

Disseminated Gastrointestinal Kaposi Sarcoma

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Figure 1: Esophagogastroduodenoscopy shows a highly vascularized polypoid lesion with a nearby second flat lesion at the gastric antrum.

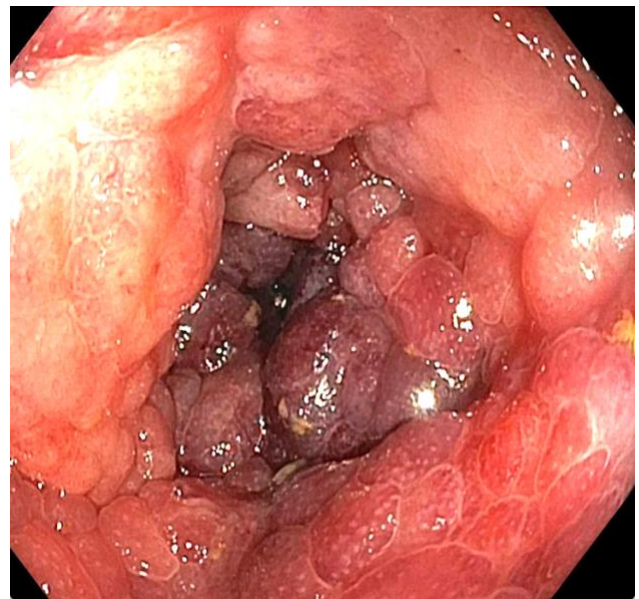


Figure 2: Colonoscopy shows a nodular mass forming obstructive anorectal lesion.

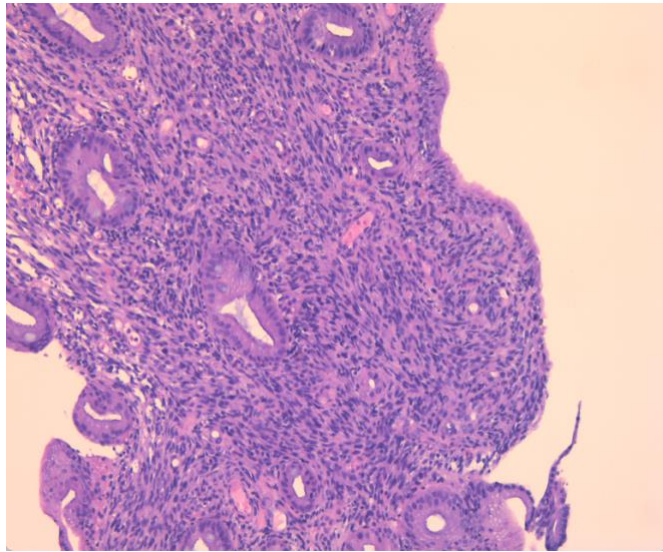


Figure 3: Histopathology image with hematoxylin and eosin stain shows spindle cell proliferation with vascular spaces.

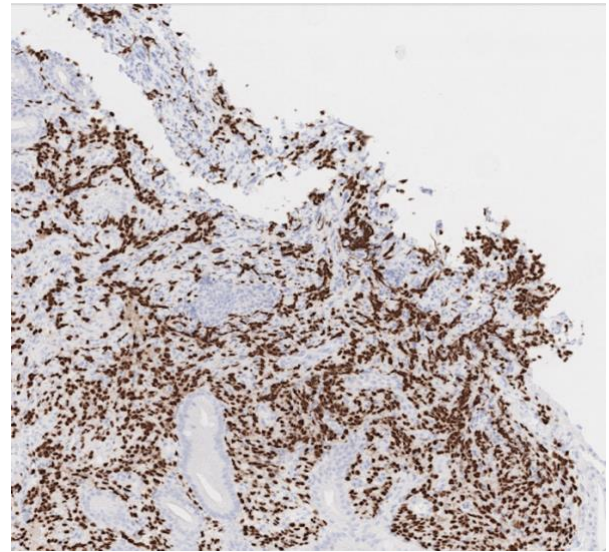


Figure 4: Human herpes virus 8 immunohistochemical staining shows diffuse nuclear positivity.

Clinical Image

A 25-year-old man presented to the emergency department with hematochezia. He denied abdominal pain, nausea, and vomiting. He had a history of HIV diagnosed 7 years ago but had been lost to follow up. Physical examination revealed multiple, violaceous nodules on his skin and palate. There was a mass in his anal canal which bled on contact. Laboratory results revealed a hemoglobin of 6.4 g/dL and CD4 count of 40 cells/mm³.

Esophagogastroduodenoscopy revealed several violaceous nodular lesions on the soft and hard palate and in the mid esophagus and a 15mm highly vascularized polypoid lesion at gastric antrum (Figure 1). Colonoscopy revealed numerous nodular, hemorrhagic, erythematous masses, in a circumferential distribution which blocked the rectum (Figure 2). Histopathology of the anorectal lesion revealed a spindle cell neoplasm positive for CD31 and human herpes virus 8 on immunohistochemical staining consistent with Kaposi sarcoma (Figure 3 and 4). The patient was not started on anti-retroviral therapy due to concern of immune reconstitution inflammatory syndrome; he subsequently died with multiorgan failure. Even though the incidence of Kaposi sarcoma has decreased with the current treatment for HIV, Kaposi sarcoma should be included in differential diagnosis of nodules in the gastrointestinal tract in these patients [1].

REFERENCES

1. Arora M, Goldberg EM. Kaposi sarcoma involving the gastrointestinal tract. Gastroenterol Hepatol (NY). 2010; 6: 459-462.