

Treating Dermatophyte Onychomycosis: Clinical Insights From Dr. Shari R. Lipner

Rising concerns about terbinafine resistance have added complexity to the management of dermatophyte onychomycosis. *Cutis* board member Shari R. Lipner, MD, PhD, discusses evolving treatment strategies, including resistance testing, selection of oral vs topical therapy, and counseling patients on realistic treatment timelines and outcomes.



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With increasing reports of terbinafine resistance, how has your strategy for treating dermatophyte onychomycosis evolved?

DR. LIPNER: Most cases of onychomycosis are not resistant to terbinafine, so for a patient newly diagnosed with onychomycosis, my approach involves evaluating the severity of disease, number of nails affected, comorbid conditions, and concomitant medications and then discussing the risks and benefits of oral vs topical treatment. If a patient's onychomycosis previously did not resolve with oral terbinafine, I would test for terbinafine resistance. If positive, I would treat with itraconazole for more severe cases and efinaconazole for mild to moderate cases.

Are there any new systemic or topical antifungals for onychomycosis that dermatologists should be aware of?

DR. LIPNER: There have been no new US Food and Drug Administration-approved antifungals for onychomycosis since 2014 (efinaconazole and tavaborole). For most patients, our current antifungals generally have good efficacy. For treatment failures, I would recommend reconfirming the diagnosis and testing for terbinafine resistance.

When do you choose oral antifungal therapy vs topical/combination therapy?

DR. LIPNER: I almost never prescribe combination antifungal therapy because monotherapy alone is usually effective, and there is no obvious benefit to combination therapy. If treatment is working (or not working),

it is hard to know which agent (if any) is effective. The one time I would use combination therapy (eg, oral terbinafine and topical efinaconazole) would be if the patient has distal lateral subungual onychomycosis and a dermatophytoma. Oral terbinafine would generally be most effective for distal lateral subungual onychomycosis, and topical efinaconazole would likely be most effective for dermatophytoma.

What is the role of adjunctive therapies in onychomycosis?

DR. LIPNER: Debridement can be effective for patients with very thick nails, combined with oral or topical antifungals. Nail avulsion generally is not helpful and should be avoided because it causes permanent shortening of the nail bed. Devices (eg, lasers, photodynamic therapy) are not subject to the same stringent endpoints as medication-based approvals. Because studies to date are small and have different efficacy endpoints, I do not use devices for treatment of onychomycosis.

How do you counsel patients about expectations and timelines for onychomycosis therapy and cure vs improvement?

DR. LIPNER: Oral treatments for toenail onychomycosis are generally given for 3-month courses, but patients should be counseled that the nail could take up to 12 to 18 months to fully grow out and look normal. If patients also have mechanical nail dystrophy, the fungus may be cured with antifungal therapy, but the nail may look better but not perfect, so it is important to manage long-term expectations.