 0.58% in 2018 in the UK and 24% of patients presenting to primary care are referred for specialist Dermatology care within a year of diagnosis (2). This indicates the impact on both general practice and specialist clinics.

Current guidelines recommend intralesional or potent topical corticosteroid for limited patchy hair loss and contact immunotherapy and the use of a wig/hair piece for more extensive hair loss, including alopecia totalis/universalis (1). However, there have been no treatments which improve the long-term outcome of disease. Other treatments reported were PUVA, minoxidil, dithranol, ciclosporin, topical tacrolimus, prostaglandin F2α analogues for eyelashes, anti TNFs, sulfasalazine, methotrexate and laser therapy but none of these were recommended, either due to lack of evidence for efficacy, side effects or both (1).

On 13th of June 2022, The U.S. Food and Drug Administration approved Lilly and Incyte's JAK 1 and 2 inhibitor Olumiant (Baricitinib) oral tablets to treat adult patients with severe AA as the first systemic treatment for this disease (3). This followed the publication of findings from the first double-blinded, randomized, placebo-controlled phase 3 trials of Baricitinib for AA, BRAVE-AA1 and BRAVE-AA2, in March 2022.4 In May 2022, The European Medicines Agency's (EMA) Committee for Medicinal Products for Human Use (CHMP) also recommended approval of Baricitinib for severe AA5 and is awaiting authorisation from the European Commission to be granted. If successful, Baricitinib would also be the first drug of its kind authorised for the treatment of severe AA in Europe.

The combination of genetic, environmental, and autoimmune factors is thought to be the cause for AA (6). Immune privilege, the body's ability to protect an organ from autoimmune reactions, is lost during the anagen phase of the hair cycle in a bulb of the AA follicle due to increased MHC 1 presentation and decreased CD200 immunoregulation. This leads to inflammation and premature entry of the follicle into telogen phase. The stem cell component is spared and therefore AA is usually reversible. IFN-ψ is one of the key mediators of inflammation and upregulates IL-15 and inflammatory chemokines via the intracellular JAK-STAT signalling pathway. In CD8+ T cells, IL-15 increases production of perforin and cytotoxic granzymes, also via the JAK-STAT pathway (6). Therefore, the latter has been a treatment target for many studies and case series over the years. A systematic review of JAK inhibitors Baricitinib, Tofacitinib and Ruxolitinib for AA, which included 30 studies and 289 cases, was published in 2019 (7). The authors of this paper concluded that there was promising evidence for JAK inhibitors for the treatment of AA. However, at the time, there were no large randomised controlled trials to confirm evidence.

BRAVE-AA1 and BRAVE-AA2 were conducted at 169 centres in 10 countries and included a total of 1200 adults with severe AA with a Severity of Alopecia Tool (SALT) score of 50 or above (hair

loss of 50% or more) (4). Persons were randomly assigned to receive once-daily Baricitinib at a dose of 4 mg, 2 mg, or placebo. The estimated percentage of those with a SALT score of 20 or less at week 36 was 38.8% with 4 mg, 22.8% with 2 mg, and 6.2% with placebo in BRAVE-AA1 and 35.9%, 19.4%, and 3.3%, respectively, in BRAVE-AA2. In addition, the percentages of patients who discontinued the trial regimen because of adverse events were low and were similar across the trial groups. Therefore, the trial concluded that Baricitinib is superior to placebo for the treatment of AA.

According to the drug website (8) common side effects of Olumiant are: upper respiratory tract infections, headache, acne, increased cholesterol levels, increased creatine kinase, urinary tract infection, increased liver enzymes, folliculitis, tiredness, lower respiratory tract infections, nausea, genital yeast infection, anaemia, neutropenia, abdominal pain, shingles and increased weight. More serious and uncommon side effects are blood clots, infections (including tuberculosis), lymphoma and other cancers, hypersensitivity including anaphylaxis and gastrointestinal perforation (increased with concomitant nonsteroidal anti-inflammatory drugs (NSAIDs) or corticosteroids).

Baracitinib had already been approved by NICE for the treatment of rheumatoid arthritis since August 2017 (9) and atopic dermatitis since March 2021 (10) in the UK. At present, NICE approval of Baricitinib for severe AA is in progress (11). NICE will take into account the clinical and cost effectiveness of Baricitinib and the importance to patients, professionals and commissioners (11). The meta-analysis and systematic review in 2019 by Phan et al noted recurrences may occur on average 2.7 months after cessation of treatment (7), indicating the need for long term treatment and NICE will likely take this into account.

