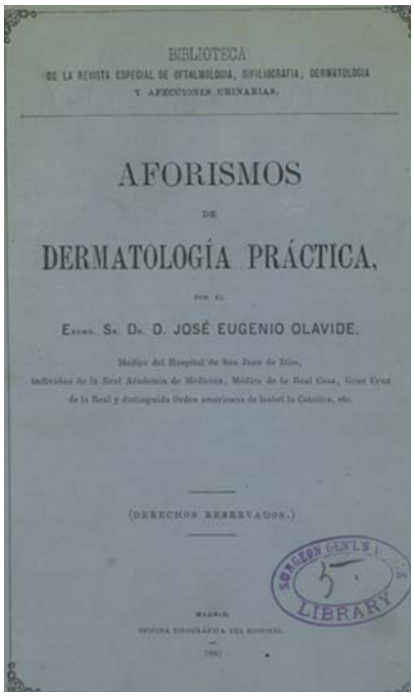

Figura 2.

passion for dermatology to the New World. Who could have imagined that in the 21st century the United States, a country unknown to Olavide, would possess copies of the majority of his books and articles?

One of the interesting aspects of this project is that, in addition to learning more about the father of Spanish dermatology, the NLM provided an opportunity to take photographs (thanks to Light, Inc. and the photographer Jeff Knab). In this way it was possible to document some of the covers of Olavide's works (Figures 1 and 2).

Acknowledgments

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To Jeff Knab of Light Incorporated, for the magnificent photographs of Olavide's books in the NLM.

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Proximal White Subungual Onychomycosis Due to *Fusarium* Species

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To the Editor:

Proximal white subungual onychomycosis (PWSO) is the most unusual presentation of onychomycosis.

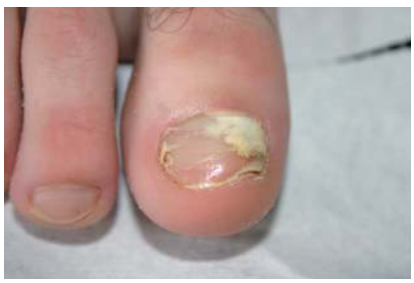

Figure 1. Whitish color on the proximal third of the nail plate and matrix.

Trichophyton rubrum is the most common causative agent, although other species such as *Trichophyton megninii*, *Trichophyton schoenleinii*, *Trichophyton tonsurans*, *Trichophyton mentagrophytes*, and *Epidermophyton floccosum* have also been implicated.

The condition has traditionally been reported in immunodepressed patients, above all those with human immunodeficiency virus (HIV) and in other immunodeficiencies. In recent years cases of PWSO have also been diagnosed in immunocompetent patients, and we report a new case of this.

The patient was a 19-year-old man receiving treatment for nodulocystic acne with oral isotretinoin and no other relevant history, who presented an abnormal toenail with onset several months previously. There had been no known previous trauma and the infection did not respond to the application of a topical antifungal agent prescribed by his family physician.

On examination, the nail plate on the right great toe revealed discreet subungual hyperkeratosis together with a creamy-white color on the proximal third of the nail with involvement of the nail matrix (Figure). There was no

sign of paronychia and no involvement of other fingernails or toenails.

Fungal cultures of the nail plate showed the presence of *Fusarium* species. Routine blood tests including full blood count, erythrocyte sedimentation rate, and biochemistry gave completely normal results, and the patient tested seronegative for HIV.

Treatment with itraconazole (200 mg/d over 4 weeks) was prescribed, and a clear clinical improvement was seen.

Fusarium species are nondermatophyte molds that tend to occur naturally as saprophytes in the soil and as pathogens in plants.[1] Although infections can occur in humans, they are normally precipitated by local or general predisposing factors. Systemic infections are rare and only occur in immunodepressed patients.[2] Onychomycosis caused by *Fusarium* species almost always affects the great toe, especially when accompanied by dystrophic and traumatic abnormalities or where nails were previously infected with dermatophytes.[3] Wearing sandals or walking barefoot can encourage the condition.[2] Most of the cases described in the literature are characterized by extensive paronychia, but this was not the case in our patient.

Invasion of the toenail by *Fusarium oxysporum* is relatively uncommon despite the widespread distribution of the mold, implying that the toenail may be a portal of entry for systemic infections in immunodepressed patients,[4-6] with the associated worse prognosis.

The condition manifests itself clinically as the typical form of proximal subungual onychomycosis, occasionally with the presence of onycholysis or subungual hyperkeratosis.

Treatment of *Fusarium* onychomycosis is not a straightforward matter.[2] Better levels of response are reported with ungual avulsion followed by the application of topical antifungal agents, giving an improvement in most immunocompetent patients. Itraconazole (200 mg/d over 4 weeks or in pulse therapy) has also been used with some success.[2]

We would like to present the case of an immunocompetent patient who was diagnosed with proximal white subungual onychomycosis caused by *Fusarium* species.

We also stress the value of microbiological cultures and the need to rule out immunosuppression—especially by HIV infection—in such ungual disorders, which are almost exclusive to immunodepressed patients and rarely diagnosed in immunocompetent individuals.

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Temporary Thrombocytopenia Probably Induced by Isotretinoin

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To the Editor:

Isotretinoin is a drug that is widely used to treat severe nodular or cystic acne.[1] It can cause serious adverse effects that should be recognized and monitored by clinicians. We report a case of profound thrombocytopenia due to treatment of severe acne with isotretinoin. This case illustrates a serious adverse effect that can occur at any stage of treatment. A review of the literature revealed only 4 studies on this topic.[2-5]

A 29-year-old Caucasian woman with nodular and cystic acne refractory to other therapies began treatment with 40 mg/d isotretinoin after providing written informed consent. The patient was taking no other medication except oral contraceptives (ethinylestradiol and cyproterone acetate), which she had begun 3 years earlier. The contraceptive medication was maintained. All laboratory test results prior to treatment (including biochemistry and blood counts) were normal.

A month later, the acne had improved significantly and treatment with isotretinoin was well tolerated, except for cheilitis. Further biochemistry and blood counts were normal. No other medication was prescribed during this period.

Six months after beginning treatment, the patient visited our department due to spontaneous vaginal bleeding that had begun 10 days earlier and was not related to menstruation. A petechial exanthema was visible on the torso and limbs. A