To the Editor:
A 58-year-old woman presented to our dermatology clinic with a pruritic weeping eruption circumferentially on the distal digits of both hands of 5 weeks’ duration. The patient disclosed that she had been receiving dip powder manicures at a local nail salon approximately every 2 weeks over the last 3 to 6 months. She had received frequent acrylic nail extensions over the last 8 years prior to starting the dip powder manicures. Physical examination revealed well-demarcated eczematous plaques involving the lateral and proximal nail folds of the right thumb with an overlying serous crust and loss of the cuticle (Figure 1A). Erythematous plaques with firm deep-seated microvesicles also were present on the other digits, distributed distal to the distal interphalangeal joints (Figure 1B). She was diagnosed with dyshidrotic-like contact dermatitis and paronychia. Treatment included phenol 1.5% colorless solution and clobetasol ointment 0.05% for twice-daily application to the affected areas. The patient also was advised to stop receiving manicures. At 1-month follow-up, the paronychia had resolved and the dermatitis had nearly resolved.

Dip powder manicures use a wet adhesive base coat with acrylic powder and an activator topcoat to initiate a chemical reaction that hardens and sets the nail polish. The colored powder typically is applied by dipping the digit up to the distal interphalangeal joint into a small container of loose powder and then brushing away the excess (Figure 2). Acrylate, a chemical present in dip powders, is a known allergen and has been associated with the development of allergic contact dermatitis and onychodystrophy in patients after receiving acrylic and UV-cured gel polish manicures.1,2 Inadequate sanitation practices at nail salons also have been associated with infection transmission.3,4 Additionally, the news media has covered the potential risk of infection due to contamination from reused dip manicure powder and the use of communal powder containers.5

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To increase clinical awareness of the dip manicure technique, we describe the presentation and successful treatment of dyshidrotic-like contact dermatitis and paronychia that occurred in a patient after she received a dip powder manicure. Dermatoses and infection limited to the distal phalanges will present in patients more frequently as dip powder manicures continue to increase in popularity and frequency.

REFERENCES