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OLGU YAZISI / CASE REPORTS

HIV NEGATİF BİR HASTADA LOKALİZE SKROTAL KAPOSİ SARKOMU OLGUSU

LOCALIZE SCROTAL KAPOSI SARCOMA IN A HIV-NEGATIVE PATIENT

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ÖZET

Kaposi sarkomu (KS) endotel kaynaklı anjiyo-proliferatif bir hastalıktır. Dört ana KS türü vardır; klasik, endemik, iyatrojenik (transplantasyonla ilişkili KS) ve HIV ile ilişkili. Hastalık daha çok mukokutanöz bölgelerde ortaya çıksa da; yüz, gövde, alt ekstremitelerin derisi ve genital bölge sıklıkla tutulur. KS ürogenital sistemde en çok peniste görülse de skrotal hastalık nadirdir. 68 yaşında erkek hasta, skrotumda mavi-mor lezyonlarla dermatoloji kliniğine başvurdu. Doku biyopsisi sonucu 'Klasik Kaposi Sarkomu' olarak sonuçlanınca tıbbi onkoloji kliniğimize sevk edildi. Serolojik testi HIV negatifti ancak merkezimizde Human Herpes Virus (HHV) 8 testi yoktu. Hasta on gün boyunca günlük 300 cGy küratif radyoterapi aldı. Komplikasyon olarak tedavi alanında lokalize dermatit ve minimal lenfosel gelişti. Bu lezyonlar lokal semptomatik tedavi ile birkaç gün içinde düzeldi. Tedaviyi tamamladıktan üç ay sonra rezidü KS yoktu. Hastanın takibi nükssüz olarak devam etmektedir. Epidemik ve HIV ile ilişkili KS sıklıkla ürogenital yolu tutsa da, klasik KS nadiren görülür. KS en çok peniste görülürken skrotum yerleşimi çok nadirdir. Literatürde HIV pozitif ve negatif hastalardan oluşan toplam 9 hasta bildirilmiştir. Bildiğimiz kadarıyla bizim olgumuz HIV negatif bir hastada tanımlanan 4. skrotal KS hastasıdır.

ANAHTAR KELİMELER: Kaposi Sarkomu, Radyoterapi, Skrotum.

ABSTRACT

Kaposi sarcoma (KS) is an endothelial originated angio-proliferative disease. There are four main types of KS; classic, endemic, iatrogenic (transplantation associated KS) and HIV-associated. Even if the disease mostly occurs in mucocutaneous sites; face, trunk, the skin of the lower extremities, and genitalia frequently involved. Even KS is mostly seen in the penis in the urogenital system, the scrotal disease is rare. A 68-year-old male was admitted to the dermatology clinic with blue-purple lesions on the scrotum. He was referred to our medical oncology clinic when tissue biopsy was resulted as 'Classical Kaposi Sarcoma'. His serologic test was negative for HIV Human Herpes Virus but (HHV-8) test was not available at our center. The patient received curative radiotherapy daily 300 cGy for ten days. Localize dermatitis and minimal lymphocele developed on the treatment field as a complication. These lesions recovered in a few days with local symptomatic treatment. There was no residual KS after the three months completed the therapy. The patients' follow-up continues as free of recurrence. Although epidemic and HIV-associated KS frequently involved urogenital tract, classic KS is rarely seen. The KS is mostly seen in the penis while scrotum localization is very rare. In the literature, a total number of 9 patients which are composed by HIV positive and negative patients is reported. To the best our knowledge, our case is 4th scrotal KS patient described in an HIV-negative patient.

KEYWORDS: Kaposi Sarcoma, Radiotherapy, Scrotum.

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INTRODUCTION

Kaposi sarcoma (KS) is an endothelial originated angio-proliferative disease. The disease is characterized by microscopic angiogenesis, mononuclear cell infiltration and the presence of the spindle-shaped tumor cells (1-3). There are four main types of KS; classic, endemic, iatrogenic (transplantation associated KS) and HIV-associated. While classic KS is mostly seen in the lower extremities of older men in the Mediterranean region, endemic KS is mostly seen in Africa. Iatrogenic KS is often seen in patients who are organ recipient or immunosuppressive. Human Herpes Virus 8 (HHV-8) is a crucial etiologic factor in KS. Although HHV-8 is an important risk factor; immune impairment, angiogenic mediators and genetic factors are composing other risk factors (4).

