Supplementary Table 1: Compilation of intralesional and topical treatments in nail psoriasis.

Molecule	Target	Dosage	Efficacy	Safety	Level of Evidence
TA					
de Berker and Lawrence[8]	Nail matrix and nail bed	TA (10 mg/mL): 0.1 mL into each of four periungual sites. Reinjection after 2 months if poor response.	Overall response: 100% improvement of digits with subungual hyperkeratosis, 83% with thickening, 94% with ridging, 45% with pitting, 50% with onycholysis. Response maintained for at least 9 months.	Subungual haematoma, temporary fingertip paraesthesia and pain, as well as reversible nail fold atrophy	Open trial of an established therapy using a modified regimen
Boontaveeyuwat E et al.[9]	Nail matrix and nail bed	Three nails of three patients were randomised into three groups: Group A: TA 10 mg/mL (Kanolone®; L.B.S Laboratory, Bangkok, Thailand): 0.02–0.1 mL per site (up to four/nail). Reinjection in 2 months if poor response. Group B: Topical clobetasol 0.05% ointment twice/day for 6 months without occlusion. Group C: No treatment.	Specific improvement in Group A (injection): Subungual hyperkeratosis: 83%; pitting: 73%; discolouration: 44%; onycholysis: 31%; crumbling: 20%. Group B (topical clobetasol): Only pitting improved (17%) No effect on deeper nail bed changes without occlusion.	Focal atrophic erythema (too superficial injection) Hypopigmentation with telangiectasia (excess dose)	Single-blind RCT
Saleem and Azim[7]	Nail matrix and nail bed	TA (10 mg/mL): 0.1 mL into each of four periungual sites. Reinjection after 2 months if there is a poor response.	Pitting improved in 57.7% of digits (25% complete response and 36.6% partial response); onycholysis improved in 45.7% of digits (CR: 18.9%; PR: 21.6%); subungual hyperkeratosis improved in 70.1% of digits (CR: 53%; PR: 17.4%); longitudinal ridging improved in 75.8% of digits (CR: 48.2%; PR: 27.5%); yellow oil drop-like discolouration improved in 80% of digits, all were CR; thickening of nails improved in 72.2% of digits (CR:	20%: subungual haematoma Self-limiting pain and paraesthesia	Case series

			16.6%; PR: 55.5%); loss of nail plate in nine digits → six of these had regrowth in 2 months.		
Nantel-Battista M et al.[89]	Matrix	Three periungual injection sites with TA 0.07±0.02 mL at 8 mg/mL delivered by needle-free jet injector. Injection every 4±1 weeks.	The mean NAPSI score was reduced by 46.25%. NAPSI scores for the nail bed and nail matrix improved by 37.5% and 50%, respectively.	Safe	Prospective study
Bleeker[90]	Matrix	5 mg/mL monthly for 6 months (using a Port-O-Jet; 0.2 mL/cm^2 and not exceeding 5 mL). A dose of 3x0–2 mL of TA was infiltrated around the base of each nail, 3–4 mm proximal to the nail plate.	No difference between Port-O-Jet and the traditional needle injection.	Injection can be given quickly, with less pain at the site of infiltration	Comparative clinical investigation (prospective cohort)
Mascaró[91]	-	Needle-free jet injectors. No dosage specified.	-	Epidermoid cysts following jet injection of TA for nail psoriasis	Case report
MTX					
Mittal and Mahajan[10]	Matrix	TA: 10 mg/mL MTX: 25 mg/mL CsA: 50 mg/mL → two intramatricial injections, spaced 6 weeks apart	NAPSI score at 24-week evaluation: MTX: 56.7% of nails showed >75% improvement TA: 50% of nails showed >75% improvement CsA: 33.3% of nails showed >75% improvement Highest efficacy with MTX, but differences are not statistically significant.	MTX has the most favourable safety profile MTX and TA → transient pain at the injection site CsA → more severe and prolonged pain MTX → careful monitoring TA → risk of skin atrophy or hypopigmentation CsA → least effective	Open-label, non-randomised comparative study Level III of evidence
Grover C et al.[12]	Nail bed	Injection of 0.1 mL of a 25 mg/mL MTX solution at 3-week intervals.	Reduction of NAPSI mean score from 4.77 to 2.43 at 15 weeks in patients with only nail bed disease, and 5.0 to 3.14 in patients with concomitant nail bed and matrix features.	Well tolerated with manageable side effects: transient pain at the injection site, injection site pigmentation, nail bed haemorrhage in some cases	Case series Level IV evidence
Sarıcaoglu H et al.[11]	Proximal nail fold (nail dystrophy symptoms)	MTX 2.5 mg/injection at the proximal nail fold on each side of the affected nail, once weekly for 6 weeks.	Significant improvement in subungual hyperkeratosis and pitting was observed by the fourth month. Clinical remission remained with no recurrence during a 2-year follow-up period.	No clinical or laboratory complications were reported during the treatment and follow-up period	Case report Level VI evidence
Choudhary P etal.[13]	Matrix	2.5 mg of MTX per injection administered at a point 2.5 mm proximal and lateral to the	The mean NAPSI score decreased significantly from 3.70 at baseline to 0.67 at 12 weeks.	Pain Acute paronychia in one patient	Uncontrolled prospective study Level III evidence

