It's often viewed as the most difficult aspect of psoriasis to treat, but success isn’t just a matter of luck. Specialists offer advice on treatment regimens and general nail care.

With the plethora of psoriasis treatments available, it seems that at least one or two agents should stand out as effective, first-line therapy for nail psoriasis. Instead, psoriasis of the nails poses significant therapeutic challenges for dermatologists and a cosmetic burden for patients. While systemic agents ranging from methotrexate to the newer biologic agents often effectively treat nail psoriasis, such therapy is not indicated for the small percentage of patients who present with only nail involvement or who present with only mild psoriasis on other body sites. Yet, even when systemic therapy is indicated, patients with widespread disease may require the addition of topical agents to specifically target the nails.

The biologic agents seem to show promise and may one day become the treatment of choice for recalcitrant or severe cases of nail psoriasis. Until then, dermatologists are left to rely on topical agents and steroid injections, which understandably can leave both you and your patients frustrated. To help minimize this frustration, several specialists offer tips on treatment selection and general nail care.

Treatment Selection
Psoriasis of the nails presents a significant physical, psychological, and cosmetic burden for patients, and simple everyday tasks such
as buttoning a shirt become arduous, while simple social customs like hand shaking are avoided. "Interestingly, it affects men equally if not, in some cases, more so than women because women can disguise it. It's more acceptable for them to cover it up to a certain extent than it is for men," says nail specialist Phoebe Rich, MD, Clinical Assistant Professor of Dermatology at Oregon Health Sciences Center and in private practice in Portland.

Dr. Rich notes that about five percent of psoriasis patients have psoriasis on their nails alone. "Those are the people that are most difficult to diagnose and treat because it can look like a lot of different things in the nails," she states. In fact, some patients may undergo several courses of antifungal medication with their primary care physician before they are referred to your care.

Of course, with psoriasis of the nails, the possibility exists that a patient will present with a concomitant infection. As a result, psoriasis specialist Charles Crutchfield, III, MD of Crutchfield Dermatology in Eagan, MN, and Clinical Assistant Professor of Dermatology at the University of Minnesota recommends doing a DTM culture and a PAS stain to determine if a concomitant fungal infection is present. "I cover both ways because if you have an underlying nail dystrophy, often times you're at a higher risk for developing an infection," Dr. Crutchfield explains.

One of the greatest frustrations for dermatologists treating nail psoriasis is that what works for one patient doesn't necessarily work for another. In fact, because treatment success varies so greatly from patient to patient, Dr. Crutchfield believes it is helpful to tell patients from the very beginning that nail psoriasis is one of the most difficult forms of psoriasis to treat. "Once I frame their expectations, and they know that sometimes it's impossible to treat, then they're not unhappy. They at least know we're trying, and about half the time we'll achieve some degree of satisfactory success," says Dr. Crutchfield.

Steroid Injections
Intralesional corticosteroid injections have the reputation of being the most effective treatment—with the exception of oral and biologic therapy—as well as the most potentially uncomfortable. But, warns nail expert Richard Scher, MD, Professor of Clinical Dermatology and Head of the Section for Diagnosis and Treatment of Nail Disorders at the College of Physicians and Surgeons at Columbia University, it's important not to over-state the discomfort. Unlike topical medications, which lack the ability to sufficiently penetrate the nail matrix or nail bed, "cortisone injections concentrate medication exactly where the problem occurs," Dr. Scher says.

Although some dermatologists are hesitant to do cortisone injections due to the associated discomfort, Drs. Rich, Scher, and Crutchfield routinely turn to this treatment and have developed strategies to enhance patient comfort. Drs. Scher and Rich explain that they anesthetize the site of injection with cooling spray, such as fluoroethyl spray or ethyl chloride, while Dr. Crutchfield finds applying a topical anesthetic such as LMX (4-5% lidocaine, Ferndale) is helpful. Dr. Rich has also found that diluting the steroid with lidocaine helps to minimize pain. "The first drop is uncomfortable, but after that the area goes numb," notes Dr. Rich, adding that even children and adolescents tend to tolerate the discomfort. For the actual injection, Dr. Scher recommends using a 30-gauge needle to slowly inject 2.5-3mg/mL of triamcinolone acetonide. He suggests doing the injections once a month until improvement and then reducing injections to once every six weeks or once every two months.

