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Case Report

Case: Diagnosting Chronic Finger Paronychia as Candidosis Based on Clinical Evaluation

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ABSTRACT

A 20-year-old male had chronic paronychia in his finger nail beds and changes in nails for 1.5 years. Basic topical treatments with also topical over-the-counter antiseptic, mild steroids and freezing devices did not give a response. Clinically, autoimmune processes, acrodermatitis continua of Hallopeau and psoriasis were as differential diagnosis. Based on a sophistigated clinical estimation as unusual candidosis in all finger nail beds, itraconazol 100 mg daily was prescribed for 4 weeks together with topical triamcilone/econazole 1/10 mg/g cream for 2 weeks resulting in a clinically healed outcome.

Keywords: Chronic paronychia; Autoimmune processes; Hallopeau and psoriasis

Introduction

Finger paronychia can be of infectious origin, mainly bacterial or fungal. Common warts are usually markedly clinically different. Resembling diseases include autoimmune diseases, acrodermatitis continua of Hallopeau and psoriasis[1].

Case Report

A non-atopic healthy 20-year-old male had dermatitis and paronychia in his finger nailbeds and changes in nails for 1.5 years. Basic topical treatments with also topical over-the-counter antiseptic, mild 1% hydrocortisone and freezing device (SyylEnd® FREEZE) did not give a response.

As diagnosed as commoin warts by a General Practitioner, a freezing device (SyylEnd® FREEZE) used 3 times in 2 to 3 week intervals did make any effect. SyylEnd® FREEZE is available at a Pharmacy without a prescription as over-the-counter as a CE-marked Medical Cryogenic Device (CE 0459) made by Oystershell NV (Merelbeke, Belgium) containing nitrous oxide (N_2O) giving the freezing tempereture down to -80°C (boiling point -89°C). SyylEnd is shown to give in a Clinical Trial a favorable efficacy as compared to other similar products (Pharmascan, Poland, 2017).

Clinically, autoimmune processes and acrodermatitis continua of Hallopeau were as differential diagnosis. There were no skin changes or dermatosis elsewhere like psoriasis and family history was negative for any skin diseases. There was no dermatitis or paronychia in toes. There were no signs of warts, but swollen finger nailbeds with paronychia outcome **(Figures 1a, 1b)**. The patient's financial situation as a student did not allow laboratory examinations. After discussing with

the patient, he agreed, after 1.5 years of the present situation, to take a 4-week short time-out and based on sophistigated clinical estimation, i.e., "guess", as unusual candidosis in all finger nail beds, itraconazol (Sporanox) 100 mg daily was prescribed for 4 weeks and topically Pevisone cream (triamcinolone/econazole 1/10 mg/g) bid for 2 weeks.

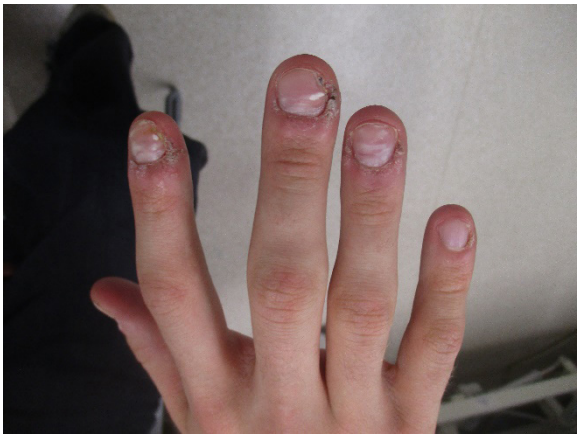

Figure 1a: Right hand at start of treatment.

