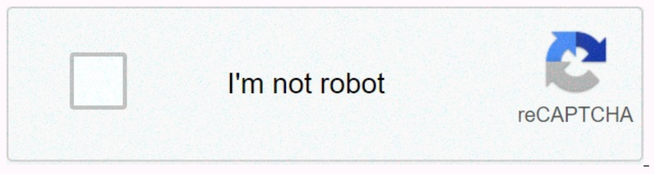


Continue

# Median canaliform dystrophy

Median nail dystrophySpecialtyDermatology Median nail dystrophy (a.k.a. Dystrophia unguis median canaliformis, Median canaliform distrophy of Heller,[1]:657 and Solenonychia) consists of a longitudinal division or the formation of a canal in the middle line of the nails, a decay that often resembles a spruce, proceeds to the skin and extends outwards as the nails grow. [2]:788 Thumbs, which are most often present, usually indicate an increased luper, which is probably caused by repeated pressure applied to the nail base. [1]:657 See also The 1980s. Fitzpatrick dermatology in general medicine. (6th ed.). McGraw-Hill. ISBN 0-07-138076-0. ^ James, William; Berger, Timothy; Elston, Dirk (2005). Andrews Skin Disease: Clinical Dermatology. (10th ed.). Saunders. ISBN 0-7216-2921-0. This condition of the skin additives article is stub. You can help Wikipedia by expanding it.vte Retrieved from Median Canaliform Dystrophy Heller is a rare but morphologically pronounced habit tic deformation of the thumb nails characterized by the middle line of the longitudinal vagus with many transverse parallel lines. The proposed etiopathogenesis is a recurrent trauma of the nail plate and skin, but in some case reports it was claimed that its causative agent is familials and the use of oral retinoids. Treatment is often long and unsatisfactory, although some topical agents have been successfully used. We report a case of a young male patient, when heller dystrophy is a moderate dystrophy affecting both the big thumb and the nails at the same time. Keywords: Median Dystrophy Heller, Habit tic deformity, Nail traumaMedian Canaliform Heller or Onychodystrophia Median Canaliformis dystrophy is a relatively rare, albeit pronounced deformation of the thumb of the thumb, which is characterized by a mid-line longitudinal vaga with several transverse parallel lines.1 Although the proposed etiopathogenesis is a recurrent trauma, pushing the skin and a recessing nail fold, in most cases the cause may be unclear. Some cases suggest a family manifestation and use of oral retinoids in its causal relationship.2 Treatment is often long and unsatisfactory, although topical agents such as 0.1% tacrolimus have been used successfully.3A a 22-year-old young male patient delivered to the dermatology dispensary department with a medium line of depressive deformation of the thumb nails for a long time, which caused him cosmetic concerns. The story of the habit of tic repetitive pushing down the cuticle and proximal nail times with blunt end pencils and pens in two years has been aroused. There has been no history of exposure to chemicals and/or known allergens. He had no history of family nail disorders. After examination, both thumb nails showed secondary longitudinal depression with several transverse ridges aligned with fir pattern [Fig. 1]. Very similar deformities have been observed in both large nails [Fig. 2]. However, the patient refuted a similar habit of tic review history, like pushing down the cuticle and proximal nail folds to greatly toe nails. The remaining nails and fingernails turned out to be normal. Nail clipping and subungual scraping for the fungus were negative in the storage of potassium hydroxide. He was diagnosed with the median Canaliform dystrophy heller and prescribed a topical 0.1% Tacrolimus ointment to be applied under the occlusion overnight daily. Psychiatric outpatient referral was carried out when he was also prescribed oral fluoxetine at a dose of 50 mg per day. It was submitted for a monthly review, but the case was lost to be monitored after the first review. Dystrophy unguis median canaliformis, solenonychina, nevus striatus unguis or median dystrophy of Heller, because it is popular called heterogeneous group of disorders, present morphologically as a middle longitudinal groove with transverse ridges fanning out the appearance of inverted fir and the classic effect on one or both