		junction of the proximal and lateral nail folds, once weekly for 6 weeks.	No recurrence during a 1-week follow-up period.		
5-FU					
Abdelmeniem IM et al.[14]	-	Four groups: Group A: intralesional injection of 0.1 ml 5-FU into the nail matrix and bed, monthly for 3 months. Group B: intralesional injection of 0.1 ml MTX into the nail matrix and bed, monthly for 3 months. Group C: intralesional injection of 0.1 ml TA into the nail matrix and bed, monthly for 3 months. Group D: topical application of calcipotriol combined with urea 20%, applied twice daily for 3 months.	After 3 months of treatment, the mean percentage of improvement in NAPSI scores was: Topical calcipotriol/urea: 57.1%±26.4 Intralesional TA: 44.2%±32.7 Intralesional MTX: 37.7%±14.2 Intralesional 5-FU: 29.6%±14 The topical calcipotriol/urea combination demonstrated significantly higher efficacy compared to all intralesional treatments.	All were well-tolerated	RCT
Botulinum toxin injection					
Juntongjin P et al.[16]	Both nail matrix and nail bed involvement	Four groups: BoNT-A group: single intralesional injection of BoNT-A at baseline TA group: intralesional injections of TA at baseline and Week 8. Topical group: daily application of a VitD/steroid combination for 16 weeks Placebo group: no active treatment. Injection sites: two proximal nailfold sites (matrix), two nail bed sites (if needed).	For total NAPSI score: no significant difference between BoNT-A and TA at any time point For nail bed NAPSI score: significant difference between BoNT-A and TA. All three active treatments were effective in improving nail psoriasis by Week 16. BoNT-A showed continued improvement beyond Week 16, especially in nail bed psoriasis, surpassing TA by Week 24. TA was effective but plateaued after Week 16. Topical VitD/steroid was modestly effective, but safe and well tolerated.	BoNT-A: one transient pain case (resolved in 6 hours) TA: one subungual hematoma (resolved in 2 weeks) Topical VitD/steroid: no adverse events	RCT with intraindividual comparisons
Botsali and Erbil[92]	-	Two cases Dosage: each patient received 15 units of aboBoNT-A, divided	Clinical improvement: both patients demonstrated significant improvement in nail psoriasis symptoms following the treatment.	No adverse effects	Case reports

