The role of histamine 2 antagonists in the treatment of immunocompetent patients with psoriasis has been controversial [1, 2]. Recently, Stashower et al. [3] have reported the case of a patient with HIV infection and psoriasis who showed a very good response to an oral cimetidine treatment.

We report a case of a 33-year-old male patient with HIV infection and psoriasis. In the course of the HIV infection, he has developed lymph node tuberculosis, chronic hepatic disease and oropharyngeal candidiasis. He also has a long-standing psoriasis which was progressively worsening during the last year. Large inflamed plaques affected extensive areas of the trunk, lower and upper extremities, scalp, palms and soles (PASI = 40). He was under treatment with zidovudine 750 mg q.d., rifampicin 300 mg q.d. and isoniazide 100 mg q.d. Significant laboratory findings included serum creatinine of 0.8 mg/dl, γ-glutamyl transferase 94 U/l, hemoglobin 13.9 g/dl, hematocrit 41.2%, leukocytes 3,300/µl, CD4 10/µl, CD8 200/µl, erythrocyte sedimentation rate 113 mm/h, HIV antigen (-), VDRL (-), FTA-ABS (-). A conventional therapy was prescribed with keratolytics, tar formulations and topical corticosteroids, with no response and progressive worsening despite 3 months of treatment. At this moment we decided to prescribe cimetidine 400 mg q.i.d. After 1 month of treatment, response was positive with an important improvement of all skin lesions (PASI = 17). Remission was practically total after the third month (PASI = 5). The treatment was then stopped, and the patient remained in remission after 1 year of follow-up.

Psoriasis and Reiter’s syndrome have an increased prevalence in HIV-infected patients. The role of HIV in the development and worsening of psoriasis remains unknown. The immune dysregulation, the opportunistic infections as a trigger factor and the direct infection of the Langerhans cells are suspected to be involved in the etiopathogenesis of the HIV-psoriasis complex [4-6]. These patients are particularly resistant to conventional treatments. Potent topical corticosteroids and PUVA therapy may have an immunosuppressive effect. In most cases, methotrexate is contraindicated. Cyclosporine is not used in spite of anecdotal good results. Oral retinoids are reserved for erythrodermic and pustular forms. Finally, zidovudine in doses of 1,200 mg seems to have a positive effect [7].

This report illustrates the positive effect of histamine 2 antagonists in the treatment of severe psoriasis in an HIV-infected patient. Moreover, the modulation of the immune response by
histamine 2 antagonists in psoriatic patients is under study. The long-term treatment with ranitidine in psoriasis has shown good results in an open prospective multicenter study [8].

References


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