SEXUALLY TRANSMITTED INFECTIONS, HIV/AIDS

HIV AND CONFLUENT AND RETICULATED PAPILLOMATOSIS (CRP): AN UNUSUAL POSSIBLE ASSOCIATION

I Maatouk [1] - R Ballout [2] - G Hélou [3]

De Montfort University, Faculty Of Health And Life Science, Leicester, United Kingdom [1] - American University Of Beirut, Faculty Of Medicine, Beirut, Lebanon [2] - Mount Lebanon Hospital, Internal Medicine Department, Beirut, Lebanon [3]

Introduction: Confluent and reticulated papillomatosis (CRP) is a rare disorder which precise cause remains a subject of further debate, with multifactorial etiologies including diabetes, obesity, ultraviolet (UV) light exposure, amyloidosis, and certain fungal infections, namely Malassezia furfur, Dietzia spp. and/or actinomycetes.

Case: A 29-year-old heterosexual man presented to our clinic complaining of brownish skin lesions dispersed over his neck and upper chest for the past 4 weeks. Two weeks prior to presentation, he tested positive for HIV (CD 4: 35 cells/mm3) and immediately started highly-active anti-retroviral therapy (HAART). At the time, his skin lesions were considered and treated as pityriasis versicolor without improvement. His lesions consisted primarily of hyperpigmented and scaly macules with interspersed plaques that were non-pruritic. Wood's lamp examination was nonrevealing. Histopathological characteristics of a skin biopsy were consistent with a diagnosis of CRP. The patient was not treated and returned 7 weeks after HAART initiation with almost inconspicuous lesions.

Conclusion: The observation that this patient's CRP did not respond to antifungal therapy, yet completely resolved within 7 weeks of HAART initiation with no antibiotic use, possibly suggests a role for HAART therapy in clearing his CRP. In fact, his lack of 'typical' CRP-predisposing factors (diabetes, obesity, UV exposure, family history), negative skin scrapings for fungi, lack of response to antifungals, and a concomitant CRP eruption with HIV seroconversion, suggests that the former was HIV-related. To our best knowledge, this is the first case report associating CRP development with HIV infection and an immunocompromised status. The chronology of events described in our case, and the fact that our patient did not require an antibiotic regimen to treat his lesions, with a concomitant rapid resolution of his CRP shortly after HAART initiation (within 7 weeks only), suggest that his CRP was most likely HIV-related.