CHRONIC PARONYCHIA

What are the aims of this leaflet?

This leaflet has been written to help you understand more about chronic paronychia. It will tell you what it is, what causes it, what can be done about it, and where you can find out more about it.

What is chronic paronychia?

Paronychia is a common infection of the skin around the finger or toenails (the nail folds). There are two types - 'acute paronychia' develops quickly and lasts for a short period of time; and 'chronic paronychia' develops slowly, lasting for several weeks and often comes back. Chronic paronychia is not caught from someone else.

What causes chronic paronychia?

Acute Paronychia is often caused by the Staphylococcus aureus bacteria, although any number of germs such as candida (yeast) or the cold sore virus (herpes simplex) can be involved. Acute Paronychia usually starts after a minor injury to the nail fold, such as from nail biting, picking or manicures. The affected area is red, warm, tender and swollen. After a while pus may be seen, which can form around the nail and may lift the nail.

Chronic paronychia is caused by a mixture of yeasts (candida, herpes simplex and bacteria Staphylococcus aureus). It is most common in people who often have their hands in water, detergents or chemicals, have poor circulation (cold hands and feet) or diabetes.

Women get chronic paronychia more often than men.

Is chronic paronychia hereditary?

No.

What are the symptoms of chronic paronychia?

- the skin may be red and shiny around the nail
- tenderness of the skin around the nail
- swelling at the base or sides of one or more nails
- pus-filled blisters, white, yellow or even greenish
- changes in nail shape, colour, or texture (ridges). This can be apparent for many months after the paronychia has cleared as the nail slowly grows out.
- detachment of the nail

How is chronic paronychia diagnosed?

The red swollen nail folds of chronic paronychia give it a characteristic look so your doctor will be able to make the diagnosis without laboratory tests. It should not be confused with ringworm (tinea) infection, which causes whitish thickening of the nail and nailbed, nail thickening and discolouration. Other conditions such as psoriasis and lichen planus can also affect the nails and cause ridging and discolouration.

Your doctor may check your urine for sugar to make sure you are not diabetic and also take a swab from the infected nail fold to be tested in the laboratory, which will often grow a mixture of bacteria and yeasts, rather than just a single type.

Acute and chronic paronychia are largely distinguished from each other by the speed of onset and the duration of the infection.

Can chronic paronychia be cured?

Yes - but remember that just as it starts slowly, it also clears slowly.

How can chronic paronychia be treated?

- Usually an antibacterial and/or antifungal cream or lotion improves the condition within a few weeks. In addition, a steroid cream may be prescribed to speed up improvement.
- If creams or lotions are not successful antibiotic or antifungal tablets by mouth may be needed.

- Surgery is not usually needed, but sometimes a doctor may make a small cut and drain the area to help clear the condition if medication treatment fails.
- Avoid frequent hand-wetting, manicures and irritating substances.
- Underlying conditions such as diabetes and poor circulation must also be treated to help improve paronychia.

Self care (What can I do?)

- You should keep your hands as warm and dry as possible; you will not get better until you do this.
- Wear gloves for any tasks using water, irritants and chemicals, including shampooing and washing up.
- Avoid biting your nails, manicuring your nail folds, and pushing back the cuticles.
- Do not use nail varnish until the condition has been treated.
- Occasionally a change of occupation may be worth thinking about.
- Do not apply false nails until the condition is resolved.

Where can I get more information?

Web links to detailed leaflets:

http://www.dermnetnz.org/fungal/paronychia.html

For details of source materials used please contact the Clinical Standards Unit (clinicalstandards@bad.org.uk).

This leaflet aims to provide accurate information about the subject and is a consensus of the views held by representatives of the British Association of Dermatologists: individual patient circumstances may differ, which might alter both the advice and course of therapy given to you by your doctor.

This leaflet has been assessed for readability by the British Association of Dermatologists' Patient Information Lay Review Panel

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