

The Old, The New and the Reemerging-HIV Dermatology

Toby Maurer, MD





Psoriasis

- Widespread psoriasis, especially if it was once stable, predicts falling CD4 count
- ?resistance to ART? ?Non-adherence?
- Tx: ARV's and topicals
- Until ARV's kick in-acitretin 10-25 mg/day



New Directions

- Is psoriasis exacerbation associated with drug resistance?
- Gene microarrays- Is HIV psoriasis different than non-HIV psoriasis?
- What cytokines are turned on and off with ARV's?



Pruritic Papular Eruption of HIV (PPE)

- Presenting sign of HIV in many countries (not in US/Europe)
- Worse with lower CD4 counts
- Histology: bug bites
- Tx: improves with ARV's within 16 weeks
- Can we use recurrent PPE to predict viral resistance?







Bed Bugs

- Epidemic in urban areas of the US
- Not related to socioeconomic
- Bed bugs live in crevices of wood and mattresses
- Come out at night
- Hard to eradicate-need professionals
- Clobetasol cream bid for relief
- Watch for secondary infections





Herpes simplex

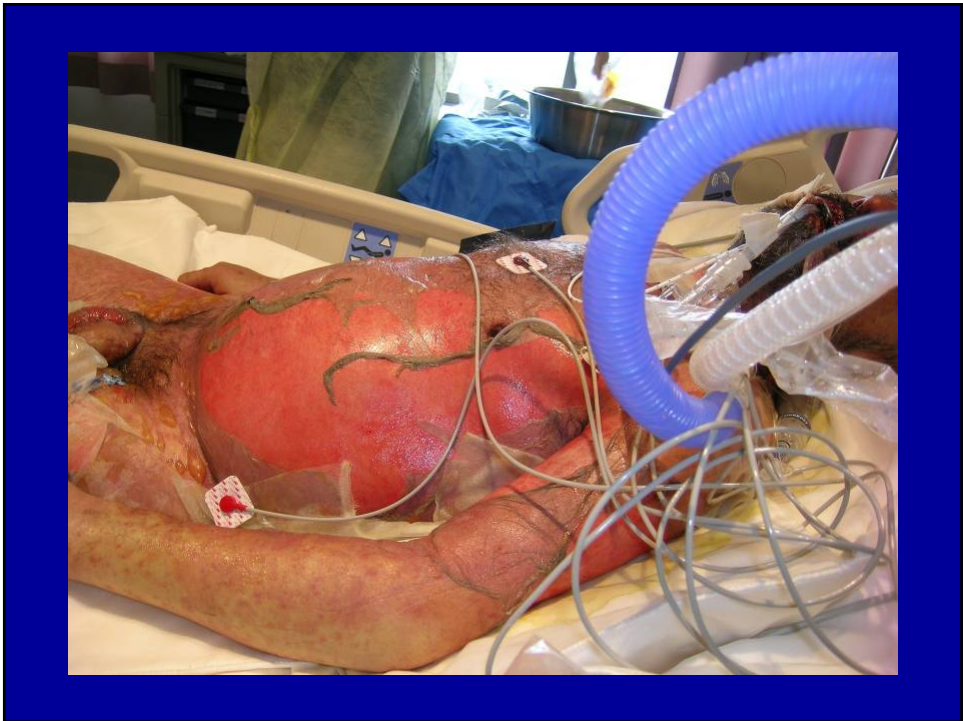
- In non-healing sores, especially on face and genital area, don't forget HSV
- Seeing a resurgence-CD4 counts > 200
- Tx with high dose ACV
- If not improving, consider ACV resistance



- Linear excoriations/straight edges-think OUTSIDE job-fingernail
- Lots of scarring on arms/face
- Methamphetamines make people itch and scratch
- Can continue for 18 months after stopping meth







Toxic epidermal necrolysis

- Complete separation of epidermis
- Watch for triangular blisters
- Higher incidence in HIV
- Higher mortality in HIV
- Septra/ vanco
- IVIG???





