Kaposi Sarcoma in Solid Organ Transplant Recipients: A challenging Case

ABSTRACT – Kaposi sarcoma is a low-grade vascular tumor, associated with human herpesvirus-8 infection. Solid organ transplant recipients have a much higher risk of this malignancy, with estimated incidence rates increased 84 to 500 times. The risk is even higher in some ethnic groups, already with a higher incidence of this disease. We report a case of a 37-year-old African male, a kidney transplant recipient, with a Kaposi sarcoma refractory to different treatment options. The present case puts in evidence the challenges associated with the management of this disease in this high-risk population and highlights the role of a multidisciplinary approach to achieve effective treatment, particularly in advanced and refractory forms.

KEYWORDS – Immunocompromised Host; Organ Transplantation/adverse effects; Sarcoma, Kaposi/etiology; Transplant Recipients.
to 500 times. The risk is even further increased in ethnic groups that already have a higher incidence of this disease.

The first line treatment of KS in solid organ transplant recipients usually consists of halving immunosuppression, which is associated with good responses, sometimes even complete remission. However, resistant and advanced cases are challenging and require other type of therapies.

CASE REPORT
A 37-year-old black male, born in a West African country, presented to our Dermatology Clinic with a six-month history of brown and violaceous nodules in his right leg. He had been submitted to kidney transplant two years before and his immunosuppressive therapy was mycophenolate mofetil 500 mg twice daily, rapamycin 3 mg once daily and prednisolone 5 mg once day. The histopathologic examination of a skin biopsy was compatible with KS with positive immunohistochemical staining for HHV-8.

After the diagnosis, immunosuppressive therapy was reduced, stopping mycophenolate mofetil. The patient had a transient improvement, but after 18 months he developed exudative skin lesions in his lower limbs and abdomen (Fig.s 1 and 2) and there was evidence of visceral disease, with gastric involvement confirmed by endoscopy and biopsy.
The patient was then evaluated by the specialty of Medical Oncology and began first line chemotherapy with pegylated liposomal doxorubicin. After a total 34 cycles, there was a good clinical response, with symptomatic improvement and partial regression of skin lesions.

However, three months after finishing first line chemotherapy, the patient presented asymmetrical edema of the right lower limb and venous Doppler revealed lymphadenopathy compressing the femoral vessels. Computed tomography (CT) revealed lymph node and peritoneal disease progression (Fig.s 3 and 4).

Chemotherapy was then changed to second-line paclitaxel, followed by radiotherapy on femoral ganglion chains. Although there was an initial apparent response, the disease remained in progression with worsening of skin lesions and progressive visceral involvement, with liver metastasis.

After 8 cycles, the patient was admitted for sepsis with bilateral infected ulcerations in his lower limbs motivating aggressive antibiotic treatment and suspension of chemotherapy (Fig. 5). In a multidisciplinary assessment with the specialties of Dermatology, Nephrology and Medical Oncology it was decided to suspend immunosuppression and to start etoposide as a third line chemotherapy. Additionally, wound cleansing was performed with potassium permanganate alternated with acetic acid. There was a significant improvement of all skin lesions.

Figure 3 - Inguinal lymph node involvement on imaging tests (CT).

Figure 4 - Peritoneal involvement on imaging tests (CT).

Figure 5 - Infected ulcerations on his right feet (superinfection with Pseudomonas aeruginosa).
However, six months later, the patient developed clinical signs of renal allograft rejection so that immunosuppressive therapy was resumed with prednisolone 20 mg once daily. He remained stable on etoposide and prednisolone with a sustained response for three years but died after sepsis following a lower respiratory infection.

DISCUSSION

Kaposi sarcoma is a challenging disease in solid organ transplant recipients, especially in those from endemic areas.4,5 Halving immunosuppression is the first-line treatment in immunosuppressed patients, and in most cases total regression of KS lesions is observed, nevertheless, it is challenging to maintain the balance between risks and benefits both for the graft and KS.5,7,9 Prognosis in patients with KS limited to the skin is favorable, whereas visceral involvement is associated with high mortality.10 Visceral disease is observed in up to 25% of kidney transplant recipients with KS.4 For these patients and those with extensive and progressive mucocutaneous disease like our patient, systemic chemotherapy is the therapy of choice.5,7,8 Anthracyclines and paclitaxel are the main drugs for the treatment of KS.5,7,8,11 Other drugs, such as vinblastine, bleomycin and etoposide are effective alternatives for refractory cases.7,8

In this case we had a very aggressive and resistant disease form, but etoposide showed good results. Also in this case, control of organ rejection was obtained with low dose of immunosuppressive therapy.

CONCLUSION

Multidisciplinary approach is essential to ensure optimization of treatment in high-risk individuals with Kaposi sarcoma, particularly solid organ transplant recipients with advanced and refractory forms of this disease.

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