

# Madigan Army Medical Center Referral Guidelines

## Onychomycosis

### Diagnosis/Definition

Fungal infection of one or more nails. Infection suggested by thickened, yellow or brown discolored friable nail plates.

### Initial Diagnosis and Management

- History and physical examination.
- Differential diagnosis includes psoriasis, lichen planus, nail trauma, and median nail dystrophy.
- A positive potassium hydroxide (KOH) preparation (done in clinic) or positive culture, or submitting nail clippings in formalin to pathology to be processed as a tissue exam to confirm the diagnosis.
- Entry into the patient's Master Problem List by the provider confirming the diagnosis.

### Ongoing Management and Objectives

- Primary care treatment should include continued documented education. This counseling should state that onychomycosis is often resistant to treatment and recurrence following successful treatment is common. The provider **MUST** confirm that there is fungus present. If patients desire a conservative trial of therapy it should consist of not less than a 6-month trial of topical clotrimazole solution or Loprox cream bid and reduction/removal of thickened or loose nails with standard nail files or clippers. Naftifine cream or gel daily plus either ammonium lactate lotion or 20% urea cream bid may be used and likely more successful than Loprox or Clotrimazole.
- Patients failing the above regimen or who are "foot-at-risk" due to chronic diabetes, immunosuppression or other significant vascular compromise (refractory stasis dermatitis, history of recurrent lower extremity cellulitis, or other chronic refractory dermatosis) of the legs, or those with nail dystrophy significant enough to cause pain on wearing shoes may be managed using oral therapy with terbinafine, itraconazole or (less commonly) fluconazole. Communication (email or phone) with a Dermatologist or Podiatrist may be necessary to use one of these medications in our managed care setting. Adjunctive aggressive topical management in these patients is still advised.
- Patients with asymptomatic onychomycosis who are not at increased risk for amputation should be given topical therapy or the option for no prescription therapy at all. Those with "cosmetic" onychomycosis seeking therapy should be managed with the aggressive topical therapy as above and may be given oral therapy to aid in clearing on a case-by-case basis.

### Indications for Specialty Care Referral

The following may be referred to Podiatry:

- Patients who request nail removal (temporary) as augmentation to the primary care regimen.

- Patients requesting permanent nail ablation via chemical cautery.

**The following may be referred to dermatology:**

- Patients who have confirmed onychomycosis and have failed oral antifungals
- Patients who have nail disease negative for onychomycosis

**Criteria for Return to Primary Care**

After completion of the surgical procedure, topical or systemic therapy, patients may be managed at the primary care level.

Pictures of [Onychomycosis](#) from NZ DermNet - New Zealand Dermatological Society

Last Review for this Guideline: **October 2009**

Referral Guidelines require review every three years.

Maintained by the Madigan Army Medical Center - Quality Services Division  
Clinical Practice and Referral Guidelines Administrator