Fixed Drug Eruption

- Most commonly to sepra
- Darunavir???-sulfa moiety
- erythema multiforme in pts with previous sepra allergy





Kaposi Sarcoma 2007

- New cases: 3-4/week
- Primarily in pts with CD4 under 100
- Presenting diagnosis of HIV in 50% of pts
- The other half are non-adherent to ART

Treatment and what to expect

- First line-ART
- Takes an average of 9 months until lesions melt away
- If pts get started on ART within 1 year of KS lesion appearing, tend to do well
- If beyond 1 year, pts disease is hard to control
- 25% of our cohort died

What else can you do?

- Consider adding chemo-doxil/taxol-don't know the indications or the results yet
- Consider adding chemo if there is edema/systemic signs of KS/rapidly progressing cutaneous lesions





Do you need to biopsy?

- YES!
- Make sure it is KS-there are mimickers
- Need tissue if you are going to add chemo or radiation



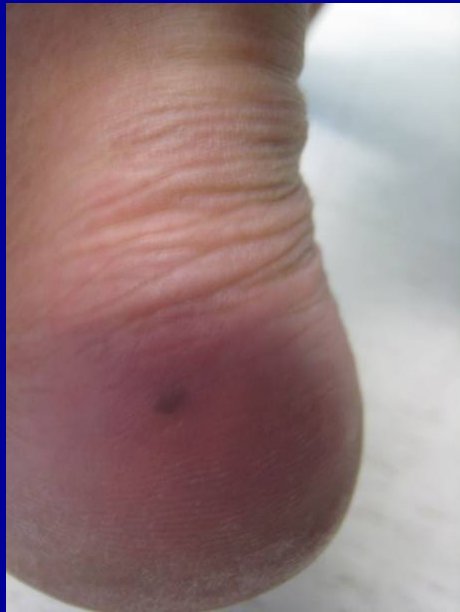




Bacillary Angiomatosis is back

- Bartonella
- Fevers, bone pain, endocarditis
- Biopsy-look for organism/do Silver stain which makes organism more obvious
- Culture it from the blood-let lab know what you are looking for so they can call ID- Jane Koehler-UCSF
- Tx: 6 weeks of erythro/doxy





Kaposi Sarcoma-new group

- 16 patients with CD4 over 300 and VL<75 for more than 2 years with new or persistent KS-entering them into SCOPE study
- All on ARV's
- Ave age 51 (range:41-74 yrs)
- Ave duration of HIV: 18 years
- Ave length of time on ARV's-7years (1- 19 yrs)

What is going on?

- Immunosenescence- is the immune system in long-term treated HIV infected patients aging prematurely??
- Functionally abnormal T cell response to HHV8
- HHV8 virus-unusual type or unusual behavior

How is this group doing?

- In 2 year period-stable from HIV perspective
- KS not rapidly progressing on skin
- No systemic signs of KS
- Looks very much like classical KS in older Mediterranean patients



Bowenoid Papulosis

- Atypical appearing condyloma-white, black-consider bx
- Bowenoid papulosis is SCC-in-situ
- Aldara (imiquimod) works-over 12 week period
- Rebiopsy





Squamous Cell Carcinoma

- Several cohort studies have now documented that there is a higher incidence of SCC and BCC in HIV
- Risk factors: Caucasians, increasing age, longer duration of HIV infection
- Low CD4 counts not a significant variable for tumor initiation
- Sun and smoking



- SCC's can metastasize from high risk areas: lip, temples
- 2000 deaths/yr in US
- good CD4 counts/VL not significant in lowering mortality
- Excise SCC's
- Discourage radiation





Basal Cell Carcinoma

- Non-metastatic but can destroy large areas of skin
- On face, surgical excision recommended
- Curretage and dessication adequate for body
- Aldara?-in the non-immunosuppressed host-okay for superficial BCC's-not studied in HIV



Melanoma

- Melanoma in HIV may be more aggressive when compared by tumor thickness
- Sentinel node biopsy recommended at shallower thickness-usually do sentinel node if melanoma is 1mm or more in thickness
- Recurrent melanoma more frequent-monitor carefully





- Early detection is key to surviving melanoma
- Screen yourselves and your patients