

## PARONYCHIAL INVOLVEMENT IN PEMPHIGUS VULGARIS

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**Summary**

A 16-year-old girl having pemphigus vulgaris developed recurrent episodes of erythema, swelling and vesiculation of the posterior nail folds of fingers and toes, often associated with vesiculo-bullous lesions elsewhere on the skin. Repeated examination of the nail folds for candida was negative. Tzanck smears from the paronychial lesions showed acantholytic cells and a biopsy from the posterior nail fold showed suprabasal split containing acantholytic cells.

KEY WORDS : Pemphigus vulgaris ; Paronychia.

**Introduction**

Pemphigus vulgaris can involve almost any part of the skin and mucous membranes. Involvement of the nail folds due to pemphigus vulgaris has been described in the text books of Dermatology<sup>1,2</sup>, but it is not commonly seen<sup>3</sup>. Several reviews on pemphigus<sup>4,10</sup> also do not mention involvement of the paronychial folds. We are describing a patient in whom relapses of pemphigus were almost always accompanied by paronychial involvement which showed positive Tzanck cell smears and a suprabasal acantholytic split.

**Case Report**

In November 1981, a 16-year-old girl noticed ulcerations in her mouth for which she was given 20 mg prednisolone a day orally. There was some improvement, but within 3 months she developed vesiculo-bullous lesions all

over the body. A Tzanck smear was positive for acantholytic cells and a biopsy from an intact vesicle showed an intra-epidermal split containing acantholytic cells. On February 26, 1982 prednisolone 60 mg daily orally was started but 2 days later, it was decided to treat her with pulse therapy consisting of 100 mg dexamethasone in 5% glucose transfused over an hour for 3 consecutive days. There was a rapid clearance of all the lesions. However on March 3, 1982 she developed pain, erythema and swelling in the posterior nail folds of all the 20 nails of her fingers and toes. These turned into vesicles and during the next 3 days she developed vesiculo-bullous lesions all over the body. Repeated KOH examination from the nail folds for candida was negative. Local treatment with 1% aqueous gentian violet and oral corticosteroids led to regression of all the lesions. The next two relapses of pemphigus, on April 11, 1982 and May 20, 1982 were not accompanied by reactivation of paronychia, but during the next relapse on June 12, 1982, she developed pain, erythema and swelling of the nail folds (Fig 1)

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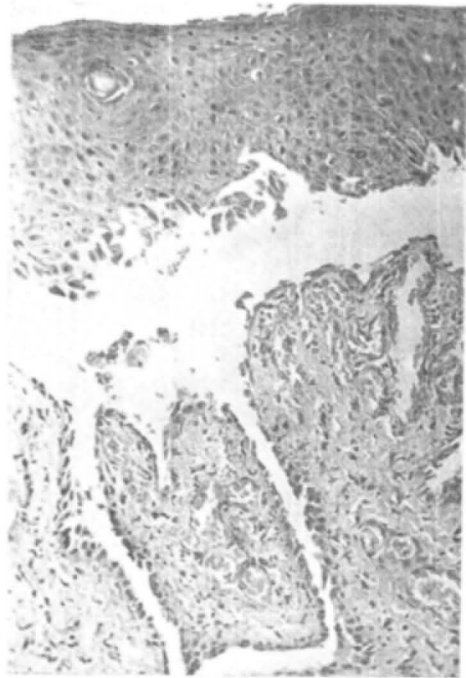


**Fig. 1**  
Paronychia of the fingers showing erythema and swelling.

of her right thumb, index and little fingers as well as of the medial four fingers of the left hand. Scrapings for candida were again negative but a Tzanck smear from the posterior nail fold showed acantholytic cells. Oral corticosteroids and antibacterial agents led to disappearance of the paronychia lesions as also the pemphigus lesions elsewhere. Subsequently, she developed 5 more relapses of pemphigus and all of these were accompanied by involvement of the paronychia folds. A biopsy taken from a lesion on the paronychia fold showed classical features of pemphigus vulgaris including a suprabasal split with several acantholytic cells (Fig 2).

### Discussion

Swelling of the paronychia folds is commonly attributed to infection with *Candida albicans* and pemphigus patients are more prone to candidiasis because of treatment with systemic corticosteroids<sup>11</sup>. In this case, however, repeated association of the paronychia involvement with bullous lesions elsewhere and demonstration of Tzanck cells from the smears along with a classical histopathological picture leave no doubt that the paronychia involvement was due to pemphigus and not candidiasis. Involvement of all the 20 nails in some of the relapses is interesting.



**Fig. 2** Skin biopsy from the paronychia fold showing suprabasal splitting with acantholysis.

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