



AIDS RELATED KAPOSI'S SARCOMA

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A case report of a 22-year-old HIV-infected heterosexual man with Kaposi's sarcoma is described. The need for high index of suspicion and new mode of therapy are discussed.

Key words : AIDS, Kaposi's Sarcoma, Heterosexual, Podophyllotoxin.

Introduction

The incidence of AIDS associated Kaposi's sarcoma (KS) is very high among homosexual and bisexual men who meet their partners in places where anonymous casual sex is common such as bath houses. Till 1992 the incidence was reported to be 13.1%.¹ However, presently the incidence is reported to be as high as 40%, and most of the cases of AIDS related KS are reported from America, Europe and Africa. There is a paucity of AIDS related KS in Indian literature. Till September



Fig.1. Nodular lesions of Kaposi's sarcoma on face

coma are registered in India.² Since then only occasional cases must have been registered but the total number may not exceed a couple of a dozen. The present case is reported due to the uncommon features and response to topical therapy.

Case Report

A 22-year-old man presented to hospital for bluish-back multiple, non-pruritic, painless nodular swelling on the nose and cheek of four months. Six months ago the patient developed similar swellings and

started uncontrolled bleeding from the site of lesion for which excision was undertaken at another hospital and histopathologically reported to have infected haemangioma. Two months later the patient again developed similar lesions at the same site for which

1997 only sixteen cases of AIDS related Kaposi's sar-

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he presented to this hospital. There was no history of local trauma, blood transfusion or intravenous drug usage. The patient was married a year ago and gave history of multi sex-heterosexual behaviour. There was history of low grade fever, significant weight loss and diarrhoea for two months. There was no history of cough.

On examination the patient was pale, wasted and had generalized lymphadenopathy. There was oral candidiasis but examination of respiratory, cardiovascular, gastrointestinal tract, genito-urinary system and nervous system was normal. Local examination of the face revealed multiple bluish black violaceous, nodular lesions on the nose and upper lip on the left side. There were crusts at the periphery of lesions but there was no free bleeding (Fig.1). The nodules were soft and did not blanch on pressure. There were no similar or other skin lesions any where on the body.

His haemoglobin was 8 gm% and ESR was 40 mm first hr. The total and differential counts were within normal limits. The Mantoux test was negative, sputum was negative for acid fast bacilli and X-ray chest was normal. His liver function tests were normal. The HIV antibody test by ELISA and Western Blot was positive for HIV-1 and 2. The histopathological examination from nodule showed covering stratified squamous epithelium. Underneath there were plenty of ectatic dilated vessels and small slit like proliferated vessels lined by spindle cells. Cells with hyperchromatic nuclei, inflammatory cells like lymphocytes and plasma cells were seen at the periphery of the lesion. PAS positive material was demonstrated. This institute has no facility for CD-4/CD-8 count and immunohistochemistry. However, considering the HIV positivity, and clinical features

the lesion was diagnosed as KS. The patient was not ready to undergo any surgical procedure or chemotherapy. 50% podophyllotoxin was applied on the lesion on every third day for 2 weeks. At the end of two weeks all the lesions regressed. The patient was discharged and was followed-up regularly for one year, there was no recurrence of the lesion and the patient lost was for further follow-up.

Discussion

KS is mostly confined to HIV infected homosexuals in America and Europe and reported to be more extensively disseminated than the benign endemic form reported in some parts of Africa. However, 15 of the 16 cases of Kaposi's sarcoma reported in India so far were homosexuals while one was heterosexual showing that the HIV infected heterosexual population is not immune to KS.²

Microscopically there is no difference in appearance of KS among the various clinical groups, however the early lesions of KS are seen most commonly now in the AIDS patients, and the subtlety of change in many cases presents an ongoing challenge to the surgical pathologist.³

The early lesion is a patch stage while the advanced is a plaque stage.³ We could not review the histopathology of earlier reports at another hospital, but from the presenting lesions in this hospital, the earlier lesions probably remained undiagnosed. Electron microscopy and CD-4/CD-8 counts proved the diagnosis of the AIDS related patient in the case reported by Shroff et al.⁴

Agarwal et al⁵ clinically suspected in one and confirmed it by histopathological examination in another.⁶ The characteristic histopathological changes which were not seen in one case⁵ may be due to the



early lesion or patch stage of KS. Recognition of the early changes of KS especially in the AIDS patient, remains one of the most difficult diagnostic problems, the irregular infiltrative pattern of the endothelial cells in early lesions is more helpful in diagnosis than the degree of cytological atypia.³

Various treatment modalities are listed including excision, electrodesiccation, curettage, intralesional bleomycin, vinblastine, infrared coagulation, cryotherapy, radiotherapy, sclerosing agents and intralesional interferon.¹ Intralesional vincristine and sublingual alpha interferon resulted in good response.⁴

Topical podophyllotoxin is the treatment of choice for venereal wart. It caused regression of the lesion of KS and there was no recurrence over one year in the present case. However, due to the

short term follow up with application of podophyllotoxin to the KS lesions it is difficult to comment with certainty about its usefulness.

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