



BRIEF REPORT

A Case of Nail Psoriasis Improved by Treatment with Golimumab in a Psoriatic Arthritis Patient

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Dear Editor:

Nail involvement in psoriasis could cause psychosocial and functional impairment to patients¹. However, the management of nail psoriasis is challenging and numerous systemic therapies and biologics are used to treat it². Herein, I report a case of nail psoriasis that improved when treated with golimumab.

A 51-year-old male patient presented with nail dystrophy, and pain in his fingers and right great toe. He had been treated with systemic antifungal agents for one year at local clinic; however, the nail dystrophy continued to worsen. On physical examination, swelling and tenderness was checked on the distal interphalangeal (DIP) joints

of his right second, fourth fingers, left thumb, and right great toe. Oil spots and nail plate crumbling were observed on the affected finger and toe nails (Fig. 1A). There were erythematous scaly plaques on the buttock and the results of skin biopsy of the buttock were compatible with psoriasis. Rheumatoid factor and C-reactive protein levels were within normal ranges. The result of KOH exam was negative and no fungal growth was observed on fungal culture. Radiographic findings showed periarticular soft tissue swelling of the DIP joints of the right second and fourth fingers, left thumb, and right great toe; although no significant bony abnormalities were observed. The Classification Criteria for Psoriatic Arthritis score was 5

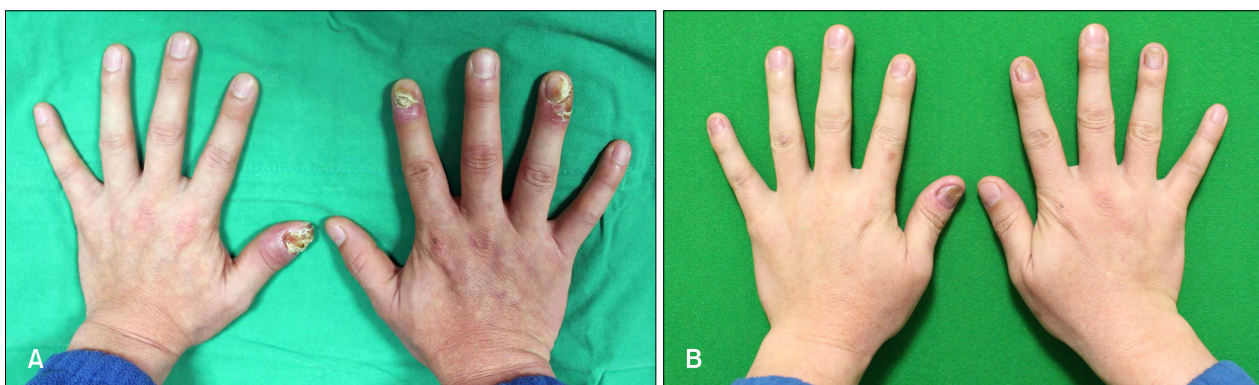


Fig. 1. (A) Erythematous patch, swelling of distal interphalangeal joints with oil spots and nail plate crumbling on the right second and fourth fingers, and left thumb. (B) Improvement with respect to nail psoriasis after treatment with golimumab for 24 months.

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points based on these findings and he was diagnosed with psoriatic arthritis with nail psoriasis. Treatment with topical betamethasone dipropionate/calcipotriol gel, 7.5 mg methotrexate per week, 500 mg sulfasalazine per day, and occasional non-steroidal anti-inflammatory drugs was initiated. After six months with the conventional treatment, there was considerable improvement of the buttock skin lesion and periarticular swelling. However, joint pain was ongoing and newly developed oil spots and onycholysis were observed on the left second and fifth fingers. I decided to change the treatment plan and administered 50 mg golimumab per month. After the third injection, there was no further pain or tenderness of the joints. The patient's nails gradually improved and no new lesions were observed for 24 months (Fig. 1B). No significant adverse events were observed during treatment.

Psoriasis is a chronic inflammatory disease that predominantly affects the skin, joints, and nails. Nail involvement in psoriatic patients is estimated to be between 80% and 90% and is more common in patients with psoriatic arthritis³. Nail psoriasis is not simply a cosmetic problem and may influence nail function; therefore, quality of life is poorer in psoriatic patients with nail involvement¹. Thus, the management of nail psoriasis is important for patients and unfortunately, the effects of conventional therapies are limited. Previous studies have shown that biologics such as ustekinumab, infliximab, and adalimumab have significant effects on nail psoriasis⁴. Furthermore, golimumab was shown to significantly improve nail psoriasis in a recent clinical trial⁵. Golimumab, a new human monoclonal antibody against TNF- α , is effective in treating psoriatic arthritis when injected subcutaneously every four weeks⁵. In this case, the patient experienced ongoing joint

pain despite conventional treatment and golimumab was administered to reduce the psoriatic arthritis-associated symptoms. After administration of golimumab, joint pain improved and impaired nails were much better than expected. In light of my experience, golimumab could play a critical role for the treatment of nail psoriasis in psoriatic arthritis patients.

CONFLICTS OF INTEREST

The author has nothing to disclose.

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