Orient Nail Biopsy Specimens With Paper Template

BY BETSY BATES
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Monterey, Calif. — Proper management and orientation of nail biopsy specimens will help ensure that the ensuing diagnosis is accurate, Dr. Phoebe Rich advised colleagues at the annual meeting of the California Society of Dermatology and Dermatologic Surgery.

"If you send these in and they're sectioned wrong, you're going to get the wrong answer or you're not going to get an answer at all," said Dr. Rich, director of the nail center at Oregon Health and Science University in Portland.

She places the properly oriented specimen on a piece of paper that contains a photocopied template of a nail. "I orient it the way that I want the pathologist to look at it," she said.

As an example, she showed how she oriented the biopsy specimen from a lesion suspicious for melanoma in which she took the nail plate, matrix, part of the nail fold, and the nail bed. The tissue was placed directly on the diagram of the nail, and the nail plate was sent to the pathologist as well.

"The pathologist knows to section this in a longitudinal way. If you were to 'breadloaf' this, you're probably not going to get your answer," she said.

The pathologist sections right through the specimen and the paper, preserving the orientation.

There is no need to affix the specimen to the paper. "If you put it down right away on the paper, it actually sticks. I let it sit there for a few minutes before I put it in the formalin and it actually will adhere to the paper," Dr. Rich explained.

She noted that in many cases, an accurate diagnosis will not require removal of the entire nail plate.

"I tell the residents: 'Unless the nail plate is deformed by the tumor, you're not dealing with a deep lesion. You can really just take off the top part and you're still going to get your answer very, very nicely,' " she said.

Biopsy any unexplained pigmented lesion at the origin of the band by cutting along and peeling back the affected part of the nail as necessary, saucerizing the lesion, and scoring around it, she explained.

The distal plate can often be preserved, she said.

In response to a question from the audience, Dr. Rich acknowledged the difficulty in knowing whether or when to biopsy a pigmented nail in a person with naturally pigmented nails, such as is often the case in African American patients.

Look for pigment that is different from that in the other nails, changing, or larger than the norm for that patient, she recommended.

"Just like in patients with a lot of moles, you look for the ugly duckling." ■

A Multitude of Initial Diagnoses Seen for Nail SCC

Monterey, Calif. — The initial preoperative diagnoses of nail lesions that prove to be squamous cell carcinoma run the gamut from onychomycosis to subungual verruca, Dr. Phoebe Rich said at the annual meeting of the California Society of Dermatology and Dermatologic Surgery.

In her own practice, one such lesion was oozing and appeared onycholytic, she explained, displaying a slide of the crusty lesion at the nail edge.

"It doesn't look like much," said Dr. Rich, director of the nail center at Oregon Health and Science University, Portland.

Among 13 SCC cases diagnosed by Dr. Rich, who is also in private practice, six appeared verrucous and six eczematoid, in addition to the onycholytic case.

Earlier this year, a clinicopathological review of SCC of the nail apparatus by French researchers revealed that subungual SCC was the preoperative diagnosis in only 10 of 35 patients (Br. J. Dermatol. 2007;156:871-4). Nine cases were originally thought to be onychomycosis, five were diagnosed as subungual verruca, and five were thought to be "longitudinal melanonychia (nevus, melanoma)." Six cases carried a variety of other preoperative diagnoses, including exostosis and onychomatricoma.

The lesson is to always be thinking of SCC of the nail as a possibility, she stressed.

—Betsy Bates

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