Subungual Exostosis of a Finger Resembling Pterygium inversum unguis

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Subungual exostoses are the most common benign bony proliferations associated with nail abnormalities. We report a case of subungual exostosis of the finger with atypical clinical appearance resembling a pterygium inversum unguis.

Fig. 1. The lateral portion of the hyponychium is anchored to the under surface of the nail plate.

Fig. 2. An x-ray showing the presence of an exostosis on the dorsal tip of the terminal phalanx.

A 47-year-old woman presented with a 7-month history of a painful lesion on her third right finger. The nail plate surface was normal, but incurvation of the lateral aspect of the nail plate was present.

The distal portion of the nail bed and hyponychium were adherent to the ventral surface of the nail plate (fig. 1). Periungual tissues were unaffected and the other digits of both hands were normal.

The radiographic examination revealed an exophytic lesion on the dorsal, lateral aspect of the distal phalanx tuft, permitting the diagnosis of subungual exostosis (fig. 2). Treatment consisted of nail plate removal, incision of the nail bed and excision of the excess bone. The 1-year follow-up did not reveal any recurrence.

Subungual exostoses are usually seen on the great toe of young females, rarely arising on the other toes or the thumb or index fingers [1,2]. Although they often develop as a firm, tender, periungual or subungual nodule, the clinical presentation of subungual exostosis may vary depending on the size and location of the osteocartilaginous outgrowth. Because of the gradual enlargement of the excess bone, the nail plate may be deformed, elevated or destroyed. Compression of the periungual tissue results in increased periungual skin tension often leading to pyogenic granuloma formation or ingrown toenail. Recently, a case of subungual exostosis arising from the ventral aspect of the distal phalanx has been reported [3].
Lemont and Christman [4] have recently divided subungual exostoses into genetic and acquired types according to location, age and pathological and radiographic findings. Our case, which according to Lemont and Christman [4] can be classified as an acquired subungual exostosis, is unusual because of the clinical appearance suggesting a diagnosis of pterygium inversum unguis. This is a rare nail abnormality characterized by adherence of the distal portion of the nail bed to the ventral surface of the nail plate resulting in subungual extension of the hyponychium and obliteration of the distal groove. Pterygium inversum unguis is usually associated with systemic connective tissue diseases, even though idiopathic forms have occasionally been described [5]. To our knowledge there are no reported cases of pterygium inversum unguis due to subungual exostosis.

Radiographic evaluations are mandatory if subungual exostosis is suspected especially when, as in our case, the characteristic clinical picture is lacking, in order to make a correct diagnosis and to avoid ineffective treatments.

References
Bologna (Italy)
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Bee-Sting Granulomas in the Skin
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The live bee-sting injection, which is one of the folk remedies for severe arthralgia/myalgia and for some chronic eczema, is occasionally being performed in the southern regions of Korea. A 43-year-old woman had multiple nodular lesions on the dorsa of her hands (fig. 1) for a period of 18 months. These mild erythematous nodules or plaque-like lesions of varying sizes were relatively fixed with some tenderness. Foci of milia-like superficial suppurations were also noted. The patient first noted the development of inflammatory swellings at the sites of ‘bee-sting therapy’ (from live honeybees), a treatment for preexisting skin lesions of chronic eczema-like dermatitis on the hands. The acute reactions from bee-sting-induced inflammation lasted for 10 days. Following the acute reaction, gradual worsening of the inflammation persisted resulting in nodular lesions at the site of each multiple sting injection. The change in the
preexisting eczematous skin lesions was not significant. In the following months before her visit, the patient did not receive any treatment for the nodular complications due to folk therapy. There was not much discomfort on her hands and she had no systemic effects relevant to the bee-sting injuries. The physical examination revealed no other positive findings, and her past medical history and family history were noncontributory.

Biopsy specimens were taken from two different sites of the firm nodular lesions and each was bisected for cultures and histologic examination. Infection with mycobacteria or fungi was excluded by smears and cultures. Histopathology showed multiple foci of foreign

Fig. 1. Multiple nodular lesions on the dorsum of the hand (white arrowheads).

Letters to Dermatology
355