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Topical steroids for the treatment of retronychia.

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Topical steroids for the treatment of retronychia / Lencastre A, Iorizzo M, Caucanas M, Cunha N, Trakatelli MG, Zaraa I, Henry M, Daniel R, Gregoriou S, Haneke E, Prevezas C, Salphale P, Piraccini BM, Starace M, Tosti A, Richert B.. - In: JOURNAL OF THE EUROPEAN ACADEMY OF DERMATOLOGY AND VENEREOLOGY. - ISSN 0926-9959. - STAMPA. - 33:9(2019), pp. 320-322. [10.1111/jdv.15603]

Availability:

This version is available at: <https://hdl.handle.net/11585/715889> since: 2020-01-21

Published:

DOI: <http://doi.org/10.1111/jdv.15603>

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(Article begins on next page)

This is the final peer-reviewed accepted manuscript of:

Lencastre A, Iorizzo M, Caucanas M, Cunha N, Trakatelli MG, Zarea I, Henry M,
Daniel R, Gregoriou S, Haneke E, Prevezas C, Salphale P, Piraccini BM, Starace M,
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J Eur Acad Dermatol Venereol. 2019 Sep;33(9):e320-e322

The final published version is available online at: <https://doi.org/10.1111/jdv.15603>

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DR. ANDRE LENCASTRE (Orcid ID : 0000-0001-7378-7068)

DR. NÉLIA CUNHA (Orcid ID : 0000-0002-6287-1798)

Article type : Letter to Editor

Title: Topical steroids for the treatment of retronychia

Short Title: Topical steroids for retronychia

André Lencastre, MD^a; Matilde Iorizzo, MD, PhD^b; Marie Caucanas, MD^c; Nélia Cunha, MD^a; Myrto Georgia Trakatelli, MD^d; Inès Zaraa, MD, PhD^e Michèle Henry, MD^f; Ralph Daniel, MD^g; Stamatis Gregoriou, MD, PhD^h; Eckart Haneke, MD, PhDⁱ; Christos Prevezas, MD;^j Pankaj Salphale, MD^k; Bianca Maria Piraccini, MD, PhD^l; Michela Starace, MD^l; Antonella Tosti, MD^m; Bertrand Richert, MD, PhDⁿ

^a Department of Dermatology, Centro Hospitalar Universitário de Lisboa Central, Lisbon, Portugal; ^bPrivate Dermatology Practice, Bellinzona, Switzerland; ^cClinique Saint-Exupery, Toulouse, France; ^dSecond Department of Dermatology and Venerology, Papageorgiou Hospital, Aristotle university school of Medicine, Thessaloniki, Greece; ^eDermatology Department, Hôpital Bichât-Claude Bernard, Paris, France; ^fPrivate Dermatology Practice, Rennes, France; ^gUniversity of Mississippi Medical Center and University of Alabama, Birmingham, AL, USA; ^hFirst Department of Dermatology and Venereology, University of Athens Medical School, Andreas Sygros Hospital, Athens, Greece; ⁱDepartment of Dermatology, Inselspital, University of Bern, Bern, Switzerland; ^jNail unit , Andreas Syggros University Hospital, Athens, Greece; ^k Department of Dermatology, RIPAS Hospital, Bandar Seri Begawan , Brunei; ^lDermatology Department of Specialized, Experimental and Diagnostic Medicine, University of Bologna, Bologna, Italy; ^mDepartment of Dermatology&Cutaneous Surgery, University of Miami, USA; ⁿHôpitaux universitaires Saint Pierre & Brugmann, Hôpital universitaire des enfants Reine-Fabiola, Université Libre de Bruxelles, Belgium.

Corresponding author:

André Jacinto Garcez de Lencastre, MD

Serviço de Dermatologia, Hospital de Santo Antónico dos Capuchos, Centro Hospitalar Universitário de Lisboa Central

This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1111/jdv.15603

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Address: Alameda Santo António dos Capuchos, 1169-50, Lisboa, PORTUGAL

Phone number: +966387487

lencastre.derm@gmail.com

Keywords: Retronychia, Topical steroids, Topical treatment, Paronychia, Ingrowing nail

Submission statement: Authors have read and agreed upon submission of the present work entitled “Topical steroids for the treatment of retronychia” to the Journal of the European Academy of Dermatology and Venereology. Authors state that the work has been found in compliance with our institution’s ethics committee guidelines. The authors have no ethical conflicts to disclose and no funding sources to report.

