NHS
Central London
Clinical Commissioning Group

Onychodystrophy

General points

The thickness of nail plates is normally 0.5mm; this consistently increases in manual workers and many disease states such as:

- Onychomycosis (Dermatophyte fungal infection)
- Psoriasis
- Chronic Eczema
- Lichen Planus
- Alopecia areata
- Norwegian scabies
- Old age
- Trauma e.g. from footwear

Treatment

Don't give antifungals unless mycology proves fungal infection

Topical treatment can only be used in mild distal disease. Not very effective

- Use amorolfine (Loceryl nail lacquer) for superficial or white onychomycosis.
- Weekly continued for 6–12 months.

Alternatively oral antifungals for more extensive disease – cure rate 80% however recurrence common

1. Terbinafine (Lamisil) 250mg od

- 12–16 weeks for toenails
- 6–12 weeks for fingernails

2. Itraconazole

- Pulse treatment, 3 pulses of itraconazole bd for 7 days repeated monthly
    - 3 cycles for toenails
    - 2 cycles for fingernails

Matrix involved Onychomycosis

- Nail matrix = most proximal part of the nail bed – at the lunula
- Where matrix involvement is encountered, a combination of oral Terbinafine and Amorolfine Lacquer has been shown to provide more effective cure rates than terbinafine alone
- A dose of 250mg of terbinafine should be given daily for up to 12 weeks and Amorolfine Lacquer applied once a week for up to 15 months.

Tips

- General cutaneous examination and examination of all the nails is necessary e.g. to pick up evidence of psoriasis

- Mycology samples – include generous scrapings of the thickened crumbly material on the underside of the nail – this is where the fungus inhabits
- If culture shows yeast - ignore
- If negative, arrange for regular chiropody to keep nails short and thin
- Asymptomatic patients may be advised to ‘leave well alone’.