Letter to the Editor

Onychopapilloma

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Sir,

A 35-year-old male, skin phototype IV, presented with a 5-year history of a nail alteration of his right thumb. He denied previous trauma, pain or discomfort. The clinical examination found an erythronychia associated with some long filiform haemorrhages on the distal part of the nail (Fig. 1). In dermoscopy, the pink band measured 1.7 mm, it interrupted the lunula and we clearly distinguished filiform haemorrhages (Fig. 2a). The dermatoscopy of the distal edge demonstrated localized subunal hyperkeratosis (Fig. 2b). There was no painful area on palpation. The evaluation of the other fingernails and toenails was normal. Partial surgical avulsion of the nail plate revealed a tumor and a total excision was made. We proceeded to a histological examination that revealed a papillomatous epithelial lining (Fig. 3), the seat of epidermal metaplasia with the presence of a keratogenous pseudo-layer. The keratinocytes were multinucleate without cytonuclear atypia. The diagnosis of onychopapilloma has been established.

Onychopapilloma is a rare benign tumor of the nail bed and the distal matrix. It was first described by Barran and Perrin in 1995. The tumor is especially seen in young women. The lesion is often monodactylic, essentially reaching the thumb [1]. They rarely cause severe pain, although Delvaux et al reported pain in 40% [2]. Longitudinal erythronychia is the most common presentation of onychopapilloma but it may have different clinical presentations like melanonychia, and leukonychia. [3,4]. Onychopapilloma can also present with splinter hemorrhages without any other lesion. On dermoscopy, the band begins in the lunula with a proximal convex border and contains one or multiple splinter hemorrhages associated with subungual keratotic mass [3]. Onychopapilloma often causes a distal V-shaped onycholysis.

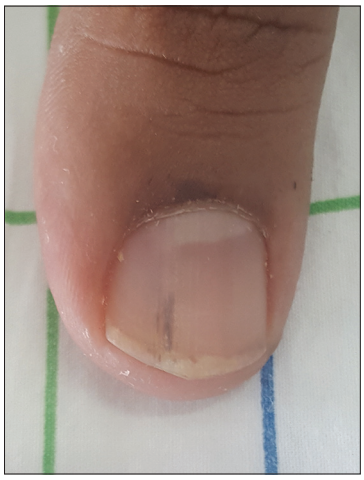

Figure 1: Localised Longitudinal erythronychia.

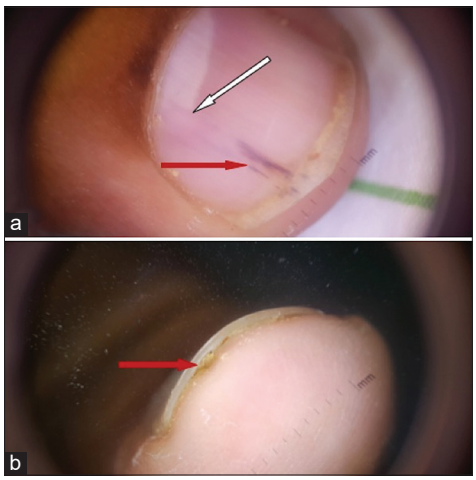

Figure 2: (a) Dermoscopy: red streak (White arrow) with splinter hemorrhages (red arrow). (b) Dermoscopy of the free edge of the nail plate shows a subungual keratotic mass (red arrow).

The main differential diagnoses are: glomus tumor, melanoma, Bowen's disease, squamous cell carcinoma, subungual wart, Darier disease (polydactylous longitudinal erythronychia), lichen planus and splinter hemorrhages which seen after trauma.

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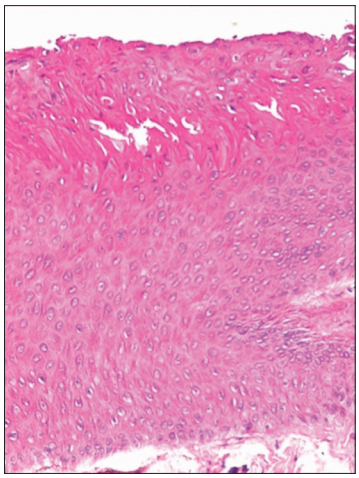

Figure 3: HES coloration (x200), keratogenous zone and Vesicular nuclei with binucleation.

Complete excision should be performed during a nail biopsy for diagnosis and treatment to avoid trauma from two procedures. Histologic findings are characterized by the presence of acanthosis, papillomatosis and metaplasia of the distal matrix and the nail bed with multinucleated cells without cellular atypia [5]. The tumor rarely recurs.

Onychopapilloma is a rare benign tumor of the nail bed and the distal matrix. Management of monodactylous erythronychia should be based on the patient's symptoms or changes in the lesion. Sudden onset or changing erythronychia should be biopsied. Dermoscopy is very important in the differential diagnosis of the nail erythronychia.

Consent

The examination of the patient was conducted according to the Declaration of Helsinki principles.

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