Complete Summary

GUIDELINE TITLE

Dermatologic manifestations.

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Dermatologic manifestations. New York (NY): New York State Department of Health; 2004. 15 p. [14 references]

GUIDELINE STATUS

This is the current release of the guideline.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

On January 20, 2006, U.S. Food and Drug Administration (FDA) announced the approval of updated labeling for two topical eczema drugs, Elidel Cream (pimecrolimus) and Protopic Ointment (tacrolimus). The labeling will be updated with a boxed warning about a possible risk of cancer and a Medication Guide (FDA-approved patient labeling) will be distributed to help ensure that patients using these prescription medicines are aware of this concern. The new labeling also clarifies that these drugs are recommended for use as second-line treatments. This means that other prescription topical medicines should be tried first. Use of these drugs in children under 2 years of age is not recommended. See the FDA Web site for more information.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Human immunodeficiency virus (HIV) infection
- Dermatologic manifestation of HIV infection:
    - Bacterial infections (cellulitis, impetigo, ecthyma, abscess)
    - Fungal infections (candidiasis, dermatophyte infection)
    - Viral infections (herpes simplex, herpes zoster, molluscum contagiosum, human papilloma virus infection)
    - Parasitic infections (scabies)
    - Inflammatory dermatoses (seborrheic dermatitis, atopic dermatitis)
    - Cutaneous manifestations of drug reactions

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Allergy and Immunology
Dermatology
Family Practice
Infectious Diseases
Pediatrics

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Physician Assistants
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

To develop guideline for diagnosis and management of dermatologic manifestations of human immunodeficiency virus (HIV) infection

TARGET POPULATION

Human immunodeficiency virus (HIV)-infected children and infants

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation

Bacterial Infections

1. Culture of purulent fluids
2. Blood culture
3. Skin biopsy

Fungal Infections

Candidiasis

1. Identification of clinically distinctive lesions

Dermatophyte Infection

1. Clinical appearance
2. Verification by potassium hydroxide preparation or fungal culture

Viral Infections

Herpes Simplex and Herpes Zoster

1. Clinical appearance
2. Culture or immunofluorescent antibody of the lesion if uncertain

Molluscum Contagiosum

1. Clinical appearance

Human Papillomavirus Infection

1. Clinical appearance
2. Confirmation by whitening of the mucosa when acetic acid is applied

Parasitic Infections (Scabies)

1. Scraping burrows and looking for mites or feces

Inflammatory Dermatoses

Seborrheic Dermatitis

1. Clinical presentation

Atopic Dermatitis

1. Clinical presentation
2. Family history of atopy
3. Progression of rashes from flexural intertriginous to extensor part of the body

Cutaneous Manifestations of Drug Reactions

1. Clinical presentation

Treatment/Management

Bacterial Infections

1. Empiric antibiotic therapy (first-generation cephalosporins, anti-staphylococcal penicillins, clindamycin)
2. Antibiotic adjustment based on culture results
3. Incision and drainage

Fungal Infections

Candidiasis

1. Fluconazole or mycostatin for oral candidiasis
2. Mouth washing and sterilization of bottles, bottle nipples, and pacifiers for oral candidiasis
3. Mycostatin or imidazole topical cream for cutaneous candidiasis (alternatives: ciclopirox and terbinafine)
4. Frequent diaper changes and keeping the affected area open to air as much as possible

Dermatophyte Infection

1. Imidazole cream in *tinea corporis* (alternatives: ciclopirox and terbinafine creams)
2. Oral griseofulvin in *tinea capitis* (alternatives: fluconazole and itraconazole)
3. Selenium sulfide shampoos, topical imidazole gel and lotions, or single-dose itraconazole in *tinea versicolor* (alternatives: topical ciclopirox or terbinafine, or oral itraconazole or fluconazole)

Viral Infections

Herpes Simplex

1. Oral or intravenous acyclovir
2. Note: Guideline developers discuss but do not make recommendations on valacyclovir, famcyclovir, and foscarnet

Herpes Zoster

1. No treatment or oral or intravenous acyclovir, depending on severity of the varicella and the severity of immune deficiency (Famcyclovir or valacyclovir are alternatives in older children.)
2. Note: Guideline developers discuss, but do not offer recommendations on foscarnet and cidofovir

Molluscum Contagiosum

1. Treatment of HIV infection with standard regimes of anti-retroviral medications.

Human Papillomavirus Infection

1. Salicylic acid or cryotherapy, imiquimod cream, podophyllotoxin gel or solution, tretinoin or fluorouracil cream, cantharidin
2. Oral cimetidine
3. 20% podophyllum resin
4. Cryosurgery or surgical excision

