CASE NOTES

ONYCHOMADESIS, KERATOSIS PILARIS-LIKE ERUPTIONS, SYMBLEPHERON AND PSEUDO-CONJUNCTIVAL CYSTS AS LATE SEQUELAE OF PENICILLIN ALLERGY

(A case report)

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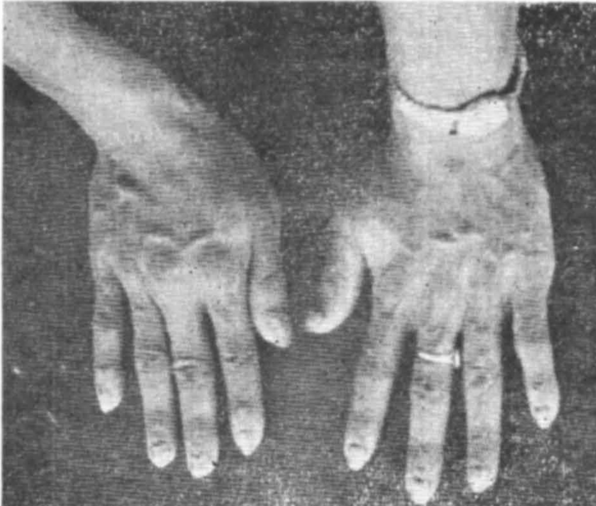
Separation of the nail plate from the nail bed beginning proximally and extending distally is known as onychomadesis. As it is relatively rare a single case of onychomadesis affecting the nails of all the fingers and the big toes, associated with Keratosis pilaris-like eruptions on the body, and symblepheron and pseudo-conjunctival cysts in the eyes occuring as sequelae to a severe exfoliative dermatitis due to penicillin allergy is being reported.

CASE REFORT

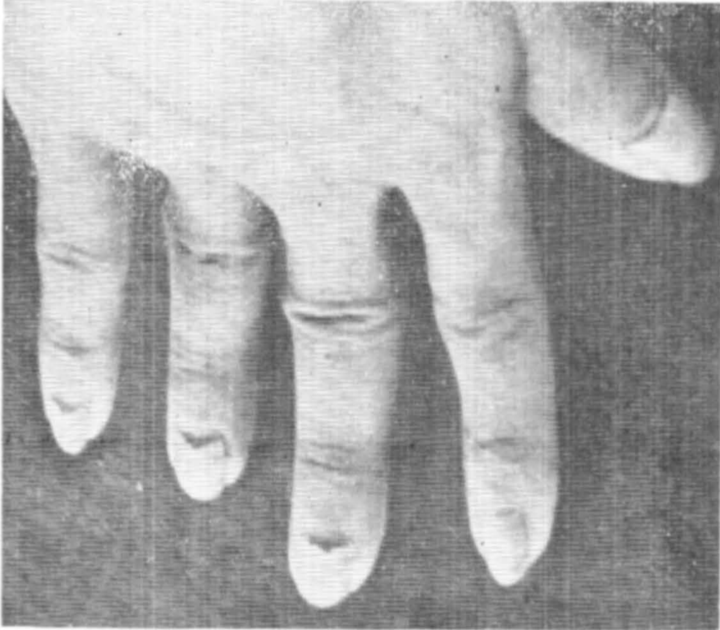
A 26 year old man attended the Kasturba General Hospital on 15-11-1962 with tha following history He had had a severe attack of generalized exfoliative dermatitis 3 months ago following a single injection of crystalline penicillin. He was "cured" of the exfeliative dermatitis after steroid therapy for 1½ months and was still on a maintainance dose of Prednisolone 5 mgm. daily. Since the last one month he was noticing the gradual separation of all the nail plates at their proximal ends, some eruptions on the body, and swelling of both the lewer eye lids.

On examination the patient was of average built. Pulse and temperature were normal. Blood pressure was 120/72 mm. hg. The proximal portions of the nail plates of all the fingers and the big toes were thin, discoloured, greyish, dull and lustreless. They were separating from the nail beds at their proximal ends. (Fig. 1)



Ffg. 1 Proximal Shedding of all the finger nails.

There was no paronychia or subungual accumulation of keratin. The skin over the body was rough with generalized pin-point to pinhead-sized greyish, dyskeratotic, nonpruritic, folliculo-papular eruptions, (Fig 2) On the face he had severely



Same as Fig I Magnified View of Rt. finger nails.

