dyscrasia by a similar mechanism.[2] To the best of our knowledge, our report represents the second case in the literature of isolated thrombocytopenia associated with oral terbinafine. It was estimated that the frequency of blood dyscrasias with terbinafine is 32 per million patient-years.[4] Furthermore, the frequency of thrombocytopenia may be of the order of 1 in 200 000 patients using terbinafine.[4] We would therefore stress the importance for clinicians to be aware of this possible side-effect.

*Department of Dermatology, Taipei Medical University Hospital, Taipei, Taiwan
†Institute of Medical Sciences, Taipei Medical University, Taipei, Taiwan
‡Department of Dermatology, Taipei Municipal Wan-Fang Hospital, managed by Taipei Medical University, Taipei, Taiwan
Correspondence: Woan-Ruoh Lee
E-mail: wrlee@tmu.edu.tw

H-H. TSAI*
W-R. LEE*†
C-H. HU‡

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Basal cell carcinoma arising in professional radiodermatitis of the nail

SIR, Chronic professional radiodermatitis affects health professionals inadequately protected against radiation. It predominantly manifests on the backs of the hands and fingers of specialists in traumatology, paediatrics, the digestive or respiratory system, general surgery or dentistry who use radiation throughout their professional life without taking the necessary radioprotective measures.[1] The disease has a long and insidious evolution, with clinical manifestations that include xerosis, loss of hair, atrophy of sebaceous and sweat glands, pigmentation disorders (speckled hypo- and hyperpigmentation), telangiectasia, ungual dystrophy, keratomas and, subsequently, persistent ulcers and carcinomas. These symptoms commonly appear 40–50 years after the patient starts to work with radiation. Squamous cell carcinoma (SCC) is the most frequent neoplasm related to professional radioexposure. Basal cell carcinomas (BCCs) have been reported in areas of the body that were previously irradiated for diagnostic or therapeutic purposes.[2]

BCC is the commonest skin cancer, although it is the rarest primary tumour of the nail unit.[3] The few cases of BCC reported in the nail predominantly affected males and individuals over 50 years old. The thumb is the most affected of the digits, with the predisposing factors including chronic trauma and, above all, the greater exposure of the thumb to the sun, due to the anatomical configuration of the hand.[4]

A 63-year-old male physician, neither a smoker nor a drinker and with no relevant personal or family history, worked as a respiratory specialist for 30 years in the early diagnosis and prevention of chest diseases, involving the use of radioscopy for at least 4 h daily. He presented with an ulcerated lesion in the proximal nailfold of the middle finger of the right hand, which extended to the nail bed (Fig. 1a). Examination showed a painless ulceration with well-defined edges and a necrotic base, which was hard to palpation and measured approximately 1·5 × 0·5 cm. The nail had lost its characteristic shine and was brownish-grey, with longitudinal grooves and onycholysis of the lateral edge. The skin of the back of the finger was smooth, hairless and atrophic, with multiple telangiectases on the surface and areas of hypopigmentation. The remaining fingers showed only partial hair loss on the back of the phalanx, and xerosis.

His family physician diagnosed a mycosis and started topical and systemic treatment with antifungals, with no response. Biopsy of the lesion showed a BCC (Fig. 1b). We proposed removal of the tumour, including the entire nail unit, using Mohs' surgery and repairing the defect with a skin flap from the adjacent finger. The patient refused this option and stated a preference for amputation of the distal phalanx, which was then carried out.

BCC is the commonest skin cancer, mostly related to chronic solar exposure but also associated with chronic trauma, scars, burns, chronic ulcers and the intake of arsenic. The role played by ionizing radiation in the onset of BCC has been reported in BCCs of the scalp that appear many years after radiotherapy for the treatment of tinea capitis.[5]

Chronic exposure to radiation can have irreversible effects, with persistent skin atrophy, sclerosis of the radiated area, secondary loss of adjacent skin, pigmentation disorders, telangiectasia and elastosis. There is also a greater tendency to ulceration, trauma and infection, alongside an increase in susceptibility of the irradiated tissue to malignant transformation and degeneration.[6] In approximately 20% of cases, SCCs and BCCs appear at, respectively, 7–12 years and up to 40–50 years after irradiation.

