Diagnosis/symptom: **ONYCHOMYCOSIS**

Referring provider’s initial evaluation and management should include:

“Onychomycosis” refers to fungal infection of the nail(s).

Features suggestive of onychomycosis include:

- Nails that are thickened, brittle, discolored, separating from the nail bed, and/or have subungual debris
- Adjacent skin involvement suspicious for fungal infection (erythematous, scaly, pruritic)

**NOTE:**
Children with onychomycosis frequently have a first-degree relative or other household member with onychomycosis and/or tinea pedis.

Ideally, all close contacts with active skin and/or nail infection should be treated by a physician to avoid re-infection.

Recurrence is common and treatment does not always guarantee a permanent cure.

Additional measures that may be helpful:
- Keep feet clean and dry
- Replace shoes if feasible
  - If not possible, replace insoles

**Steps to take:**

- Confirm presence of fungal infection
  - Send adequate clipping of involved nail for fungal stain (PAS) and/or fungal culture
  - Specimens for stain to go to pathology
  - Specimen for culture to go to microbiology

(*CONFIRMATION of diagnosis is important since not all nail dystrophy is fungal in origin! Hints: If all nails are abnormal or dystrophy is bilaterally symmetric, consider another etiology.*)
Texas Children’s Hospital
Dermatology Service
PCP Referral Guidelines - ONYCHOMYCOSIS (continued)

Treatment:

If involvement is superficial only and/or does not involve the lunula, may try topical therapy with Ciclopirox nail lacquer solution 8%.
  • Apply to affected area nightly until nail clears
  • Residue may be removed from nail once weekly with alcohol (not required)
If lunula/matrix involved and fungal stain and/or culture are positive for dermatophyte, systemic therapy will be required to clear infection.
  • Griseofulvin is not preferred
    o Low cure rates
    o High relapse rates
  • Terbinafine (Lamisil) preferred (comes as 250 mg tab)
    o If no contraindications (e.g., history of significant liver disease or potential drug interaction)

AND

  o If baseline CBC and LFT’s WNL:
    ▪ <20 kg = 62.5 mg/day
    ▪ 20-40 kg = 125 mg/day
    ▪ >40 kg = 250 mg/day

Repeat CBC and LFT’s after 4 weeks on therapy prior to continuing course if treating for more than 6 weeks.

  o Fingernails
    ▪ 6 week course
  o Toenails
    ▪ 12 week course

Ideally, send two nail clippings for testing:
  • One to pathology lab for fungal stain (usually PAS)
    - results available within days
  • One to micro lab for culture
    - results generally within 4 weeks

❖ LABORATORY CONFIRMATION of fungal infection is frequently required by insurance to cover cost of medication and any recommended laboratory testing during treatment.

Educational recommendations are made from the best evidence, expert opinions and consideration for the patients and families cared for by the service. This is NOT intended to impose standards of care preventing selective variation in practice that are necessary to meet the unique needs of individual patients. The physician must consider each patient’s circumstance to make the ultimate judgment regarding best care.