'Fungal Fridays' and Other Tips for Onychomycosis

BY DOUG BRUNK
San Diego Bureau

CORONADO, CALIF. — A patient who has abnormal-looking nails with a normal plantar and web surface is unlikely to have onychomycosis, Dr. Boni E. Elewski said at the annual meeting of the Pacific Dermatologic Association.

The presence of tinea pedis on the plantar surface or web space confirms that clinical suspicion. "There are several exceptions, one of which is someone who has obtained an infection from a pedicure," said Dr. Elewski, professor of dermatology at the University of Alabama, Birmingham.

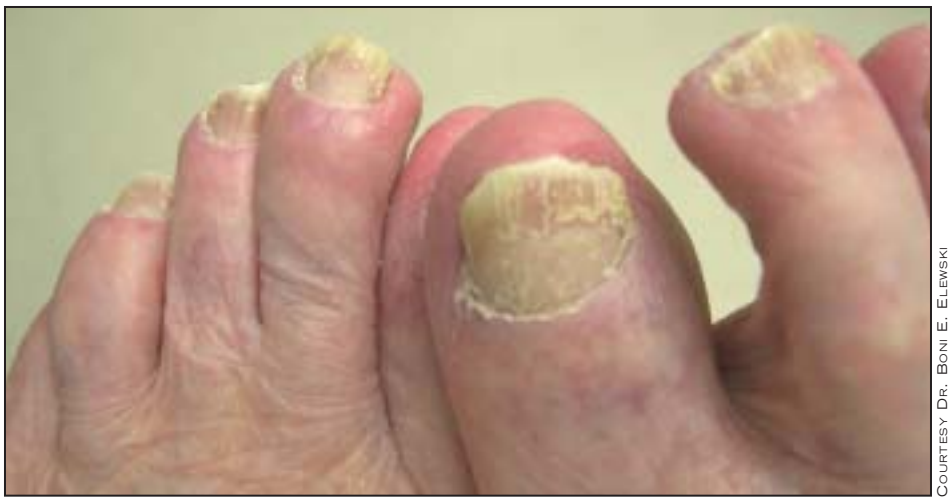
"You can't eliminate that. So if you have a patient with pristine feet and they have no [previous] history of tinea pedis, ask if they get regular pedicures, because you can get a direct infection of the nail plate from a pedicure," she explained.

The other exceptions are white superficial onychomycosis and proximal white subungual onychomycosis, two subtypes in which the fungus directly attacks the nail plate rather than the skin first.

Dr. Elewski provided several other clinical pearls regarding onychomycosis:

► **A patient with abnormal fingernails and normal toenails is unlikely to have onychomycosis.** The exception is *Candida* onycholysis. "This occurs commonly in women who have Raynaud's syndrome and other patients who have collagen vascular disease, but that's a very small minority of patients," she said.

► **Fluconazole 200-400 mg once a week is effective for *Candida* onychomycosis or paronychia.** "We underuse this drug in dermatology," she said. "It is a good antifungal and it's very cheap, about 25 cents per tablet. You only need to treat for 6-8 weeks in most patients."



COURTESY DR. BONI E. ELEWSKI

Factors that have been identified to be associated with a bad prognosis for onychomycosis include dermatophytoma, thick nail, and a total dystrophic nail.

She usually instructs her patients to take fluconazole on Fridays and uses the term "fungal Fridays" as a catchy reminder. Some of her dermatology residents prefer Tuesdays or, as they call it, "Toesdays."

► **Know the bad prognostic factors of onychomycosis.** These include dermatophytoma, thick nail, a total dystrophic nail, predominantly lateral nail involvement, and immunocompromised and/or diabetic patients.

Physicians can improve the prognosis in patients with dermatophytoma by debriding the area as much as possible. "You can give patients antifungal cream, lotion, or gel to smear under it, and then treat it with an oral antifungal," said Dr. Elewski, a past president of the American Academy of Dermatology.

She also noted that patients with thick nails require careful evaluation because not all of them will have onychomycosis. "Thick nails could come from trauma, from running or skiing, or from runner's toe," she explained.

In patients with lateral nail involvement, she clips away at the lateral edge, smears in antifungal cream and continues treatment with oral antifungals.

Most patients with a bad prognostic factor will require treatment with oral terbinafine 250 mg daily or itraconazole 400 mg daily for 1 week per month for 4 months or longer.