Whether the psoriasis affects the nail matrix or the nail bed
will determine the site of injection. Dr. Rich says injections tend to work best for psoriasis of the nail matrix since it is impossible to get topical agents down into the root of the nail. For nail matrix psoriasis, Dr. Scher says to inject in the nail fold. Dr. Crutchfield additionally cautions against injecting too deeply to avoid bruising. On the other hand, for patients with psoriasis of the nail bed, Dr. Scher recommends injecting the steroid along the lateral nail fold. Keep in mind, however, that the nail bed may respond to topical agents. “It’s a little easier to get medication down there because you can drip it under the nail,” Dr. Rich says. Therefore, if a patient presents with both nail matrix and nail bed psoriasis, then a combination approach with a steroid injection and one or more topical agents such as topical steroids, topical tazarotene, topical calcipotriene, or topical cyclosporine may be the most effective non-systemic approach.

Although intralesional steroid injections prove helpful for some patients, results are not long-term. “Even if you can get patients’ nails looking pretty good, when you stop the injection, they usually eventually get it back, just like they do with psoriasis elsewhere,” Dr. Rich states. In addition, not all patients will respond to this therapy. To spare patients of unnecessary discomfort, Dr. Crutchfield typically treats only one or two fingers initially to see whether the patient’s nail psoriasis responds.

Topical Agents

Topical agents may also be helpful in the management of nail psoriasis, but as Dr. Rich points out, they tend to target the nail bed more effectively than the nail matrix. Unfortunately, no one topical agent stands out as the treatment of choice for nail psoriasis, but the specialists we spoke with did offer specific combinations that have proven beneficial for some of their patients.

Psoriasis specialist Lawrence Green, MD, Assistant Professor of Dermatology at George Washington University School of Medicine and in private practice in Rockville, MD, has found using a combination of Tazorac gel (tazarotene, Allergan) and Aquaphor (Beiersdorf) with or without an alternating day class I or II steroid ointment for one to two months is helpful, particularly for patients who experience pitting and crumbling of the nails. He instructs patients to apply the Aquaphor around the edges of the nail plate and then to apply Tazorac over the entire nail, carefully avoiding the edges to minimize irritation. He then has patients apply another layer of Aquaphor over the entire nail. “Aquaphor over Tazorac helps make it more moisturizing,” Dr. Green explains. “A lot of times I’ll use Aquaphor and Tazorac without topical steroids.”

Dr. Crutchfield notes that for some patients, a nightly application of a class III steroid such as triamcinolone proves helpful. He also has found that two-week “bursts”—two weeks on, two weeks off—with Cordran Tape (flurandrenolide, Oclanss) benefit some patients when applied to the nail matrix and left on overnight. Dr. Scher also has found flurandrenolide tape to benefit some patients, noting that it works better than steroid creams or ointments. Psoriasis specialist Robert Kalb, MD of the Buffalo Medical Group and Clinical Associate Professor of Dermatology at State University of New York at Buffalo, finds a minority of his patients respond well to a combination of topical steroids and topical calcipotriene.

Systemic Therapy

Although nail psoriasis tends to respond best to systemic agents, not all patients...
are candidates for such therapy for various reasons. “Methotrexate and cyclosporine should only be used for severe, incapacitating psoriasis because of their adverse effects,” notes Dr. Scher. Unlike older systemic agents like methotrexate, the biologic agents appear to be associated with far fewer side effects and also appear to be very effective for nail psoriasis, according to Dr. Scher and Dr. Rich. Unfortunately, until studies prove that the five percent of patients who present with nail involvement alone are candidates for biologic therapy, most insurance companies will not cover this therapy.

Even for patients with widespread psoriasis who are candidates for systemic therapy, no one agent has proven most effective for the nails. As all the experts noted, any systemic agent that clears the skin may benefit the nails. At the same time, Dr. Kalb points out, “There are many patients whose psoriasis can clear or clear completely, but their nail psoriasis may not change at all.” In setting patients’ expectations, it’s particularly important to educate patients that the nails respond more slowly to systemic therapy than does the skin. “There’s always a delay from the time the skin clears until the time the nails clear,” Dr. Rich explains, pointing out that it takes up to 12 months to grow a new toenail and approximately six months to grow a new fingernail.

