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GASTROINTESTINAL KAPOSI SARCOMA PRESENTING IN A NIGERIA AFRICAN WITH HIV/AIDS

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ABSTRACT

Adult intussusception is a rare condition that is seen once in a while in surgical practice, 1. In this report we the case of a thirty-five year old Nigeria male, on medical treatment of earlier diagnosed AIDS who had no evidence of cutaneous Kaposi Sarcoma. He later presented with a palpable right lower quadrant mass and classic symptoms of intestinal obstruction for which he was referred to surgery. The findings at laparotomy were right ileo- colonic intussusception with polypoid lead point. There were also multiple intra-Luminal growths involving the entire right colon, the caecum, the appendix and the terminal ileum. A right hemi-colectomy with ileo-colonic anastamosis was performed, and the resulting specimen sent for histological examination confirmed Kaposi Sarcoma. Assessment of the patient's clinical condition five months post-operatively revealed a significant improvement; patient regained from 43 kg on admission to 58.3 kg. We conclude that Kaposi Sarcoma be included in the aetipathogenesis of adult intussusception.

KEY WORDS: Kaposi Sarcoma, Adult Intussusception, Surgical Outcome.

INTRODUCTION

Kaposi Sarcoma (KS) usually presents with cutaneous lesion nut it may involve other organs mostly the pulmonary and gastrointestinal systems,[2,3] Isolated intestinal KS without cutaneous involvement is rare. Although KS is a well recognized manifestation of AIDS,[4] the few reports of visceral KS available in literature have emanated from countries where HIV-I is the dominant cause of AIDS[1,5] To the best of our knowledge, there has not been any previous report of adult intussusception as a presentation of AIDS associated gastrointestinal KS. Among the objective of this report is to highlight the fact visceral KS may not be restricted to only countries where HIV-1, is the predominant cause of AIDS, and to emphasize the need to always include gastrointestinal KS, in the differential diagnosis of acute abdomen in every case of AIDS' patient; more so as surgery may improve the quality of life in such patient.

CASE REPORT

O.G. was a thirty-five year old Nigeria referred by a physician to Lorencis Specialist Hospital Enugu for surgery with a diagnosis of partial intestinal obstruction. He presented first for surgical consultation on the 7th July 2001 and was admitted on the same day. The history revealed that the patient had fever, intermittent diarrhea, and progressive weight loss since the previous sixteen months. He was diagnosed and placed on a combination anti-viral therapy, (Combivir)[6], by the attending physician who also admitted him for him for initial resuscitative care. While on admission in the referral hospital the patient manifested with alternating constipation and diarrhea. This was, what the patient described as un bearable right colicky abdominal pains. He also noticed that he had been constipated for about five days with slight abdominal distension. He admitted being able to pass flatus, initially but later developed complete constipation. Physical examination of the patient revealed an emaciated and chronically ill looking young man, moderately pale, anicteric, afebrile and tarchypnoeic. His pulse rate was 94b/m, blood pressure 130/100mmHg, respiration rate 24c/m, axillary temp 36.90C, and weight 43kg. The abdomen was full, soft, and moved with respiration. A tender mass was palpable in the right lower quadrant of the abdomen. The mass became harder with each peristaltic wave and was mobile vertically but not transversely. The bowel sound were accentuated. The cardiovascular, respiratory, and other system were essentially normal. Rectal examination revealed an empty rectum. A clinical diagnosis of acute-on-chronic intestinal obstruction was made. Laboratory investigations ordered included A complete blood count, fasting / two hour post prandial blood glucose levels, plain chest and abdominal X-rays and abdominal ultrasonography.

The only significant findings were in the ultrasound which showed a large, in-homogenously hyper echoic solid mass with eccentric "onion skin" appearance in the right lower quadrant of the abdomen measuring 8.cm. in diameter. A polypoid lead point of about 18mm. in diameter was also detected. After adequate resuscitation with intravenous fluid as appropriate under went elective laparotomy, two days later.