► **Itraconazole is the choice in nondermatophyte mold infections of the nail.** There are two other drugs on the horizon "that may supersede itraconazole in this situation," Dr. Elewski said. These include posaconazole (Noxafil), which is not approved for this indication but is under investigation, and a drug in development called albaconazole.

Currently, itraconazole given in a pulse fashion is preferred. The recommended dose is 400 mg/day for 1 week per month. "I generally use it for 4 months or longer if it's a nondermatophyte mold," she said.

► **Topical antimycotic agents may be sufficient to treat onychomycosis in certain situations.** The only topical agent that is approved by the Food and Drug Administration for onychomycosis is 8% ciclopirox olamine lacquer. Dr. Elewski said that she also finds it useful in white superficial onychomycosis and in minimal nail disease.

► **The nail can provide clues to skin disease.** She discussed the case of a patient who presented with a scaly dermatosis on the pretibial area. "Is this eczema? Stasis dermatitis?" she asked. "If the toes are abnormal and the patient has onychomycosis, there is a high likelihood that a scaly rash on the lower legs could be a dermatophyte infection. If the toes are normal, the patient probably does not have a dermatophyte infection on the lower legs."

Diagnosis of onychomycosis is made by a microscopy with potassium hydroxide test (KOH), culture, and nail biopsy. Dr. Elewski warned, however, that culture can be the most variable of the three. "Even in the perfect situation you may not grow a dermatophyte, or you may grow a contaminant that is unrelated to the true infection that is in the nail," she said. "Think of your KOH nail biopsy as yielding about the same information. If KOH is positive, the diagnosis is made."

Dr. Elewski disclosed that she has conducted clinical research for Novartis, Barrier Therapeutics, and Stiefel Laboratories. ■

Warning Labels on Tanning Beds to Be Scrutinized by FDA

BY ALICIA AULT
Associated Editor, Practice Trends

The Food and Drug Administration soon will begin to scrutinize the warning labels on tanning beds, under a new federal law signed by the president in late September.

The Tanning Accountability and Notification Act was included in the Food and Drug Administration Amendments Act of 2007. Four members of Congress—Sen. Jack Reed (D-R.I.), Sen. Johnny Isakson (R-Ga.), Rep. Carolyn Maloney (D-N.Y.), and Rep. Ginny Brown-Waite (R-Fla.)—originally sponsored the TAN Act.

Under the new law, the FDA is being directed to determine if the label is positioned correctly, whether it gives sufficient risk data, whether alternative warnings would better communicate risks, or if there is no warning that could communicate the risk of using tanning beds adequately.

To reach those determinations, the law requires the FDA to conduct tests with consumers; the agency is to issue a report by September 2008.

The American Academy of Dermatology Association applauded the passage of the TAN Act.

"The current labeling on tanning equipment inadequately explains the serious risks associated with indoor tanning," said AAD president Dr. Diane R. Baker in a statement. "The TAN Act is the first step to correct this and ultimately will help educate the millions of Americans who tan each day about the potential cancer risks associated with ultraviolet radiation."

AAD estimates that 30 million Americans use tanning beds each year, and that 2.3 million are teenagers.

The Indoor Tanning Association does not have exact figures, but said the industry estimates that at least 25 million Americans are indoor tanners.

John Overstreet, executive director of the association, said that requiring the FDA to study new warnings is not necessary. The current warning—which was devised by the FDA—is very detailed and blunt, said Mr. Overstreet in an interview.

"With all the challenges facing FDA and all they have to do, this seems a little unnecessary," he said, adding that the industry believes that the AAD and other organizations exaggerate the dangers of UV radiation.

The American Medical Association has continued to support the strengthening of state and local laws to regulate indoor tanning more stringently, including toughening the warnings posted in salons and spas.

©DRAGAN TRIFUNOVIC/FOTOLIA.COM

At least 25 million Americans are indoor tanners, according to industry estimates. Medical groups want warnings to be updated and placed more prominently.

Dr. Jessica Krant, an AMA alternate delegate representing the American Society for Dermatologic Surgery, said that passage of the bill means that Congress recognizes that teenagers still are being exposed to unnecessary risks from tanning. "I think it's the first step and a very good and important change," she said in an interview.

But the AMA and the ASDS both feel that the current warnings—created in the 1970s—need to be updated and placed more prominently in tanning beds, said Dr. Krant, also of State University of New York, Brooklyn. ■