Common Skin Conditions in HIV/AIDS

a case based approach

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Case 1

- Seborrhoeic Dermatitis
- Tinea capitis
- Molluscum contagiosum (Pox virus)
- Plane warts (HPV)
Seborrhoeic dermatitis

- Commonest inflammatory dermatosis
- Incidence ranging 32 to 83%
- Severity ↑ immunosuppression
- Infants erythema, scaling progresses to erythroderma
- >2ys flexural predominance
- Often superinfected staph and HSV
- Frequently relapses
Therapy

• Mild disease

• Topical steroids
  – 1% hydrocortisone for the face
  – methylprednisolone aceponate cream or dilute betamethasone valerate cream for the body

• Scalp
  – Ketoconazole
  – Zinc pyrimenthamine
  – Tar shampoos
Therapy

• If infected (weepy and malodorous):
  – systemic broad spectrum antibiotic
  – Potassium permanganate soaks
  – Sedating antihistamines
Molluscum Contagiosum

- 5-18% HIV infected children
- Especially CD4 <200 cells/mm³
- Although common in children
- Atypical sites: face, neck
- Extensive, large, confluent, disfiguring
- Verrucous, pruritic, and eczematous
- Recalcitrant and challenging to treat
Therapy

- 1\textsuperscript{st} line salicylic/lactic acid prep  cost effective
- Duofilm
- Less effective: tretinoin, imiquimod
- Scratching discouraged to prevent transmission and autoinoculation
- The important differentials to consider in AIDS patients include
  - cryptococcosis, histoplasmosis and penicilliosis.
Plane Warts

- HIV infected children multiple HPV types
- persistent
- Common warts, flat warts, EDV-like lesions
- Zimbabwean study prev 24% in adolescents
- Extensive photodistribution
- marker of vertical transmission of HIV
- Risk of tumour development, surveillance
- No improvement with HAART
Therapy

- 1st line salicylic acid/lactic acid preparations  Duofilm
- tretinoin cost effective
- Genital warts podophyllin 20%
- Imiquimod effective in facial, genital and extragenital warts
Case 2

- Secondary syphilis
- Drug reaction
- Pityriasis rosea
- Psoriasis
Syphilis

• “great mimicker”
• presents as it does in the immunocompetent individual.

• in HIV infection:
  – more than one primary lesion
  – primary and secondary lesions may co-exist
  – Ulcerated secondary lesions (Lues Maligna)
  – more rapid conversion from secondary to tertiary syphilis.
• Classic lesions are
  – an asymptomatic papulosquamous truncal eruption
  – annular plaques especially of the “muzzle” area of the face
  – split papules involving the angles of the mouth
  – snail track ulcers of the tongue
  – hyperpigmented papules of the palms and soles.
  – moth eaten alopecia
Case 2 continued

- HAART introduced
- CD4 18
- 3TC/EFZ/TFV
- Rash 2 weeks later
Case 2

- Drug reaction
- Syphilis
- Immune reconstitution
IRIS

• Successful HAART, ↓VL, ↑CD4 and CD8
• Skin manifestations in 54-78%
• Commonest being:
  • HSV
  • VZV
  • Warts
  • Molluscum
Case 3

- Herpesvirus infection
Herpes simplex 1

• Severe, chronic and recurrent in HIV infected children
• As CD4 count declines, lesions more atypical, episodes prolonged
• CD4 > 400, 13% ulcerated lesions
• CD4 < 50 , 58% ulcerated lesions
HSV 1

- Impt to differentiate recurrent ulcers from
- Chronic non-healing ulcers
- Herpetic ulcers > 1 month AIDS-defining
- Persistent viral shedding as immsuppression declines
Therapy

- Aciclovir effective
- < 2 yrs: for primary infection
  - 100mg 5 x dly or 200 tds for 10d
- >2ys: 200 5x dly x 10d; 400 tds x 10d
- Valacyclovir 500 bd
- Recurrence duration ↓ to 5 days
- Severe oral involvement IVI 5mg/kg 8 hourly
- Valaciclovir bioavailability 3-5X >er
Resistance

- Unresponsive ulcers, exclude CMV
- Suspect resistance, especially large ulcers
- Sensitivity proven
- IVI foscarnet 120-200mg/kg/d 2-3 doses
- Imiquimod
- Cidofovir
Case 4

- Papular eruption of HIV
- Scabies
- Tuberculous hypersensitivity
Tuberculids

- group of eruptions associated with an underlying focus of TB

- Papulo- necrotic tuberculids present with asymptomatic papular lesions that can become pustular or necrotic.

- recurrent crops with spontaneous resolution and heal with scarring
Therapy

• Lichen scrofulosorum asymptomatic follicular papules, truncal, extensors

• The decision to treat is based on:
  – The characteristic skin lesions,
  – A strongly positive Mantoux and
  – Histological confirmation of PNT.
  – Standard anti-Tuberculosis treatment for 6 to 9 months results in resolution of the lesions.
Case 5

- Deep fungal infection
- Balstomycosis
- Histoplasmosis
- Lupus vulgaris