thumb nails.4 Although self-induced nail trauma associated with manipulation of cuticle and proxymal nail fold as part of habit tic was identified as a common cause, as well as family grouping. Certain subungual tumors, such as glomus tumors and myxoid cysts, have also been linked to its causality.4 Another theory suggests that that the nail matrix does not contain the adhesion of keratinocytes to disceratosis, which, due to centrally fragmentation of the nail plate in 2007, has a weaker tensile strength.2 One study also revealed a temporary link with oral isotretinoin treatment, as well as a link to dental diseases and macrolunula.5 In the absence of family history and habit tic , unproven tons of nails, differential diagnosis of the main lichen striates, raynauds disease, cysts and tumors maybe entertain. However, the absence of proximal periungual and/or secondary growth in lithium striatus and Raynauds diease, and the absence of proximal periungual and/or secondary growth, and the fact that this condition was asymptomatic and symmetrical due to the nature of their participation, prevented the possibility of these basic conditions in this case. The management of this rare disorder is complex, since the main pathogenetic mechanisms remain weak. Psychiatric referral is always indicated where there is a habit and/ or obsessive compulsive disorder and usually helps to treat fluoxetine, a serotonin rearbation inhibitor (SSRIs). Topically, agents such as 0.1% tacrolimus and 0.05% Tazarotene ointment after occlusion were described in the literature.4 In our case, oral fluoxetine with topical Tacrolimus ointment was exhibited. The median of heller dystrophy continues to intrigue dermatologists with its pronounced morphology and severe treatment. The novelty of this case lies in the fact that, although tic was presented to explain thumb nail dystrophy, the presence of identical lesions during so large toe nails remains interesting and inexplicable. The author must not declare.1. Tosti A., Piraccini B.M. Nail and nail disorders biology. In: Wolff K., Goldsmith L.A., Katz S.I., Gilchrist B.A., Paller A.S., Leffell D.J., editors. Fitzpatrick dermatology in general medicine. 7th ed. McGraw Hill; New York: 2008. p. 793. [Google Scholar] 2. Avhad G., Ghuge P. Mediana canaliform dystrophy Heller. Indian pediatrician. November 8, 2013 50:1073. [PubMed] [Google Scholar] 3. Kim B.Y., Jin S.P., Won C.H., Cho S. Treatment median canaliform nail dystrophy with topical 0.1% tacrolimus ointment. J Dermatal. June 2010;37:573-574. [PubMed] [Google Scholar] 4. Madke B., Gadkari R., Nayak C. Median canaliform dystrophy Heller. Indian Dermatol Online Sep 2012 September;3:224-225. [PMC Free Article] [PubMed] [Google Scholar] 5. Griego R.D., Orengo I.F., Scher R.K. Median nail dystrophy and habit tic deformity: are they different in the same forms of disorder? Int J Dermatol. November 1995;34:799-800. [PubMed] [Google Scholar] Articles from the Medical Journal of the Armed Forces of India are presented here courtesy of Elsevier CASE REPORT Of the Year : 2020 | Scope: 21 | Question: 1 | Page : 53-55 Median canaliform dystrophy thumb and perfect toe nails 8 year old boy Sonia P Jain, Ajinkya K Sawant, Pratiksha Sonkusale department of Skin and VD, MGIMS, Sewagram, Maharashtra, Date of submission of India26-Aug-2019 Date of adoption21-Sep-2019 Web publication date24-Dec-2019 Correspondence address:Dr. Sonia P JainDepartment of Skin and VD, MGIMS, Sewagram, Maharashtra IndiaSource of Support: NoneCheckDOI: 10.4103/ijpd. IJPD_88_19 Median canaliform dystrophy is a rare nail disorder characterized by the longitudinal getting rid or splitting of the middle line with the formation of a canal on the nail plate of one or both thumbs. This is an acquired condition that mimics habit-tic deformation, which leads to a temporary defect in the nail matrix and cuticle. Treatment is often long-term and unsatisfactory. Some doctors used topical tacrolimus (0.1%) ointment and tazarotene (0.05%) ointment