Gastric Kaposi’s sarcoma simulating gastric lymphoma during endoscopic ultrasound examination

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We present a 27-year-old male with severe watery diarrhea and three bouts of melena in the last 2 months. Upper endoscopy revealed diffuse nodular mass lesions extending from the gastroesophageal (GE) junction to the end of the body of stomach, easily bleeding upon touch [Figures 1-3]. Helicobacter pylori urease test was positive. Colonoscopy with terminal ileoscopy was free. Our first possibility was lymphoma but histopathology revealed chronic active gastritis with intestinal metaplasia, mild atypical and fibrocellular lamina propria, no mitotic activity. There are several bites of the gastric wall showing an intact hyperplastic surface covering [Figure 4]. Numerous slit-like blood vessels and spindle cell population were seen infiltrating the muscularis mucosa. Numerous extravasated red blood cells were seen in the lamina propria [Figure 5]. Immunohistochemical staining was negative for cytokeratin, CD117, and CD31 and positive for CD34 [Figure 6].

Figure 1. Large nodular mass extending from the gastroesophageal junction to the proximal gastric body by upper endoscopy

Figure 2. Large nodular mass occupying most of the circumference of the proximal gastric body and fundus as seen by the retroverted endoscope

Images and Videos

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How to cite this article: Okasha HH, Galal A, Baddour N. Gastric Kaposi’s sarcoma simulating gastric lymphoma during endoscopic ultrasound examination. Endosc Ultrasound 2017;6:347-9.

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Received: 2016-11-04; Accepted: 2017-01-02
Endoscopic ultrasound (EUS) shows nonhomogeneous thickening of most of the circumference of gastric fundal and body wall (13 mm in diameter) involving the mucosa, muscularis mucosa, and submucosa with preserved muscularis propria and serosa [Figure 7a and b]. Fine-needle aspiration from one abdominal lymph node, 1 cm [Figure 8], and thickened gastric wall revealed the same results. HIV-antibody was positive. HIV polymerase chain reaction was 738,000 IU/mL and CD4 count was 20 (570–1840) cells/mm³. Hence, the diagnosis of Kaposi’s sarcoma (KS) was made according to the combined histopathological, immunohistochemical, and serological studies with negative cytokeratin, CD117, and CD31 and positive CD34 that tends to show stronger expression than CD31 in advanced-stage lesions of KS.[1]

KS is a low-grade vascular tumor predominantly present at mucocutaneous sites and less commonly affects the gastrointestinal tract; however, it is the most common gastrointestinal malignancy in patients with AIDS.[2,3]

Marked circumferential wall thickening of the stomach commonly occurs in gastric lymphoma and signet ring adenocarcinoma and less commonly in Menetrier disease and eosinophilic gastroenteritis. It also occurred in our case with KS, wall thickness of 13 mm, so it was mistaken for gastric lymphoma and diffuse type adenocarcinoma. Hence, though rare, KS should be included in the differential diagnosis of significant diffuse gastrointestinal wall thickening during EUS examination. Our case is similar to those described by Zoller et al.[4] but differs in that there was
circumferential wall thickening and continuous lesion from the GE junction to the end of the body of stomach. EUS is a great useful tool in detecting the extent of the tumor and diagnosis of endoscopically negative or inconclusive cases.[4]

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient has given his consent for his images and other clinical information to be reported in the journal. The patient understand that his name and initial will not be published and due efforts will be made to conceal his identity, but anonymity cannot be guaranteed.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

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