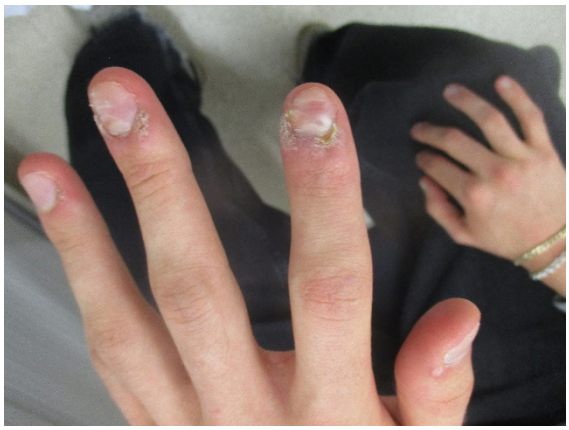

Figure 1b: Left hand at start of treatment.

At a control 1.5 months later the situation was clinically clear **(Figures 2a, 2b)**. After an additional 1 month, remission was stayed.

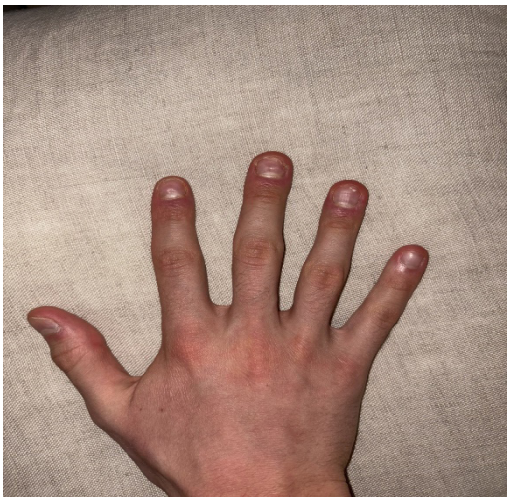

Figure 2a: Right hand after 1.5 months.

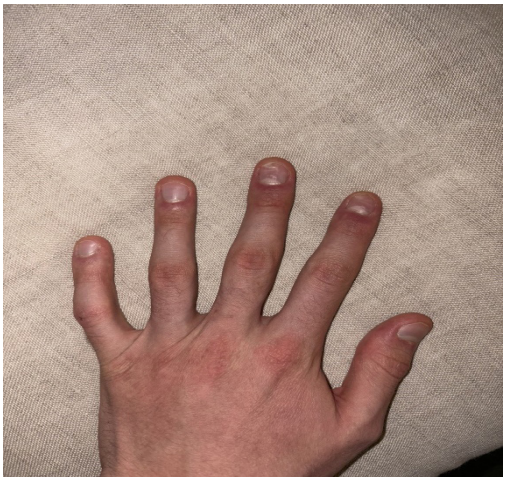

Figure 2b: Left hand after 1.5 months.

Discussion

The financial situation of the patient may be an crucial factor to take laboratory tests and skin biopsies for diagnosis and differential diagnosis. If taken a small punch biopsy from the nailbed area, the consequence might be a permanent growth disturbance of the nail and still no clear fungi might be seen in the biopsy specimen under the microscope. Thus, treatment of the patient might be justified and based on only clinical assessment, when the pros and cons are put to the evaluative risk-benefit balance. By own personal clinical experience for over 30 years, finger nail bed candidosis is only in a few fingers, not seen earlier in all fingers.

In this case, autoimmune diseases and Hallopeau as differential diagnosis were unlikely when he otherwise was young and healthy. Also psoriasis was unlikely. It was not possible to confirm or exclude the presence of warts in this patient when was treated earlier in the past, but according to the patient, the clinical outcome was the same after the freezing treatments. The diagnosis here in all finger candidosis was based on only clinical effect of antifungal oral and topical treatment. With other similar patients with clinically paronychia candidosis in the past, this 4-week oral and 2-week topical antifungal-moderate steroid treatment has been usually sufficient. It is noteworthy to mention that the penetration of topical econazole as well as steroids deep enough into the skin likely may not be sufficient alone to make the treatment complete.

Ethical Approval

The patient has given his consent for this case report.

Conflict of Interests

Author declares no conflicts of interests.

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1. Champion RH, Burton JL, Burns DA, Breathnach SM. Rook's Textbook of Dermatology. Eds., 6. Edition. Oxford: Blackwell 1998.