successfully. We report a case of an 8-year-old boy, when heller canaliform dystrophy, affecting both thumbs and big toy nails, is moderate. Keywords: Median nail dystrophy, nail matrix, Pediatric nail disorders How to mention this article:Jain SP, Sawant AK, Sonkusale PA. Median canaliform dystrophy thumb and very toe nails 8 year old boy. Indian J Paediatr Dermatol 2020;21:53-5 How to mention this URL:Jain SP, Sawant AK, Sonkusale PA. Median canaliform dystrophy thumb and very toe nails 8 year old boy. Indian J Paediatr Dermatol [serial online] 2020 [quoted 8 Dec 2020];21:53-5. Available from: Median Canaliform Dystrophy Heller is a rare nail disorder median longitudinal lines or decomposition with the formation of a canal on the nail plate. Heller reported the first case in 1928 [1] The condition is clinically diagnosed. [2] The mean occurrence is 25 years. Although the proposed etiopathogenesis is a recurrent trauma of the cuticle and axibal nail fold, which led to the temporary defect of the nail matrix, in most cases the cause is unknown. [3] Some reports suggest that the use of drugs such as retinoids is family and consequence. [4] This is an idiopathic condition and returns to normal after a few months or years. Habit-tic deformity should be separated from this condition. Self-inflicted nail and nail bed trauma can be associated with depressive, obsessive-compulsive or impulse control disorders. [5] There are only a few cases reported in the Indian literature about the median nail canaliform dystrophy. An 8-year-old school-going boy came into the dermatology outpatient division of midline depression in both miniatures and great toenails over the past 4 years, which has caused cosmetic disfigurement, as complained of by parents. Neither story of chewing thumbnails during stress was there, nor was the child any long-term medication. There has been no history of exposure to chemicals and/or known allergens. The father denied having any nail disorder or mental disorder to other family members in the past. After examining both miniatures, the longitudinal depression of the middle line was found with several transverse rows resulting from the medium split on both sides, reminiscent of the inverted pattern of the fir [Figure 1]. The development of cuticles has been observed. Similar deformation has been observed in both large toenails, more in the right-hand city [Figure 2]. The rest of the nails turned out to be normal. The rest of the skin surface was unrelated, and the systemic study was inconspicuous. The mountain of potassium hydroxide scratches from the nail plate and subungual region was negative for fungal hyphae. According to clinical data, dystrophy of the thumb and toenail nails was diagnosed. Histopathology was not done because it nedi would offer no additional benefits to treatment. The child was started tacrolimus (0.1%) ointment and is currently monitored. Figure 1: Medium longitudinal groove of the fir pattern over both thumb nagaiClick here viewFigure 2: Medium longitudinal groove of leg nailsClick here to viewMedian canaliform dystrophy also known as solenonychia or nevus stustus unguis or dystrophy unguis median canaliformis. [6] It is characterized by a middle line or paralytic, riddled or divided by the formation of a canal, which breaks down towards the edge of the nails, giving the appearance of an inverted herringbone or herringbone. Thickening of the proximal nail fold, increase and redness of the lunul. [2] This condition is usually symmetrical and usually affects the thumbs; although other nails and nails may be included. It idiopathic acquired status, but in 2005 Sweeney et al. reported the emergence of marital cases. [2] This is a temporary matrix defect that interferes with the normal formation of the nails. [7] The exact etiology of this condition is unknown. Intentional trauma, pushing the cuticle and proximal nail fold, was suggested as one of the causes of secondary nail dystrophy. [8] Sometimes subungual skin tumors such