Editor,

The term retronychia originated in 1999 (1) and a first series of cases was published in 2008. (2) A disturbance in the continuous longitudinal nail growth (3) leads to an upward and backward nail displacement with posterior embedding. Several nail plates pile up beneath the proximal nail fold (PNF) generating paronychia and granulation tissue. Repetitive footwear-related microtrauma appears to be the main trigger, although others have been described, differing between fingernails and toenails. (2-4). Young women are mostly afflicted. (2, 4, 5-7) Retronychia typically manifests by the clinical triad: nail growth arrest, xanthonychia and paronychia. (8)

Studies claim that nail avulsion is the treatment of choice (2, 7, 9). Some patients refuse surgery and ask only for pain relief. Some case reports mention alternatives such as taping or topical steroids (TS) with some results (2, 7-10). We thus considered evaluating the efficacy of potent TS in retronychia.

This retrospective study was performed using a physician-addressed online questionnaire sent to the European Nail Society mailing list. Patients were included if they had been treated with TS only. Assessed clinical features were as specified on Table 1. Treatment parameters were: 1) use of potent/ultrapotent TS; 2) with/without occlusion; 3) duration; 4) response (absent, partial,

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complete). Treatment response statistical analysis was performed using Fischer's Exact Test, with IBM® SPSS® Statistics software, version 22.

Among the 175 physicians approached, eighteen physicians replied, cumulating 56 cases. From those, 38 (69%) were female, the youngest was 12 and the oldest 73 y. o. (mean 29.6 years). The lowest reported disease duration was 2 months, and the longest 20 years, with a 6-month median. Toenails were affected in 51 patients (91,1%) and 4 had fingernail retronychia (0,07%). In this group, none showed symmetrical contralateral involvement. In the remaining 51 patients, one toenail involvement occurred in 36 (69,2%), 2 toenails in 15 (28,8%) and 3 toenails in 1. Symmetrical contralateral changes were noticed in 14 (87%) of the multiple toenail subgroup of patients. The cause was trauma in 3 fingernail cases, trauma/walk-related in 22 of the toenail cases, and unknown in the remaining.

Thirty-one patients were treated with TS under occlusion. Treatment periods lasted 8 weeks on average (the least was under a week, the longest recorded were 24 weeks). Complete healing was seen in 23 occasions (41,1%), partial results (i.e. improvement of paronychia without resumption of nail growth) in 16 (28,5%) and failure in 17 (30,4%).

Complete response (Figure 1) was more common in grade I cases ($p=0.005$). A statistical difference concerning the duration of treatment was observed between: patients with partial response vs. no response, where duration of therapy averaged 9.5 ± 1.7 vs. 5.3 ± 0.6 weeks ($p=0.022$) and patients with complete response vs. no response, where therapy lasted 10.3 ± 1.5 vs. 5.3 ± 0.6 weeks on average, respectively ($p=0.012$). No statistical difference was noticed when considering presence of granulation tissue, TS use under occlusion and disease duration.

TS may work by reducing the inflammation and edema of the PNF which elevate the proximal nail. Consequently, realignment is obtained, halting further distal rocking and stabilizing growth. We

found TS were completely and partially efficacious on 41.1% and 28.5% of cases, respectively. Response correlated with milder paronychia and longer treatment durations (9.5-10 weeks).

The main limitation of this study is its retrospective, physician questionnaire-based design. TS should be the first line treatment of retronychia, especially in milder forms. Shoewear/gait biomechanics-related issues should always be addressed. If there is no improvement after 10 weeks, nail avulsion should be performed.

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2.

Table 1 – Clinical features assessed and number of patients demonstrating such (n = 56)

Clinical feature	Number
Paronychia grade:	
I) none to very little swelling and inflammation of the PNF*;	12
II) moderate swelling and inflammation of the PNF;	31
III) severe swelling and inflammation of the PNF;	14
Presence of granulation tissue;	18
Presence of xanthonychia;	46
Presence of onycholysis (proximal; distal; proximal and distal)	20; 17; 9

*PNF – proximal nail fold

