Yellow Nail Syndrome with Bilateral Bronchiectasis

A J Zerfas MB (for H J Wallace MD FRCP)
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Miss M M, aged 51

When she was 10 years old, this patient developed a right empyema, shortly followed by attacks of erysipelas on the left leg and face. These attacks occurred yearly until she was 20. There was no further trouble until she was 46, when cellulitis involved in turn her face, legs, left arm and sacral region. In the past two years she has had four further episodes in the left leg and more recently the face. We have started continuous antibiotic therapy.

Since the age of about 10, she has noticed her finger-nails to be yellow and shiny and to require filing only every few months. The left leg was first swollen also at about this age; the other areas were affected many years later. There was no family history of any similar condition. She has had a chronic intermittent winter cough with sputum, but the timing of the chest infections was not related to the cellulitis.

There is now lymphœdema involving the legs, arms and sacral region. The face is slightly affected. All the finger-nails are yellow, curved and shiny. Some show onycholysis. There are bilateral basal rales and rhonchi. Because of her bronchiectasis, lymphangiography under a general anæsthetic has not been done.

Chest X-ray shows tubular shadows and crowding of the basal lung markings. Hæmoglobin, white cell count and serum proteins are normal.

Comment

The lymphœdema is widespread. The finger-nails show the typical dystrophy, while the toe-nails are fairly normal in spite of obvious leg lymphœdema. The onset of the yellow finger-nails and the leg lymphœdema appeared to coincide; the arm swelling presented years later. The recurrent cellulitis may have been an important factor in unmasking her lymphœdema, although Kinmonth (1965) has stated that in cases with cellulitis, some swelling is usually present before any attack occurs.

The precise relationship of these nails with lymphœdema remains to be settled. That there is some association is suggested by Samman & White (1964).

Hurwitz & Pinals (1964) reported two siblings with œdema of the legs since birth. They presented with bilateral pleural effusions when adults. By this time, œdema had reached the abdominal wall. One patient required pulmonary decortication but there was no mention of the pathology.

REFERENCES
Hurwitz P A & Pinals D J (1964) *Radiology* **82**, 246
Kinmonth J B (1965) *Proc. R. Soc. Med.* **58**, 1021
Samman P D & White W F (1964) *Brit. J. Derm.* **76**, 153

Dr P D Samman: The yellow nail syndrome consists of the curious slow-growing nails and lymphœdema. A feature which has come to light since the syndrome was described is the presence of recurrent pleural effusions in some cases probably due to impaired lymph drainage.

Dr G C Wells: In my patient also (p 447) one should consider the extent of the lymphatic inadequacy. In view of the facial œdema, the persistent hoarseness, with visible œdema of the vocal cords, might be due to lymphœdema rather than chronic sinusitis. And indeed the sudden swings of mood with episodes of severe depression might conceivably be related to meningeal œdema, though this is purely speculative.

Dr D E Sharvill: Mr President, you will remember a woman under your care at the Middlesex Hospital with yellow nail syndrome. She came under the care of our physicians in Folkestone with rheumatoid arthritis which was treated with gold. While in hospital she developed pulmonary emboli and later recurrent pleural effusions which required prolonged bed rest. During some two months the lymphœdema of her legs subsided and the nails started to grow at a normal rate and to lose their colour and thickening. It is interesting that this improvement in the nails continued in the presence of repeated effusions.

Purpura Progressiva Chronica

Major A G Jarrams MRCS
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Sergeant W B, aged 32

History: In December 1964, about two months after his arrival in Aden, he developed a symmetrical eruption on both feet and ankles. During his tour of duty there was a steady progression up the legs and after his return to UK in July 1965 this continued on to the lower trunk, upper arms and forearms. The eruption has been associated with slight occasional irritation.

While in Aden he had intermittent diarrhœa for three months for which no cause was found (in particular no bacterial pathogens or *E. histolytica* were isolated). He was treated symptomatically and with tetracycline, propantheline bromide and chlorpromazine hydrochloride. He was also taking proguanil as a causal prophylactic. There is no clear time