Lilly and Incyte may face competition in the not-too-distant future however, as Pfizer has already reported positive results in the pivotal ALLEGRO trial of its JAK3 inhibitor Ritlecitinib in AA, with a filing due this year, assuming a companion, long-term study called ALLEGRO-LT hits the mark in its initial readout (12). Also in contention is Concert Pharmaceuticals, whose deuterated JAK1/2 inhibitor CTP-543 has positive data in a first phase 3 trial (13) with a second due to report in the third quarter of this year.

Though AA may have an effect on the quality of life, it only rarely causes physical disability. Messenger A. and Harries M (14) highlighted the importance of the inclusion of quality-of-life measures in future research, perhaps even as primary end point, as one of the main recommendations from the 2008 Cochrane review on interventions for AA.

In summary, topical and intralesional steroids and contact immunotherapy are the current treatments for AA. The latter is not available at all centres and requires multiple and frequent visits to the specialist clinic by the patient. Regular clinic appointments and the wearing of wigs, along with the unpredictable disease course may add to the negative psychosocial impact for patients. Many other treatments are used off licence and are not recommended in current national guidelines due to the lack of evidence for efficacy or the risk of side effects. The recent first randomised controlled phase 3 trials show that Baricitinib is superior compared to placebo for those with extensive severe disease and has recently been approved by the FDA. NICE is currently undergoing a review for its approval for this indication in the UK. There is ongoing promising research into a number of JAK

inhibitors for the treatment of AA and the authors look forward to Baracitinib being the first of many treatments becoming available for this condition which has been historically challenging to treat.

References:

1. Messenger AG, McKillop J, Farrant P, McDonagh AJ, Sladden M. British Association of Dermatologists' guidelines for the management of alopecia areata 2012. Br J Dermatol [Internet]. 2012 May 1 [cited 2022 Jun 28];166(5):916–26. Available from: https://onlinelibrary.wiley.com/doi/full/10.1111/j.1365-2133.2012.10955.x
2. Harries M, Macbeth AE, Holmes S, Chiu WS, Gallardo WR, Nijher M, et al. The epidemiology of alopecia areata: a population-based cohort study in UK primary care*. Br J Dermatol [Internet]. 2022 Feb 1 [cited 2022 Jun 28];186(2):257–65. Available from: https://onlinelibrary.wiley.com/doi/full/10.1111/bjd.20628
3. US Food and Drug Administration. FDA Approves First Systemic Treatment for Alopecia Areata | FDA [Internet]. 2022 [cited 2022 Jun 28]. Available from: https://www.fda.gov/news-events/press-announcements/fda-approves-first-systemic-treatment-alopecia-areata
4. King B, Ohyama M, Kwon O, Zlotogorski A, Ko J, Mesinkovska NA, et al. Two Phase 3 Trials of Baricitinib for Alopecia Areata. N Engl J Med [Internet]. 2022 May 5 [cited 2022 Jun 28];386(18):1687–99. Available from: https://www.nejm.org/doi/full/10.1056/NEJMoa2110343
5. European Medicines Agency Committee for Medicinal Products for Human Use. Summary of Opinion (post authorisation): Olumiant [Internet]. 2022 [cited 2022 Jun 28]. Available from: https://www.ema.europa.eu/en/documents/smop/chmp-post-authorisation-summary-positive-opinion-olumiant-ii-29-g_en.pdf
6. Olayinka J (Jadé) T, Richmond JM. Immunopathogenesis of alopecia areata. Curr Res Immunol [Internet]. 2021 [cited 2022 Jun 28];2:7. Available from: /pmc/articles/PMC9040139/
7. Phan K, Sebaratnam DF. JAK inhibitors for alopecia areata: a systematic review and meta-analysis. J Eur Acad Dermatol Venereol [Internet]. 2019 May 1 [cited 2022 Jun 28];33(5):850–6. Available from: https://pubmed.ncbi.nlm.nih.gov/30762909/
8. Eli Lilly and Company. How to take Olumiant [Internet]. [cited 2022 Jun 28]. Available from: https://www.olumiant.com/dosing-side-effects
9. National Institute for Health and Care Excellence. Baricitinib for moderate to severe rheumatoid arthritis Technology appraisal guidance [TA466] [Internet]. 2017 [cited 2022 Jun 28]. Available from: https://www.nice.org.uk/guidance/ta466
10. National Institute for Health and Care Excellence. Baricitinib for treating moderate to severe atopic dermatitis Technology appraisal guidance [TA681] [Internet]. 2021 [cited 2022 Jun 28]. Available from: https://www.nice.org.uk/guidance/ta681/chapter/1-Recommendations
11. National Institute for Health and Care Excellence. Baricitinib for treating severe alopecia areata ID3979 In development [GID-TA10941] [Internet]. 2022 [cited 2022 Jun 28]. Available from: https://www.nice.org.uk/guidance/indevelopment/gid-ta10941
12. King B, Guttman-Yassky E, Peeva E, Banerjee A, Sinclair R, Pavel AB, et al. A phase 2a randomized, placebo-controlled study to evaluate the efficacy and safety of the oral Janus kinase inhibitors ritlecitinib and brepocitinib in alopecia areata: 24-week results. J Am Acad Dermatol. 2021 Aug 1;85(2):379–87.
13. Concert Pharmaceuticals Reports Positive Topline Results for First CTP-543 Phase 3 Clinical Trial in Alopecia Areata | Business Wire [Internet]. Businesswire. 2022 [cited 2022 Jul 9]. Available from:

https://www.businesswire.com/news/home/20220523005329/en/
14. Messenger A, Harries M. Baricitinib in Alopecia Areata. N Engl J Med [Internet]. 2022 May 5 [cited 2022 Jun 28];386(18):1751–2. Available from: https://www.nejm.org/doi/full/10.1056/NEJMe2203440

By Dr Rona Applewaite, Dr Nekma Meah and Dr Anita Takwale



Alopecia UK - Charter for Best Practice for NHS Wigs Provision

Alopecia UK are the charity which provides support for people with alopecia through face to face and online self help groups, various social media channels and events; many of which support young children and families. They hear the good and bad stories around wig provision across the UK. It was great that they took the initiative to understand the facts around wig provision and after collecting some sound market research data engaged a group of clinical stakeholders from the dermatology professional associations to help them develop a Charter for Best Practice for NHS wigs provision. NHS England & NHS Improvement also supported this valuable piece or work.

We understand the psychological impact of hair loss can take a significant toll, including social anxiety, loss of confidence and other mental health issues. Wearing wigs can be a way to reduce social anxiety, improve confidence and ensure people can fully participate in day-to-day life. Please remember that not all patients with alopecia feel they need a wig but for those who do, having access to the appropriate quality and quantity of wigs can be life changing. In fact, from Alopecia UK data, around 75% of people with alopecia wear a wig at some time, and of those who wear wigs, 75% wear wigs most of the time.

We know that many health professionals are keen to ensure patients with alopecia get the best possible level of care. Sometimes there is lack of clarity on wig provision with some organisations having unclear policy and procedure in place. Access to wigs can be the difference between living well with alopecia, or not.

When working on the wigs charter we discussed areas which could 'enable' wig provision:

- Enabling timely wig provision - while wigs are funded from secondary care, can we look at a shared care approach, so that wigs can be prescribed before a first dermatology appointment, and routinely for repeat prescriptions
- Which patients should receive a wig prescription? - this was a long discussion! Alopecia Uk ask for clinicians to consider those people 'who need and want a wig'. This talks to the need to consider degree of anxiety and psycho-social impact, as well as percentage of hair loss
- Psychological Support - consider how a wig provides that support and do signpost patients

to alopecia UK.

The Charter for Best Practice for NHS Wig Provision is designed to provide guidance on what NHS clinicians should offer to patients in need of wigs. And Alopecia UK thank and want recognise those Trusts and health boards and the healthcare professionals who take the time and effort to advocate for their patients.

In addition to the Charter, based upon Alopecia UK's research, dialogue with patients, healthcare professionals, and wig manufacturers, we recommend that best practice is up to 4 x synthetic fibre wigs per year, or one human hair wig per year, with an absolute minimum level of provision of 2 x synthetic wigs per year.

Alopecia UK published their market data in the March 2022 edition of Dermatological Nursing: Johnson A, Wilks L, Zucchelli F, Sharratt N. Why a charter for best practice for NHS wig provision? Dermatological Nursing 2022. 21(1):32-36.

