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A comparative study of dermoscopic features and monitoring of congenital and acquired nevi of the nail apparatus in pediatric patients

To the Editor: A conservative approach for melanonychia in children is generally recommended because the vast majority are benign; however, the occasional presence of melanoma-like features in pediatric nevus of the nail apparatus (NNA) can complicate management.[1] In addition, few data have been reported previously.[2]

We describe and compare clinical and dermoscopic features of congenital and acquired NNA in 32 Colombian children who presented with melanonychia between 2008 and 2018. Inclusion criteria were age <15 years and a clinical and dermoscopic diagnosis of congenital or acquired NNA. Congenital NNA (including late onset) was defined as brown melanonychia appearing before 3 years of age.

Clinical and dermoscopic features of pediatric NNA are presented in Table I. Compared with acquired NNA (n = 13), congenital NNA (n = 19) were found to be wider (mean, 4.6 ± 2.9 mm vs 2.5 ± 1.6 mm; $P = .025$) and more likely to have irregular bands (47.4% vs 7.7%; $P = .020$) and a pseudo-Hutchinson sign (84.2% vs 46.2%; $P = 29$). Periungual pigmentation (Hutchinson sign) was found only in congenital NNA (31.6% vs 0%; $P = .030$), whereas a triangular sign (wider pigmentation proximally) was observed in 21.9% of all cases, without a significant difference between groups.

The Cohen κ showed moderate to good agreement between 2 observers (F.P. and C.M.) for most dermoscopic variables. In the 16 patients monitored over time, with mean follow-up of 13.2 ± 22.2 months, increased width and new structures with dynamic changes were observed (Fig 1). Biopsy specimens in 2 patients confirmed the diagnosis of melanocytic nevus of the nail matrix.

Previous reports have shown a benign dermoscopic acral pattern for periungual pigmentation in congenital melanonychia.[2,3] In other studies, Hutchinson sign and other melanoma-like features were observed in pediatric NNA.[1,4]

Although this is a retrospective analysis with a small sample size and only 2 cases confirmed by pathology, we have found significant differences between congenital and acquired NNA in children, with substantial changes during follow-up. As dynamic changes in melanocytic nevi at other anatomic sites are often observed during childhood,[5] evolution of pediatric NNA over time is not surprising.

In conclusion, congenital NNA is more likely than acquired NNA to present with melanoma-like dermoscopic features in pediatric patients. The diagnostic approach should include a thorough clinical history and careful examination including dermoscopy. Follow-up with digital dermoscopy can help to avoid unnecessary biopsies that may lead to emotional distress and nail dystrophy. A biopsy should be performed in uncertain cases with concerning features and evolution. However, specific criteria for pediatric melanoma of the nail apparatus have not been defined. More research is needed to identify signs of high-risk lesions and the significance of changes seen in follow-up.

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Table I. Comparison of clinical and dermoscopic features of melanonychia due to congenital and acquired nevi of the nail apparatus

Variables*	Congenital nevi	Acquired nevi	Total	*P* value†
Patients	19 (59.4)	13 (40.6)	32 (100)	
Clinical features				
Age of onset, y‡	1.4 ± 1.2	7.3 ± 3.8	3.8 ± 3.9	<.001§
Sex				
Female	12 (63.2)	7 (53.8)	19 (59.4)	.435
Male	7 (36.8)	6 (46.2)	13 (40.6)	
Location				
Hand	15 (78.9)	9 (69.2)	24 (75)	.413
Foot	4 (21.1)	4 (30.8)	8 (25)	
Digit				
1	9 (47.4)	8 (61.5)	17 (53.1)	.667
2	5 (26.3)	4 (30.8)	9 (28.1)	
3	3 (15.8)	0	3 (9.4)	
4	1 (5.3)	1 (7.7)	2 (6.3)	
5	1 (5.3)	0	1 (3.1)	
Fitzpatrick phototype				
II	3 (15.8)	1 (7.7)	4 (12.5)	.89
III	9 (47.4)	7 (53.8)	16 (50)	
IV	8 (36.8)	5 (38.5)	12 (37.5)	
Band width of the melanonychia, mm‡	4.6 ± 2.9	2.5 ± 1.6	3.7 ± 2.6	.025§
Dermoscopic features				
Dominant color of bands				
Light brown	8 (42.1)	6 (46.2)	14 (43.8)	.271
Dark brown	11 (57.9)	5 (38.5)	16 (50)	
Black	0	2 (15.4)	2 (6.3)	
Triangular sign				
No	15 (78.9)	10 (76.9)	25 (78.1)	.611
Yes	4 (21.1)	3 (23.1)	7 (21.9)	
Number of colors present				
1	4 (21.1)	7 (53.8)	11 (34.4)	.189
2	12 (63.2)	5 (38.5)	17 (53.1)	
3	3 (15.8)	1 (7.7)	4 (12.5)	
Pattern of bands				
Irregular	9 (47.4)	1 (7.7)	10 (31.3)	.02
Regular	10 (52.6)	12 (92.3)	22 (68.8)	
Dark dots and globules				
No	17 (89.5)	11 (84.6)	28 (87.5)	.542
Yes	2 (10.5)	2 (15.4)	4 (12.5)	
Periungual pigmentation				
No	13 (68.4)	13 (100)	26 (81.3)	.03
Yes	6 (31.6)	0	6 (18.8)	
Pseudo-Hutchinson's sign				
No	3 (15.8)	7 (53.8)	10 (31.3)	.029
Yes	16 (84.2)	6 (46.2)	22 (68.8)	
Periungual pigmentation‡				
Fibrillar	4 (66.7)	0	4 (66.7)	.146
Peas in a pod	1 (16.7)	0	1 (16.7)	
Undetermined	1 (16.7)	0	1 (16.7)	

