Series Editor: William W. Huang, MD, MPH

AIDS-Related Noninfectious Dermatoses

Lindsay C. Strowd, MD

Dr. Strowd is from Clinical Associates at Reisterstown, Maryland.
The author reports no conflict of interest.

Disease Category	Condition	HIV/AIDS Stage of Initial Presentation	Clinical Cutaneous Features	Treatment	Notes
Neoplastic	Anal and cervical intraepithelial neoplasms (AIN/CIN)	HIV	Flesh-colored, verrucous or fleshy growths, erosions, and friable tissue	Surgery +/− adjunctive therapy based on staging	HPV associated; infected patients should have routine anal and cervical Papanicolaou tests
	Basal cell carcinoma	HIV	Pearly papule with telangiectases and ulceration	Surgery +/− adjunctive therapy based on staging	More likely to metastasize in this population
	Kaposi sarcoma	AIDS; CD4 count, <200 cells/mm^3	Violaceous macules, patches, plaques, nodules; lesions can be solitary, localized, or disseminated; can involve the oral cavity, skin, lymph nodes, and visceral organs	HAART is first-line treatment in AIDS; also can use cryotherapy, intralesional vinblastine, or imiquimod	Caused by HHV-8; may develop in up to 35% of patients with AIDS
	Non-Hodgkin lymphoma	AIDS; more common with CD4 count <200 cells/mm^3	Perianal nodules; solitary flesh-colored, erythematous or violaceous nodules	HAART plus conventional chemotherapy regimens such as CHOP	Most prevalent HIV-related lymphoma is diffuse large B-cell non-Hodgkin lymphoma, followed by Burkitt lymphoma; HAART has drastically decreased incidence; HIV-associated lymphoma also can be associated with EBV
	Squamous cell carcinoma	HIV	Rapidly growing pink keratotic nodules with ulceration	Surgery +/− adjunctive therapy based on staging	Some sources state more common than basal cell carcinoma in HIV patients
Inflammatory	Atopic dermatitis	HIV	Classic eczema lesions but more widespread	Topical steroids, antihistamines, emollients	Can be more recalcitrant to treatment
	Eosinophilic folliculitis	AIDS; CD4 count, <300 cells/mm^3	Small monomorphic, dome-shaped pustules with surrounding erythema on face, neck, trunk	Improves with HAART	Skin biopsy shows eosinophils around hair follicles and sebaceous glands; blood tests can show eosinophilia and elevated IgE
	Pruritic papular eruption	HIV	Symmetric nonfollicular papules mostly on arms and legs	Topical steroids, antihistamines, phototherapy	Diagnosis of exclusion; variant of prurigo nodularis

continued on next page

(continued)

Disease Category	Condition	HIV/AIDS Stage of Initial Presentation	Clinical Cutaneous Features	Treatment	Notes
Inflammatory (continued)	Psoriasis	HIV	Similar lesions to classic psoriasis; more widespread and severe groin involvement	Avoid MTX or cyclosporine; can use retinoids, biologics or phototherapy	Psoriasis may be associated with nail disease, arthritis, and Reiter disease
	Seborrheic dermatitis	AIDS; CD4 count, >500 cells/mm^3	Widespread pale erythematous patches with greasy yellow adherent scale; can affect face, scalp, chest, and back	Topical antifungals, corticosteroids, and keratolytics	Typically seen in young males; can involve larger geographic areas in HIV patients; most common skin disorder in HIV
Miscellaneous	Acquired ichthyosis	HIV	Thick scaly plaques on extensor skin more than flexor surfaces	Topical retinoids, emollients, and keratolytics	
	Lipodystrophy	HIV	Lipoatrophy of face, arms, legs, buttocks; hypertrophy of abdomen, breasts, upper back	Use of statins, metformin, and pioglitazone can improve fat distribution; can use fillers in facial areas	Poly-L-lactic acid and calcium hydroxylapatite are FDA-approved fillers for lipodystrophy
	Porphyria cutanea tarda	HIV	Blisters and erosions on dorsal hands, milia, hypertrichosis	Phlebotomy or low-dose antimalarials	HIV can be isolated from blister fluid via PCR

Abbreviations: HIV, human immunodeficiency virus; AIN, anal intraepithelial neoplasia; CIN, cervical intraepithelial neoplasia; HPV, human papillomavirus; HAART, highly active antiretroviral therapy; HHV-8, herpes simplex virus type 8; CHOP, chemotherapy with cyclophosphamide, doxorubicin, vincristine, and prednisone; EBV, Epstein-Barr virus; MTX, methotrexate; FDA, US Food and Drug Administration; PCR, polymerase chain reaction.

Practice Questions

1. **What is considered to be the most common skin finding in human immunodeficiency virus/AIDS patients?**
   a. atopic dermatitis
   b. atypical nevi
   c. basal cell carcinoma
   d. psoriasis
   e. seborrheic dermatitis

2. **You are treating a patient with widespread psoriasis who also has human immunodeficiency virus and is currently on highly active antiretroviral therapy. What would *not* be the best option for treatment?**
   a. acitretin
   b. adalimumab
   c. cyclosporine
   d. infliximab
   e. topical steroids

3. **Which of the following conditions is seen in human immunodeficiency virus patients and is associated with the human papillomavirus?**
   a. basal cell carcinoma
   b. cervical intraepithelial neoplasia
   c. eosinophilic folliculitis
   d. Kaposi sarcoma
   e. squamous cell carcinoma

4. **Which of the following cosmetic products is US Food and Drug Administration approved for treatment of AIDS-associated lipodystrophy?**
   a. abobotulinumtoxin
   b. calcium hydroxylapatite
   c. hyaluronic acid
   d. incobotulinumtoxin
   e. silicone

5. **Which of the following dermatologic conditions typically does not present until the CD4 count is less than 200 cells/mm^3?**
   a. atopic dermatitis
   b. basal cell carcinoma
   c. Kaposi sarcoma
   d. pruritic papular eruption
   e. psoriasis

Fact sheets and practice questions will be posted monthly. Answers are posted separately on www.cutis.com.