Pulmonary and cutaneous nodules in an immunocompromised patient

CLINICAL PRESENTATION
A 74-year-old man was admitted to hospital due to dyspnoea, malaise and purple, plaque-like papular nodules on his hands (figure 1A), soles (figure 1B) and genitalia for a duration of 1 month. He reported a 5-month history of systemic corticosteroid use for treatment of giant cell arteritis. Laboratory tests disclosed severe lymphopenia and hypogammaglobulinaemia. Pancultures and serological tests were negative, including repeated HIV serology. Contrast-enhanced CT of the chest (2.5 mm slice thickness) demonstrated multiple bilateral solid pulmonary nodules with peribronchovascular distribution and a cavitating nodule in the left lower lobe (figure 1C). Abdominal CT revealed multiple hepatic ring-enhancing lesions (figure 1D). A bronchoscopy for inspection, bronchoalveolar lavage and transbronchial biopsies was discussed but deemed difficult to be performed safely due to the worsening respiratory status of the patient.

QUESTION
What is the diagnosis?
See page 1108 for the answer
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REFERENCES

Pulmonary puzzle

ANSWER
From the question on page 1103
A CT-guided percutaneous core needle biopsy of the left lower lobe cavity nodule and a skin biopsy were performed. Pathological findings in both cases showed spindle-shaped cells with vascular channels (Figure 2A) positive for human herpes virus 8 immunostaining (Figure 2B). A final diagnosis of Kaposi’s sarcoma (KS) was established, in the absence of positive cultures and stains for bacteria, fungi, protozoa, viruses or tumour cells from aspirated content of the cavitary lesion. The patient rapidly deteriorated and died.

Multiple pulmonary nodules with focal cavitary lesions may represent neoplasms such as bronchogenic carcinomas and lymphomas, or benign lesions including many types of infections or abscesses, immunological disorders such as Wegener granulomatosis and rheumatoid nodules, septic emboli, pulmonary infarcts, progressive massive fibrosis with pneumocooniosis, lymphocytic interstitial pneumonia, localised bronchiectasis and some congenital lesions.1

Intrathoracic KS, often in the context of AIDS, presents as nodular masses, with characteristic thickening of bronchovascular pathways, often accompanied by pleural effusions.2 Cavi- tation after necrosis of larger nodules is uncommon3 and should be associated with KS only after other causes, particularly infection, have been ruled out, as in this case. KS should not be thought of as exclusively associated with HIV infection. The emergence of KS in non-HIV persons is a rare but existent clinical condition, involving classic Mediterranean, endemic African and the iatrogenic form in patients on immunosuppressive medications4 as in this case. Corticosteroid immuno-suppression can be significant even at moderate doses, as evidenced in this case and a previous report of non-HIV KS in an old person with giant cell arteritis.5


REFERENCES