A 24-year-old transgender woman with Treacher-Collins syndrome (mandibulofacial dysostosis) and AIDS (CD4+ cell count, 151 cells/mm³) presented with a 1-month history of a pruritic, mildly erythematous, polycyclic papular eruption distributed diffusely over her face. She had no history of any similar eruptions and no history of facial implants or facial surgeries for Treacher-Collins syndrome. She denied fever, chills, or other systemic symptoms and had no contact with plants, metals, or new cosmetics. The remaining findings of the review of systems were unremarkable. The patient had been sexually active within the previous 6 months, often without barrier protection. She had received a diagnosis of AIDS 4 years earlier and had been receiving continuous antiretroviral therapy, with the exception of a break in therapy just prior to the onset of the skin eruption. The patient had no recent travel
history but had exposure to dogs. Medications included tenofovir, emtricitabine, atazanavir, ritonavir, sulfamethoxazole-trimethoprim, azithromycin, and conjugated estrogen. The findings of the physical examination were remarkable for concentric annular eruptions that were slightly erythematous and pruritic and that involved the cheeks, forehead, dorsal nose, chin, occipital scalp, neck, and upper back (Figures 1 and 2).

On initial examination, there was no alopecia, lymphadenopathy, or oral or ano-genital lesions. Routine serum chemistry and hematological tests had normal results, and a recent rapid-plasma reagin test had been reported to have negative results. Empirical treatment for a possible zoonotic dermatophyte infection or tinea imbricata was started with terbinafine (250-mg tablets administered once daily) and topical ketoconazole foam (administered twice daily for 21 days). At the 3-week follow-up visit, there was some decrease in pruritis but no improvement in the initial facial eruption.

What is your diagnosis?

Figure 2. Concentric annular eruption on the cheeks.