INTRODUCTION

Kaposi's sarcomas (KS) are vascular lesions which usually originate from multiple sites in the mid-dermis extending to the dermis. The aetiology is unknown, but infection from human herpes virus type 8 has been suggested. Several reports of KS had come from Africa initially and from worldwide later due to the close association with HIV/AIDS. Prior to this however, KS was very frequent in Eastern Europe, Italy and the United States where it existed in an indolent form in the elderly men of Jewish ancestry. KS may also be due to iatrogenic immune suppression from chronic use of steroids, elevated degree of expression of numerous cytokines and angiogenic growth factors including TNF alpha, IL-6, bFGF, HIV-tat protein and oncostatin M. Lymphadenopathic KS involves the lymph-nodes, viscera and the gastrointestinal tract and may run a disseminated and aggressive course. We are reporting one such case in an immunocompetent male.

CASE REPORT

A 45 years old Hausa farmer from a village in Sokoto state was referred with history of neck swelling and low grade fever for 18 months. Swellings were painless, started on the right side of his neck and grew slowly to involve the left. He had low grade fever and occasional night sweats. There was no history of cough, contact with a chronically coughing patient, diarrhoea, bleeding, dysphagia or pruritus. Three years prior to his admission with us, he was diagnosed as being hypertensive at a peripheral hospital but did not maintain regular follow-up and / or medication. He had never smoked nor imbibed alcohol. He is married to 2 wives with 10 children, all well and healthy.

Examination revealed a middle aged man with bilateral enlarged cervical lymph nodes; right measuring 19.0 x 10.0 cm and left measuring 10.0 x 8.0 cm in diameter (Figures 1a and b) firm to hard, matted, mobile over the skin but fixed to the underlying muscles. No other
peripheral lymph node or skin lesions were noted. His pulse rate was 88 beats per minute and admission blood pressure was 160/100 mmHg. There was no significant abdominal or CNS findings.

Chest X-ray showed normal cardiac silhouette with prominent aortic knuckle. ECG showed an enlarged left atrium with sinus tachycardia. Lymph node histopathology reported bundles of spindle cells surrounding numerous vascular channels compressed into slit-like spaces and containing red cells. There was mild infiltration by mononuclear cells (Figure 2). A histological diagnosis of Kaposi’s sarcoma was made. His serum was non-reactive for HIV I and II antibodies using the ELISA kit. He had normal haemogram and chemistry.

He was treated with combination therapy with chemotherapeutic agents and radiotherapy. Following the first course of his treatment, the patient made a remarkable improvement in terms of marked reduction of the nodal mass and general well being. Three to six courses of the combined treatment is being planned for the patient.

Figure 1a: Right neck lymph node.

Figure 1b: Left neck lymph node.

DISCUSSION

KS was recognized as a relatively common neoplasm endemic to native populations in equatorial Africa. Lymphadenopathic, also called African or endemic KS is common in portions of Africa and particularly prevalent among young Bantu children of South Africa, who present with localized or generalized lymphadenopathy, and in whom the disease is extremely aggressive. KS is the most common malignancy seen in HIV-infected patients, especially where access to HAART is limited. In the US, KS serves as a defining illness in 2-3% of HIV-infected homosexual men. In the mid 1990s it was the initial presentation in approximately 15% of the homosexual men. However, in Africa, heterosexual men tends to be more affected with AIDS-related KS while it is a very rare finding in children. Skin lesions are sparse, and the male to female ratio is comparable to that of classic KS. It has been suggested that cigarette smoking may be protective for KS risk in HHV-8 sero-positive patients infected with HIV, while relative affluence may increase the risk in similar patients.

Our index patient however, was HIV negative and had no history of smoking of cigarette and also came from a poor socioeconomic background. He was a middle aged man that was initially seen and started on treatment for tuberculous adenitis following evaluation at another hospital. This was not surprising; because all forms of tuberculosis (pulmonary and extra-pulmonary) constituting over 90% burden of the disease is being reported in the developing world, with more than 25% being tuberculous adenitis. Screening for HIV I and II antibodies were negative. Excisional lymph node biopsy histopathology confirmed the diagnosis of KS. Our patient had only nodal involvement without any proven dissemination. Although his initial response to therapy was good, some patients may need multiple modalities of management including electrochemotherapy in case of lack of response or resistance to treatment regimes.
REFERENCES


Lymphadenopathic Kaposi’s sarcoma in an immunocompetent adult