CONTRIBUTION TO THE STUDY OF KAPOSI'S

(SARCOMA-A Case Report)

By

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Kaposi[10] (1872) described five cases of "Idiopathic multiple pigment sarcoma of the skin". This consisted of multicentric development in men of red or purple nodules of skin especially over feet and hands. He, in addition observed that the nodules were invariably associated with oedema and diffuse thickening of skin which some time ulcerated. More-over while individual nodule might regress the disease was fatal, and he described findings of visceral involvement at autopsy.

On the basis of clinical and histopathological evidence, Kaposi's sarcoma can easily be differentiated from malignant melanoma. As the component of haemorrhage was an important feature in this disease, Kaposi subsequently altered the name of this tumour to "Idiopathic multiple haemorrhagic sarcoma" and this terminology has generally been accepted.

The disease is ordinarily slow, unrelenting and progressive, causing death after varying intervals. Death is usually the result of gastro-intestinal or bronchial haemorrhage, intercurrent infection, or at times, of and associated lymphoma. In some cases, it is due to cachexia or gangrene. Its histogenesis still remains undetermined.

For quite some time it was believed that this entity was primarily a disease of Jewish males between forty to seventy years of age. But, during the last twenty two years various investigators have reported a large number of cases among Africans also, and it is now evident that the disease is apparently encountered everywhere in Africa, probably more frequently so than in temperate countries([5],[8],[9],[11],[18]). Mortada[12] (1967) reported first two cases of Kaposi's disease from Cairo. The lesions started in conjunctiva and the disease ran a benign course.

Though a large number of cases of Kaposi's sarcoma have been reported from different parts of the world, the disease is practically non-existent in India. The extreme paucity of cases with this lesion among Indians has prompted the documentation of this report.

CASE REPORT

G. M., a male aged 42 years was admitted in Dermatology ward on 20-3-1966 with diffculty in walking due to painful swelling on the left foot. He also drew attention to rounded swellings about three years back on the hands. The condition in left foot developed only a year back.

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PHYSICAL EXAMINATION

General:- Average built middle aged male with slight pallor. There was pitting oedema on both legs, but more marked on the left.

SYSTEMIC EXAMINATION: Did not reveal any evidence of organic lesion

LOCAL EXAMINATION: Elevated violaceous lesions with well defined margins on the dorsal and palmar aspects of both hands Three nodule were

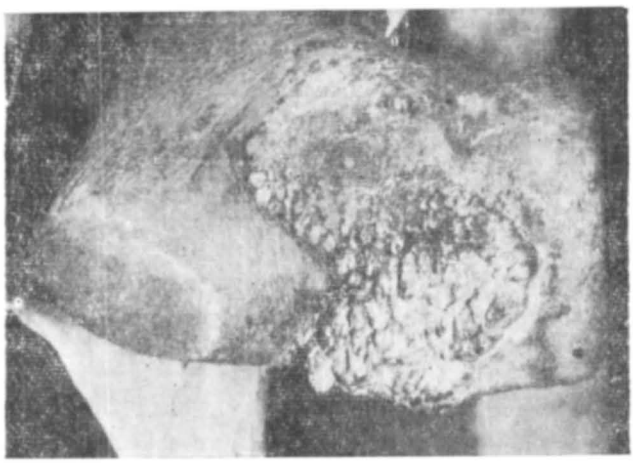

Fig. 1.
Verrucous lesion on the left foot.

present on the inner aspect of each forearm above the wrist. A few nodules, violaceous in colour, were scattered on both legs. Violaceous plaques with scaly surface were present on dorsal and plantar surfaces of both feet. Besides, there was a verrucous mass about 12 cm x 9 cm on the plantar surfaces of left foot approximately 6 cms elevated from the surface (Fig. I). This verrucous lesion was extremely tender.

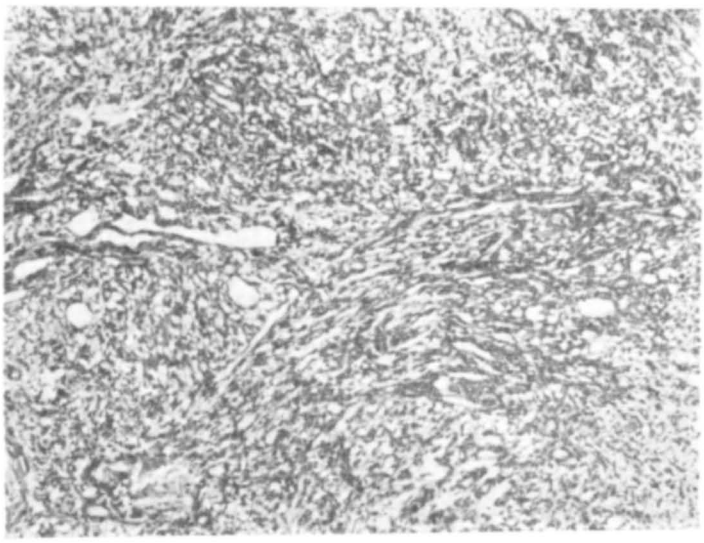

Fig. 3.
Fibroblastic-neoplastic tissue mixed with Angiomatous areas. H and E Stain x 63.