Parasitic Infections (Scabies)

1. 5% permethrin cream
2. Laundering of all clothing and bedding at the time of treatment
3. Prophylactic treatment of all household members at the same time from the neck down
4. Head treatment in infants

Inflammatory Dermatoses

Seborrheic Dermatitis

1. 1% or 2.5% hydrocortisone cream
2. Ketoconazole cream or shampoo

Atopic Dermatitis

1. Emollients, antihistamines, non-fluorinated topical steroid ointments, tacrolimus, pimecrolimus
2. Avoidance of harsh soaps and detergents, wool clothing, and bathing too frequently
3. Dermatology consult

Cutaneous Manifestations of Drug Reactions

1. Considering discontinuation of suspected medication
2. Symptomatic treatment, including antipruritics (benadryl, ativan) and topical preparations

MAJOR OUTCOMES CONSIDERED

- Effectiveness of treatment
- Side effects of treatment

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Human Immunodeficiency Virus (HIV) Guidelines Program works directly with committees composed of HIV Specialists to develop clinical practice guidelines. These specialists represent different disciplines associated with HIV care, including infectious diseases, family medicine, obstetrics and gynecology, among others. Generally, committees meet in person 3 to 4 times per year, and otherwise conduct business through monthly conference calls.

Committees meet to determine priorities of content, review literature, and weigh evidence for a given topic. These discussions are followed by careful deliberation to craft recommendations that can guide HIV primary care practitioners in the delivery of HIV care. Decision making occurs by consensus. When sufficient evidence is unavailable to support a specific recommendation that addresses an important component of HIV care, the group relies on their collective best practice experience to develop the final statement. The text is then drafted by one

member, reviewed and modified by the committee, edited by medical writers, and then submitted for peer review.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Primary care clinicians should refer human immunodeficiency virus (HIV)-infected children to a dermatologist when they cannot determine the etiology of a skin lesion based on clinical evaluation.

Bacterial Infections

Presentation	• Redness, warmth, and swelling • +/- purulent drainage or nodule • +/- fever or leukocytosis
Diagnosis	• Culture of purulent fluids • Blood culture • Consider skin biopsy if empiric treatment fails
Treatment	• Empiric antibiotic therapy (first-generation cephalosporins, anti-staph penicillins, clindamycin) • Adjust antibiotics based on culture result • Decide exposure level of antibiotics (topical versus oral versus intravenous) based on type of infection and severity of immune compromise • Consider incision and drainage

Diagnosis

The clinician should attempt to identify bacterial pathogens by culture of purulent fluids.

The clinician should perform a blood culture in patients with cellulitis

Treatment

In patients with cellulitis, impetigo, and abscesses, the clinician should immediately initiate empiric antibiotic therapy (e.g., first-generation cephalosporins, anti-staph penicillins, clindamycin) that covers *Staphylococcus aureus* and beta hemolytic streptococci. Antibiotics should be adjusted based on culture result.

In an immunocompetent patient, the clinician should treat mild, localized impetigo with topical antibiotics that are effective against both staphylococci and streptococci. A child who has more severe impetigo or who is more severely immunocompromised will require systemic treatment.

Fungal Infections

Candidiasis

Presentation	• White, curd-like material that can be wiped off revealing an erythematous mucosa • Pink, slightly raised rash in intertriginous areas with satellite lesions • *Candidal diaper rash* is a pink rash, sometimes slightly raised, that can involve the skin folds and often contain small satellite lesions outside of the affected area
Diagnosis	• Clinical
Treatment	• *Oral candidiasis*: fluconazole or mycostatin Mouth washing and aggressive sterilization of all bottles, bottle nipples, and pacifiers • *Diaper candidiasis*: Mycostatin or imidazole topical cream • Alternatives: ciclopirox and terbinafine

Diagnosis

Diagnosis of candidiasis should be made by the identification of clinically distinctive lesions.

Treatment

The clinician should treat oral candidiasis with fluconazole (3 to 6 mg/kg/day) or mycostatin (lozenges or oral suspension).

The clinician should advise the caregiver to regularly wash the mouth of younger children and sterilize all bottles, bottle nipples, and pacifiers to prevent recurrence of oral candidiasis.

Mycostatin or imidazole topical cream should be used to treat candidal infection of the skin.