as myxoid tumors and glomus tumors can also cause longitudinal grooving and nail plate lift from the nail bed. [9] Secondary tumours, such as glomus tumors and papilloma, form a tube-like structure (solenos) distalia, and the middle nail dystrophy resembles an spruce with branches facing backwards. The absence of adhesion of keratinocytes in the nail matrix with discretatosis is responsible for the central division of the nail plate due to the weak tensile strength. [7] Histopathology shows parakeratosis and melanin accumulation in and between nail bed keratinocytes. Habit-tic deformity, digital mucosal cyst (synovial cyst), lichen striatus, Raynaud's disease and trachyonychia were considered differentials of this condition. The absence of skin lesions elsewhere, the asymptomatic and symmetrical nature of the lesion did not include lichen striatus, Raynaud's disease and other poungual tumors as the main causes of this nail dystrophy. Managing the median of nail dystrophy is difficult many times, since no therapy is at odds with success. The opinion of the psychiatrist should be used in patients with stressful diseases, such as depression, obsessive-compulsive or impulse control disorders, to avoid further nail damage. Injecting triamcinolone acetonide at the site is one of the children, but it is very painful and also has some negative effects. Recent use of terin tacrolimus (0.1%) the literature has been informed of the ointment. [7].[10] It is effective due to the effect of the inflammatory component of this condition. Current tazorotene (0.05%) ointment, which normalizes the keratinization process, was also used with variable success. [10] There are only a few published reports in indian literature about the median of Heller's dystrophy. We report this case because until now, the Indian literature has not reported a paediatric case involving both finger and toenails with moderate tubular dystrophy. This rare nail disorder is diagnosed clinically. Scientific reporting of new cases not only complements our knowledge of nail disorders, but also helps in advising patients and their worried parents or carers. Declaration of consent of the patient The authors confirm that they have received all appropriate forms of consent of the patient. In the form, the patient consented to his images and other clinical information in the journal. The patient understands that the name and initials will not be published and that the necessary efforts will be made to conceal the identity, cannot be guaranteed. Financial support and sponsorshipNil.Conflicts of interestThere are no conflicts of interest. 1.Beck M, Wilkinson S. Nail disorders: Median canaliform dystrophy. In: Burns T, Breathnach S, Cox N, Griffiths C, editors. Rook's Textbook Dermatology. 7.ed. Oxford: Blackwell Science; 54-5, 2004. 2.Sweeney SA, Cohen PR, Schulze KE, Nelson BR. Familial median canaliform nail dystrophy. Cutis 2005;75:161-5. 3.Pathania V. Median canaliform dystrophy Heller takes place in the thumb and very toe nails. Med J Armed Forces India 2016;72:178-9. 4.Dharmagunawardena B, Charles-Holmes R. Median canaliform dystrophy after isotretinoin therapy. Br J Dermatol 1997;137:658-9. 5.Kota R, Pilani A, Nair PA. Median nail dystrophy, covering the nail of the thumb. India's J Dermatol 2016;61:120. [PUBMED] [Full text] 6.Wu CY, Chen GS, Lin HL. Median canaliform dystrophy Heller with associated bedbug neck deformity. J Eur Acad Dermatol Venereol 2009;23:1102-3. 7.Kim BY, Jin SP, Won CH, Cho S. Treatment median canaliform nail dystrophy with topical 0.1% tacrolimus ointment. J Dermatol 2010;37:573-4. 8.Griego RD, Orengo IF, Scher RK. Median nail dystrophy and habit tic deformity: Are they different forms of the same disorder? Int J Dermatol 1995;34:799-800. 9.Avhad G, Ghuge P. Median canaliform dystrophy Heller. Pediatrician of India 2013;50:1073. 10.Madke B, Gadkari R, Nayak C. Median canaliform dystrophy Heller. Indian Dermatol Online J 2012;3:224-5. [PUBMED] [Full text] [Figure 1], [Figure 2] 2]