*Values are expressed as the number (%) for categorical data and as the mean ± SD for continuous data.
†Fisher exact test.
‡Applicable to 6 patients with periungual pigmentation.
§Analysis of variance test.

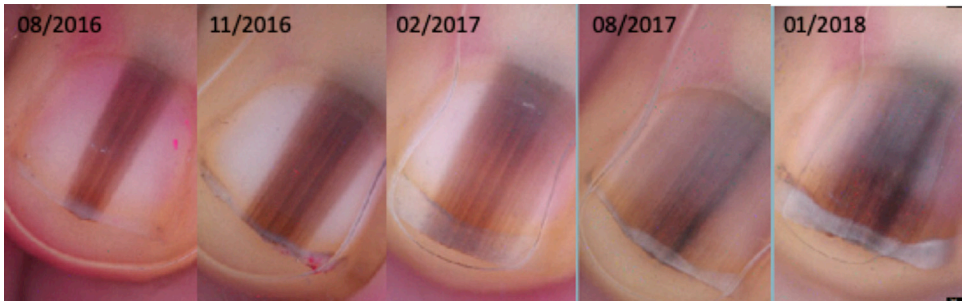

Fig 1. Congenital nevus of the nail apparatus showing broadening of the band of melanonychia, new bands appearing, and new colors. A biopsy confirmed the diagnosis of melanocytic nevus of the nail matrix.

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Treatment discontinuation and rate of disease transmission in psoriasis patients receiving biologic therapy during the COVID-19 pandemic: A Canadian multicenter retrospective study

To the Editor: Limited data are available to guide use of biologics for moderate to severe plaque psoriasis in the current coronavirus disease 2019 (COVID-19) health care landscape.[1,2] We aimed to further understand the rate of patient-driven biologic discontinuation in moderate to severe psoriasis because of concerns regarding COVID-19 complications. Furthermore, our goal was to add to the limited but increasing body of literature on whether biologic use should be considered a risk factor for greater susceptibility to COVID-19.

After research ethics approval, a multicenter retrospective study was undertaken of all patients from 2 tertiary academic hospitals affiliated with the University of Toronto, Canada, and a community practice in Hamilton, Canada. Inclusion criteria were patients aged 18 years or older with moderate to severe psoriasis who received at least 1 dose of a biologic before February 1, 2020. Data were retrospectively obtained from Patient Support Program case managers of all major suppliers of biologic agents for psoriasis. February 1, 2020, was the starting point of data collection (5 documented COVID-19 cases and 0 deaths in Canada) and patients were followed up until June 1, 2020 (91,703 cumulative cases and 7594 deaths).[3]

As of February 1, 2020, there were 2095 patients receiving biologic therapy for psoriasis who met inclusion criteria. Total number of patients who temporarily discontinued their biologic at any point during the 4-month period because of COVID-19–related concerns was 23 (1.1%) (Table I). Of the 23 patients who temporarily discontinued their biologic, 7 did so in February, 11 in March, 3 in April, and 2 in May. This corresponded to a total of 17 (0.81%), 18 (0.86%), and 18 (0.86%) patients discontinuing treatment at each of April 1, May 1, and June 1, 2020 timepoints, respectively. Biologic discontinuation by class included tumor necrosis factor α inhibitors (8/749, 1.07%), interleukin 12 and 23 inhibitors (5/371, 1.35%), interleukin 17 inhibitors (4/482, 0.83%), and interleukin 23 inhibitors (6/493, 1.22%) (Table II). Mean duration of biologic treatment before discontinuation was 50.6 ± 35.7 months. Five patients who temporarily discontinued their biologic elected to restart the same biologic before June 1 compared with 18 who remained without treatment. All patients who restarted their biologic (5/5, 100%) did so because of a flare of their psoriasis. Of the 23 patients who temporarily discontinued treatment, 14 (60.9%) were men, mean age was 56.4 ± 12.6 years, and 1 (4.3%) also had psoriatic arthritis. Of the 2095 patients in our cohort (2072 [98.9%] of whom continued to receive a biologic throughout the entire follow-up period), 0 had a confirmed positive diagnosis of COVID-19.