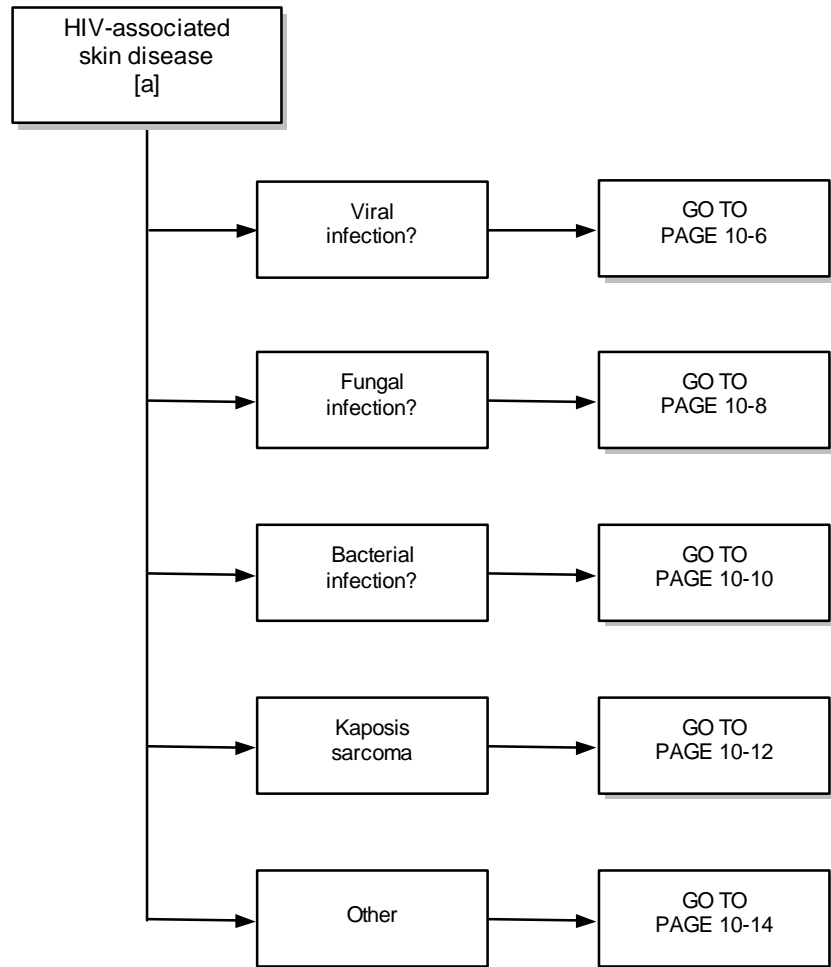


CHAPTER 10

HIV-ASSOCIATED SKIN DISEASES



Annotations

- (a) **Definition:** The presence of a dermatosis in a patient with symptomatic HIV infection.

