Psoriasis in an HIV-Positive Patient Treated with Cimetidine

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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/ μ l, CD4 10/ μ l, CD8 200/ μ l, 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 etio-pathogenesis 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. Cy-closporine 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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