Dermatophyte Infection

Presentation	• *Tinea corporis*: single or several scaly oval patches, often hyperpigmented, with a raised outer rim • *Tinea capitis*: area of flaking within the scalp, with or without hair loss, or a weeping or crusting kerion or diffuse flaking throughout the scalp • *Tinea versicolor*: many small hypopigmented lesions, often on the shoulders, neck, and face • *Onychomycosis*: yellowed, darkened, thickened, or pitted nails
Diagnosis	• Clinical, verified by potassium hydroxide preparation or fungal culture
Treatment	• *Tinea corporis*: imidazole cream twice a day Alternatives: ciclopirox or terbinafine creams • *Tinea capitis*: a 4- to 6-week course of oral griseofulvin (10 to 20 mg/kg/day) or fluconazole (3 to 6 mg/kg/day) • *Tinea versicolor*: selenium sulfide shampoos, topical imidazole gel and lotions, or single-dose itraconazole Alternatives: topical ciclopirox or terbinafine, or oral itraconazole or fluconazole

Diagnosis

Diagnosis of dermatophyte infections should be made on a clinical basis and can be verified by the presence of fungal organisms on potassium hydroxide preparation or fungal culture.

Treatment

The clinician should treat tinea corporis with application of an imidazole cream twice a day. Topical ciclopirox or terbinafine creams are alternative treatment options.

Tinea capitis should be treated with a 4- to 6-week course of oral griseofulvin (15 to 20 mg/kg/day). Possible alternatives include fluconazole (3 to 6 mg/kg/day) and itraconazole (5 mg/kg/day).

The clinician should treat tinea versicolor with selenium sulfide shampoos, topical imidazole gel and lotions, or single-dose itraconazole. Topical ciclopirox and

terbinafine and oral itraconazole and fluconazole are alternative treatment options.

Viral Infections

Herpes Simplex

Presentation	• Crusting erosions of the lips, gums, and tongue • Vesicular and ulcerative lesions of the fingers
Diagnosis	• Clinical • Culture or immunofluorescent antibody of the lesion if uncertain
Treatment	• *Mild Herpes Simplex Virus (HSV) infection and good immune function*: oral acyclovir 40 to 80 mg/kg/day divided into 3 doses (every 8 hours), maximum of 1,200 mg/day for 7 to 10 days • *Severe mucocutaneous HSV infection or severe immune deficiency*: intravenous acyclovir 15 to 30 mg/kg/day divided into three doses (every 8 hours), given over 1 hour for 7 to 14 days • *Chronic suppressive therapy*: oral acyclovir 40 to 80 mg/kg/day divided into 2 to 3 doses (max 1,200 mg/day)

Diagnosis

The clinician should perform culture or immunofluorescent antibody testing for the presence of HSV for any chronic ulcer of the mouth or skin.

Treatment

The clinician should treat children with mild HSV infection and good immune function with oral acyclovir (see the Table above for dosages).

The clinician should treat children with severe mucocutaneous HSV infection or severe immune deficiency with intravenously administered acyclovir (see the Table above for dosages).

Herpes Zoster (Varicella-Zoster Virus)

Presentation	• *Varicella zoster (or chickenpox)*: vesicular and ulcerative lesions all over the child's body in multiple different stages • *Herpes zoster (or shingles)*: painful or pruritic blistering lesions, usually in a single dermatome on one side of the body.* At the time of presentation, it may look more ulcerative • *Chronic varicella*: following an episode of chickenpox or shingles, vesicular and ulcerative lesions, often expanding in diameter, each with a "dry" central core and a wet, active outer

	ring
Diagnosis	• Physical examination for classical lesions • Culture or immunofluorescent antibody if uncertain
Treatment	• *Chickenpox or zoster and good immune function*: no treatment • *Moderate disease and mild immune deficiency*: oral acyclovir 80 mg/kg/day (maximum 3,200 mg/day) divided into 4 to 5 doses/day • *Severe disease or severe immune deficiency*: intravenous acyclovir 30 mg/kg/day or 1,500 mg/m^2/day divided every 8 hours • *Chronic varicella*: intravenous acyclovir 30 mg/kg/day or 1,500 mg/m^2/day divided every 8 hours

* Occasionally, in children with immune deficiency, shingles can affect multiple dermatomes and/or both sides of the body.

Diagnosis

Diagnosis of chickenpox, shingles, or chronic chickenpox should be based on the appearance of classical lesions noted on physical examination. If the diagnosis is unclear after physical examination, diagnosis should be made by culture or fluorescent antibody of the lesions.

Treatment

Treatment of all forms of varicella zoster should be dependent on the extent and severity of the varicella and the severity of immune deficiency of the child. Most HIV-infected children with normal immune function will not need treatment for chickenpox.

Clinicians should treat children with mild immune deficiency with oral acyclovir and those with severe immune deficiency with intravenous acyclovir.

Clinicians should treat HIV-infected children with shingles with oral or intravenous acyclovir, depending on the severity of immune deficiency and number of lesions. Multidermatomal lesions or recurrent lesions should be treated with intravenous medication.

