Dermatology Practical & Conceptual

Spotted Lunula in Alopecia Areata: Clinical and Onychoscopic Features of an Unusual Sign

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Dear Editor,

Alopecia areata (AA) is an autoimmune disorder characterized by non-scarring alopecia that can affect any hair-bearing area, although the scalp is the most common site. AA can also involve the nail apparatus. The most frequent nail manifestation associated with AA are nail pitting and trachyonychia; however, other signs can also aid in its diagnosis, such as punctate leukonychia or Beau lines [1,2]. In this article, we would like to highlight another non-diagnostic but characteristic nail sign of AA, the spotted lunula (SL).

SL is a sign that, upon clinical examination, presents as small, circular, reddish areas that do not disappear under vitropressure. Its borders are well-defined and regularly distributed throughout the lunula. On onychoscopy, dilation and tortuosity of the distal matrix vessels can be observed, reflecting an involvement of the papillary dermis (Figure 1). SL is a sign of nail matrix inflammation associated with various diseases, including AA and nail psoriasis [3].

Nail involvement in AA is not uncommon, although it is not pathognomonic, and according to the literature, it can affect anywhere from 7% to 66% of patients, especially due to matrix inflammation [1,2]. It is more commonly observed in severe forms of AA, such as AA Totalis or AA Universalis, as well as in children [4].

SL was initially described by Shelley in 1980 [5]. A total reddish involvement of the lunula, due to arteriolar vascularization, has also been reported [6]. Notably, SL is not commonly referenced in major dermatology textbooks [7], and in large population studies, such as the one published by Sharma et al with 1000 patients [8]. To the best of our knowledge, SL has only been reported in two studies: Tosti et al documented this finding in a series of 126 pediatric cases, reporting 6 affected patients, and Roest et a. reported a prevalence of 13% in a case-control study [9,10].

Regarding prognosis and treatment, spontaneous remission is often observed in patients with AA, typically with hair regrowth. In cases of isolated nail involvement, some patients may require treatment, which is mainly based on personal clinical experience and small case series. Topical therapy with corticosteroids, such as mometasone 0.1% ointment or clobetasol 8% nail lacquer, is the first choice. For resistant forms, the same systemic treatment regimens used for scalp involvement can be considered [1].

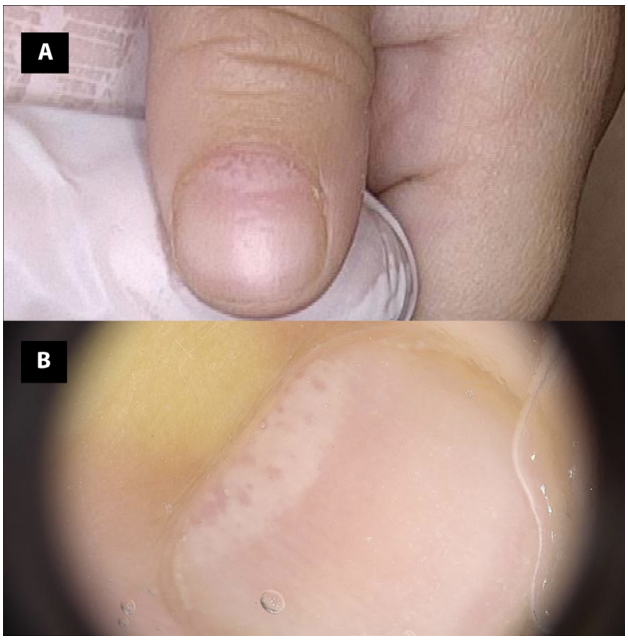

Figure 1. (A,B) Clinical (A) and onychoscopic (B) image of the spotted lunula that appears as a small, circular, reddish area with visible dilation and tortuosity of the distal matrix vessels.

In conclusion, SL is an underappreciated finding in suspected AA without obvious manifestations, and onychoscopy once again proves to be a crucial non-invasive diagnostic tool.

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