		into two injection points per affected nail. Injection sites: the toxin was administered into the nail fold and nail bed. Frequency: a single treatment session was conducted.	Pain reduction: there was a notable decrease in nail discomfort and pain, with a drop of four points on the VAS. Symptom relief: improvements were observed in features, such as onycholysis and pitting.		
Intralesional secukinumab					
He F et al.[15]	Fingernails that are resistant to systemic and topical therapy	Intramatricial low-dose secukinumab injection. The dosage was 0.1 mL diluted secukinumab per fingernail, and the concentrations were 7.5, 15, and 30 mg/mL, respectively, for the second to fourth fingers of the left hand. The total dose was 5.25 mg every time, and repeated every 2 weeks for 12 weeks.	The percentage improvement of the target NAPSI score at Week 6 relative to baseline from the second to fourth fingers of the left hand was 66.7%, 80%, and 75% for Case 1, and 35.7%, 58.3%, and 50% for Case 2. The percentage improvement at Week 24 relative to baseline from the second to fourth fingers of the left hand was 91.7%, 90%, and 75% for Case 1, and 57.1%, 58.3%, and 83.3% for Case 2. Nail matrix and nail bed lesions both improved at the same time.	Mild, transient pain at the injection sites	Case reports
Topical corticosteroids					
Sánchez Regaña M et al.[17]	Nail bed and matrix psoriasis	Colourless nail lacquer containing 8% clobetasol-17-propionate that was applied once daily for 21 days and then twice weekly for 9 months.	Nine out of 10 patients showed a good clinical response. Observed after only 4 weeks and marked at the end of treatment. Among the clinical signs, onycholysis, pitting, and salmon patches showed the best improvement. Subungual hyperkeratosis → moderate improvement. Splinter haemorrhages seemed to be most persistent.	No local or systemic side effects Easy to apply, high tolerability	Prospective study
Nakamura RC et al.[93]	Nail bed and matrix psoriasis	Group A: 0.05% clobetasol nail lacquer Group B: 1% clobetasol nail lacquer Group C: 8% clobetasol nail lacquer. Clobetasol nail lacquer on the left hand and base coat nail lacquer as a control on the right, twice a week for 16 weeks.	The variation of the NAPSI on the treated hand, and Group C showed an improvement of 39% more than that of the A and B groups.	No reports of adverse effects	Prospective, controlled, d randomised pilot study
Topical calcipotriol					

Zakeri M et al.[19]	-	Calcipotriol ointment (50 µg/g) applied twice daily without occlusion to the affected nail plates, lateral, and proximal nail folds for 3 months.	14/24 patients: significant improvement. Two complete remissions after 5 months. Particularly effective in reducing hyperkeratosis, onycholysis, and discolouration Fingernails responded better than toenails.	Adverse reactions in two patients (periungual irritation and inflammation in one, and irritation, pruritus, and oozing in the other).	Prospective study
Kokelj F et al.[18]	-	Calcipotriol 50 µg/g cream was applied to the affected nails and periungual tissues twice daily for 3 months.	71.4% (5/7) of patients: subjective and objective improvement, clearly effective in reducing the subungual hyperkeratosis and associated distal onycholysis.	None declared	Prospective, uncontrolled clinical trial
Tosti A et al.[20]	-	Two groups: Group A: calcipotriol ointment (50 mg/g). Group B: betamethasone dipropionate (64 mg/g) and salicylic acid (0.03 g) ointment Twice daily.	Calcipotriol is as effective as a combination of a topical steroid with salicylic acid in the treatment of nail psoriasis.	Erythema, periungual irritation, burning at the application site, and diffuse urticaria	Double blind, randomised study
Tacalcitol ointment					
Márquez Balbás G et al.[94]	-	Application of tacalcitol ointment 4 µg/g (Bonalfa® ointment) daily at night in occlusion with cotton gloves for 6 months.	Of the clinical parameters: Greatest improvement is in subungual hyperkeratosis and onycholysis, followed by oil-drop discolouration and pitting. ⇨ acts on the nail bed and nail matrix Significant improvement of the NAPSI score (median: 5.5 at baseline; median: 1 at 6 months).	At the beginning of the study: 10 patients → presented with pain None reported discomfort after 6 months	Case report
Topical calcitriol					
Kole L et al.[21]	-	Group A: calcitriol ointment (3 mcg/g). Group B: betamethasone dipropionate ointment (64 mg/g). Twice daily for 24 weeks.	Both reduced nail thickness. The difference between the two groups was not statistically significant.	No significant adverse effects	RCT without blinding
Usmani and Wilson[95]	-	Calcitriol ointment 3 µg/g (Silkis®) to be used twice daily to the proximal and lateral aspects of the nail fold (switched from calcipotriol and calcitriol because of skin irritation).	Within 2 months, the new nail growth was significantly healthier, and by 6 months, further improvements were noted. However, some recurrence of symptoms, like onycholysis, hyperkeratosis, and pitting, occurred after discontinuing calcitriol.	No adverse effects reported	Case report
Combined treatment VitD/corticoids					