Chronic varicella is indicative of severe immune deficiency and should be treated with intravenous acyclovir.

Molluscum Contagiosum

Presentation	• Pearly, flesh-colored, umbilicated papules containing caseous material, often on the face, shoulder, or back
Diagnosis	• Clinical appearance

	• Can be confirmed by clusters of large clear cells on potassium hydroxide
Treatment	• Treatment of HIV infection

Diagnosis

Molluscum contagiosum should be diagnosed by its characteristic appearance.

Treatment

Clinicians should treat patients with widespread molluscum contagiosum lesions with standard regimens of anti-retroviral (ARV) medications.

Human Papillomavirus Infection

Presentation	• *Verruca vulgaris*: widespread flat warts and condylomata acuminata • *Verrucae*: thickened keratotic papules • *Flat warts*: thin discrete papules • *Condylomata*: filiform or hyperkeratotic papules on the mucous membranes
Diagnosis	• Clinical appearance • Confirmed by whitening of the mucosa when acetic acid is applied
Treatment	• Initial therapy not always necessary • *Severe or refractory cases*: either daily application of salicylic acid or cryotherapy Additional options: imiquimod cream, podophyllotoxin gel or solution, tretinoin or fluorouracil cream, and cantharidin • *Extensive lesions unresponsive to topical therapy*: oral cimetidine 40 mg/kg/day divided every 12 hours • *Small condylomata acuminata*: 20% podophyllum resin washed off thoroughly after 2 hours • *Large condylomata acuminata*: cryosurgery or surgical excision

When prepubescent children beyond infancy present with anogenital warts, clinicians should consider the possibility of sexual abuse.

Diagnosis

Diagnosis of anogenital warts should usually be made by clinical presentation and, in mucosal cases, can be confirmed by whitening of the mucosa when acetic acid is applied.

Treatment

If ordinary warts persist for an extended amount of time, the clinician should treat with daily application of salicylic acid or cryotherapy (refer to the original guideline document for additional options).

Small condylomata acuminata should be treated with 20% podophyllum resin, which should be washed off thoroughly after 2 hours.

A multidisciplinary approach, including consultation with a gynecologist, should be used to treat female patients with large lesions of condylomata acuminata.

Parasitic Infections

Scabies

Presentation	• Punctate, itchy papules on the hands, feet, arms, legs, periumbical area, face, or scalp; may be somewhat disguised by self-inflicted scratch marks • *Crusted or "Norwegian" scabies*: widespread eczematous eruption, no characteristic papules and burrows
Diagnosis	• Scraping burrows and looking for mites or feces
Treatment	• Single application of 5% permethrin cream • Laundering of all clothing and bedding at the time of treatment • Treatment of all household members at the same time from the neck down • For infants: the head should also be treated

Diagnosis

Diagnosis of scabies should be made by scraping burrows and looking for mites or feces.

Treatment

Clinicians should treat children with scabies with a single application of 5% permethrin cream. In infants, the head should also be treated.

The clinician should advise the caregiver to launder, in hot water, all bedding and clothing that was worn next to the skin during the 4 days prior to treatment initiation.

The clinician should provide prophylactic treatment for household members. All household members should be treated at the same time to prevent reinfestation.

Inflammatory Dermatoses

Seborrheic Dermatitis

Presentation	• Erythema and scaling of the scalp, skin behind the ears, and nasolabial folds in areas with maximal numbers of sebaceous glands, including the scalp, ears, T zone of the face, chest, and genital areas
Diagnosis	• Clinical presentation
Treatment	• 1% or 2.5% hydrocortisone cream and/or ketoconazole cream or shampoo

Diagnosis

Seborrheic dermatitis should be diagnosed by clinical presentation.

Treatment

The clinician should treat seborrheic dermatitis with 1% or 2.5% hydrocortisone cream and/or ketoconazole cream or shampoo.

Atopic Dermatitis

Presentation	• Erythematous, flaky skin • *In infants*: involves the face and extensor surfaces and often spares the diaper area • *In children*: involves the flexural surfaces
Diagnosis	• Clinical presentation • The clinician should ask for a family history of atopy (i.e., asthma, urticaria, hay fever) • Progression of rashes since childhood from flexural intertriginous to extensor parts of the body is also indicative of atopic dermatitis
Treatment	• Emollients, antihistamines, non-fluorinated topical steroid ointments, or immodulatory topical treatments (tacrolimus and pimecrolimus) • Avoidance of provocative factors such as harsh soaps and detergents, wool clothing, and bathing too frequently • Dermatology consult in severe cases

Diagnosis

Atopic dermatitis should be diagnosed by clinical presentation.

