CASE OF THE PERSISTENT RASH WITH HIGH GRADE EOSINOPHILIA

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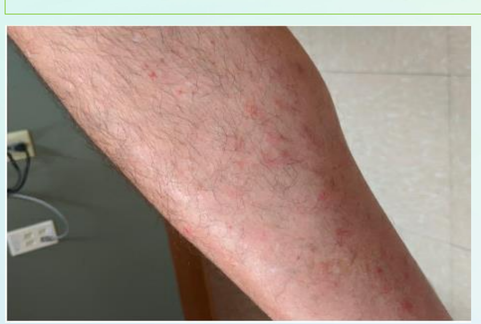
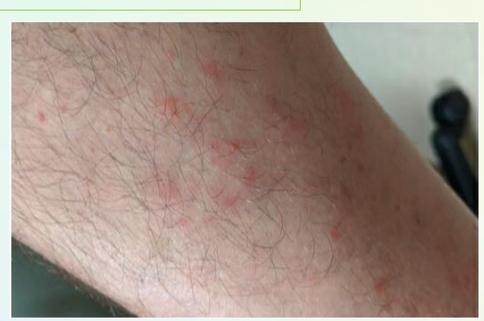
Introduction

Strongyloides stercoralis is a soil transmitted intestinal nematode present in tropical regions and a common chronic infection, typically asymptomatic in immunocompetent host. A change in immune status can lead to hyperinfection syndrome and dissemination. Strongyloidiasis should be considered in the differential diagnosis of persistent (non-resolving) rash with or without eosinophilia in patients from endemic areas.

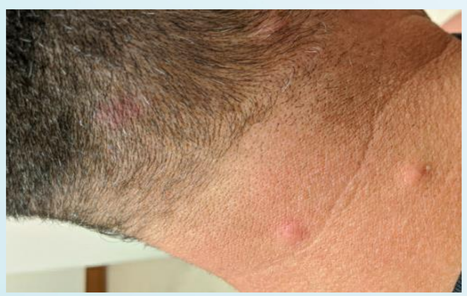
Images



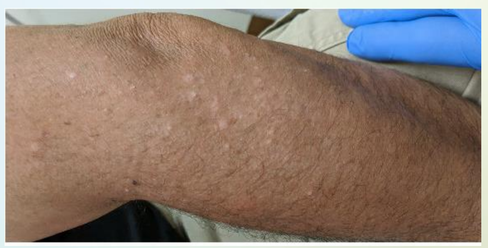
Right shin



Left shin



Neck



Left arm

Methods

59-year-old male presented after extensive workup for evaluation of erythematous, papular, purpuric rash with persistent eosinophilia of 18 months duration.

The rash started on his bilateral legs, then spread to his bilateral arms and neck. Described as intensely pruritic. He was initially treated with a change in his antihypertensive medication, topical creams, and steroids, systemic steroids, and different antihistaminic medications without relief. Next, he was seen by dermatology and skin biopsy performed which was inconclusive. His eosinophilia had been persistently elevated and high as 3000 absolute cell count. He was evaluated by an allergist and extensive IgE screening was negative. Rheumatologic workup was unrevealing. Bone marrow biopsy was negative for clonal hypereosinophilia. Screening colonoscopy 8 months prior notable for adenomatous polyps and multiple white nodules on pathology consistent with eosinophilic colitis.

History was notable for hypertension, hyperlipidemia, originally from rural Puerto Rico and moved to US 40 years prior. Social history notable for monogamous, heterosexual male married second time 8 years ago. Other ROS notable for per patient intentional 12 lb weight loss.

Results

He had HIV test done which was positive with CD4 count significantly low at 34, furthermore Strongyloides antibody was strongly positive.

He was started on antiretroviral therapy and treated with Ivermectin for Strongyloides. His rash and eosinophilia improved with Ivermectin but not complete resolution. After improvement of his CD4 count and another round of treatment two months after with Ivermectin there was resolution of the rash, normalization of eosinophilia and clearing of antibody titers.

Conclusion

We present a case of a middle-aged male with persistent erythematous, papular rash with hypereosinophilia with history of growing up in tropical region found to have Strongyloidiasis in the setting of immunocompromised state with new diagnosis of HIV/AIDS.

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