Rigopolous D et al.[22]	-	Application: calcipotriol cream every night, five times/week on weekdays, and clobetasol propionate cream two times/week, on Saturday and Sunday nights. Instruction: use both creams on the nail folds, on top of and under the nail plate, on the hyperkeratosis of the nail bed, and on the hyponychium. Treatment duration: 6 months Then, 6-month follow-up using only clobetasol propionate cream twice/week.	After 2 months of treatment: The mean thickness of hyperkeratosis was reduced by 35.2% on the fingernails, 32.6% on the toenails. At Month 4: 44.9% for fingernails, 47.5% for toenails. At Month 6: 72.3% for fingernails, 69.9% for toenails. At Month 12: 81.2% for fingernails, 72.5% for toenails.	Mild burning sensation at the site of application of the creams	Prospective study
Sánchez Regaña M et al.[17]	-	For 6 months, all patients applied tacalcitol monohydrate ointment 4 µg/g under occlusion five nights a week (Monday–Friday) and used a colourless nail lacquer containing 8% clobetasol-17-propionate at night on weekends.	Substantial improvement in all signs of nail psoriasis (both bed and matrix) at the end of the 6-month study. The modified target NAPSI decreased by an average of 78% compared to baseline levels.	Well tolerated with no significant local or systemic side effects reported	Prospective cohort study without a control group
Tzung T et al.[23]	-	Two groups (A and B) for a 12-week treatment. Group A applied 0.005% calcipotriol plus 0.05% betamethasone dipropionate ointment. Group B applied 0.005% calcipotriol ointment. Twice daily	Compared with the baseline, 53% of patients treated with either calcipotriol monotherapy or combination therapy with betamethasone dipropionate showed at least a moderate improvement after 12 weeks of treatment. A reduction in total scores using NAPSI was noted in both treatments. No statistical difference between the two groups. Both are effective in improving oil drop discolouration. Other nail bed features, as well as nail matrix features, failed to show significant improvement regardless of the treatment. Nail crumbling worsened during the treatment course.	-	Randomised, investigator-blind, actively controlled, parallel group comparison study
Tazarotene					
Rigopoulos A et al.[24]	Nail matrix and nail bed	Two groups:	The fingernail response was faster than the toenail response.	Tazarotene group: desquamation, erythema, periungual	Randomised, double-blind clinical trial

	of fingernails and toenails	Group A: tazarotene 0.1% cream applied to the affected nail plates, surrounding nail folds, and periungual skin under occlusion at bedtime for 12 weeks. Group B: clobetasol propionate 0.05% cream applied in the same way.	Significant time-effect improvement for all four measures (pitting, onycholysis, hyperkeratosis, and salmon patches) based on the NAPSI score. No statistically significant difference in overall efficacy between tazarotene and clobetasol. Tazarotene demonstrated a more sustained improvement in subungual hyperkeratosis at 12 weeks.	irritation, paronychia, and irritation of the surrounding skin. Clobetasol group: burning sensation on the nail fold skin	
Bianchi L et al.[96]	-	Tazarotene 0.1% gel on unoccluded psoriatic fingernails and toenails, surrounding nail folds, and periungual skin, at bedtime for a 12-week period.	VAS score assessed Initial changes were seen after only 4 weeks 76% of patients (19/25): good clinical response. Specific signs (onycholysis, hyperkeratosis, oil spots, pitting) showed a statistically significant VAS reduction after 12 weeks. Nonspecific signs (thickened/brittle nails, paronychia, splinter haemorrhages) demonstrated substantial clinical improvement. Lack of efficacy in treating nail matrix psoriasis.	Tolerability was reported by 74% of patients 70%: mild erythema 15%: peeling of the proximal nail fold 15%: burning	Open prospective study
Scher RK et al.[97]	Fingernail psoriasis affecting at least two fingernails, each exhibiting a minimum of three of the following characteristics: pitting, onycholysis, subungual hyperkeratosis, leukonychia, nail plate crumbling/loss, splinter haemorrhage	Two groups: - tazarotene 0.1% gel every evening for 24 weeks to two target fingernails, one under occlusion and one unoccluded vehicle: same way	Onycholysis: significant reduction observed in occluded nails at Weeks 4 and 12 ($p \leq 0.05$). Significant reduction in nonoccluded nails at Week 24. Pitting: significant reduction in occluded nails at Week 24. Other parameters: no significant differences between tazarotene and the vehicle groups in subungual hyperkeratosis, leukonychia, nail plate crumbling/loss, splinter haemorrhages, or nail growth rate.	-	Double-blind, randomised, vehicle-controlled study

