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An atypical presentation of Kaposi sarcoma in a person with human immunodeficiency virus

Uma apresentação atípica de Sarcoma de Kaposi numa pessoa com vírus de imunodeficiência humana

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Case Presentation

Kaposi sarcoma is an angioproliferative neoplasm of the vascular endothelium, triggered by Human herpesvirus 8 (HHV-8) infection[1,2]. Of its four possible variants – endemic, epidemic, classic, and drug-induced – the epidemic form predominates in HIV patients, particularly in cases of advanced immunosuppression. However, HIV patients originating from Sub-Saharan Africa may present the endemic variant, requiring differential diagnosis[3].

We report a case of endemic Kaposi sarcoma in a man living with HIV from Angola, with virological suppression and good immunological status under antiretroviral therapy (ART).

The patient presented to our HIV clinic in May 2024 after a 4-year stay in Angola, reporting right inguinal lymphadenopathy, measuring 6.5 × 4.3 cm, first noted approximately 1 year earlier (figure 1.1). He denied ART interruption and was virologically suppressed at the time. An incisional biopsy was performed, revealing lymph-node involvement by Kaposi Sarcoma. After thorough investigation, additional cutaneous, mucous, and visceral involvement was excluded.

Treatment with pegylated liposomal doxorubicin at a dose of 20 mg/m^2 every three weeks was initiated, and six cycles were completed with a favorable response. However, treatment was stopped after 6 cycles, as the patient went back to Angola, against medical advice.

Eight months later, he returned to Portugal reporting worsening of the lesion. Upon observation, an exophytic 10 × 8 × 6 cm lesion was noted (figure 1.2), with superficial ulceration, invasion of the right femoral muscle, and no clear plane of separation from the adjacent vascular structures (figure 1.3). The patient reported no interruption of ART, and laboratory testing confirmed viral suppression, with a CD4+ T-cell count of 839 cells/mm^3. Following histologic confirmation and exclusion of systemic involvement, the patient restarted treatment with pegylated liposomal doxorubicin 20 mg/m^2 every three weeks. To date, ten sessions have been completed, resulting in favorable clinical response.

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Imagem



Figura 1. (1) Right inguinal 6.5 × 4.3 cm, exophytic, infiltrative polypoid mass. Following biopsy with immunohistochemical analysis, a lymphoplasmacytic infiltrate with intense and diffuse nuclear positivity for HHV-8 was identified, indicating Kaposi Sarcoma. (2) A 10 × 8 × 6 cm Kaposi Sarcoma lesion in the right inguinal region, with a violaceous appearance and vaguely sessile, featuring infiltrated borders, deep ulceration, and a fibrinous base. (3) Parasagittal CT scan of the right lower limb, evidencing a 9.1 x 5.9 x 7 cm vascularized inguinal mass with lobulated contours, extensive cutaneous ulceration, and internal necrosis, consistent with Kaposi Sarcoma (delimited by arrows). It lacks a clear plane of separation from the adjacent vascular structures (identified with *).

Author Contributions

José Pinho: conceptualization, investigation, writing – original draft, writing – review and editing.
Margarida Mouro: investigation, writing – review and editing.
Margarida Prata: conceptualization, writing – review and editing.
Pedro Silva, Gonçalo Cruz, Cristina Valente: writing – review and editing.

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Ethics Statement

This study was conducted in accordance with the ethical principles of the Declaration of Helsinki. Written informed consent was obtained from the patient for publication of clinical details and images.

Conflicts of Interest

The authors declare no conflicts of interest.

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