

Alopecia HIV. A review

MORENO-COUTIÑO, Gabriela*†

General Hospital "Dr. Manuel Gea González, Department of Dermatology.

Received January 21, 2015; Accepted October 20, 2015

Abstract

The term alopecia (the Gr. Alopes) applies to abnormal hair loss or rarefaction in any hairy area. However, the area to which most commonly referred is to the scalp.

For patients living with HIV, not androgenetic alopecia has been associated with the ingestion of medicines, infections, or diseases of inflammatory origin and / or autoimmune.

Alopecia, HIV, hair loss.

Citation: MORENO-COUTIÑO, Gabriela. Alopecia HIV. A review. ECORFAN Journal-Republic of Guatemala 2015, 1-1: 10-13

* Correspondence to Author (email: gmorenocoutino@gmail.com)

† Researcher contributing first author.

Alopecia of the scalp has been reported in association with antiretroviral therapy; particularly indinavir is a protease inhibitor. This adverse effect is dose-dependent and is not associated with age, gender or CD4 lymphocyte counts. It is the only dermatological adverse effect of this drug; however, the negative impact on the patient's self-image is the main cause for discontinuation.

Alopecia that occurs in up to 12-30% of patients receiving the drug, the scar type and cannot be diffuse or patchy alopecia occur anywhere in the body. It is believed that brings retinoid-like as xerosis, cheilitis, and alopecia onicocriptosis effects. Often that is more of a demonstration in affected patients. The pathophysiology is unknown but is believed to indinavir may interfere with the metabolism of retinoids, and seen from the first two months of treatment. The main differential diagnosis must be made with alopecia areata.

The best solution for hair loss is to replace the drug by another protease inhibitor [1-3]. It has also been associated with lopinavir and ritonavir. One patient had alopecia totalis of the scalp, eyebrows and eyelashes that were recovered by changing these antiretroviral nelfinavir. Another patient had diffuse loss of scalp hair also decided to replace lopinavir and ritonavir efavirenz [4].

And another in association with ritonavir and zidovudine [5,6]. The cause Darunavir indinavir similar to the adverse effects, which sometimes have been reported cases of alopecia [2].

Conversely, zidovudine (AZT), which was the first drug used for the treatment of HIV in the 80s, apparently caused increased hair growth, and even reported the reversal of alopecia areata after the start of AZT treatment [7,8]. and only report what associated with alopecia [9].

Besides association with antiretroviral alopecia, it is known that there is a higher incidence of alopecia areata is one of the most common autoimmune diseases compared to the HIV negative population [10].

And Conversely, only one report mentioned that a patient who since childhood had presented refractory alopecia areata treatment, spontaneously resolved with treatment for HIV infection almost 40 years later [11].

The diagnosis of alopecia areata should be confirmed with a biopsy, and so differentiate it from other types of alopecia patch.

As for infectious causes, tinea capitis in adults is rare, with less than 3% of all cases. In particular, adults living with HIV, is extremely rare to find cases. Some authors explain this as a result of increased colonization of *Malassezia* spp competitively inhibiting the development of dermatophytes.

Therefore, to diagnose a high level of suspicion is needed, in addition to relying on traditional diagnostic methods as direct KOH examination and culture. The treatment is the same as any other case of tinea capitis [8, 12].

The co-infection of HIV and syphilis is extremely high, reported in some cities in the US to 60%

Alopecia caused by secondaries can be described as "mouse bites" fuzzy form or a combination of both. Its prevalence varies 4-12.5% of secondary alopecia, predominantly homosexual men.

Syphilitic alopecia is no scar, and may be the only manifestation of secondaries or accompanied by other mucocutaneous lesions.

It is a common manifestation of syphilis, but should be considered for differential diagnosis should also include telogen effluvium, androgenetic alopecia, alopecia areata, tinea capitis and trichotillomania.

As no scar, it resolves with treatment of the infection. Treatment is with penicillin G benzathine 2.4 million units once a week for three weeks [13].

However, most of alopecia associated with HIV are classified as TE, triggered as a result of damage caused systemic infection such as HIV infection, endocrine diseases, immunological disorders, nutritional deficiencies, wasting syndrome, among many other causes that must be addressed properly [14].

Conclusions

Hair loss is, in most cases an aesthetic problem. However, we can not let it pass without taking into account the psychological impact it has on our patients, which may be as important to influence adherence to antiretroviral therapy. That is why, it is important to make a correct diagnosis and to influence changes that promote hair growth.

Most of the information in the literature focuses on the alopecia associated with drugs, because it is part of the long list of adverse reactions that are published. But we must not forget that there are multiple causes and should investigate.

References

- [1] Calista D, Boschini A. Cutaneous side effects induced by indinavir. *Eur J Dermatol* 2000; 10:292-296.
- [2] Luther J, Glesby M. Dermatologic adverse effects of antiretroviral therapy. *Am J Clin Dermatol* 2007; 8: 221-233.
- [3] Hawkins T. Appearance-related side effects of HIV-1 treatment. *AIDS patient care STDs* 2006; 20: 6-18
- [4] Chrysos G, Mikros S, Kokkoris S, Pastelli A, Kontochristopoulos G. Alopecia induced by lopinavir plus ritonavir therapy in an HIV patient. *J Drugs Dermatol* 2007; 6:742-743.
- [5] Torres HA, Barnett BJ, Arduino RC. Alopecia associated with ritonavir-boosted atazanavir therapy. *AIDS* 2007; 21: 1391-1392.
- [6] Borrás-Blasco J, Belda J, Rosique-Robles D, Casterá E, Abad J, Amorós-Quiles I. Hair loss induced by lopinavir-ritonavir. *Pharmacotherapy* 2007; 27:1215-1218
- [7] Harindra V, Sivapalan S, Roy RB. Increased nail and hair growth in a patient with AIDS. *Br J Clin Pract* 1993; 47: 215-216
- [8] Prose NS, Abson KG, Scher R K. Disorders of the nails and hair associated with human immunodeficiency virus infection. *Int J Dermatol* 1992; 31: 453-457
- [9] Geletko SM, Segarra M, Mikolich DJ. Alopecia associated with zidovudine therapy. *Pharmacotherapy* 2007; 16: 79-81

[10] Nikolic DS, Viero D, Yana Tije VC, Toutou-Trellu L. Alopecia universalis associated with vitiligo in an 18-year old HIV positive patient: Highly active anti-retroviral therapy as first choice therapy. *Acta Derm Venereol* 2014; 94: 116-117

[11] Ramot Y, Tetro T, Levi I, Zlotogorski A. Remission of long-standing alopecia universalis after human immunodeficiency virus infection. *Clin Exp Dermatol* 2014; 39: 399–400

[12] Narang K, Pahwa M, Ramesh V. Tinea capitis in the form of concentric rings in an HIV positive adult on antiretroviral therapy. *Indian J Dermatol* 2012; 57: 288-290.

[13] Bi MY, Cohen PR, Robinson FW, Gray JM. Alopecia syphilitica-report of a patient with secondary syphilis presenting as moth-eaten alopecia and a review of its common mimickers. *Dermatol Online J* 15(10):6

[14] Almagro M, del Pozo J, García Silva J. Telogen effluvium as a clinical presentation of human immunodeficiency virus infection. *Am J Med* 2002; 112: 508-509