



Ingrowing toenails

by Dr Jon Garvey

Ingrowing toenails are considered a trivial problem by the full-time surgeon, but, as an erstwhile senior registrar once told me, there is no such thing as minor surgery, only minor surgeons. Perhaps it is the failure to realise this which leads to the treatment of toenails being left to the most junior house-surgeon. This is a pity, since it may be done better by a GP with even modest surgical aspirations.

Causes of ingrowing toenails

There are four contributing factors, any of which may be present at the same time.

Anatomy: Highly arched toenails are much more likely to cause trouble because the nail fold in this case is deep and the nail edge hidden from view in its depths, in a far better position than usual to dig into the toe.

Footwear: Feet need room to move, but a significant proportion of the human race has failed to appreciate this. An at-risk toe may sometimes give trouble only when pointed shoes or high heels come back into fashion.

Trauma: Occasionally a toe is trouble-free until somebody drops a brick on it. The resulting nail-fold injury becomes swollen and infected, and then becomes self-perpetuating as the nail cuts into the swollen tissue.

Poor cutting: This is by far the most important factor, and could be avoided if everybody learnt the proper technique. In perhaps 95% of cases presenting, a careful look at the affected toe shows the situation illustrated in *Figure 1*. Attempting to trim the nail back into the nail fold, in a misguided attempt at an aesthetic curve, invariably leaves a small ragged spur of nail. This grows into the skin of the nail fold and becomes surrounded by a foreign-body granulomatous reaction and frank infection. It is impor-

tant to spot, point out, and explain this at the initial consultation since there are four potential sites for ingrowing nails (the medial and lateral sides of each great toe), and the doctor who is too busy to instruct his patient in correct cutting will find he has to cut away at another piece of toe before too long.

Conservative management

The initial presentation is usually an acute paronychia, and treatment is

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therefore with antibiotics. The infecting organisms can be fairly mixed, but are mainly staphylococci. Most of these seem to be sensitive to broad-spectrum antibiotics (unless the patient has just had his other toenail treated in hospital).

Treating the infection makes the toe more suitable for surgery and may sometimes clear the trouble completely.

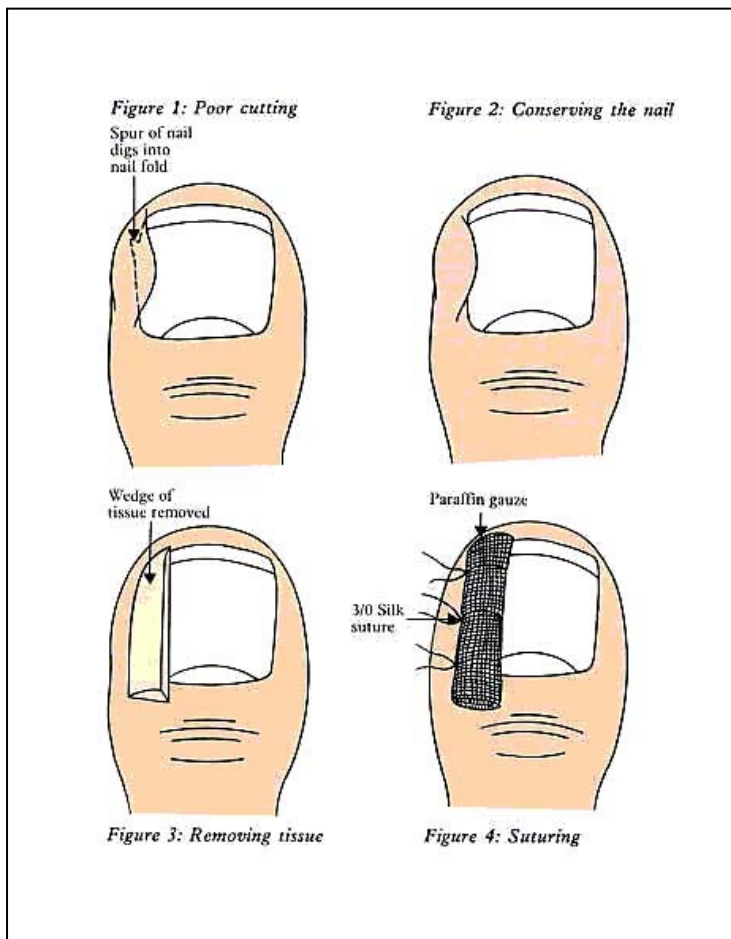
Very often it enables some attempt to be made to conserve the nail: This involves careful instructions about cutting, footwear, and avoiding bricks. Once the patient understands why his toenails have become troublesome, it may be possible to teach him carefully to use a scissor blade to keep the corner of the nail from growing into the flesh until, with luck, it grows out beyond the fold (*Figure 2*).

If the patient cannot be made to understand exactly what he is trying to achieve by this, he should be told to leave well alone. I have my doubts that the old trick of a pledget of cotton wool works, but again, it will be worse than useless unless done properly. Rammed indiscriminately into the fold, the cotton wool only presses the nail further in. The chiropodists’ complicated filing and cutting of V-shaped nicks in nails never seems to do my patients any good, so I avoid it.

Sometimes this regimen effects a cure and prevents a recurrence, although a further course or two of antibiotics may be required as the nail grows out. I certainly put more effort into conservative treatment in the case of young girls, to whom the mutilation of a nail has serious cosmetic implications. More often than not, however, conservation fails and one has to resort to surgery.

Surgery

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Although these procedures are simpler and cause less immediate disability, they still require a ring block and the recurrence rate is high, presumably because scarred swollen tissue remains. In addition, removal of the nail can damage its bed and cause uneven, sometimes bizarre regrowth.

In my youth I was taught to remove the whole nail and ablate its bed, but since I consider this an unnecessarily mutilating operation, I now always perform a wedge resection.

A 2% lignocaine (plain) ring block is put on the toe and left for 10 to 15 minutes to become effective. (Nevertheless a few do not, however consistent the technique. I have a theory that in some people the digital nerves run dorsally and ventrally, instead of medially and laterally, but there is probably a more boring explanation.)

Using a rubber band as a tourniquet, strong scissors are used to cut down the affected side of the nail (Figure three) as far as its bed. A scalpel is then used to cave out a wedge of tissue including the nail, the bed, the nail fold, and the

diseased tissue. Some doctors use phenol to destroy the nail bed, but I do not; there should be no recurrence of growth if excision is adequate. If in doubt the bed can be curetted.

A wad of rolled paraffin gauze is applied to the raw area left, and this is then sutured in place with a strong nonabsorbable suture on an even stronger needle, since it has to pierce the nail. Three or four sutures are usually enough (Figure four).

It then remains simply to apply a dressing, remove the tourniquet, and check that there is no great bleeding. The outer dressing is changed after 24 hours, and the sutures and gauze are removed after five days. Even at this stage, healing has progressed remarkably, and is almost complete in a fortnight. After several months there is little sign that anything has been done, apart from the narrower nail.

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