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The Nails in Psoriatic Arthritis

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Nail involvement is often present in patients suffering from psoriatic arthritis. Up to the present, no data concerning the rate of onychopathy associated with psoriatic arthropathy have been reported. 52 patients with psoriatic arthropathy have been studied with particular attention to the possible presence of and the typical features of onychopathy. Nail changes were noted in 86.5% of patients affected by arthropathic psoriasis. The commonest toenail alteration was subungual hyperkeratosis, while the most frequent fingernail change was pitting. ***Key words: onychopathy; arthropathy; psoriasis.***

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Nail involvement in psoriasis vulgaris is reported in some 10–55% of patients, while psoriatic arthropathy changes are present in about 85% of cases. The possible relationship between psoriatic arthropathy and onychopathy regarding morphology, localization, and time of occurrence of the ungual alterations is still unknown. In this study we evaluated nail alterations in a group of patients affected by arthropathic psoriasis.

PATIENTS AND METHODS

During the period May 1990–August 1993 we studied 52 patients admitted to our Institute and affected by arthritic psoriasis. All these patients (28 men and 24 women; mean age: 48 years) with a clinical (Ritchie Index), biohumoral and instrumental diagnosis (bone total body scanning; radiography) of arthropathic psoriasis have been studied in order to evaluate the presence of associated onychopathy. All of them also presented skin lesions due to psoriasis (PASI >1). Typology, localization of the lesions and time of occurrence of nail alterations have been evaluated.

RESULTS

Nail changes were noted in 45 out of 52 patients (86.5%) affected by arthropathic psoriasis and were observed in all of the 16 patients affected by severe arthopathy (Ritchie Index: >9). We noted the following lesions: subungual hyperkeratosis (hands: 35%; feet: 61%), pitting (hands: 47%), onycholysis (hands: 35%; feet: 36%), severe nail plate surface abnormalities (hands: 25%; feet: 27%), salmon patches (hands: 22%; feet: 14%) and splinter hemorrhages (hands: 1%).

In 69% of the patients, ungual changes concerned both hands and feet, while in 19% only fingernails were involved and in 12% only toenails. As regards the time of occurrence, onychopathy had occurred prior to arthropathy in 52% of the cases, later in 38% and at the same time in 10%.

DISCUSSION

The Present study has confirmed the high frequency of nail alterations in patients affected by arthropathic psoriasis (86.5%). In agreement with both Baker (83%) and Eastmond (84.8%), this result underlines the difference of these data from the incidence of onycopathy associated with scalp psoriasis which is lower, ranging from 10% to 55% (1–6).

In our cases we observed both matrix and bed onycopathy: the commonest toenail alteration was the subungual hyperkeratosis often associated with distal onycholysis while, according to Baker et al. (1), the most frequent fingernail change was pitting. In the majority of our cases there was an involvement of both hands and feet, while no particular relationship between site of onychopathy and localization of arthopathy has been noted.

The occurrence of alterations has been evaluated anamnestically: in 52% of the cases, patients reported onychopathy prior to arthropathy, in 38% arthritis had occurred prior to onychopathy and in 10% the two features had started simultaneously. We emphasize the correlation between severity of the arthropathy and nail involvement; in fact in all the patients with a Ritchie Index higher than nine, some nail involvement was present. We have not noted any particular relationship between the various features of psoriatic arthritis and onychopathy. Moreover we stress that onychopathy associated with arthropathy could be of use in the diagnosis of psoriasis when cutaneous manifestations are not present.

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