Etiology

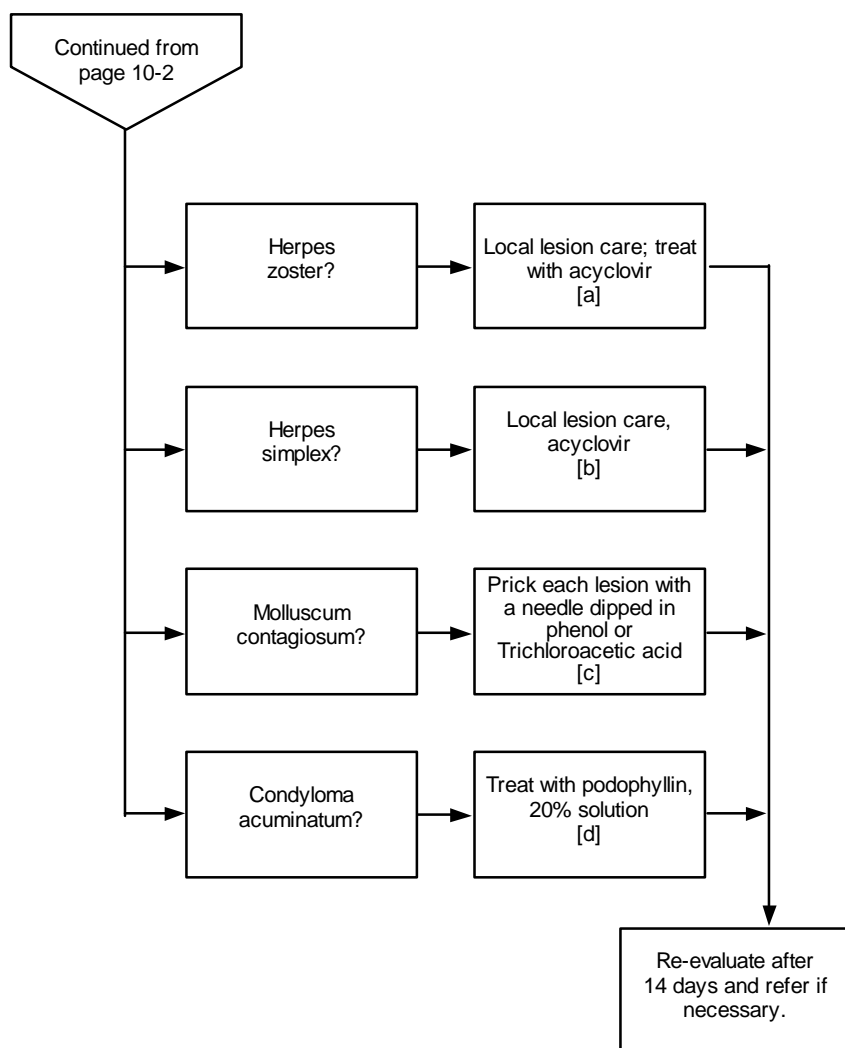
- (1) Viral infections
 - herpes simplex
 - herpes zoster
 - molluscum contagiosum
 - condyloma acuminatum
- (2) Bacterial infections
 - furunculosis
 - impetigo and pyoderma (staphylococci, streptococci)
 - hidradenitis suppurativa
 - discharging sinuses
- (3) Fungal infections
 - candidiasis
 - dermatophytosis
- (4) Malignancy
 - Kaposi sarcoma
- (5) Other dermatoses:
 - drug eruptions

- chronic prurigo or urticaria (blood parasites or other common etiologies excluded)
- severe seborrhoeic dermatoses
- generalized erythroderma
- severe psoriasis
- Scabies

Some sexually transmitted diseases occur with increased frequency or altered expression and the management needs to be reviewed (see national guidelines).

A list of the main causes in order of significance should be established in the light of available national or local information.

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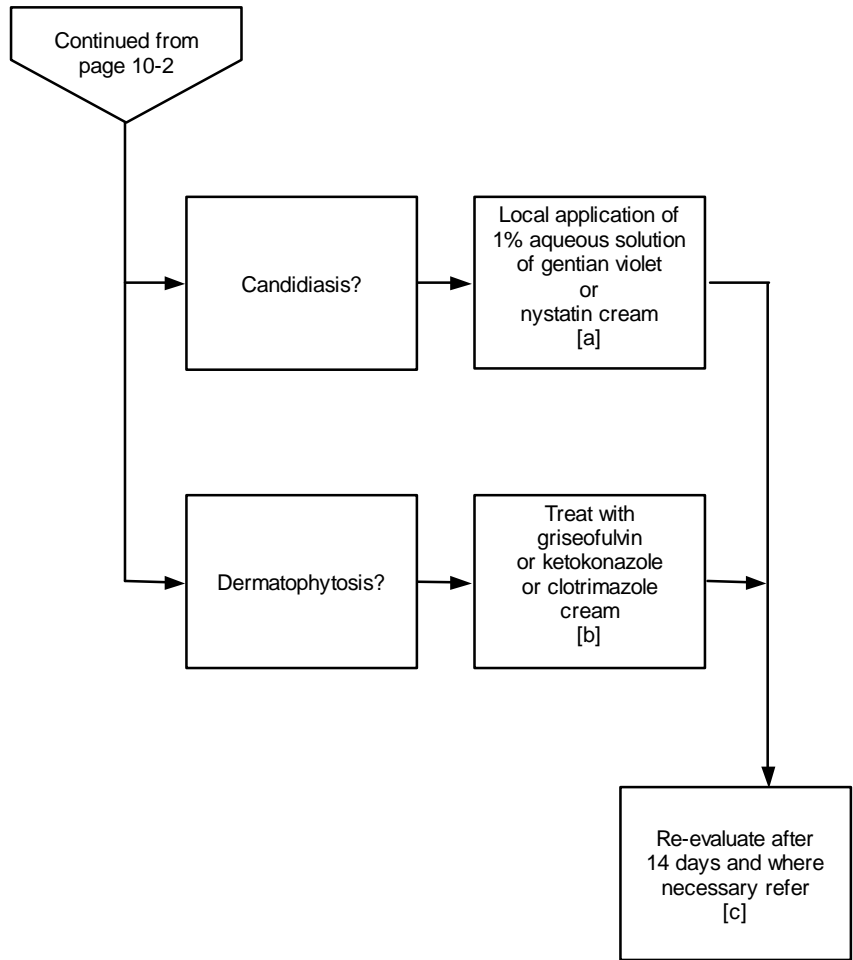


