Psoriasis Scotland Arthritis Link Volunteers

Patient Factsheet - Nail Psoriasis

Psoriasis in its classical form usually forms thick dry and scaly plaques on “extensor” surfaces such as elbows and knees. It can of course be more widespread, occasionally affecting the whole body including the scalp and nails. Sometimes people may have psoriasis affecting just their scalp or nails including fingers and toes. When making a diagnosis of psoriasis, doctors will often ask about any particular problems with the nails and will examine them to look for the distinctive features which can be seen with psoriasis. At least 25 % of psoriasis patients will have some nail changes. Less than 5% will have nail changes alone.

The commonest nail change associated with psoriasis are small dents on the surface of the nail described as “nail pitting”. Although even simple trauma can produce a similar appearance, In psoriasis there will usually be more than one nail involved. This also applies to the other nail changes which may be found. These include the nail lifting up and away from the nail bed which is termed *onycholysis*. Nails tend to be thicker, can often be discoloured with a pink/brown "oil spot" sign, and crumble easily at the edges. To confuse matters- a fungal infection in the nails, one similar to the fungus seen in athletes foot, can produce these changes, however it is less likely to affect multiple nails of the hands and feet simultaneously. Occasionally psoriasis nail changes are mistakenly treated for long periods with antifungal tablets, but fail to respond. Psoriatic nails are however, at greater risk of developing coexisting fungal infection than the general population. This is why it is important for nail samples to be taken before antifungal treatment is suggested.

Nail psoriasis still remains difficult to treat despite newer treatments for psoriasis generally. It is poorly responsive to creams applied directly to the nail. Often the changes affecting the nails are deep within the nail bed and nail growth point making it difficult to control. Patients, who are started on tablet treatments such as methotrexate and newer “biologic” injection treatments for widespread psoriasis, report some improvement in their nails. The main issue with nail psoriasis is commonly the cosmetic appearance rather than any other symptoms, although they can often me uncomfortable particularly the toes.

Current treatment for nails would include an early trial of a strong steroid cream applied to the base of the nail. This is aimed at reducing the body’s immune reaction in the nail bed which results in the development of psoriasis changes. Liquid steroid scalp solutions or Vitamin – D analogue creams/scalp gels such as Dovobet© are used sometimes successfully for mild to moderate psoriasis and can be applied to the nail bed . These topical applications require twice daily applications for at least three months to notice any improvement. Even this method has a poor response rate. There have been a number of case reports of steroids being injected deeper into the nail growth plate/matrix, again with mixed results. This is a time consuming and rather uncomfortable procedure which would need repeated. This is not commonly offered as a treatment

It is unlikely that powerful immunosuppressive systemic therapies would be used for nail psoriasis alone, however those with more extensive psoriasis treated with these drugs may notice significant improvements in the appearance of their nails. Methotrexate, Ciclosporin and Acitretin are reported to occasionally help psoriatic nails. Withdrawal of these treatments unsurprisingly can lead to recurrence. Acitretin can sometimes aggravate nails. Rarely physical

interventions such as surgical removal or avulsion will be helpful in relieving discomfort, particularly big toe nails. Podiatry can be useful and nails should be kept short.

More recently there have been some case studies of patients getting improvements specifically in their nail psoriasis after receiving biologic drugs including adalumimab and ustekinumab. This class of drug however is normally only licensed for use in moderate to severe chronic plaque psoriasis. A number of even newer biologic drugs are in trials and may offer useful therapy for nail involvement.
Increasingly it is felt that early onset or severe nail disease may be linked to the development of underlying psoriatic arthritis, and may form a useful clinical sign to look further at the joints and initiate investigations and potent treatments at an early stage.

Although it only affects a small area, nail disease can be very visible and so is an important element to take into account when considering options for treatment. Hopefully as psoriasis treatments improve generally, this will translate into improved treatments for patients with nail disease.

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