We hope that the Charter, can be shared with your colleagues responsible for decisions regarding wig provision. This may be dermatology departments, orthotics departments and/or budgetary decision makers and commissioners. Please help, by advocating for fairer NHS wig provision; an important treatment that can provide confidence to overcome the challenges of living with a visible difference. Thank you for your support.

By Dr Yusur Al-Nuaimi - Clinical Hair Lead, British Hair and Nail Society

Hair Loss Treatment Algorithms

On the 4th of May 2022 worldwide experts on hair came together online. The 2-hour event on Hair Loss Treatment Algorithms was organised by TrichoLab on Hair to support the Ukrainian Hair Research Society.

The full recording is available to buy on https://tricholab.com/on-hair, To respect the effort of the organisers, and to encourage the purchase of this excellent resource for hair loss practitioners, some of the highlights are summarised here.

The experts were requested to provide their experience in management of the hair loss conditions on one slide, the highlights are as below.

Androgenetic alopecia. Low oral minoxidil was appearing at the beginning of treatment

algorithms for men and women. For men, for 5 alpha reductase inhibitors, there was the more common use of oral Dutasteride as an alternative option to oral finasteride in advanced cases or those previously on finasteride. There was a recommendation to use low dose oral minoxidil in a young patient without a beard which could be used until the age of 20 is reached. The option of tapering doses of 5 alpha reductase inhibitors was presented. Interestingly topical minoxidil would be considered further down the line if there were side-effects or contra indications to oral minoxidil.

In female AGA treatment algorithms would start with an anti-androgenic drug and low dose oral minoxidil. In postmenopausal women dutasteride 0.5 mg per day would be considered.

For **androgenetic alopecia** in the paediatric population, it was noted that there is no approved therapy. A key theme was the scarcity of studies in children and adolescent patients with AGA. Future methods of regenerative medicine in the treatment of male pattern Hair Loss were considered. The hypothesis is that the transcription of signal of the dermal papilla 'protects' occipital hair follicles from miniaturisation in male pattern Hair Loss.

Telogen effluvium. It was essential to identify triggering factors such as suspected drug, and measurable deficiencies and dietary imbalance in acute telogen effluvium. In chronic telogen effluvium-the use of topical minoxidil or systemic minoxidil day were considered as treatments along with possibly nutritional supplements or topical corticosteroids in the case of trichodynia.

Anagen effluvium, (the abrupt loss of hair in Anagen due to an event that impairs the mitotic or metabolic activity of the hair follicle) is commonly observed after radiotherapy or chemotherapy. It was stressed that this condition is typically reversible with hair regrowth typically occurring after a delay of 1 to 3 months when the follicle resumes its normal activity after withdrawal of the antimitotic factors. Trichoscopy will be helpful. High doses or systemic steroids were recommended for alopecia areata, topical steroids plus minoxidil were recommended for cancer chemotherapy.

Lichen Plano Pilaris. Treatments can be targeted according to mild inflammation (mild follicular erythema and hyperkeratosis), moderate and severe inflammation. Treatment can be stopped and monitored for relapses. If there is mild pruritus, topical clobetasol can be used. If control is still poor then low dose oral naltrexone, or pioglitazone daily could be prescribed. Treatments which would be only available in the private sector in the UK such as low-level laser therapy 655 nm daily or platelet rich plasma injections could also be considered.

Frontal fibrosing alopecia. The importance of allergen avoidance, and topical anti-inflammatories 2 to 3 times per week or at bedtime was highlighted. In second line or moderate disease: phototherapy, oral hydroxychloroquine, intralesional scalp and or eyebrow injections every three months is recommended. Other options include, low-dose oral naltrexone, oral gabapentin, oral cetirizine twice daily or fexofenadine. In recalcitrant or severe disease topical or Janus kinase inhibitors could be used. Concomitant female pattern hair loss can be treated with oral spironolactone daily plus oral low-dose minoxidil.

Fibrosing alopecia in a pattern distribution. Treatment options include oral Finasteride at the

appropriate dose for men and women with no risk of pregnancy. In addition, oral hydroxychloronolone acetonide every 4 to 6 weeks. In late stage fibrosing alopecia in a pattern distribution the recommendation was oral finasteride in men and women with no risk of pregnancy plus topical minoxidil 5% plus low dose oral minoxidil.

Discoid lupus erythematosus. A helpful treatment pathway was presented with the path taken depending on the extent of the disease with the cut of being less than 10% or more than 10% of the scalp affected.

