Other conditions should also be considered in the differential diagnosis, including joint tophi, xanthomatous deposits, and paraneoplastic acroacraly.

The histopathological findings of pachydermodactyly include a thickened dermis, with an increase in the number of collagen fibers accompanied by a discreet increase in the number of fibroblasts. There is also a slight increase in the quantity of mucin, with no significant inflammatory infiltrate. The overlying epidermis often shows hyperkeratosis with compact orthokeratosis.

Local infiltration of triamcinolone hexacetonide and resection of the fibrotic subcutaneous tissue can improve the outward appearance. Treatment with topical corticosteroids has not been shown to be effective.

To date, few cases of pachydermodactyly have been reported in the medical literature, probably because its prevalence is underestimated due to its asymptomatic nature and the fact that it does not limit joint mobility. We believe it is necessary to consider other disorders in the differential diagnosis in order to avoid unnecessary additional tests and treatments, as pachydermodactyly is a completely benign disorder and does not require treatment.

References


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Subungual Squamous Cell Carcinoma. Presentation of two Cases

Carcinoma escamoso subungueal. Presentación de dos casos

To the Editor:

Primary malignant subungual tumors are rare, although, of these, squamous cell carcinoma (SCC) is the most frequent. Initial diagnosis is frequently delayed by the relatively nonspecific clinical presentation, easily confused with benign inflammatory conditions such as paronychia, pyogenic granuloma, or a common wart. Diagnosis of this kind of lesion is only possible by pathology study of a biopsy. Treatment requires complete excision of the lesion, often leading in turn, to amputation of the distal phalanx of the affected finger. We describe 2 new cases of difficult-to-diagnose subungual SCC.

The first patient was a man aged 73 years, with a history of hypertensive-ischemic heart disease, who consulted with an excrecent lesion of the nail bed of the first finger of the right hand which had developed over the previous 4 years (Figure 1). The patient reported no possible triggering factors such as repeated injury or viral warts at this site. Surgery was performed twice on the patient, and the pathology diagnosis was digital fibrokeratoma. The patient had responded poorly to treatment with different topical antibiotic and antifungal agents. Examination revealed a suppurating tumoral lesion, adherent to the nail plate of the first finger of the right hand and causing painful onychodystrophy. An ingrown nail with excessive granulation tissue was suspected. A biopsy confirmed the diagnosis of subungual SCC, and the lesion was excised. No bone involvement was evident on an x-ray of the first finger of

Malignant subungual tumors may be primary or metastatic. Metastasis from internal tumors, which is very rare, usually originates from tumors in the lung, genitourinary tract (especially the kidney), or breast. Metastasis indicates a poor prognosis as it is a sign of disseminated disease.1

Subungual SCC, first described by Velpeau in 1850,2 is a tumor with little aggressive potential, and axillary lymph node spread and metastasis are both rare. Bone involvement has been reported in 17% and 66% of cases,3,4 with the difference explained by diagnostic delay.

The condition, which generally affects men aged over 50 years, most typically occurs on the distal phalanx of either of the first two fingers of the hands, but has also been reported on the toes.3-6 The etiology of these tumors is unknown, although repeated injury, chronic infection, ionizing and nonionizing radiation, arsenicals and tar, and, above all, human papillomavirus infection can all be considered as risk factors.6-8 The fact that clinical presentation resembles conditions such as ingrown nails, pyogenic granuloma, warts, and melanonychia frequently leads to incorrect or delayed diagnosis, resulting in inappropriate or delayed treatment.

In recent years, a viral origin has been postulated as the cause of many skin tumors, among them subungual SCC. Type 16 human papillomavirus, which is typical in genital warts, is most associated with subungual SCC; transmission probably occurs from scratching of the genital region.8-10 Other factors are undoubtedly involved in the malignancy, as viral warts on the hands are very common, whereas the development of subungual SCC is rare.

The therapeutic options vary depending on the extent of the tumor. Mohs surgery achieves a satisfactory outcome for noninvasive lesions with no bone involvement. For tumors with bone involvement, the treatment of choice is amputation at the level of the distal or middle phalanx, depending on the extent of the tumor.11-13 Some authors recommend performing sentinel lymph node biopsy to
detect subclinical lymphatic metastasis, as the method carries a low morbidity.\textsuperscript{14}

In conclusion, our most important recommendation regarding the management of a subungual lesion that is progressing unfavorably is to perform a suitable and timely biopsy. The aim is to make an early diagnosis, thereby avoiding, if at all possible, amputation and the associated distress.

References


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