HIV Dermatology 2019

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Learning Objectives

1) Familiarize yourself with current dermatologic problems in HIV
2) Review pathophysiology of dermatologic diseases
3) Identify current treatments for dermatologic diseases in HIV

Disclosures

• No Relevant Disclosures
• Off-label investigations will not be discussed
CD4 60 when started ARV’s-got up to CD4 160-could not tolerate regimen-started a new regimen-now itchy rash

The correct treatment for this condition is

1) Do nothing
2) itraconazole
3) permethrin
4) prednisone
Eosionophilic folliculitis

- Pruritic urticarial papules on the face/neck scalp and chest
- CD4 under 50 and when starting ARV’s or new regimen as immune reconstitution syndrome
- Not a drug reaction
- DO NOT STOP ARV’s

Treatment

- Wait it out 12-16 weeks until immune system stabilizes
- Itraconazole is the first line drug-works as an antieosinophilic agent- titrate up from 200 qd to 400 qd. Watch drug-drug interactions
- Permethrin is second line drug which we usually add to itraconazole if not working as a single drug
- Prednisone is overkill and would not elect to use it first line in pt with CD4 under 200

Expert Opinion
Eosinophilic folliculitis
This pts psoriasis cleared after 3 days. What was the agent that resulted in this dramatic effect?

• 1) ustekinumab (stelara)
• 2) ultraviolet light
• 3) prednisone
• 4) calcipotriene and clobetasol
• 5) antiretroviral-atripla

• Most people take 12-16 weeks to respond to ARV’s re: psoriasis
• In the interim, can use acitretin 25 qd
• Topicals can be used after ARV’s stabilize the pt—much easier to handle the psoriasis and don’t really need much more than the occasional topical
• We have never had to go to biologics for HIV related psoriasis—can theorize on many to the possible side effects

Expert Opinion
This green pus incised and drained from abscessed areas revealed

- 1) pseudomonas
- 2) mycobacteria
- 3) deep fungal infection
- 4) no organisms
Immune Reconstitution Herpes zoster
Eczema—Example of Chronic Inflammation in HIV

- Eczema will always recur in spite of well controlled HIV if the patient started ARV’s under 200.
HIV replication associated with irreversible damage thru INFLAMMATION because of the reservoir

Even though our assays reveal an undetectable viral load, there is activation / inflammation

Hunt PW, Brenchley J, Sinclair E, et al. Relationship between T cell activation and CD4+ T cell count in HIV-seropositive individuals with undetectable plasma HIV RNA levels in the absence of therapy.

J Infect Dis. 2008;197:126–133

Concept of the Reservoir

• Starting Antiretrovirals early after seroconversion can decrease the size of the reservoir
• Start HIV meds as early as possible

Herpes simplex

- Fewer episodes in our well treated cohort
- Valacyclovir—500 mg tid
- ? Suppressive doses?—treat when you have it

Expert Opinion
Herpes simplex
Verrucous HSV

- Usually ACV resistant
- Emerging as a problem worldwide
- Suppressive doses of ACV used in recurrent HSV infection in HIV may be selecting out resistant strains
- Treat with topical or injectable cidofovir

*Expert Opinion*
Human Papilloma Virus

• Still a burden on cutaneous skin and genital skin
• ? Vaccines decreasing severity or incidence?
• Local destructive techniques to include liquid nitrogen and podophyllin under occlusion
• Think about squamous cell cancer in those warts that won’t respond and get bigger—BIOPSY
• Cidofovir injections
Living longer—chronic actinic damage

• Seeing the ravages of aging skin – actinic keratoses, basal cell cancers and squamous cell cancers

• SUNSCREEN 100

• HIV increases the rate of recurrent squamous cell cancer so in your pts who have had 1 episode of squamous cell cancer
  • monitor closely (q 6 months) and have a low threshold for biopsy
Syphilis

• Many morphologies on the skin
• Lots of syphilis-PrEP????
• Biopsy if in doubt, empiric treatment
• Monitor for reinfection or failed treatment—at 1 month, 3 months, 6 months, 12 months, 18 months post treatment

CDC STD Guidelines. Nov 1, 2017
Drug eruption-like rash that does not itch = syphilis
Kaposis sarcoma

- First sign of HIV in low CD4 counts
- Recurring in pts who are virally suppressed (may have had KS in the past)
  - blips of non-adherence; aging (immunosenescence), steroid-induced
- Seeing in MSM's—not HIV infected—ages 40-50's
• Cluster of KS Cases of HIV infected pts with high CD4 count and low VL\(^1\)
  - never had low CD4 counts
  - not old, not Mediterranean

• Immunosenescence is associated with KS in ARV treated HIV infected *pts*\(^2\)

Work-up

- Biopsy to confirm diagnosis
- HIV test once-if positive, start ARV’s
- Ask about symptoms; IMAGING of limited use
  - **PULMONARY**: coughing, hemoptysis, SOB
  - **GI**: tumor in mouth that interferes with chewing, GI pain, blood in stool
  - **Lymphedema**: sustained
- START CHEMO-liposomal doxorubicin is first line-at least 6 cycles
- START COMPRESSION for lower limbs

**Expert Opinion**

Compression is KEY
IF HIV Negative

- Ask about symptoms: Pulmonary, GI, Lymphedema

OPTIONS:
- Do nothing
- Intraleisonal chemo (Velban)
- Spot radiation
- Talk about triggers-avoid systemic steroids

Expert Opinion
Summary

• Escape from the reservoir allows for acute and chronic inflammation

• Start ARV’s early to shrink the reservoir

• Kaposis sarcoma is here to stay

• Don’t turn your back on syphilis!