A 34-year-old Hispanic male without significant past medical history presented to our hospital with a one month history of cough; productive of whitish sputum.
At presentation, he denied fever, chills, night sweats, chest pain, hemoptysis, back pain, recent travel or sick contacts.
He reported that he had approximately a 15–20 pound weight loss during the last six months.
He denied smoking, socially drank alcohol, and had unprotected sexual intercourse with multiple partners in the past.
On admission, his temperature was 97.9°F; heart rate was 85 beats per minute, respiratory rate was 16 breaths per minute, blood pressure was 107/66 mm Hg, and oxygen saturation was 100% on room air.
Examination showed oral thrush, decreased breath sounds and crackles on the right lower lung base.
No cutaneous lesions were reported and the rest of clinical examination was unremarkable.
His complete blood count (CBC) showed hemoglobin of 9.7 g/dL, WBCs 2.3×109/L, and platelets of 164×109/L.
His creatinine was 0.62 mg/dL, and blood urea nitrogen was 10 mg/dL.
Radiograph of the chest showed extensive right and left perihilar opacity more on the right side, and computed tomography (CT) scan of the chest showed a right sided large perihilar mass (Figure 1) with multiple thoracic and lumbar vertebrae, ribs, and sternal tiny lytic lesions consistent with bony metastasis (Figure 2).
Blood and sputum cultures were negative.
Tuberculosis was ruled out by three consecutive negative sputum smears for acid fast bacilli and a negative QUANTIferon gold test.
He tested positive for human immunodeficiency virus (HIV) and his CD4 counts came back at 7 cells/uL.
He was started on prophylaxis with bactrim 80–160 mg daily and azithromycin 1200 mg weekly for opportunistic infections.
Bronchoscopy with biopsy was performed but was unrevealing and he underwent a video assisted mediastinoscopy with biopsies of the right hilar mass.
Pathology showed spindle cells positive for CD34, BCL2, vimentin, and HHV-8 with diffuse positivity for CD31 diagnostic of KS.
He started treatment with HAART in the form of emtricitabine and tenofovir disoproxil fumarate 200/300 mg and dolutegravir 50 mg.
The patient was actively involved in decisions regarding management options.
He favored HAART isolated regimen without additional chemotherapy.
His condition showed continuing clinical improvement; a repeat CT scan of the chest at three months showed profound regression of the disease with disappearance of most of the lesions (Figure 3).