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Short Communication

Kaposi Sarcoma---Need for High Index of Suspicion in Low Prevalence Areas

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A 63 old year male presented with an 8 month history of raised nodules and plaques, purplish in color, on face, trunks and extremities. The lesions were non pruritic and symptom less. Patient visited different hospitals where he was treated with the suspicion of tuberculosis and leprosy. However, no improvement was observed. On the basis of clinical suspicion of Kaposi Sarcoma, a skin biopsy was performed. Histopathological examination of the skin biopsy revealed a diffuse spindle cell proliferation within dermis. On high power examination there were slit like vascular spaces lined by endothelial cells. The surrounding stroma showed extravasation of RBCs and hemosiderin laden macrophages. On the basis of histopathological findings a diagnosis of Kaposi Sarcoma was rendered. Patient however, denied any history of sexual contact or blood transfusion. HIV screening was positive for AIDS.

Comments

Kaposi sarcoma was described by Moritz Kaposi for the first time as "idiopathic multiple pigmented sarcoma of the skin."[1] It was initially considered as an indolent slow growing tumor. The aggressive course of Kaposi sarcoma has become part of devastation of AIDS especially in young homosexual males.

Clinically, KS presents as multiple vascular nodules in skin and other organs. KS occurs in three forms (localized nodular, locally aggressive and generalized KS) and six stages including patch, plaque, nodular, exophytic, infiltrative and lymphadenopathic. KS clinically needs to be differentiated from Bacillary Angiomatosis[2], Blue Rubber Bleb Nevus Syndrome, Melanocytic Nevi, Pyogenic Granuloma, and Tufted Angioma.

Histopathologically, three forms are recognized based on relative contribution of spindle cells, fibrosis, and nuclear pleomorphism. These include: (1) a mixed form with an equal amount of spindle cells, vascular

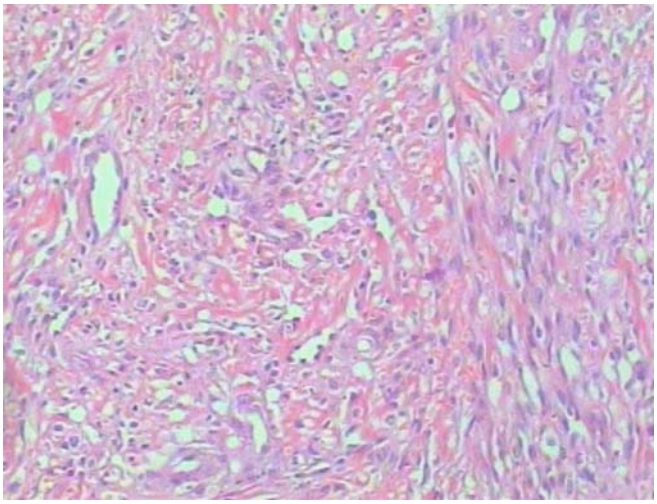

Figure 1: Slit like Vascular Spaces

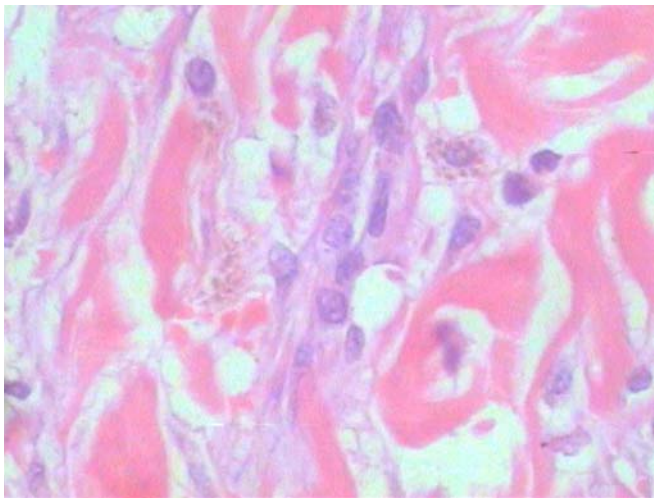

Figure 2: Prominent Endothelial Cells Lining the Slit like Spaces with Hemosiderin Laden Macrophages

clefts and capillaries, (2) a mononuclear type with predominance of 1 cell type and (3) an anaplastic form with cellular pleomorphism and numerous mitoses. CD-34, factor VIII related antigen, the lectin Ulex europaeus I and HLA- DR may be helpful to support or confirm the diagnosis of KS.

Clinical classification may be the best prognostic indicator of the disease. Localized nodular KS has the best prognosis, locally aggressive KS has intermediate and generalized KS that is mostly seen in patients with KS-AIDS, has the worst prognosis.

In current case, the patient was treated for

tuberculosis and leprosy. In countries like Pakistan, where AIDS is not very prevalent, one should have a high index of suspicion in such cases so that the diagnosis should not be delayed.

References

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