Annotations

- (a) In early stages pain relieving agents like paracetamol and narcotic drugs can be used depending on the severity of the pain.

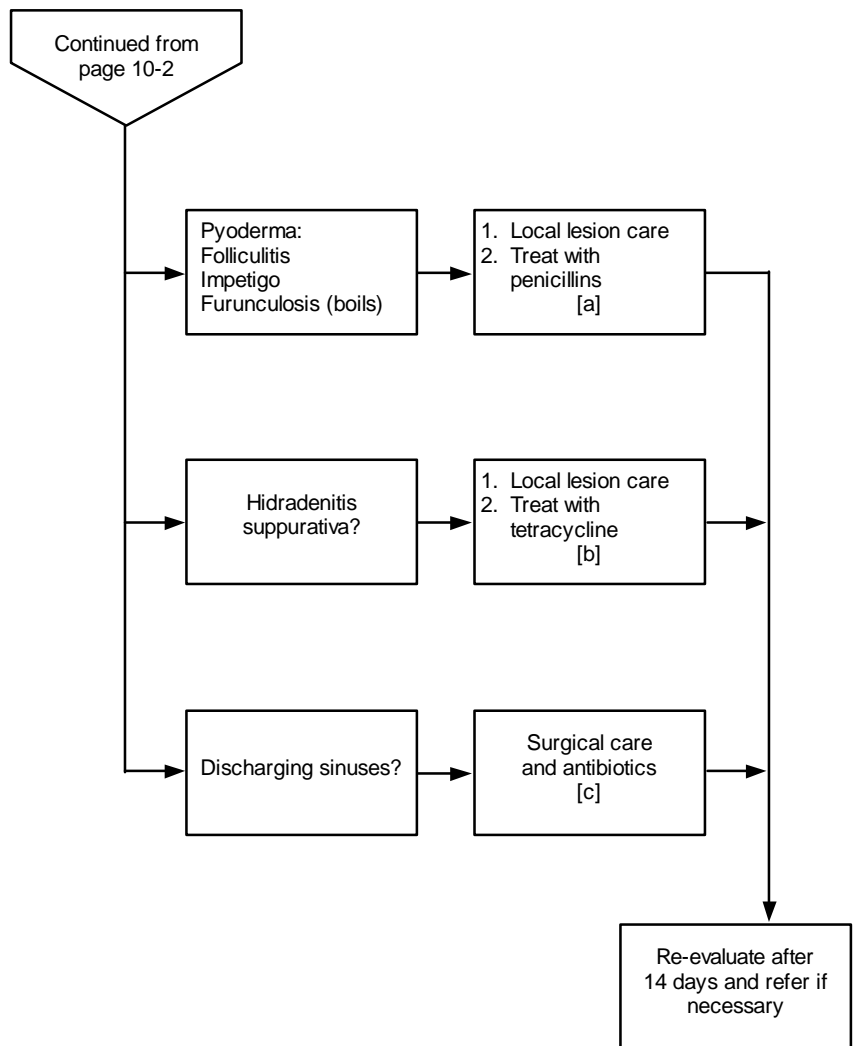
The greatest benefit of acyclovir is seen in patients with ophthalmic or disseminated zoster. Treatment should be commenced within 4 days of presentation and should continue until new lesions have stopped forming or old lesions have scabbed. The dosage of acyclovir is 10mg/kg 3 times daily for 7 days. Post-herpetic neuralgia is uncommon; if present, pain-modifying agents are considered useful, e.g. phenytoin (100 mg daily slowly increasing to 250-300 mg daily) or carbamazepine (100 mg daily increasing to 400 mg daily in 10 days).