The clinician should ask for a family history of atopy (i.e., asthma, urticaria, hay fever).

Treatment

The clinician should treat atopic dermatitis with emollients, antihistamines, nonfluorinated topical steroid ointments, or immodulatory topical treatments (tacrolimus and pimecrolimus).

The clinician should advise the caregiver to avoid provocative factors, such as using harsh soaps and detergents, dressing children in wool clothing, and bathing children too frequently.

The clinician should consult with a dermatologist in severe cases.

Cutaneous Manifestations of Drug Reactions

Presentation	• *Most common*: simple, morbilliform rash • *Less common*: diffuse redness, papules, or targetoid lesions • *Rare*: blisters, skin desquamation, erythema multiforme, Stevens-Johnson syndrome, or toxic epidermal necrolysis
Diagnosis	• Clinical presentation
Treatment	• Consider discontinuing suspected medication, depending on severity of rash and urgency of causative medication • Symptomatic treatment, including antipruritics, such as benadryl or ativan, and topical preparations

Diagnosis

Clinicians should suspect drug reactions as the cause of a rash in any patient who develops a rash while he/she is on medication. Antibiotics should be suspected first when drug reaction is being considered.

Treatment

The decision to discontinue drug therapy in a child with a rash should be individualized and based on the severity of cutaneous disease and the availability of treatment alternatives.

When abacavir is stopped, it should NEVER be restarted.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis and management of dermatologic manifestations

POTENTIAL HARMS

- Development of *acyclovir*-resistant strains of varicella has been reported.
- In immunodeficient children, treatment of oral candidiasis with *mycostatin* is associated with high failure rate.
- *Penicillins* and *cephalosporins* may result in exanthems

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Following the development and dissemination of guidelines, the next crucial steps are adoption and implementation. Once practitioners become familiar with the content of guidelines, they can then consider how to change the ways in which they take care of their patients. This may involve changing systems that are part of the office or clinic in which they practice. Changes may be implemented rapidly, especially when clear outcomes have been demonstrated to result from the new practice such as prescribing new medication regimens. In other cases, such as diagnostic screening or oral health delivery, however, barriers emerge which prevent effective implementation. Strategies to promote implementation, such as through quality of care monitoring or dissemination of best practices, are listed and illustrated in the companion document to the original guideline (*HIV clinical practice guidelines*, New York State Department of Health; 2003), which portrays New York's HIV Guidelines Program. The general implementation strategy is outlined below.

- Statement of purpose and goal to encourage adoption and implementation of guidelines into clinical practice by target audience
- Define target audience (providers, consumers, support service providers).
    - Are there groups within this audience that need to be identified and approached with different strategies (e.g., HIV Specialists, family practitioners, minority providers, professional groups, rural-based providers)?
- Define implementation methods.
    - What are the best methods to reach these specific groups (e.g., performance measurement consumer materials, media, conferences)?

- Determine appropriate implementation processes.
    - What steps need to be taken to make these activities happen?
    - What necessary processes are internal to the organization (e.g., coordination with colleagues, monitoring of activities)?
    - What necessary processes are external to the organization (e.g., meetings with external groups, conferences)?
    - Are there opinion leaders that can be identified from the target audience that can champion the topic and influence opinion?
- Monitor progress.
    - What is the flow of activities associated with the implementation process and which can be tracked to monitor the process?
- Evaluate.
    - Did the processes and strategies work? Were the guidelines implemented?
    - What could be improved in future endeavors?

IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads
Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Dermatologic manifestations. New York (NY): New York State Department of Health; 2004. 15 p. [14 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004

GUIDELINE DEVELOPER(S)

New York State Department of Health - State/Local Government Agency [U.S.]

SOURCE(S) OF FUNDING

New York State Department of Health

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Committee for the Care of Children and Adolescents with HIV Infection

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 5 Penn Plaza, New York, NY 10001; Telephone: (212) 268-6108

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Dermatologic manifestations. Tables and recommendations. New York (NY): New York State Department of Health; 2004 Mar. 11 p. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.
- HIV clinical practice guidelines. New York (NY): New York State Department of Health; 2003. 36 p. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 5 Penn Plaza, New York, NY 10001; Telephone: (212) 268-6108

This guideline is available as a Personal Digital Assistant (PDA) download from the New York State Department of Health AIDS Institute Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on January 14, 2005. This summary was updated by ECRI on January 31, 2006, following release of a public health advisory from the U.S. Food and Drug Administration regarding the use of Elidel Cream (pimecrolimus) and Protopic Ointment (tacrolimus).

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