Folliculitis decalvans. Antiseptic shampoo and topical clindamycin are usually helpful and may be sufficient for mild cases. Finasteride and minoxidil are useful for any associated androgenetic alopecia as folliculitis the caravans is partially patterned, finasteride could affect it. The tetracycline family of antibiotics are often suppressive for moderate disease.

Dissecting cellulitis of the scalp. Topical, systemic and surgical approaches were described. For mild to moderate disease topical antibiotics, antiseptic shampoo (Hibitane scrub) plus minoxidil 5% lotion are recommended. Some recommend oral zinc and anti-androgenic medications such as cyclic cyproterone acetate. Others, intracavitary foam sclerotherapy.

Pseudopelade of Brocq. Treatment is determined by disease extent i.e. less than 10% more than 10%. Medical treatment pathways were detailed according to severity and progression. PRP and low-level light therapy can be considered if there is progression. Background seborrhoea to be treated with ketoconazole and keratolytics. Topical and oral minoxidil or can also be added in. CCCA: There were recommendations on how to manage the condition for Olsen's grade one to 3, with mild inflammatory infiltrate on histology. Guidance on the use of topical steroids and Calcineurin inhibitors was outlined. The management of clinically moderate to severe CCCA (Olsen grading more than three) with moderate to severe inflammatory infiltrate on histology was described. Options include 10% Metformin gel in Lipobase, Minoxidil 5% lotion or foam twice daily, low dose oral minoxidil for six months and platelet rich plasma monthly for three months. Hair should be washed weekly. A wash off conditioner should be used, traction inducing hairstyles should be avoided along with avoiding chemicals and heat.

Erosive pustular dermatosis was covered including the triggers including topical Imiquimod. Clobetasol under occlusion for four days a week, oral doxycycline for two weeks, shampoo daily and follow-up in two months. Some success has been shown with Tofacitinib.

By Dr Ingrid Wilson

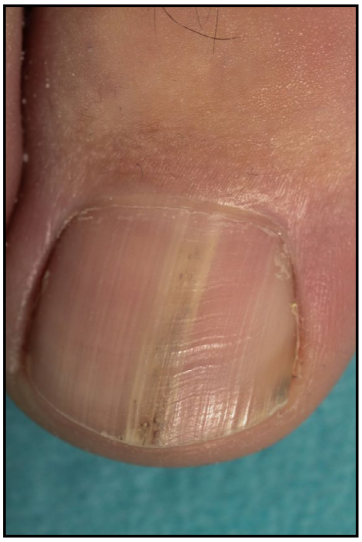
BHNS CASES

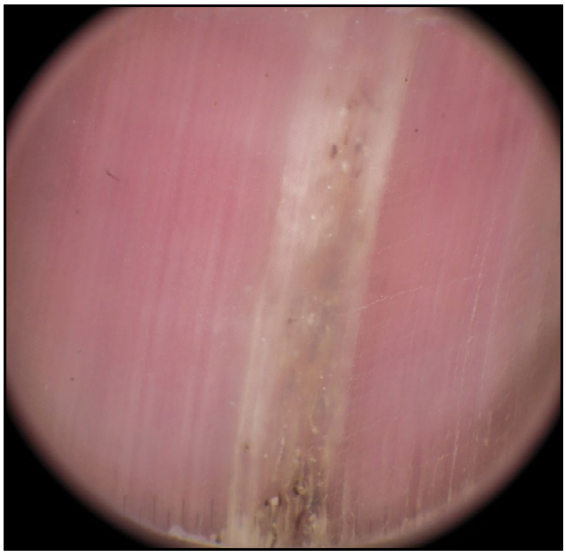
Two grand round cases submitted for expert panel review

Case 1: A case of onycholysis

A 60 year old gentleman who works as a builder was referred with a six month history of a streak on his right big toenail.
He did not report any preceding trauma and denied any pain or other associated symptoms.

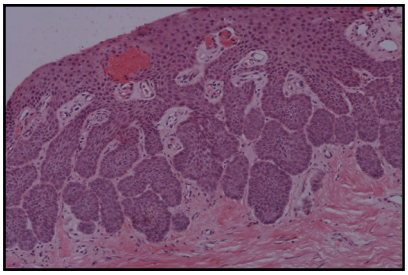
On examination he had 4mm onycholysis of his right big toenail and all other nails had a normal appearance. Differential diagnoses at this time were: possible lesion – benign in nature (for example a fibroma) or Bowen's disease or SCC.

