Antibiotics as an adjunct to phenol matrixectomy did not decrease healing time of ingrown toenails


QUESTION: In patients with infected ingrown toenails, is the addition of oral antibiotics to phenol matrixectomy more effective than matrixectomy alone in decreasing healing time?

Design
Randomised (allocation concealed*), unblinded,* controlled trial with follow up to healing.

Setting
Outpatient clinic in San Antonio, Texas, USA.

Patients
154 patients who were 10–60 years of age (mean age 21y, 59% men) and had locally infected ingrown nails of the big toe (nail borders exhibited paronychia, granulation tissue, oedema, and the presence of exudates). Exclusion criteria were immunocompromised states (long term steroid use, diabetes mellitus, collagen vascular disease, or HIV infection), cellulitus proximal to the interphalangeal joint, or peripheral vascular disease. 148 patients (96%) were included in the analysis.

Intervention
Patients were allocated to a 1 week course of oral antibiotics (cephalexin, 500mg, 4 times/d) and simultaneous phenol matrixectomy at the initial visit (AMs) (n = 53), oral antibiotics at the initial visit and phenol matrixectomy 1 week later (AMw) (n = 51), or phenol matrixectomy at the initial visit (M) (n = 50).

Main outcome measure
Healing time (interval between matrixectomy and resolution of drainage and inflammatory changes around the nail border).

Main results
Healing occurred sooner among patients in the AMs group than among patients in the AMw group (p < 0.04) (table). Healing times did not differ between the AMs and M groups [p = 0.50]† (table).

Conclusion
In patients with infected ingrown toenails, the addition of oral antibiotics to matrixectomy did not decrease healing time more than matrixectomy alone.

COMMENTARY
Reyzelman et al provide a cogent argument for avoiding systemic antibiotics when using chemical matrixectomies to manage infected ingrown toenails. Healing time did not differ with phenol matrixectomies and nail border removal with or without concurrent administration of a typical oral regimen of cephalaxin. Indeed, they found that healing time is prolonged if antibiosis is started a week before phenol matrixectomy. The authors correctly point out that unnecessary antibiosis contributes to clinical antibiotic resistance (and super infection) and adds to treatment cost.

Chemical (phenol) matrixectomy, as described by Dag-nall,1 has been done with minor variations for over 100 years with good success. On the basis of a meta analysis of randomised and quasi-randomised trials, Rounding and Hulm concluded that phenol treatment is more effective in preventing recurrence than is surgical excision alone but it carries an increased risk for postoperative infection.2

Given these earlier results, one must be mildly concerned that in the study by Reyzelman et al, 2 of 47 patients (4.3%) who had chemical matrixectomies alone, compared with no patients in the antibiotic treated group, had postoperative infections. Nevertheless, phenol matrixectomy without antibiosis can be considered an appropriate technique for the treatment of moderately infected ingrown toenails.

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