FINDINGS

The intra-operative findings were, a marked dilation of the whole of the small intestine and the right colon up to the hepatic flexure, and ileo-colic intussusception with palpable nodules along the ascending colon. Attempted reduction of the intussusception revealed non-viable gut-segment. The walls of the caecum, ascending colon, and terminal ileum were grossly thickened and rigid. The appendix was also rigid with numerous hyper plastic lymph nodes covering the entire mesoappendix and the regional mesocolon. The intestinal lumen was also completely occluded, the mucosae being the irregularly ulcerated. The serosa of terminal ileum had petechial Spots.

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In view of the above findings a right hemi-colectomy with ileo-colonic anastamosis was performed on the patient. He was transfused with a total of three units of blood post operatively. The patient made an uneventful recovery from the surgery and was consequently discharged for ambulatory follow-up on the 16th day post-up. He was followed up for thirty-three weeks (33wks.), during which his weight appreciated to 58.3kg, although the other symptoms of fever, occasional diarrhea, and excessive sweating persisted.

DISCUSSION

Kaposi Sarcoma (KS) is the most common tumours associated with HIV-1 infection; affecting 30% of HIV infected homosexual men before the advent of highly active anti-viral therapy (HAART)[7]. The most commonly and usually present with cutaneous lesion, but it may involve other organs, most commonly the pulmonary and gastro-intestinal systems[8].

The majority of the affected individuals have advanced immuno-suppression at the time of initial diagnosis of KS. While not presently curable, multiple treatment potions exist, including treatment by the herbalists and the spiritualists. They must therefore, be evaluated in terms of the specific needs of the individual patients.[9] The initial evaluation of a patient with KS consists of through physical examination with special attention paid to those areas typically affected by the disease. Many patient have 'symptoms referable to the gastrointestinal tracts and abdomen and undergo imaging studies. Localizing signs and symptoms are frequently misleading due to underlying immuno-suppression, debilitation, and prior or current antibiotic use[10].

The ultrasound report corresponded with the intra-operative findings emphasizing the importance of pre-operative imaging of a patient with abdominal symptoms. The radiologist thus plays a pivotal role in establishing a presumptive diagnosis, which may lead to empirical treatment until definitive diagnosis is established[11]. In many elective abdominal surgeries AIDS was unknown to the attending physician until diagnosed by surgical pathology[12]. In this our report the diagnosis of AIDS was made and the patient already being treated, before the superimposed intestinal obstruction manifested. These aspects are matters for discuss as whether to operate borders on ethical considerations, and personal convictions, but the outcome of the surgery lays credence to the former[1,10,13].

As the number of patient with AIDS continue to escalate, surgical evaluation and intervention will be require more frequently[10,14] An understanding of this syndrome and its complications is mandatory for the surgeon to adequately appreciate and properly evaluate the AIDS' patients with abdominal pain. Visceral Karposi Sarcoma occurrence without muco-cutaneous involvement is extremely rare[3,4,11,15]. But one must have high index of suspicion of the possibility of intestinal obstruction secondary to KS-induced intussusception.

All organs and /or systems can be affected by HIV, and the clinical manifestations are protean, but to the best of our knowledge there has not been reported case(S) of adult intussusception secondary to KS in a known AIDS patient. The AIDS related neoplasm of primary importance is Kaposi sarcoma, and non-Hodgkin's lymphoma. The radiological findings of these gastro intestinal disease are frequently non-specific. However, interpretation of the images with knowledge of the underlying pathological entities, and the level of compromise of the immune system helps to narrow the diagnosis and often leads to identification of the presumptive diagnosis.

CONCLUSION

Infection with HIV result in profound immuno-suppression that place the patients with AIDS at risk for the development of numerous opportunistic infections and neoplasm. In this patient, with a survival time of over five months, laparotomy with right hemicolectomy and ileo-colonic anastamosis was a welcome therapy. We conclude that among the causes of intestinal obstructions in AIDS' patient is adult intussusception, secondary to KS. And surgical intervention should not be denied to these unfortunate patients. The surgical outcome may be good!

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