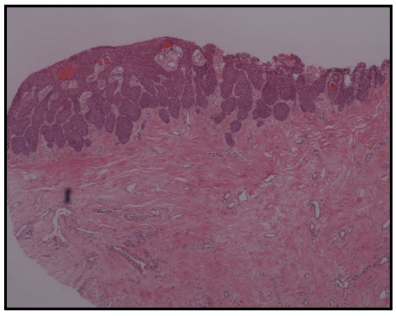




A biopsy was taken from the nail matrix/nail bed margin and on removal of the nail, there was no lesion within the nail matrix. There was a slight undulation of the nail bed but the nail matrix appeared normal.

The pathology report demonstrated an epidermis with a non-keratinising hyperplastic appearance with elongated and relatively bulbous rete ridges accompanies by acute congestion of the papillary dermis and underlying hyalinised thickened-looking upper dermis. There was no significant dysplasia or melanocytes that were identified. There was no evidence of inflammatory changes, candida elements or malignancy. A PAS stain was requested.





The histology was further discussed at a CPC meeting and felt to represent a seborrhoeic keratosis-like lesion. As this was an unusual finding within the nail matrix, the case was referred for the BHNS expert panel review.

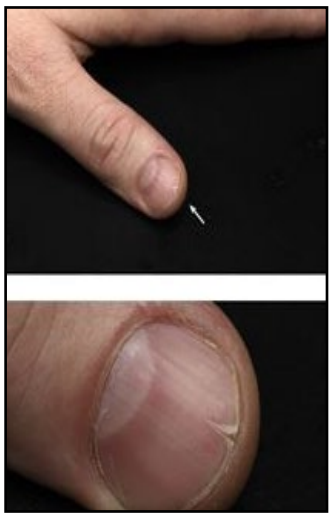
Expert panel comments:

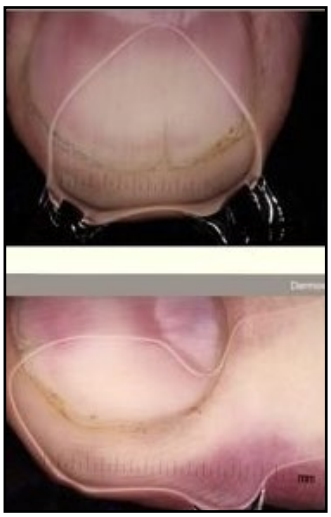
- Nail bed seborrheic keratoses though rare, can present as leucoxanthonychia
- Clinical appearances are those of seborrheic wart and would fit with the histology impression (as long as sampling was representative and SCC/Bowen's disease has been ruled out)
- Other thoughts: onycho/benign nail papillomas have a very strong tendency to be adherent to the nail plate under the surface itself. If the nail elevation was carried out in the streaked area with smooth nail elevators, this could have been left behind or fragmented on the underside of nail plate and then reattached back to nail.
- If there is recurrence of the lesion at follow up, a blade can be used to separate the lesion from the nail plate before elevating and then the nail bed/matrix can be sampled longitudinally
- The expert panel would advise a 'watch and wait' approach

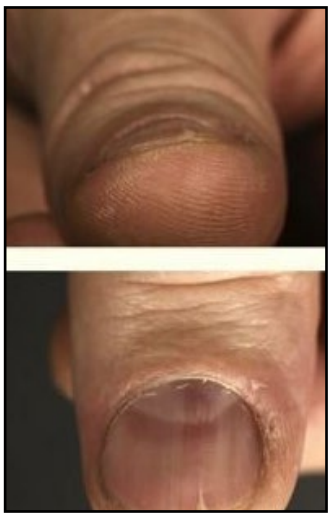
Case 2: A 'V' shaped notch on the left thumbnail

A male patient presented with a two year history of a V-shaped notch on the left distal thumbnail which kept catching on his clothes. The cuticle was normal in appearance and there was no history of pain.

There was no history of eczema, lichen planus or alopecia areata and no history of repeated microtrauma. The other nails were normal in appearance. He did have a history of a scaly papular rash affecting his posterior neck and lower back and biopsies of these areas identified non-specific inflammation. He was referred for the expert panel review for aid with diagnosis and management.







Expert panel comments:

On examination there was thinning of the underside of the nail plate proximal to the V-notch at

the lunula that accounts for nail weakness resulting in notching. There was also the presence of a band of linear erythronychia. These findings would support an onychopapilloma.

