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Research Quickie

Chylothorax as Fatal Complication in Fulminating Kaposi's Sarcoma in a Patient with AIDS

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Kaposi's sarcoma (KS) is one of the earliest and most frequent manifestations of the acquired immunodeficiency syndrome. About 20 percent of all German AIDS patients present with KS as their first sign of AIDS. Visceral involvement occurs in up to 40% percent of patients with disseminated KS [1, 2, 3]. Fatal complications are known in pulmonary and gastrointestinal KS. They include respiratory failure and fatal bleeding [1, 2]. To our knowledge an arrosion of the thoracic duct with chylothorax has not yet been reported.

Case report: A 48 year old homosexual AIDS patient was admitted with fever (39° C), dyspnoea and dry cough. Five months earlier cerebral toxoplasmosis had been treated. Four months earlier, the first signs of disseminated coutaneous KS led to histological confirmation. The patient reported about rapid expansion and dissemination of KS during the two months before admission.

Physical examination revealed disseminated KS in the face (maximum surface 2×1 cm), on the trunk and on the extremities. The gingiva, palatinum and uvula were involved as well. The respirations were 40 per min. The pulse was 112/min, the blood pressure 100/70 mmHg. The roentgenogram of the chest revealed nodular infiltrations but no pleural effusion. Pneumocystis carinii was not detected by bronchioalveolar lavage. Ultrasonic examination and computed tomography showed nodular lesions in the liver and lung, retroperitoneal and paratracheal lymph nodes and a thickened wall of the esophagus. Histology of a thin needle liver puncture revealed KS.

The patient rapidly deteriorated within six days. Serum total protein fell from 6.3 to 3.8 g despite substitution. On the seventh day the patient died of cardiorespiratory failure before any further therapy could be implemented.

Autoptic findings included disseminated cutaneous, visceral (lungs, liver, esophagus, ileum, colon) and lymph node KS with infiltration and partial obliteration of the thoracic duct (Fig. 1). The volume of a left sided chylothorax was 1.5 l. In addition, generalized cytomegalovirus infection (heart, lungs, adrenals, esophagus, colon) and the residuum of toxoplasma encephalitis were detected histologically.

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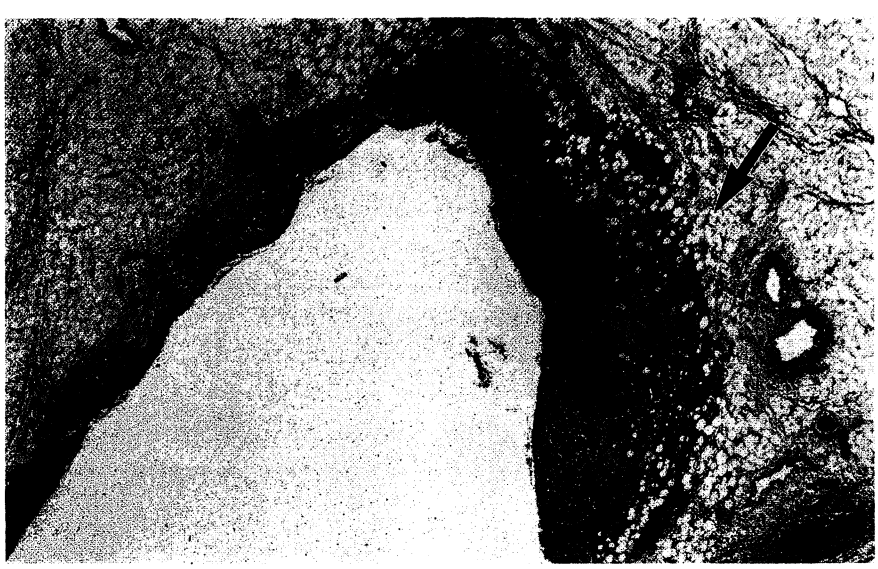

Fig. 1. Section showing infiltration of the thoracic duct