

## Nail lichen planus: A true nail emergency



*To the Editor:* Tziotzios et al<sup>1,2</sup> have written an informative review on the clinical presentation, subtypes, and underlying molecular mechanisms for lichenoid skin diseases, as well as the current and emerging therapies for lichen planus. They describe the clinical signs of nail lichen planus, which might include nail atrophy, longitudinal ridging and fissuring, distal splitting, trachyonychia, and erythema of the lunula. They appropriately state that in severe cases permanent scarring might ensue. I would like to emphasize that nail lichen planus is a true nail emergency requiring rapid and aggressive treatment to prevent permanent nail loss. Formation of a dorsal pterygium represents a scar in the matrix and end-stage disease, which is not treatable. The occurrence of pterygium generally correlates with duration of disease; scarring rarely occurs in the first year.<sup>3</sup> Permanent nail loss is catastrophic in these patients, having a significant effect on activities of daily living and quality of life.<sup>4</sup>

The authors state that topical, intralesional, and systemic corticosteroids are preferred treatments for nail lichen planus and recommend oral corticosteroids only for disease affecting more than a few nails. They also mention alitretinoin as a potential treatment. The authors also recommend pulse or tapering of systemic corticosteroids, as opposed to intralesional steroids, due to convenience and efficacy and occlusion of treatment with topical steroids.<sup>1,2</sup>

Although I acknowledge that systemic steroids are often necessary to halt the disease process and preserve the existing nail, intralesional corticosteroid matrix injections (triamcinolone 2.5 mg/cc in 1% lidocaine) are effective in many patients with nail lichen planus affecting 1-20 nails (Figs 1 and 2). When the injections are performed with ethyl chloride spray and talkesthesia with a slow controlled technique, the therapy is quite tolerable for patients, with the majority returning for subsequent treatments.

Intramuscular corticosteroid injections (triamcinolone 0.5-1 mg/kg every 30 days for 5-7 months) have also been shown to have excellent efficacy in treating nail lichen planus, in both the adult and pediatric populations, and might decrease the risk for systemic side effects compared with oral corticosteroids.<sup>3</sup> However, with both oral and intramuscular corticosteroids, relapse might occur after therapy in some patients.



**Fig 1.** Lichen planus of the right thumbnail. Nail atrophy, longitudinal ridging and fissuring, distal splitting, and trachyonychia are evident. A punch biopsy through the nail plate and distal nail matrix with histopathology showed a patchy band-like lymphocytic infiltrate, with focal exocytosis of lymphocytes into the lower portion of the epithelium, consistent with a diagnosis of nail lichen planus.

Although I agree that when a significant number of nails (particularly the fingernails) are involved, more aggressive therapy is warranted, I disagree that systemic therapy must be avoided when only a few nails are affected. Nail loss involving the first 3 digits might have significant functional consequences. Patients might also have symptoms, such as sensitivity or pain, or decreased quality of life due to trouble with social interactions or employment. We should be following guidelines from the psoriasis literature, in which experts recommend systemic therapy for nail psoriasis patients with significant pain in whom topical therapy has failed.<sup>5</sup>

Nail lichen planus is a true nail emergency, and dermatologists should be familiar with the clinical presentation of the disease, treatment options, and need for prompt and aggressive therapy to prevent permanent nail loss. Increased research efforts into targeted treatment for this disease are desperately needed because treatment options are often unsatisfactory.

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**Fig 2.** Lichen planus of the right thumbnail from the patient shown in Fig 1 after monthly intralesional matrix injections. The proximal nail matrix was injected with 0.1 mL of triamcinolone 2.5 mg/cc in 1% lidocaine monthly for 3 months. There is significant improvement in longitudinal ridging and fissuring, distal splitting, and trachyonychia.

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