Predominantly, KS is located in mucocutaneous body regions. Even if the disease mostly occurs in mucocutaneous sites; face, trunk, the skin of the lower extremities, and genitalia frequently involved. Also, KS can invade visceral organs which located notably in the respiratory and gastrointestinal tract (5).

Even KS is mostly seen in the penis in the urogenital system, the scrotal disease is rare. Here, we want to present an HIV negative patient with localizing KS in scrotal site.

CASE

A 68-year-old male was admitted to the dermatology clinic with blue-purple lesions on the scrotum. The lesions were developed for within three month time and located near the penile root. The patient denied any pain and ulceration. He was referred to our medical oncology clinic when tissue biopsy was resulted as 'Classical Kaposi Sarcoma'. His medical history was positive for benign prostatic hypertrophy and lumbar disc operation. He denied any immunosuppressive condition or suspicious sexual behavior. Physical examination revealed multiple blue-purple nodular lesion, each nearly 0,5x0,5 in dimension, on the scrotum. Pathologic lymphadenopathy was not detected. The routine laboratory tests were normal. His serologic test was negative for HIV but HHV 8 test was not available at our center. The systemic evaluation was performed with computed tomography for visceral metastasis and no visible tumor was detected. The patient was referred to radiation oncology for radiation therapy. The patient received curative radiotherapy daily 300 cGy for ten days. Localize dermatitis and minimal lymphocele developed on the treatment field as a complication. These lesions recovered in a few days with local symptomatic treatment. There were no residual KS after the three months completed the therapy. The patients' follow-up continues as free of recurrence. Written consent was obtained from the patient for the case report.

DISCUSSION

The KS is first described as an idiopathic multiple pigmented sarcoma by Moritz Kaposi in 1876 [6]. Although etiopathogenesis has not been clearly explained, relationship with HIV infection is well defined. HIV associated or epidemic form is the most common type. Classical KS commonly seen in an older male patient of Mediterranean region and more often presents as indolent multiple purple plaques on the hands, feet, and extremities. In this form, visceral involvement has rarely seen. HHV-8 is another virus which associated with KS. Other predisposing factors for KS are gender, genetic predisposition, and immunosuppression.

Although epidemic and HIV associated KS frequently involved urogenital tract, classic KS is rarely seen. The KS is mostly seen in the penis while scrotum localization is very rare (7). The first case of scrotal KS in an HIV negative patient was presented in 1976 by Vyas et al. (8). In the literature, a total number of 9 patients which are composed by HIV positive and negative patients, is reported. To the best our knowledge, our case is 4th scrotal KS patient described in an HIV negative patient (7-9).

The diagnosis of KS is based on clinical suspicion and histopathologic examination of the skin lesions. For investigating organ involvement radiological imaging has suggested. Our case had no visceral involvement and any other skin lesions. The primary goal of localizing KS treatment is a cure. Patients with non-fit for curative treat-

ment or metastatic disease should treat for palliating the symptoms, decrease the size and number of skin and visceral organ lesions and delay the progression. Although various treatment options are available after a diagnosis such as total excision, radiotherapy, cryotherapy, laser ablation, chemotherapy for classical KS, there is no standard treatment for genital KS cases due to rarely seen (8, 10).

Özmen et al. (7) and Yenice et al (10) performed local excision for their small, early-stage HIV negative scrotal KS patient and no recurrence was observed. Gümüşay et al (9) have administered palliative external scrotal radiotherapy and obtained %90 regression of the lesions. For our case, we also preferred 30Gy external radiotherapy to then scrotum and lesions regressed completely.

In conclusion, classical KS has typically seen in the lower extremities and HIV negative scrotal KS is a very rare vascular neoplasm of the skin. To achieve early diagnosis high clinical suspicion and careful physical examination is necessary.

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