Nail Lichen Planus

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A 56-year-old woman presented with a 1-year history of altered nail growth and fragility, causing pain and cosmetic concern. Examination revealed onychodystrophy of multiple fingernails and toenails, with onycholysis, distal nail plate splitting, pterygium, longitudinal ridging, and subungual hyperkeratosis (Figure). She had a concomitant pruritic eruption on her chest and extremities and gingival ulceration. The scalp and vulva were uninvolved.

The periodic acid–Schiff stain reaction of nail clippings was negative for fungus. Matrical biopsy showed focal lichenoid interface inflammation. Clinical and histopathologic findings led to a diagnosis of lichen planus. The patient's nails improved several months after intralesional triamcinolone injections to affected matrices, topical triamcinolone cream to affected proximal nail folds, and oral mycophenolate mofetil and hydroxychloroquine (Supplemental Figure 1, available online at http://www.mayoclinicproceedings.org).

Nail lichen planus is manifested with nail plate thinning, longitudinal ridging, distal nail plate splitting, onycholysis, onychorrhexis, subungual hyperkeratosis, lunular erythematous patches, and pterygium.[1-3] Nail lichen planus can occur independently or in association with mucocutaneous involvement.[1] Differential diagnosis may include onychodystrophy from onychomycosis, psoriasis, alopecia areata, or trauma.[4] Clinical examination is often sufficient for diagnosis, but histopathologic features of bandlike lymphocytic infiltrate of nail matrix or bed epithelium (Supplemental Figure 2, available online at http://www.mayoclinicproceedings.org) are confirmatory.[3] Treatment should be commenced promptly to avoid permanent nail dystrophy. First-line treatment of nail lichen planus is corticosteroids (topical, intralesional, or rarely, systemic), but persistence or relapse of disease may justify corticosteroid-sparing immunosuppressants.[3] Nail lichen planus should be considered in the differential diagnosis of progressive nail changes, and patients with onychodystrophy should be examined carefully for other mucocutaneous manifestations of lichen planus.

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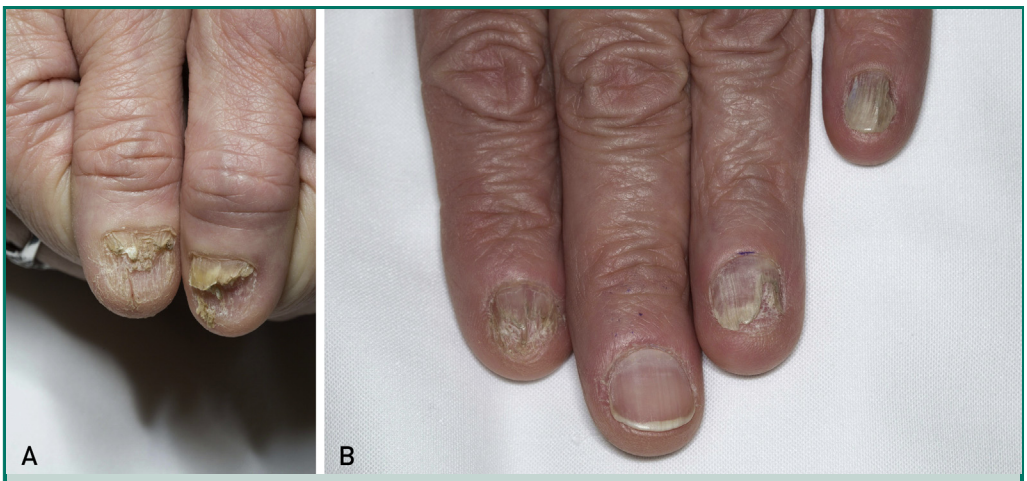

FIGURE. Nail lichen planus showing subungual hyperkeratosis and onychorrhexis (A) and onycholysis, dorsal nail plate splitting, and pterygium formation (B).

SUPPLEMENTAL ONLINE MATERIAL

Supplemental material can be found online at http://www.mayoclinicproceedings.org. Supplemental material attached to journal articles has not been edited, and the authors take responsibility for the accuracy of all data.

Potential Competing Interests: The authors report no competing interests.

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