	s, or nail-bed discolouration				
Fischer-Levancini C et al.[25]	-	Tazarotene 0.1% ointment applied under occlusive dressings at night for 6 months.	A statistically significant improvement in the lesions was observed at 3 months (48%). Improvement increased at 6 months (88%). NAPSI decreased from a mean of 14.3 at baseline to 2.33 at 6 months. Improvement is best seen in subungual hyperkeratosis, onycholysis, and associated pain. Splinter haemorrhages disappeared in two-thirds of patients. Oil spots were seen in one-third. Pitting in half of the patients.	No adverse effects	Observational study
Topical tretinoin					
Grover and Daulatabad[6]	-	Tretinoin 0.025% cream was applied regularly on the distal nail bed + hyperkeratotic nail plate for 3 months	NAPSI score decreased from 25 at baseline to 5 after 12 weeks of treatment. Almost complete resolution of nail changes was observed at the end of the treatment period	Mild dryness at the digital tips	Case report
Topical roflumilast					
Johnston and Poelman[27]	PDE4 inhibitor	Daily topical application of 0.3% roflumilast cream.	After 5 months of using topical roflumilast, the patient had complete resolution of pain, erythema, and scaling of the skin surrounding the nail, and complete regrowth of the affected nail without onychodystrophy.	No side effects reported	Case report
Jasso-Olivares J.[26]	PDE4 inhibitor	Roflumilast 0.3% cream daily for at least 16 weeks. Roflumilast 0.3% cream was used both as monotherapy and/or in combination with topical steroids or acitretin.	The mean baseline NAPSI score was 19, which decreased to 6.8 after 16 weeks of topical treatment. Complete lesion clearance was achieved in almost all patients.	No side effects reported	Case series
Apremilast					
Kushwaha AS et al.[28]	PDE4 inhibitor	Apremilast nail lacquer was prepared using Eudragit® S 100 as a film-forming polymer, with a solvent system comprising ethanol, ethyl acetate, and water. Applied twice daily for 15 days.	In human studies: the cumulative amount of apremilast retained in the free distal edge of the nail plate was approximately double (0.93±0.14 µg/mg) compared to the control (0.41±0.04 µg/mg).	No adverse effects reported	*In vitro* studies and a small-scale human volunteer study without a control group
Tacrolimus 0.1%					