Provisionally only two conditions were entertained viz; Kaposi's Sarcoma and Chromoblastomycosis.

INVESTIGATIONS: Blood. Haemoglobin 10.2 gm per 100 ml. Total eucocyte count = 7,200 per c. m. Differentiai leucocyte count. Polymorphonuclears = 64% Lymphocytes = 32% Large monocytes = 2% Eosinophils = 2% Urine. Except for slight proteinuria, no abnormality was detected. Stool. Ova of Ascaris lumbricoides present. No occult blood detected. Flouroscopy chest. N. A. D. E. C. G. N. A. D.

Biopsy from verrucous lesions on the plantar aspect of left foot showed on H and E stain diffuse angiomatous tissue. The cells composing the tissue were spindle or stellate shaped and ran in fascicles forming capillary channels in between them. Tumour tissue infiltrated the dermal collagen, fat and vessel wall. In addition clusters of haemosiderin laden histiocytes were seen. There were inflamnatory cells mixed with the tumor tissue and there appeared to be a progression of angioblastic tissue to collagenous connective tissue (Fig 3 and 4).

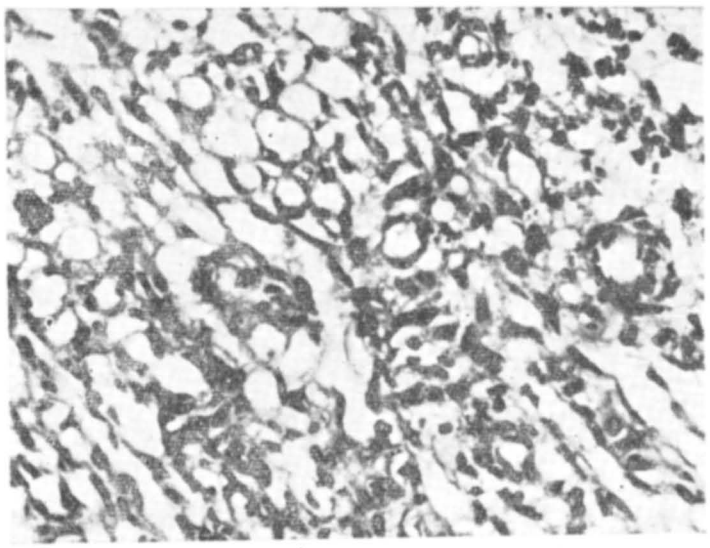

Fig. 4.
Endothelial proliferation in a predominantly angiomatous area with a fair amount of inflammatory cells.
H ant E stain x 250.

Silver impregnated sections showed predominantly angiomatous areas and reticulin pattern.

TREATMENT AND FOLLOW UP

The patient was subjected to deep X-Ray therapy for the verrucous lesions on the left foct. A dose of 150 given daily for ten sittings. The verru-cous lesions regressed markedly.

The patient reported again after a year. The lesions on the left foot were almost completely healed and he could walk without difficulty. A systemic check up did not reveal any visceral involvement.

DISCUSSION

To the best of our knowledge, Kapoiss sarcoma has not been reported from India. Datta and Saini[6] (1969) in Chandigarh, observed a case at autopsy. The reason for this rarity cannot be readily understood. Johnstone[8] (1965) believed that in tropical countries Kaposis sarcoma may be treated as nodular leprosy because the clinician is unaware of the disease.

The verrucous lesions on the planter surface of left foot in this patient were so painful that he was forced to take to bed and came to the hospital on a stretcher. Similar lesions were described by Ferrera[7] (1968) and his patient was treated surgically with relief. We, however, employed roentgenotheraphy and our case improved considerably after a year. Palmia[15] (1966), Oswald and Stam[14] (1968) and Dana and Touati[2] (1968) obtained regression of cutaneous lesions in their cases with radiotherapy. But permanent and long term cures are probably rare. As is pointed out in the review Mordada reported two cases of regressive type of Kaposis sarcoma beginning in cunjunctiva. The present patient has not yet developed visceral lesions but the follow up has been too short.

Though the nature and histogenesis of this tumour remain obscure, most of the authorities hold the view that it is a peculiar low grade recrudescent angiosarcoma of multicentric origin[4, 13, 02]. But some invesigators opine that it is a tumour of reticuloendothelial system very similar to Hogkins disease, lymphomas or leukaemias [1, 3, 16, 17, 19]. Still oters are inclined to the view that it may prove to be an infective, possibly viral, granulomatous disease[21].

SUMMARY

1. A case of Kaposi's disease in a Kashmiri male is reported.
2. Beneficial effect of radiotherapy on this tumour is noted.
3. No visceral involvement recorded after a year of initial observation.

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