A 49-year-old male, one month prior diagnosed with AIDS, neurotoxoplasmosis and single cutaneous Kaposi Sarcoma (KS) lesion was admitted with a 10 day-history of fever. Physical examination revealed bilateral cervical adenopathy, besides oropharyngeal candidiasis. Ordinary laboratorial exams were innocent, but his latest CD4 count was 13 cells per mm$^3$ and viral load was 113,417 copies per mL. Thorax and abdominal CT demonstrated diffuse lymphadenomegaly. Due to the oropharyngeal candidiases he was submitted to an upper gastrointestinal endoscopy (UGE) to investigate esophageal involvement. Although we expected to find more candidiases lesions, the UGE verified diffuse violaceous plaques in esophagus mucosa. Few days later patient developed severe diarrhea but despite of a comprehensive non-invasive investigation the etiology was not elucidated. Therefore, a colonoscopy was performed, demonstrating mucosal violaceous lesions, similar to those of the UGE. Concurrently to that investigation, the patient was submitted to a lymph node biopsy. The histopathological results confirmed the suspicion of KS. Thus, the patient was diagnosed with AIDS related Kaposi sarcoma with visceral and cutaneous disseminated manifestations, classified as stage T1I1S1 by ACTG criteria. Because of high rates of morbimortality associated with this stage, chemotherapy with paclitaxel was initiated, although the appropriate treatment was applied, the patient's status over the following weeks declined, worsening CD4 count (4 cells/mm3) and developing more skin lesions in a rapidly progressive pattern. Hence, this case report suggests that chemotherapy in patients with highly impaired immunological functions may not have a successful outcome, reinforcing the importance of immune reconstitution in AIDS related KS treatment.

Biography

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