De Simone C et al.[29]	-	The application was only on the affected nails of a randomly selected hand, whereas the nails of the other hand did not receive any treatment. Application once daily at bedtime for 12 weeks to the nail folds of the affected nails, without occlusion systems.	Decreased NAPSI by 57% (overall), 65% (target nails). Effective for both matrix and bed signs.	Acute paronychia in one patient	RCT without blinding
Topical cyclosporine					
Cannavò SP et al.[31]	Inhibition of the serine–threonine protein phosphatase calcineurin	Two groups: Group A: 70% cyclosporine solution dissolved in maize oil, applied twice daily to the affected nails for 12 weeks. Group B: maize oil alone was used as a placebo in the control group.	Group A: Complete remission in three out of 16 patients Five patients showed substantial improvement (between 55 and 70%). Group B: Slight improvement (44%) in one patient Minimal improvement (between 10 and 25%) in three patients No changes in four patients. The mean improvement in the treatment group was 77%, compared to 12% in the placebo group. The best results were obtained in onycholysis and hyperkeratosis.	No significant adverse effects noted	RCT without blinding
Prins AM et al.[32]	-	The commercially available oral Neoral® solution was mixed with maize oil (pharmaceutical-grade) exactly as described by Cannavò et al.[32] This resulted in a ciclosporin emulsion (70 mg/mL).	The turbid emulsion appeared to separate into initially three and ultimately two distinct layers already within less than 4 hours after shaking. Emulsion is pharmaceutically unstable → it should be properly homogenised before each application. The patient should be carefully instructed before starting treatment with the topical emulsion. If the topical emulsion is not homogenised before each application → Poor penetration of ciclosporin into the nail structures and consequently inadequate topical treatment ➔ Risk of treatment failure.	-	Case report
Prins AM et al.[32]	-	The commercially available oral Neoral® solution was mixed with maize oil (pharmaceutical-grade) exactly	The turbid emulsion appeared to separate into initially three and ultimately two distinct layers already within less than 4 hours after shaking. Emulsion is pharmaceutically unstable → it should be properly homogenised before each application.	-	Case report

		as described by Cannavò et al.[32] This resulted in a ciclosporin emulsion (70 mg/mL).	The patient should be carefully instructed before starting treatment with the topical emulsion. If the topical emulsion is not homogenised before each application → Poor penetration of ciclosporin into the nail structures and consequently inadequate topical treatment ➔ Risk of treatment failure.		
Tosti A et al.[30]	-	Ciclosporin 10%, 0.2 mL once daily on the proximal nail fold and nail bed.	At 2 months: Significant improvement in nail lesions. At 3 months: Lesions were almost completely cleared. No systemic absorption was detected.	No systemic absorption Well tolerated Potentially effective where corticosteroids and retinoids failed	Case report
Topical 5-FU					
Fiallo P[98]	Inhibition of thymidylate synthase using the cofactor 5,10-methylene tetrahydrofolate → inhibits DNA replication	Application of 5-FU at 5% concentration in ointment base twice a day on the affected nails.	(Not declared)	After 3 months: yellowish discolouration of the distal two-thirds of all the fingernails, thickening of the distal nail plate, mild subungual hyperkeratosis. In one patient, there was a lack of cuticles with loss of the lunulae. After a few months of stopping the application: yellow discolouration disappeared, and the nails completely cleared without any treatment.	Short report
Fredrikkson T[99]	Inhibition of thymidylate synthase using the cofactor 5,10-methylene tetrahydrofolate → inhibits DNA replication	1% 5-FU solution twice daily for 6 months to the borders of the nail while massaging it into the nail fold.	After 6 months: 85% showed a mean 25% reduction in pitting and hyperkeratosis. One patient with partial onycholysis as the only symptom of psoriatic nail involvement lost four fingernails after 2 months of treatment; the fingernails subsequently grew back with persistent onycholysis after treatment discontinuation.	One percent 5-FU should be used only for patients with nail pitting or hyperkeratosis, not for those with onycholysis	Prospective study
De Jong EM et al.[33]	-	Once daily either with 1% 5-fluorouracil in Belanyx® lotion or with its vehicle, Belanyx® lotion, for 12 weeks Then, follow up after 4 weeks	Nail area severity improved by 39% after 12 weeks and by 46% after 16 weeks. For the NAS score after 12 or 16 weeks, there is no difference in efficacy between 1% 5-fluorouracil lotion and the vehicle lotion alone after 12 weeks or after 16 weeks.	Pain, swelling, discolouration, inflammation, onycholysis, and perforations	Randomised, double-blind, left/right study