- (b) Ulcers which are persistent and very painful may be treated with oral acyclovir, 200 mg 5 times daily, until healed. Where available, chemosuppression with oral acyclovir, 400 mg twice daily, should be administered if indicated.
- (c) Each lesion is pricked with a needle dipped in phenol or trichloroacetic acid and then twisted. The recurrence rate is high.
- (d) Alternatively, glacial trichloroacetic acid may be applied 1-2 times per week until the lesion has cleared. The recurrence rate is high.



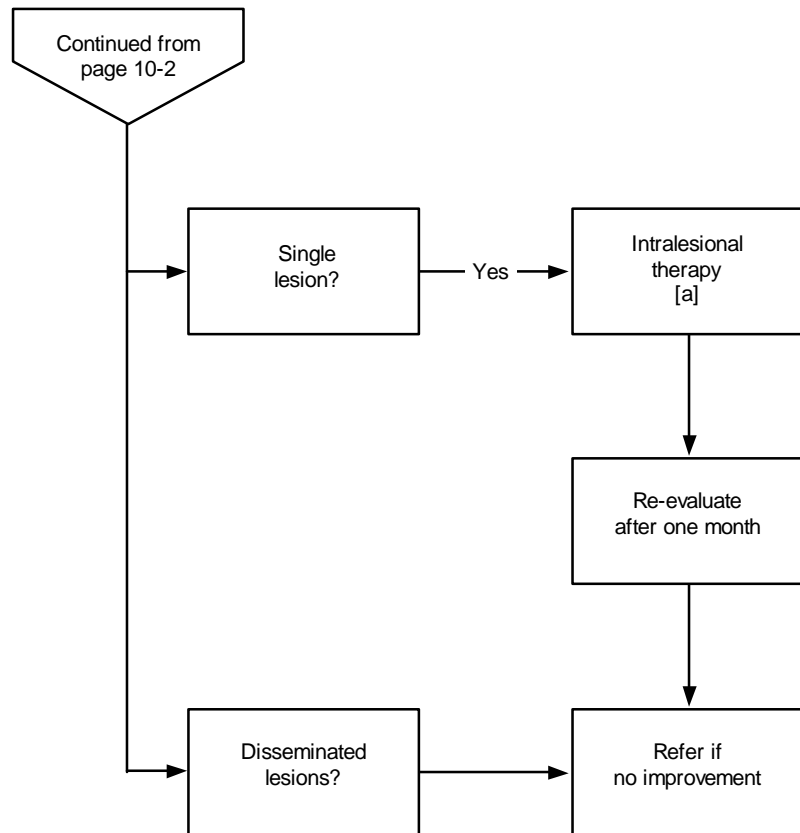
Annotations

- (a) If there is no response to therapy, try other topical antifungal drugs, e.g. clotrimazole, 1% cream. In severe cases systemic therapy, e.g. ketoconazole, 200 mg twice daily may be required.
- (b) Widespread dermatophytosis treat with griseofulvin, 500 mg twice daily, where available. Alternative drugs are ketoconazole oral or clotrimazole 1% cream.
- (c) Cutaneous lesions of systemic cryptococcosis or disseminated histoplasmosis are rare, but respond well to antifungal chemotherapy.



Annotations

- (a) For example, phenoxymethylpenicillin, 250-mg tablets 4 times daily for 10 days. In case of treatment failure, penicillinase-resistant penicillin, e.g. cloxacillin, should be given. In severe cases the patient may require intravenous treatment with penicillinase-resistant penicillin or cephalosporins because of the risk of systemic spread.
- (b) Treat with tetracycline 500 mg four times a day for 7 days then 500mg twice daily for 6 weeks.
- (c) Where facilities are available to determine the sensitivity of the organism identified, the treatment should be in accordance with the findings.