“*To minimize trauma, instruct patients to keep fingernails and toenails filed and trimmed short so that they do not extend beyond the tip of the finger.*”

**Nail Care**

Although all of the agents discussed above can play an important role in managing nail psoriasis, don’t overlook the important role general nail care can play in keeping the psoriasis under control. In particular, general nail care should aim at moisturizing, strengthening, and protecting the nails. General moisturizing and strengthening agents can benefit all patients with nail psoriasis. In fact, Dr. Crutchfield instructs his patients to keep the cuticle and matrix regions moisturized with AmLactin Lotion (Upsher-Smith) and to strengthen the nail by taking Appearex (2.5mg biotin, Merz).
Patients must also understand the importance of protecting the nails by avoiding any trauma. “That Koebner reaction in the nail keeps the psoriasis going,” says Dr. Rich. “I don’t mean traumatized by major injury, but rather minor, repetitive bumping all day long.” To minimize trauma, instruct patients to keep fingernails and toenails filed and trimmed short so that they do not extend beyond the tip of the finger. “Keeping them filed—not filing the surface of the nail—but filing the free-edge and keeping them clipped back is quite helpful,” Dr. Rich explains. Caution your patients against buffing the nails in attempt to buff out the pits. “I think that can actually worsen the psoriasis,” Dr. Rich says, noting that men tend to do this more so than women.

Although keeping nails short is helpful for all patients, this is particularly important for patients who complain of their nails catching on everything due to onycholysis, says Dr. Scher. For patients who complain of hyperkeratosis, Dr. Scher instructs them to gently smooth the nails down, and for those who complain of brittle nails, he recommends keeping them well lubricated. He adds that patients can use a soft toothbrush to gently clean nails. For psoriasis of the toenails, Dr. Green advises his patients to avoid traumatizing the nail. Helpful strategies include wearing shoes that fit properly, keeping toenails short, and wearing socks to cushion the toes.

Equally important to your male and female patients is advice on nail cosmetics. Patients are desperate for ways to disguise pitting, crumbling, and discoloration and have many questions on how they can safely mask the unappealing appearance of the disease. The experts we spoke with encourage patients to use nail cosmetics, but Dr. Green does caution his patients against overusing nail polish and remover since this can dry out the nails. For patients who desire to use nail polish, recommend that they use formaldehyde-free products and acetone-free nail polish remover. “Some men do wear clear nail polish. The problem is the shine. There are a few matte ones that aren’t shiny and don’t look like nail polish. That can actually give the illusion of the nail plate being more smooth,” explains Dr. Rich. Ridge fillers can also help with pitting by giving the illusion of a smooth nail, but similar to colorless nail polish, ridge fillers do not hide the discoloration commonly associated with nail psoriasis.

Visits to the nail salon are even acceptable, as long as patients warn the nail technician not to use mechanical instruments that may injure the nail, advises Dr. Scher. “What I don’t like to see women do is use acrylic nails, especially long acrylic nails,” states Dr. Rich. Long acrylic nails not only traumatize the nail but also increase the risk for infection. “You have this space under the nail and moisture gets under there. It’s a warm, moist, dark place for things to grow,” explains Dr. Rich.

In certain situations, however, when women are willing to keep the enhancements very short—not longer than the tip of the digit—Dr. Rich believes exceptions can be made and recommends patients consider gels and silk wraps rather than acrylics. “Acrylic nails can be a problem because people wear them too long,” she explains. “Nail gel overlays and silk wraps are better than the acrylics that are so hard you really do injure the nail bed with bumping.”

Best Is Yet to Come

Unfortunately, even patients who comply with their treatment regimens, practice good nail care, and take advantage of nail cosmetics often find themselves unhappy with their nails. Some of this dissatisfaction may result from putting too much faith in the available nail treatments. As Dr. Crutchfield stated, it’s important to frame patients’ expectations from the very beginning to minimize disappointment. Hope focuses on the future role of biologics for nail psoriasis, but until studies prove this patient group qualifies as candidates, dermatologists should focus on making the most of topical agents and steroid injections.