SEXUALLY TRANSMITTED INFECTIONS, HIV/AIDS

ATYPICAL SOLITARY PLAQUE MULTIBACILLARY LEPROSY IN AN HIV PATIENT PRESENTING AS IMMUNE RECONSTITUTION INFLAMMATORY SYNDROME

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Background: HIV has been responsible for atypical presentation of common dermatological conditions. However, available studies showed that HIV did not alter the clinical, histopathologic, and immunologic picture of leprosy.

Observation: A 26-year-old HIV-infected male presented with twenty month history of a solitary erythematous hypoesthetic patch on the right cheek, which became indurated, scaly, and eroded two months after initiation of antiretroviral therapy. There was no nerve involvement. Clinical diagnosis of tuberculoid leprosy in type 1 reaction was made but was reclassified as borderline lepromatous leprosy after skin biopsy and skin smear were performed. Slit skin smear from the lesion revealed a bacterial index of 4+ while negative for six other routine sites. Histopathological findings showed granulomatous infiltrates with foamy histiocytes and numerous solid and fragmented bacilli upon Fite Faraco stain. CD8+ and CD4+ stains confirmed presence of lymphocytes with predominance of CD8+ further supporting borderline lepromatous classification. Patient developed slightly tender nodules on the legs, which were histopathologically proven to be erythema nodosum leprosum. Diagnosis of immune reconstitution inflammatory syndrome (IRIS) was established when a concurrent rise in his CD4+ count coincided with the lepra reactions. Because the patient had adverse drug reaction to rifampicin, he was started on alternative multibacillary regimen of clofazamine, clarithromycin, and moxifloxacin. Leprosy lesions improved after initiation of antibiotics.

Key Message: This case illustrates that in contrast to general observation, leprosy in HIV may present atypically, implying that HIV and leprosy may not be entirely independent infections. The rising number of HIV cases on antiretroviral therapy may lead to the unmasking of more leprosy cases.