INFECTIOUS DISEASES (BACTERIAL, FUNGAL, VIRAL, PARASITIC, INFESTATIONS)

# HIV-ASSOCIATED TYPE VI PITYRIASIS RUBRA PILARIS: CASE REPORT

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Background: Pityriasis rubra pilaris (PRP) is a papulosquamous dermatosis with an unknown etiology and a wide spectrum of clinical subtypes. It is described as a follicular keratinization disorder and is characterized by reddish orange scaly coalescente plaques, which are often intercalated with spared skin areas. A new subtype, HIV-associated (type VI), was described in 1995.

Observation: A 27-year-old male patient with a one-month diagnosis of HIV presented erythematous pruritic plaque on right arm, that quickly spread to chest, left arm, cervical region and facial area. He was in antiretroviral treatment for 3 weeks.
Examination revealed erythematous hypochromic well-demarcated plaques with coalescent follicular papules, intercalated with spared skin areas, located in the arms, chest, legs, cervical and facial area.
Direct mycological examination was negative, viral load was 27.301 copies/ml and T CD4+ lymphocytes levels were 81/mm$^3$.
The hystopathological examinations showed hyperkeratotic epidermis, with follicular keratotic plugs and parakeratosis, as well as irregular acanthosis with a few vacuolar alteration of the basal layer and perivascular infiltrate of lymphocytes. PAS, Grocott and Fite-Faraco stains were negative.
The clinical findings, as well as the hystopathological exam led to the type VI pityriasis rubra pilaris (HIV-associated) diagnosis.
The patient was treated with acitretin 25 mg/day and had significative improvement of his clinical condition.

Key message: The type VI PRP (HIV-associated) doesn't have a clear etiology and pathogenesis, although some theories say that the HIV may cause a follicular inflammation, triggering the disease. The hystopathological exammination often shows epidermal psoriasiform hyperplasia and alternation between orthokeratosis and parakeratosis, producing a "chessboard" pattern. Keratotic plugs are commom. Dermal inflammation is

moderate, with predominance of lymphocytes taking a lichenoid pattern. The treatment can be done with acitretin, isotretinoin, UVB phototherapy and antiretroviral therapy. However, some spontaneous resolution cases have been described.