Dermatological Manifestations of HIV  Pt. 1

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5/2/2016
Revised 10/11/16
Sources

• American Academy of Dermatology; HIV Dermatology Basic Dermatology Curriculum, updated 9/6/11.

• HIV Dermatology; UCSF Dermatology, updated 9/9/10.

• Cutaneous Manifestations of HIV, Robert A Schwartz, MD, updated April 27, 2015.
• Learn to identify, by sight, many of the most common HIV-associated rashes.

• Learn what impact HIV has on skin conditions.

• Learn the association between CD4 count and likelihood of certain skin conditions.
Skin Lesions

- May be initial sign of HIV infection
- May result from HIV itself or OI
- May lead to early diagnosis of disease
- Many common skin diseases more severe in HIV--eg, psoriasis
• With ART, many skin diseases decreased, except for drug reactions and other non-infectious skin problems.

• ART will most likely improve any HIV-related skin condition.
• Neoplastic, infectious, non-infectious diseases (including inflammatory dermatoses), can produce skin manifestations.

• Skin diseases, even common ones affecting non-HIV, occur more frequently and more severely in those with HIV

• May be less responsive to tx

• 80-90% w HIV have skin diseases
Skin Diseases in HIV

- HSV
- VZV
- Staph Aureus
- Syphilis
- Scabies
- Drug reaction
- Lymphoma

**Any CD4 Count**

**CD4 < 500**

- HPV
<table>
<thead>
<tr>
<th><strong>Infection</strong></th>
<th><strong>Inflammatory</strong></th>
<th><strong>Neoplasm</strong></th>
<th><strong>Other</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacterial, Mycobacterial, Fungal, Viral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EBV</td>
<td>Psoriasis</td>
<td>Kaposi’s Sarcoma</td>
<td>Eosinophilic Folliculitis</td>
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<tr>
<td>Candida</td>
<td>Seb derm</td>
<td></td>
<td></td>
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<tr>
<td>Bacillary angiomatosis</td>
<td>Acquired Icthyosis</td>
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<tr>
<td>Molluscum C.</td>
<td>Atopic Dermatitis</td>
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<tr>
<td>Histoplasmosis</td>
<td>Xerosis</td>
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<tr>
<td>Coccidiomycosis</td>
<td>Pruritic papular eruption (insect bite hypersensitivity)</td>
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<tr>
<td>Cryptococcosis (CD4 &lt; 50)</td>
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</tbody>
</table>

American Academy of Dermatology

Monday, October 10, 16
Pearl

With any rash, you don’t want to miss these four things:

1. HIV
2. Syphilis
3. Drug reaction
4. Scabies

Always run HIV test on anyone who presents with disease that’s on prior slides.
On each visit, always inspect inside the mouth.
Primary HIV Infection

50%
Does not itch
Resolves in 1-2 weeks
Dusky red macules and papules

pedaids.org
Primary HIV Infection
Kaposi’s Sarcoma

oval and spindle neoplastic endothelial cells
hyaline globules
erythrocytes in spaces between spindle cells
Kaposi’s Sarcoma

- Can occur before the onset of immunosuppression
- New group of those with long-standing, medicine controlled HIV, CD4 more than 300, who are getting this
- ART helps; think about IRIS
- Cause HHV-8
- Biopsy recommended; refer to derm.
- Lesions most likely on skin, but mucous membranes, GI tract, lymph nodes, lungs may be involved. Consider cxr and stool for OB.
Shingles
Dermatomes are areas on the skin supplied by sensory fibers of the spinal nerves.
Seborrheic Dermatitis
Oral Hairy Leukoplakia
Thrush
Pseudomembranous thrush
Oral Candidiasis:
Lesions may be scraped off--will leave bleeding or red base.
Most common fungal disease in HIV+
Assume if they have HIV and oral thrush, it is extending into the esophagus, so treat accordingly. That means, avoid nystatin liquid and clotrimazole troches, which just treat oral thrush. Use fluconazole 200 mg/day for 14 days. Endoscopy, if no improvement in 72 hours.
Warts
Warts
Warts
Herpes Simplex
Aphthous Ulcer
Molluscum Contagiosum

Henderson-Patterson Bodies
Molluscum

Benign
Asymptomatic
DNA poxvirus
Transmission: Skin to skin and sex
Lesions may become HUGE in HIV
ART will improve