Although professional radiodermatitis has become uncommon, thanks to the use of protective measures, the introduction of novel surgical procedures based on fluoroscopy, especially the angioplasty of coronary arteries, is now causing an increased incidence of this disease.[7]

When these lesions appear in professionally exposed individuals, it is mandatory to insist on the adoption of

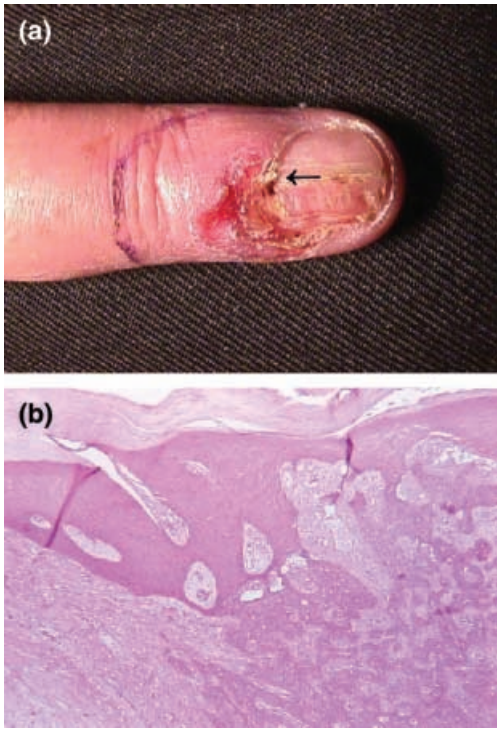

Figure 1. (a) Basal cell carcinoma (BCC) of the nail unit. Arrow indicates the localization of the BCC. (b) Photomicrograph showing BCC infiltrating the dermis (haematoxylin and eosin).

radiological protection measures and to perform a biopsy on any ulcerated finger ulcer that is refractory to medical treatment. Although SCC and acral lentiginous melanoma are the most frequent tumours of the nail unit, the possibility of a BCC must be considered. The most effective approach to BCC is surgical treatment using Mohs' surgery with secondary intention healing or closure of the defect with a skin flap.[8] The radical amputation that used to be applied in these cases offers no advantages.

Departments of Dermatology and †Pathology, University Hospital San Cecilio, Granada, Spain S.SERRANO-ORTEGA I.FERNÁNDEZ-ANGEL E.DULANTO-CAMPOS
**Department of Oral Medicine, School of Dentistry, University of Granada, Spain* A.RODRÍGUEZ-ARCHILLA* J.LINARES-SOLANO†
E-mail: alberodr@ugr.es
Correspondence: Isabel Fernández-Angel, C/Torre del Capitan 12, 'Edif. Gala' Portal 1 2°A, E-18008 Granada, Spain.

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Book Reviews

Diseases of the Nails and their Management, 3rd Edition (2001). Edited by R.BARAN, R.P.R.DAWBER, D.A.R.DE BERKER, E.HANEKE and A.TOSTI. Oxford: Blackwell Science Ltd. ISBN: 0632053585, 656 pp. Price: £125.

This is the third edition of the 'Nail Bible'. As the editors record, the book has grown steadily since the 1st edition published by Baran and Dawber as long ago as 1984; indeed this book is, according to the preface 50% larger than the original. It is now co-edited by de Berker, Haneke and Tosti, and there are additional contributions from new authors Zook, Drapé and Richet, which have focused largely around tumours, surgery of the nail and physical signs. The core of the work remains the same, however, with chapters covering the basic science of the nail, a description of signs, developmental aspects, and the nail in a variety of disease states and their management.

Most dermatologists will be familiar with the presentation of the work: short, incisive sections grouped together under broad headings, each with its own reference list. This 'Rook-like' style makes it extremely easy to pick up, find what you want and assimilate the information quickly and effectively. The reader will be unlucky not to find what he or she wants in this book and the referencing is comprehensive and clear, and the index works well. Equally, for those with more time to browse, there is a wealth of fact and experience here. It is very tempting just to read on and learn about all sorts of conditions and disorders that may present with nail changes.

Another huge strength of this, as of previous editions, is the quality of the photographs. I do not think I exaggerate if I express the view that this must be a candidate for the best-illustrated dermatological book ever published.