Onychopapillomas can be very adherent to the underside of the nail, so if an avulsion is not done carefully then the sample can become "lost" on the underside of the nail that is put back or can be thrown away. Such nail matrix biopsies may not identify the lesion and reports may suggest 'benign tissue only'.

Other differentials:
Erythronychia
Onychorrhexis - rule out tumour compressing nail matrix
Darier's – however given the skin biopsy results, this has already been ruled out

Management advice:
A 'watch and wait' approach
Careful avulsion and shave or 3mm biopsy nail matrix (however, intervention may weaken the nail further and make notching symptoms worse due to the scarring process)
Brittle nails advice including 6 month trial of biotin 2.5mg once daily
Supportive treatment with emollient to nails and nail folds

By Dr Sonia Sharma, BHNS Trainee Representative

Subungual exostosis: A summary and case report

Introduction:
Subungual exostosis is an acquired, benign, solitary bone tumor which is fairly uncommon. It most commonly affects the distal phalanx of the great toe and presents with a tender bony mass with associated nail destruction and elevation. We present in this article a summary of subungual exostosis as well as a case report.

Case:
A 45-year old man presented to the dermatology department with a 1-year history of a progressively enlarging tender lesion to his right distal hallux. The gentleman was otherwise fit and well and recalled that two years previously he was frequently played racket sports and badminton where there was forward shearing forces and micro and macro trauma leading to traumatic avulsion of both hallux nail plates. It was following this that he noted a bony spur growing from underneath his nail, which failed to heal. Examination in clinic revealed an 8mm area of hard keratinised tissue located to the medial distal aspect of the right hallux nail plate.

A plain x-ray of his right big toe confirmed the presence of a large subungual exostosis which had been suspected clinically.

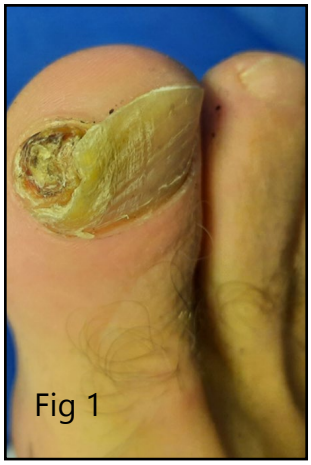


Fig 1

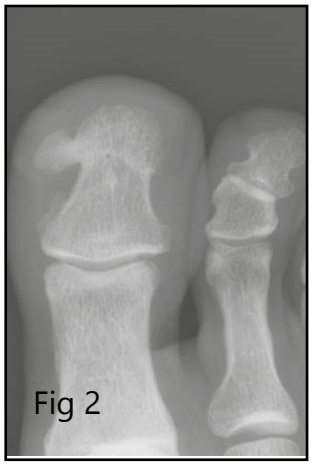


Fig 2

Subungual exostosis is a benign, osteocartilaginous tumor, which represents outgrowths of normal bone or calcified cartilaginous remains. They are rare with a recent literature review identifying a total of 500 documented cases with 84.4% of these occurring in the lower extremities and 15.6% occurring in upper extremities (1). It is very likely that this is compounded by significant underreporting. Subungual exostosis are seen most often in adolescents and young adults with the most commonly affected site being the dorsomedial aspect of the tip of the great toe. It presents as a firm, fixed nodule, which is tender on palpation. As the lesion grows, it can lead to surrounding paronychia as well as destruction and elevation of the nail from the nail bed.

Preceding trauma is often implicated as a contributing factor (2,3,4) although this is not identified in every case. Chronic infection, irritation and genetics may also play a role. The triad of pain, nail deformation and radiographic features are usually diagnostic for subungual exostosis. Plain x-ray images show broad based trabeculated bone with distal flare.

Differential diagnosis include malignant melanoma, epithelioma, keratoacanthoma, glomus tumor, pyogenic granuloma, cysts and warts.

One (important) clinical differential is subungual osteochondromas which can present in a very similar fashion with a preceding history of trauma. Osteochondromas however tend to have a male predominance and the onset is usually been 10-25 years of age. Unlike subungual exostosis they have a slow growth rate and x-ray imaging shows a sessile bone growth projecting from the dorsum of the distal phalanx near to the epiphyseal line (5,6). It is important to note that controversy exists regarding the differentiation between these two entities. But crucially, helping actively rule these diagnoses in, helps rule out other more concerning pathology.

