

Lindsay nails (half-and-half nails) in chronic kidney disease: A classical image

Vigneshvarprashanth Umapathy¹ , Ivan A Jones²

From ¹Resident, ²Consultant Physician, Department of Internal Medicine, Kauvery Hospital, Trichy, Tamil Nadu, India

A 75-year-old male from South India, who is known to have type 2 diabetes mellitus and systemic hypertension for 5 years, presented with complaints of dyspnea and altered sensorium for 1 day and a history of bilateral lower limb swelling and facial puffiness for 3 days. He was alert, oriented, and afebrile. General clinical examination revealed pallor, bipedal pitting edema, and the nail finding shown in Fig. 1 in all fingers of both hands. However, he did not know the duration of the presence of this nail finding. There was no icterus, cyanosis, clubbing, or lymphadenopathy.

On evaluation, he was noted to have normocytic normochromic anemia, elevated erythrocyte sedimentation rate, elevated serum urea (111.5 mg/dL), and creatinine (8.59 mg/dL), hyponatremia, hyperkalemia, and hyperphosphatemia. Table 1 shows the laboratory parameters of our patient. Ultrasonography of the abdomen and pelvis revealed bilateral medical renal disease. A diagnosis of chronic kidney disease (CKD) was made. He was managed with diuretics; electrolytes were corrected, and hemodialysis was initiated.


The yellow arrow in Fig. 1 points to a pinkish-red band occupying the distal half of the nail bed and a whitish band

occupying the proximal half. This finding is consistent with Lindsay's nail or half-and-half nail. The finding was first reported in 1963 by Bean [1]. In 1965, Lindsay termed the finding as a half-and-half nail [2]. In 1967, Lindsay, in a study [3] involving 1500 patients, found 25 patients to have the finding, out of which only one did not have renal disease. He also found that the severity of azotemia did not correlate with distal band longitudinal length. Baran and Gioanni hypothesized in 1968 that uremic substances may stimulate melanocytes, producing increased melanin deposition in the distal half of the nail, and that the finding may not resolve with hemodialysis [4]. Lindsay's nails may disappear completely following successful renal transplantation [5]. Although Lindsay's nails are most frequently seen in CKD patients, the finding is not specific to renal failure. Lindsay's nails can also be seen in liver cirrhosis, Crohn's disease, and Kawasaki disease. The finding has also been described in healthy individuals [2,6].

Close differential to Lindsay's nails would be Terry's nails, which are characterized by a whitish proximal nail bed (constituting approximately 80% of the nail bed) with a pink distal band [7,8]. Terry's nails can be seen in association with



Figure 1: The left-hand fingernails of the patient show a pinkish-red band occupying the distal half of the nail bed and a whitish band occupying the proximal half (marked by a yellow arrow)

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Correspondence to: Vigneshvarprashanth Umapathy, Resident, Department of Internal Medicine, Kauvery Hospital, Tennur, Trichy, Tamil Nadu - 620 017, India. E-mail: worldofuv@gmail.com

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Table 1: Laboratory parameters of our patient

Hemoglobin	MCV	MCH	Total WBC count
10.7 g/dL	83 fL	29 pg/cell	11700 cells/cu.mm
Platelet count	ESR	Serum urea	Serum creatinine
2,79,000 cells/uL	73 mm/h	111.5 mg/dL	8.59 mg/dL
Serum sodium	Serum potassium	Serum calcium	Serum phosphorus
130 mEq/L	5.3 mEq/L	8.53 mg/dL	5.62 mg/dL

MCV: Mean corpuscular volume, MCH: Mean corpuscular hemoglobin, WBC: White blood cell, ESR: Erythrocyte sedimentation rate

liver cirrhosis, CKD, and congestive heart failure [9]. Another nail finding termed as Mees' lines can also be confused for Lindsay nails. Mees' lines are true leukonychia characterized by transverse bands of leukonychia running parallel to the lunula [10,11]. This finding is characteristic of arsenic exposure.

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