

## Lichen Amyloidosis in an HIV-infected Patient. A Case Report and Review of the Literature

Sir,

HIV disease is associated with a myriad of dermatologic manifestations. However, lichen amyloidosis has been reported in only two HIV-infected patients, and the significance of this association is still a mystery. This article presents third such case, as well as a review of the literature.

### CASE REPORT

A 62-year-old man was referred to our infectious diseases clinic for management of his recently diagnosed HIV disease which he had acquired through intravenous drug usage (IVDU). He also complained of pruritic skin lesions, which had been present for about a year. His medical history was significant for chronic pancreatitis due to alcohol abuse. The patient denied any history of dermatological condition in his family members. His medications included multivitamin in a pancreatic enzyme preparation. Physical examination was remarkable for flat-topped, hyperpigmented papules on the anterior and lateral aspects of the lower extremities. There was superficial lichenification, but no scaling or discharge (Fig. 1). The remainder of his examination was unremarkable. Laboratory data showed a leukocyte count of  $8,200/\text{mm}^3$ , haemoglobin of 14.8 g/dl and a CD4 cell count of  $365/\text{mm}^3$ . Histopathological examination of the skin revealed acanthosis, papillomatosis and hyperkeratosis. The dermis contained deposits of amorphous eosinophilic material, which stained positive with Congo red and hue green with polarized light. These findings were consistent with the diagnosis of lichen amyloidosis. The patient was initially treated with topical corticosteroids and emollients without any significant



Fig. 1. Right leg showing lichen amyloidosis.

improvement. He was then started on oral etretinate, but did not return for follow-up.

### DISCUSSION

Lichen amyloidosis is characterized by lichenoid papules, which typically occur over the shins, with intense pruritus (1). However, the lesions may also occur on the on the thighs, calves, forearms, and even on the back. The skin of the knee is spared, and there is no systemic involvement.

The aetiology and pathogenesis of lichen amyloidosis in HIV disease are unknown, as is the case with many other skin disorders associated with this disease. While most cases of lichen amyloidosis occur sporadically, a few familial examples have been noted (2). In addition, the condition has been described in association with Alagille syndrome, connective tissue disorders (e.g. systemic lupus erythematosus), primary biliary cirrhosis and multiple endocrine neoplasia type 2a (3, 4). A computerized literature search revealed only two reports of lichen amyloidosis in patients with HIV disease (5, 6).

Several important observations can be made in evaluating the profiles of these patients (including ours). All patients were male and had acquired HIV infection through IVDU. The skin lesions in these patients were present on the extremities for 1–3 years before they were diagnosed by skin biopsy. A variety of therapeutic modalities were used, including topical corticosteroids, ketoconazole and ultraviolet radiation, without success. Our patient was started on oral etretinate, but was lost for follow-up.

We believe lichen amyloidosis should be considered as another dermatological manifestation of HIV disease. Clinicians should include this disorder in the differential diagnosis of all pruritic maculo-papular skin lesions when assessing an HIV-infected patient.

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