African Immigrant with Weight Loss and Disseminated Skin Lesions
(See pages 726–7 for Answer to Photo Quiz)

A 30-year-old Nigerian man who had been living in Switzerland for the past 3 years but who visited his native country regularly presented with a 2-week history of worsening maculopapular skin lesions disseminated over his whole body, accompanied by intermittent fever, night sweats, and chills. He had a history of *Shigella* infection. Family history was unremarkable.

In addition to maculopapular skin lesions (figure 1, *upper left*), physical examination revealed cervical lymphadenopathy,
a slight tenderness of the abdomen with splenomegaly, and anal ulcers. Blood pressure was 100/65 mm Hg, pulse was 104 beats/min, and core temperature was 39.2°C.

Laboratory tests revealed the following values: hemoglobin, 6.5 g/dL (erythrocytes were microcytic and hypochromic); WBC count, 3.37 × 10³ cells/µL without left shift; platelet count, 408 × 10³ platelets/µL; C-reactive protein, 12 mg/L (normal value, <5 mg/L); aspartate aminotransferase, 100 U/L (normal value, <50 U/L); alanine aminotransferase, 50 U/L (normal value, <50 U/L); lactate dehydrogenase, 1000 U/L (normal value, <120 U/L); and bilirubin, 250 µmol/L (normal value, <60 µmol/L). There was no evidence of malaria found during examination of a peripheral blood smear. The results of a screening test for HIV antibodies were positive, and Western blot examination confirmed infection with HIV-1. The CD4 cell count was 2 cells/µL, and the virus load was 308,000 copies/mL. The results of serologic tests for *Toxoplasma gondii* and *Bartonella henselae* were negative, as were results of a plasma reagin test and a microhemagglutination test for *Treponema pallidum*. The results of tests for cytomegalovirus IgG antibodies were positive, and the results of tests for IgM antibodies were negative. Sputum cultures were negative for bacteria and mycobacteria, and immunofluorescence testing of sputum samples for *Pneumocystis carinii* had negative results as well.

The findings of chest radiography were normal. A CT scan of the head and neck revealed multiple enlarged bilateral lymph nodes (figure 1, upper right). Findings of CT of the abdomen, including the lower pulmonal fields, were normal, except for splenomegaly of 18 cm.

Routine histologic examination of a cervical lymph node specimen revealed a nonspecific inflammation with noncaseating granulomas and without microorganisms. Histologic examination of the skin biopsy specimen revealed a combination of granulomas and suppuration, and there was evidence of some microorganisms (figure 1, lower right).

Two weeks after institution of medical therapy, the skin eruptions disappeared, and the patient was afebrile. Six months later, the patient stopped all of his therapy after attending a prayer week in Nigeria, hoping he had been healed from AIDS. Subsequently, he experienced a relapse of the skin eruptions (figure 1, lower left), and treatment was again successfully instituted 2 months later. Skin biopsy again revealed a granulomatous infection. This time, the responsible organism could be cultivated.

What is the underlying diagnosis? What is the most likely cause of the skin eruptions?