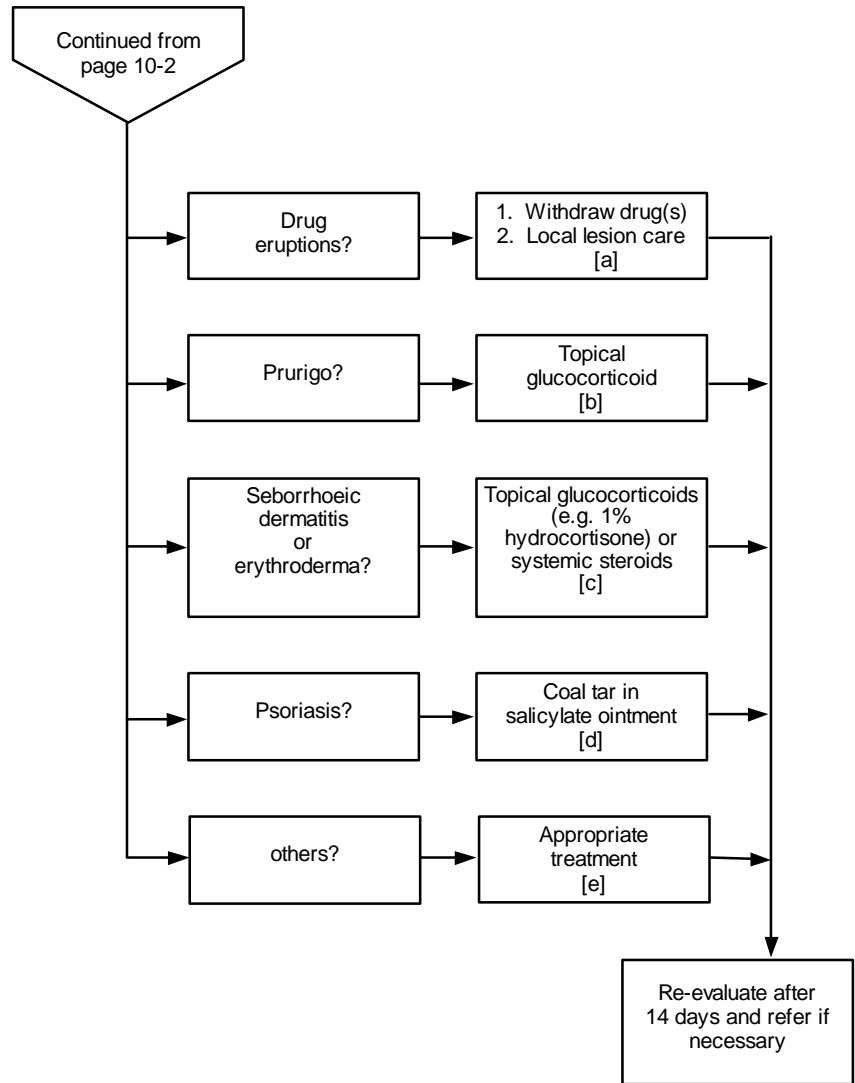
Annotations

Treatment of these conditions at district level may not be available and patients may have to be referred for treatment.

- (a) Lesions on the face or exposed parts of the body may be treated locally with intralesional vincristine.

For the treatment of systemic KS, vincristine has been used. The treatment may benefit up to half of the patients but only temporarily.

For rapidly progressive and/or disseminated mucocutaneous disease, or when the tumour compromises the function of vital organs, chemotherapy may effect rapid tumour regression and be life saving. Among the drugs reported to be effective as single agents or as part of a combination regimen are bleomycin, doxorubicin, etoposide, vinblastine, and vincristine. However because such drugs may not be available at district level the patient should be referred for further treatment.



Annotations

- (a) Trimethoprim-sulfamethoxazole, sulfadiazine, pentamidine, ampicillin and acyclovir are the drugs most often associated with drug eruptions. Thiacetazone has also been incriminated. Corticosteroids should only be given in life-threatening situations.
- (b) Prurigo can be very disabling. Sometimes antihistamines, e.g. diphenhydramine, 50-mg tablets every 6 hours may be helpful.
- (c) The application is left on the skin to dry and then repeated the next day. Avoid contact with the eyes.
- (d) 1-5% Topical coal tar is also helpful. In severe cases with coexistent candidiasis, topical ketoconazole is beneficial.
- (e) Any other dermatoses, refer to a higher facility.