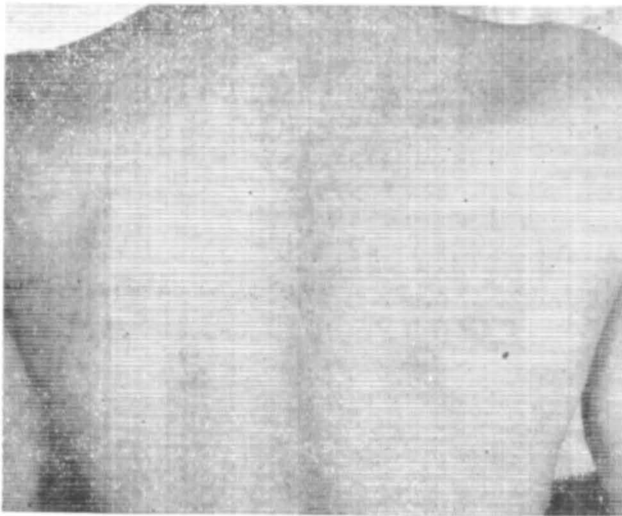


Fig. 2 Folliculo papular eruptiyna.

infected acneform eruptions. On the medial side of the left lower lid there was a swelling measuring about 1.5 x I cm. It was cystic and nontender. The margins

were diffuse. The right lower lid was swollen diffusely. On retracting the lids up and down there were multiple fibrous bands stretching from the lids to the globe which used to become more prominent on movements of the eye in the opposite direction. In the left lower fornix there was a big conjunctival cyst. Many small conjuctival cysts were present in fornices between the fibrous bands of symblepheron. (Fig. 3) Rest of the eyes were normal. Systemic examination did not reveal any abnormality.

Fig. 3 Acne on face Symblepheron and Pseudoconjunctival cysts in both eyes.

Routine blood, stool and urine studies were normal. Blood for V. D. R. L. was negative. A direct microscopic examination of the scrapings from the nail bed mounted in 20% K. O. H. solution showed no fungi. Culture for fungus was not done. An intradermal test with an aqueeus solution of penicillin G. containing 1.00,000 units per c. c. was positive.

Prednisolone was stopped after tailing off the dose in a week. Acne responded well to systemic chloramphenicol (250 mgms. Q. D. S.) for 15 days and topical applications of calamine lotion containing 3% sulphur. The applications of 3% Benzoic acid ointment did not improve the keratosis pilaris-like eruptions.

DISCUSSION

According to Sutton (1956) Onychomadesis is the term applied to the spontaneous and intermittent shedding of the nail plates from the nail beds and it is due to hereditary influence. But Pillsburry et al (1956) and Ormsby and (1954) Montgomery have used the term in a general way for shedding of the nail plates beginning proximally and extending distally due to any cause. It is to be differentiated from onycholysis in which the separation of the nail plate begins distally.

It is known that acute febrile reactions like scarlet fever, pneumonia for chronic systemic diseases like syphilis, diabetes and tuberculosis can lead to inflammatory changes in the nail matrix resulting in cessasion of the keratin production. Shedding of the nails can occur also as sequelae of severe dermatoses like exfoliative dermatitis, radio-dermatitis, and severe paronychia when the matrix is involved. It has also been reported after sudden shock and emotional upsets, and in association with alopecia areata as a psychosomatic expression.

In this patient from the sequence of events there could be no reason to doubt that the exfoliative dermatitis was due to penicillin allergy. The intradermal test with penicillin was positive. The onychomadesis, symblepheron and pseudo-conjunctival cysts, were the sequelae of exfoliative dermatitis. On the body there were folliculo-papular eruptions resembling keratosis pilaris. These and the severe acne-form lesions on the face were also the result of exfoliative dermatitis but the prolonged steroid therapy might have also contributed to some extent for the acne-form eruptions The withdrawal of steroid therapy neither improved nor worsened the keratosis pilaris-like eruptions. The improvement in the acne-form eruptions was to a great extent due to the systemic antibiotics and topical therapy though in part it might be due to withdrawal of steroids. From the history it is evident that even the early administration of steroids in this case of exfoliative dermatitis could not prevent the development of onychomadesis. One should remember that the lesions on the nail plate only indicate a past insult to the nail matrix.

SUMMARY

A case of onychomadesis affecting the nails of all fingers and big toes is reported. The patient also had keratosis pilaris-like eruptions on the body and severe acnei-form eruptions on the face, symblepheren and pseudo-conjunctival cysts in the eyes. All these occured as sequelae of exfoliative dermatitis due to penicillin allergy.

REFERENCES

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