			No clear difference in efficacy was found between the active treatment and the vehicle lotion across all parameters.		
Fritz K[34]	-	Formulations: -1% 5-FU liquid -1% 5-FU combined with 20% urea cream. On the affected nails twice daily for 6 months.	Patients treated with the combination of 1% 5-FU and 20% urea cream experienced more than a 50% improvement in clinical signs of nail psoriasis, including oil spots and subungual hyperkeratosis. ➔ The addition of urea likely enhanced the penetration of 5-FU through the nail plate, increasing its therapeutic efficacy.	None declared	Prospective cohort study without a control group
Topical anthralin					
Yamamoto T et al.[100]	-	Formulation: anthralin ointment at concentrations ranging from 0.4–2.0% in petrolatum. Application: applied once daily to the affected nail bed and washed off with water after 30 minutes. Post-application care: 10% triethanolamine cream was applied to prevent undesired pigmentation. Duration: up to 5 months	Within 5 months, 12 out of 20 patients (60%) showed moderate to obvious improvement. Onycholysis and pachyonychia responded clinically, and the number of pitting was markedly decreased in some cases.	The main side effect was reversible pigmentation of the nail plate	Case series without a control group
Topical anthralin					
Yamamoto T et al.[100]	-	Formulation: anthralin ointment at concentrations ranging from 0.4–2.0% in petrolatum. Application: applied once daily to the affected nail bed and washed off with water after 30 minutes. Post-application care: 10% triethanolamine cream was applied to prevent undesired pigmentation. Duration: up to 5 months	Within 5 months, 12 out of 20 patients (60%) showed moderate to obvious improvement. Onycholysis and pachyonychia responded clinically, and the number of pitting was markedly decreased in some cases.	The main side effect was reversible pigmentation of the nail plate	Case series without a control group
Indigo naturalis					

Lin YK et al.[101]	-	Lindioil applied topically to affected nails twice daily: First 12 weeks: Lindioil was applied to the fingernails of one hand, with olive oil (placebo) applied to the contralateral hand. Weeks 13–24: Lindioil was applied to all affected nails on both hands.	After 12 weeks: 49.8% reduction in NAPSI scores for the treated hand and a 59.3% reduction for the single most severely affected nail in the Lindoil-treated nails versus 22.9% and 16.3% respectively, in the placebo group. Difference statistically significant.	No adverse events were reported during the 24-week treatment period	Randomised, observer-blind, vehicle-controlled trial
Liang CY et al.[102]	-	One drop (0.05 mL, containing 0.1 mg/mL of indirubin) of indigo naturalis oil extract, twice daily After 6 months: once per day, then every other day	The pustulation of the nails and the crusted, keratotic erythematous lesions disappeared within 4 weeks of starting treatment. A completely normal nail unit, without Beau's lines, was achieved after 6 months. Remission for longer than 1 year after treatment.	No side effects	Case reports
Lin YK[103]	-	1–2 drops (0.05 mL) of indigo naturalis oil extract onto the nail plate fold and hyponychium of affected nails twice daily	The mean reduction in the NAPSI score was 51.2% after 3 months of treatment. Two patients had reductions in their NAPSI score of 87.9% and 80.5%, respectively, after 6 months.	No adverse effects	Case series
Lin YK et al.[35]	-	Application of 1–2 drops (0.05 mL/drop) of Lindioil to the fingernails of one hand, and calcipotriol to the other hand, twice daily for 24 weeks	At Week 24, use of Lindioil showed significant improvements compared with calcipotriol for shNAPSI and mtNAPSI scores. The percentage reduction in shNAPSI scores between baseline and Week 24 was 51.3% (lindioil) versus 27.1% (calcipotriol). In both groups: most improvement in onycholysis and subungual hyperkeratosis. Lindioil was statistically superior for onycholysis.	-	RCT

5-FU: 5-fluorouracil; aboBoNT-A: abobotulinumtoxinA; Belanyx®: Yamanouchi Pharmaceutical Co, Tokyo, Japan; Bonalfa®: Reijin Pharma, Tokyo, Japan; BoNT-A: botulinum toxin Type A; CR: complete response; CsA: ciclosporin; Eudragit® S 100: Evonik Industries AG, Essen, Germany; Kanolone®: L.B.S. Laboratory Co., Bangkok, Thailand; mtNAPSI: modified target nail psoriasis severity index; NAPSI: nail psoriasis severity index; Neoral®: Novartis, Basel, Switzerland; PR: partial response; shNAPSI: single hand nail psoriasis severity index; Silkis®: Galderma Ltd, Zug, Switzerland; TA: triamcinolone acetonide; VAS: visual analogue scale; VitD: vitamin D.