HIV-Dermatology Cases

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Learning Objectives

At the conclusion of this presentation, attendees should be better able to:

• Apply evidence-based principals and clinical judgment to the management of dermatologic conditions in those living with HIV
Disclosures

- This presentation includes discussion of investigational uses of TNF alpha blockers

- Patient recommendations in this presentation are based on expert opinion/clinical experience unless otherwise noted.
ACV resistant herpes simplex
If pt not improving on standard doses of ACV

- Culture for HSV and hold culture if positive to be sent for ACV resistance testing
- Biopsy to confirm herpetic changes histologically
- Maximize absorption of ACV by increasing dose and lengthening time of treatment
If resistant

- IV Cidofovir—careful in pts on tenofovir—can be hard on the kidneys
- IV Foscarnet—careful in uncircumcised men
- Can shrink eyeball (hypotony) with protease inhibitors
- Topical cidofovir (formulated to 1%-3% gel) can be used in addition
- Triflouridine drops can be used in addition
Herpes vegetans

• In 20 cases that have been reported, 14 have been ACV resistant
• we have 7 men, on ARV’s with high CD4 counts for long period of time-with these vegetative lesions and ACV resistance

Herpes Vegetans as sign of HIV infection. Patel, Rosen Dermatol Online J 2008 Apr15; 14 (4)6
For HSV vegetans

• Debride or debulk thick skin then
• tx for ACV resistant HSV (IV cidofovir or foscarnet)
• Resistance to cidofovir and foscarnet has been reported
• Agents to add that work on a different mechanism:
  Imiquimod-works on toll like receptors
  Thalidomide-turns down inflammation
  Prednisone-turns down inflammation
Treatment

• IV cidofovir
• Topical cidofovir 3%
• Triflourodine drops tid
• Prednisone 40-tapered dose
• Can thalidomide be used to turn off the process?
• We discontinued cidofovir, restarted high dose ACV to kill of wild type virus, tapered prednisone and substituted topical clobetasol
Resistant HSV

Should we continue suppressive doses of ACV?

• Our pts have been on and off suppressive doses of ACV for years—selected out for mutations?
Widespread KS with Declining CD4 counts
Widespread KS with low CD4

- Often have other concomitant disease like toxoplasmosis, PCP
- CD4’s under 100
- Non-adherent patients
- At risk for Immune reconstitution syndrome
- 25-30% mortality rate even with best of treatment
• Start ARV’s with doxil to a) prevent immune reconstitution? b) treat appropriately?
• These guys are sick-too sick for doxil?
• Too well for doxil-so just start ARV’s?
• Pts with KS immune reconstitution-high risk of dying
• Can we add something like thalidomide to turn off the inflammation?
• NOT PREDNISONE
KS started with low CD4-pt now with High CD4-KS persisted

- Diagnosed with KS long ago with low CD4’s
- Have been ARV adherent for years
- VL undetectable, high CD4’s for years
- KS NEVER went away
- KS usually involving lymph channels
- Maintained on doxil, taxol, etc
- NEED new meds-CLINICAL trials coming to town
Indolent KS with High CD4 (KS eliters)

• Reminiscent of Classical KS (older Mediterranean man with few lesions on lower legs)
• Not old and not Mediterranean
• 50 year olds
• HIV since the beginning (ave. duration of HIV 17 years)
• Adherent to every new drug that came along
• Saw all their partners die of AIDS and KS
• CD4 counts 500-800, virally undetectable for years, CD4 nadir never less than 300
• Compared to HIV infected subjects without KS:
  • More CD57+ cells, CD28- cells and waning pools of naïve T cells suggesting immunosenescence (Unemori)
• Following 30 such patients-look at other indicators of immunosenescence?
How do we treat these patients?

• We watch them
• Not sick enough to get chemotherapy

Trying to use meds that specifically target inflammatory markers and proteins that are expressed
Aroused quiescent KS/HHV8

- Some of these pts are our KS eliters, others are KS pts being treated with doxil, etc
- Some are HIV negative but with KS
- Sudden exacerbation of KS with steroids in all forms-potent topical, intrarticular injections, inhalers
- BEWARE…..
- Treatment: stop steroids, check for other strange ingredients like growth stimulants
- ?follow?, XRT, doxil?
• Antiretrovirals have a direct effect on the inflammation, on those cytokines
• Act immediately even before the CD4 cells have a chance to stabilize
• CD4 cells stabilize after 12-16 weeks on HIV meds
Can we use antiretrovirals in psoriasis in non-immunusuppressed hosts?

- Area being explored
- AZT has been used but side effects too dramatic
- TNF alpha blockers-can they be used in HIV psoriasis?
• Don’t want to use in pts who have latent TB
• Don’t want to use in pts with Hepatitis B-deaths
• Being explored in HIV to turn off cytokines before cytokines have a chance to damage the patient
• Worry about turning off TNF alpha in HIV—may be good but may be bad
Drug eruption like rash that does not itch = syphilis
Syphilis/HIV

- More neurologic signs at presentation - hearing loss and uveitis Therefore treat as neurosyphilis
- Osteochondritis not uncommon
- Close follow-up after treatment to make sure titers falling - often pts become reininfected or require more aggressive treatment in HIV
Lichenoid and psoriasiform lesions

- Form of syphilis
- Pt had bulging eyeball
Immune Reconstitution Syndrome

- Occurs within 3-6 months of initiating ARV’s
- Affects 10-20% of those initiating ARV’s (Murdoch, Veter, Fellner-AIDS 2008)

- Usually occurs in lower CD4 counts (under 50)
Scrofula

• Not yet on antiretrovirals

• Treat the scrofula first-anti-TB meds for several months then start antiretrovirals

• If patient’s TB unmasked as a result of antiretrovirals, can use prednisone to treat immune reconstitution while treating the TB
Molluscum Immune Reconstitution

• Low CD4 nadir
• Rapid rise in CD4 count
• Sterile pus
• All biopsies c/w molluscum with surrounding inflammatory cells
Buttock/flank Acne

- Looks like folliculitis
- Occasionally grows out staph
- Usually sterile pustules, boils, cysts
- Do not respond to antibiotics
- Long term ARV controlled patients with high CD4 counts
Treatment

- Low dose isotretinoin to decrease inflammation
- Prevent chronic inflammation
- Start effective ARV’s before chronic inflammation can set in