Subungual exostosis are best treated surgically either with curetteage or with complete marginal excision through a fishmouth incision up to the normal bone tissue to preserve the nail plate and prevent recurrence. (7,8)

References:

(1) M E Womack et al. Subungual Exostosis of the Hand: A Case Report in a 5-Year-Old Boy and Literature Review (March 2022)
(2) Davis DA , Cohen PR . (1996) Subungual exostosis . Case report and review of the literature. pediatr Dermatol 13 : 212 – 18 .
(3) Sebastian G. (1977) Subunguale Exostosen der Grosszehe, Berufsstigma bei Tänzern . Dermatol Monatsschr163 : 998 – 1000 .
(4) Fikry T , Harfaoui A , Zahid M et al . (1998b) Exostose sous-unguéale digitale. A propos d ' un cas . Main 3 : 77 – 82 .
(5) Schulze KE , Hebert AA . (1994) Diagnostic features, differential diagnosis, and treatment of subungual osteochondroma . Pediatr Dermatol 11 : 39 – 41 .
(6) Kim SW , Moon SE , Kim JA . (1998) A case of subungual osteochondroma . J Dermatol 25 : 60 – 2
(7) Senff H , Kuhlwein A , Janner M . (1987) Subungual Exostose . Zeitschr Hautkrankh 62 : 1401 – 4 .
(8) Garcia Carmona FJ , Pascal Huerta J , Fernandez Morato D . (2009) A proposed subungual exostosis clinical classification and treatment plan . J Am Podiatr Med Assoc 26 : 747 – 8 .

By Dr Aamna Adel, Dermatology Registrar, Royal Berkshire Foundation Trust

BHNS NEWS & EVENTS

NEWS

New Members
Dr Bryan McDonald
Dr John Frewen
Dr Louise Bovijn
Dr Prativa Jayasekera
Dr Sudaxshina Murdan

Announcements
Congratulations to Dr Christos Tziotzios, for winning the Wycombe Prize for outstanding contribution to Dermatology for his work on alopecia research.

Congratulations also to Dr Julian Pearce & Dr Oluwadamilola Jagun for winning the BHNS Travel Fellowship Award (£500x2) to attend the WCHR in Melbourne and the First Barcelona Hair Meeting in Barcelona, respectively.

Finally, congratulations to Dr Marianne De Brito for winning the BHNS' Andrew Messenger Oral presentation prize and Dr David Rutkowski for best poster at the BAD annual meeting in July 2022.

EVENTS

European Hair Research Society Events

First Barcelona Hair Meeting
29 September-1 October 2022

World Congress for Hair Research
18-21 November 2022 - Melbourne, Australia

European Meeting for Hair Research
14-16 June 2023 - Sheffield, UK

BHNS Events

BHNS X BSPD 21 April 2023

We are planning to run an event with the British Society of Paediatric Dermatology next year. The event will be virtual. The event will be advertised through the BAD website closer to the time.

BHNS Hair Education Day November 2023

This two-day event will be held in Manchester next year. The event will be advertised through the BAD website closer to the time.

Charter for Best Practice for NHS Wig Provision

Not everybody with alopecia chooses to wear a wig, but for those that do, a wig can help them manage the profound and complex medical, social and psychological consequences of living with alopecia, giving them the confidence to engage in society.

Alopecia UK's aim with this Charter is to support fair access to wigs for people with dermatological hair loss (alopecia and other hair loss conditions, not hair loss due to chemotherapy).

We would like to see the examples of 'Best Practice' for wig provision that some of our members report to us become 'standard of care' across the UK. This is the aim of our charter.

1 CHARTER RECOMMENDATION

All NHS Trusts/healthboards set up a 'Best Practice wigs policy' so that all people with alopecia, who need and want a wig, can receive wig prescriptions or vouchers in a way that is as easy and timely as possible, whilst reducing pressures on secondary care.

2 CHARTER RECOMMENDATION

All people with alopecia, who need and want a wig, should be offered the right number of wigs for their condition based upon the support they need, and how and when they wear wigs.

3 CHARTER RECOMMENDATION

All people with alopecia, who need and want a wig, should be offered a suitable choice and quality of wigs, whatever their race, natural hair colour, age and preferences, and be supported with face-to-face consultations with a wig supplier.

"I won't go out to the shops or socially without a wig on – a wig gives me the confidence to have a normal life."

Patient case studies, Alopecia UK

alopecia uk