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PHOTO QUIZ

Skin lesions in a HIV-positive female

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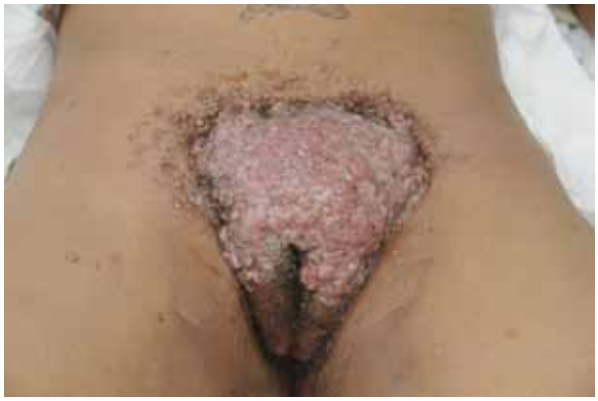
A 25-year-old HIV-positive female was admitted to our hospital with fever and pain in the groin region. She had been HIV positive since 2004 with poor compliance. Highly active antiretroviral therapy (HAART) was reintroduced two months prior to admittance. Further medical history mentioned skin lesions of the pubic mound for one year. On admission physical examination showed profound redness, tenderness and lymphadenopathy of the groin, along with the known skin lesions of the pubic mound (*figure 1*). Recent laboratory results showed a CD4 count of 80 x 10^6/ mm^3.

Figure 1.



WHAT IS YOUR DIAGNOSIS?

See page 475 for the answer to this photo quiz.

ANSWER TO PHOTO QUIZ (PAGE 452)

SKIN LESIONS IN A HIV-POSITIVE FEMALE

DIAGNOSIS

Our diagnosis was cellulitis of the groin region secondary to the skin lesions. The differential diagnosis of the skin lesions included molluscum contagiosum, verruca vulgaris, keratoacanthoma, syringoma or condylomata accuminata. In addition, cutaneous manifestations of opportunistic infections such as histoplasmosis, cryptococcosis and coccidiodomycosis were considered. A dermatologist with experience in HIV-related skin disorders confirmed the clinical diagnosis of an 'agminated' form of molluscum contagiosum, based on the combination of the central plaque on the pubic mound and the peripheral lesions on the lower abdomen and thighs, which presented as dome-shaped, round to oval papules with a pale pink waxy surface and central umbilication.

Molluscum contagiosum is caused by a pox-like DNA virus,[1] usually seen in children as a benign self-limiting disease.[1] In adults the incidence is growing and it can be considered a sexually transmitted disease.[1] Up to 18% of HIV patients are infected with the molluscum contagiosum virus and in patients with a reduced cellular immunity, molluscum contagiosum can manifest for several years, presenting with giant lesions (>1 cm) as well as agminated clusters of over a hundred lesions.[1]

Treatment of molluscum contagiosum in HIV patients is challenging since conventional methods are often refractory.[1] Initiation of HAART has shown improvement,[2,3] but can also result in molluscum contagiosum as part of an immune reconstitution inflammatory syndrome (IRIS), as reported in one HIV patient.[2] Pharmacological treatment with cidofovir demonstrates promising effects.[2,4]

Cidofovir is a nucleotide analogue of deoxycytidine monophosphate that has shown broad antiviral activity against DNA viruses, including molluscum contagiosum.[4] Cidofovir has shown effectiveness in HIV patients, both intravenously and topically.[4]

Our patient was admitted and treated for cellulitis with flucloxacillin intravenously with good clinical response. HAART was continued. IRIS seemed unlikely since the skin lesions already existed prior to HAART and no apparent worsening had been noted. Topical cidofovir therapy was started to maximise treatment benefit. Although the patient discontinued both HAART and cidofovir treatment after several weeks, the mollusca contagiosa improved dramatically over the course of several months leaving only scar tissue.

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