Supplemental Table 2. Distinguishing features of nail unit squamous cell carcinoma vs. nail unit keratoacanthoma.*

	Nail unit squamous cell carcinoma	Nail unit keratoacanthoma
Clinical features	Periungual type: warty, hyperkeratotic papule involving the nail fold or groove. Subungual type: localized subungual nodular-ulcerated lesion, with onycholysis and/or longitudinal erythronychia. Most frequently affects the thumb, index, or middle fingernail in a male patient.	Dome-shaped subungual nodule with central plug of horny material filling the crater, most frequently affecting the thumb, index, or middle fingernail in a male patient.[10]
Historical features	Slow growth (years). Pain is uncommon.	Rapid growth (weeks). There is almost always progressive and persistent pain.
Dermoscopic features**	In a retrospective analysis of 103 SCCs and keratoacanthomas, white circles and vessel coils occurred more frequently in SCC (P=0.001, P=0.04).[11]	In a retrospective analysis of 103 SCCs and keratoacanthomas, central keratin occurred more frequently in keratoacanthoma (P=0.03).[11]
Histopathology	Stronger expression of Ki-67 with diffuse staining pattern.[10,12] Strongly positive laminin-322 staining.[13] High index staining of p53.[14] Other supportive distinguishing features include infiltrative growth pattern, mitoses, ulceration, cytologic atypia, acantholysis, marked pleomorphism, paradoxical maturation, subcutaneous or deep dermal invasion.[15-17]	If Ki-67 expression present, it is weak and localized to basal cell layer.[15] Weakly positive laminin-322 staining confined to isolated cells or small groups of cells in benign keratoacanthoma.[13] Higher levels of expression of nuclear factor kappa-B p50 subunit and cortactin.[10] Other supportive distinguishing features include crateriform architecture, epithelial lipping, symmetry, pushing growth pattern, sharp outline between tumor and stroma, abundant glassy cytoplasm, and intraepithelial elastin fibers.[16,17]
Radiologic findings	Radiologically indistinguishable. There may be bony erosion secondary to tumor compression or invasion on X-ray.	Radiologically indistinguishable. There is often a well-defined cup-shaped border secondary to rapid tumor compression on X-ray.[10]
Management	Mohs micrographic surgery.	Management is typically conservative excisional surgery or Mohs micrographic surgery for recurrent cases.[18] Atypical or histopathologically challenging cases should be treated as NSCC.[17]
Prognosis	Slow growing. MMS cure rates 92 to 99%.[19] Metastasis is very rare. Incidence of bony involvement previously reported to be 16%.[20]	Subungual keratoacanthoma is an aggressive keratoacanthoma variant.[21] Regression is rare.[22] Underlying bony erosion is common and may result in destruction of the distal phalanx.[23] Recurrences may occur after surgery.[24]

Abbreviations: NSCC: nail unit squamous cell carcinoma; SCC: squamous cell carcinoma.

*Keratoacanthoma and squamous cell carcinoma are closely related entities which are difficult to distinguish both clinically and histopathologically. Some dermatologists consider keratoacanthoma to be a variant of squamous cell carcinoma.

**Dermoscopic features have not been evaluated for nail unit squamous cell carcinoma vs. nail unit keratoacanthoma.