Cátedra de
Enfermedades Infecciosas

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Ateneo Clínico
Sarcoma de Kaposi

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Historia Clínica

- SF, 31 años, procedente de Canelones, mal medio socioeconómico

- **AP:**
- 2006 VIH diagnosticado en contexto de embarazo, TARV durante el mismo.
- 2012 Criptococosis meníngea, Sarcoma de Kaposi con compromiso visceral. Inicia TARV y tratamiento oncoespecífico alternativo dado cardiopatía con FEVI severamente disminuida que luego no continúa.
- Actualmente sin TARV, ni profilaxis.

- AE y AA: nada a destacar

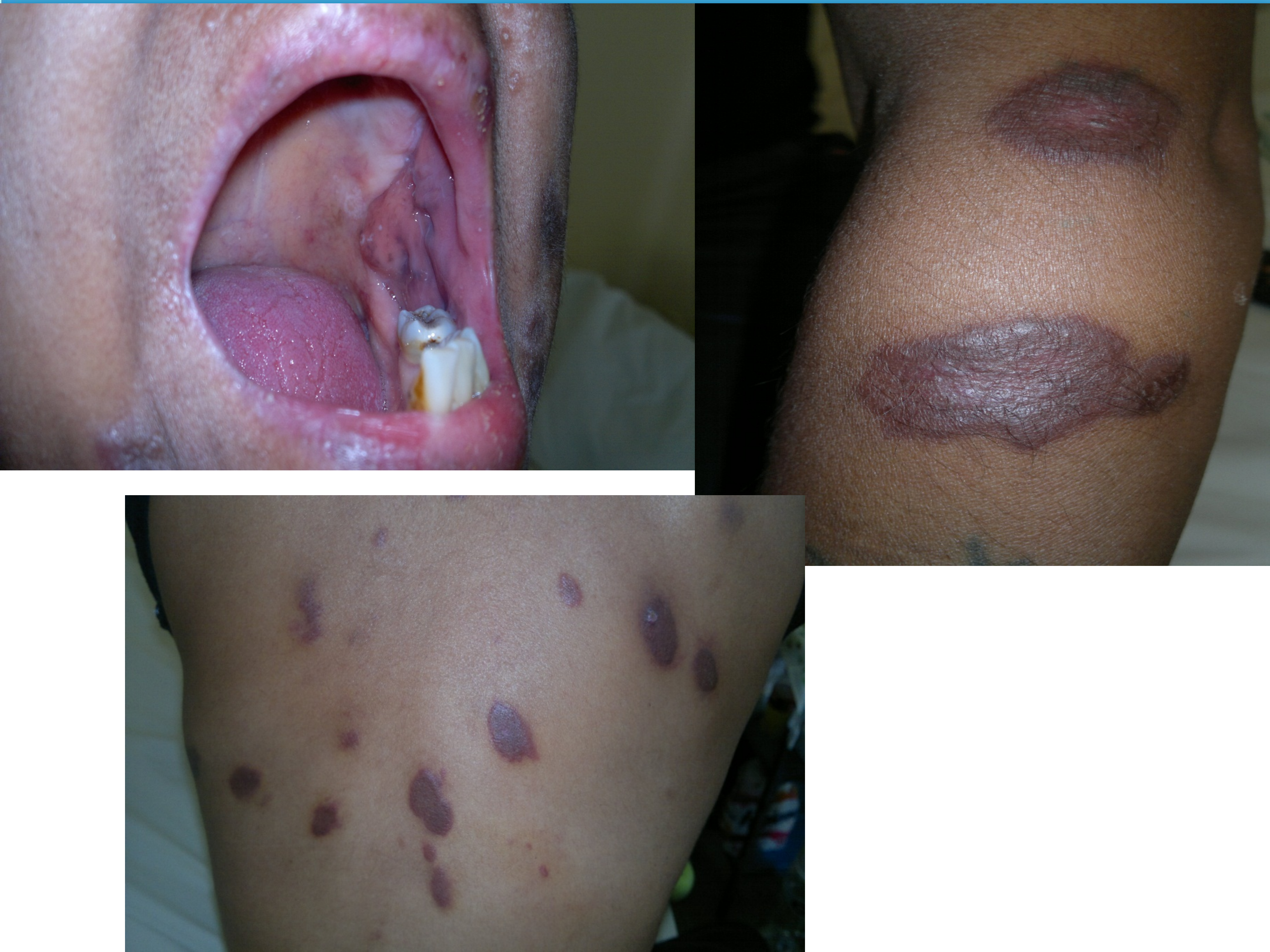
HISTORIA CLINICA:

- 21/03 Emergencia: disnea de esfuerzo de varias semanas de evolución que aumenta en las últimas 48 hs.
- Agrega el día de la consulta: tos y expectoración mucopurulenta. Sin fiebre.
- Refiere aumento de las lesiones de piel ya presentes en internación previa.
- No hemoptisis, no hematemesis.
- No sintomatología digestiva.

EXAMEN FÍSICO:

Al ingreso:

- Lúcida, apirética, bien perfundida, oximetría de pulso 94% VEA.
- *PyM:* bien hidratada, múltiples lesiones rojo vinosas universales, predominio en cara y tronco, similares en mucosa yugal. También lesiones compatibles con molluscum contagiosum.
- *CV*: taquicardia regular de 105 lpm, no soplos, no elementos de falla cardíaca.
- *PP*: polipnea de 22 rpm, no tirajes, estertores crepitantes bibasales.
- Resto del EF: sp.



Paraclínica del ingreso

GB: 8510 cel/ml

Hb: 10,9 g/dl

Plaquetas: 120.000 cel/ml

Azoemia: 0,20 g/l

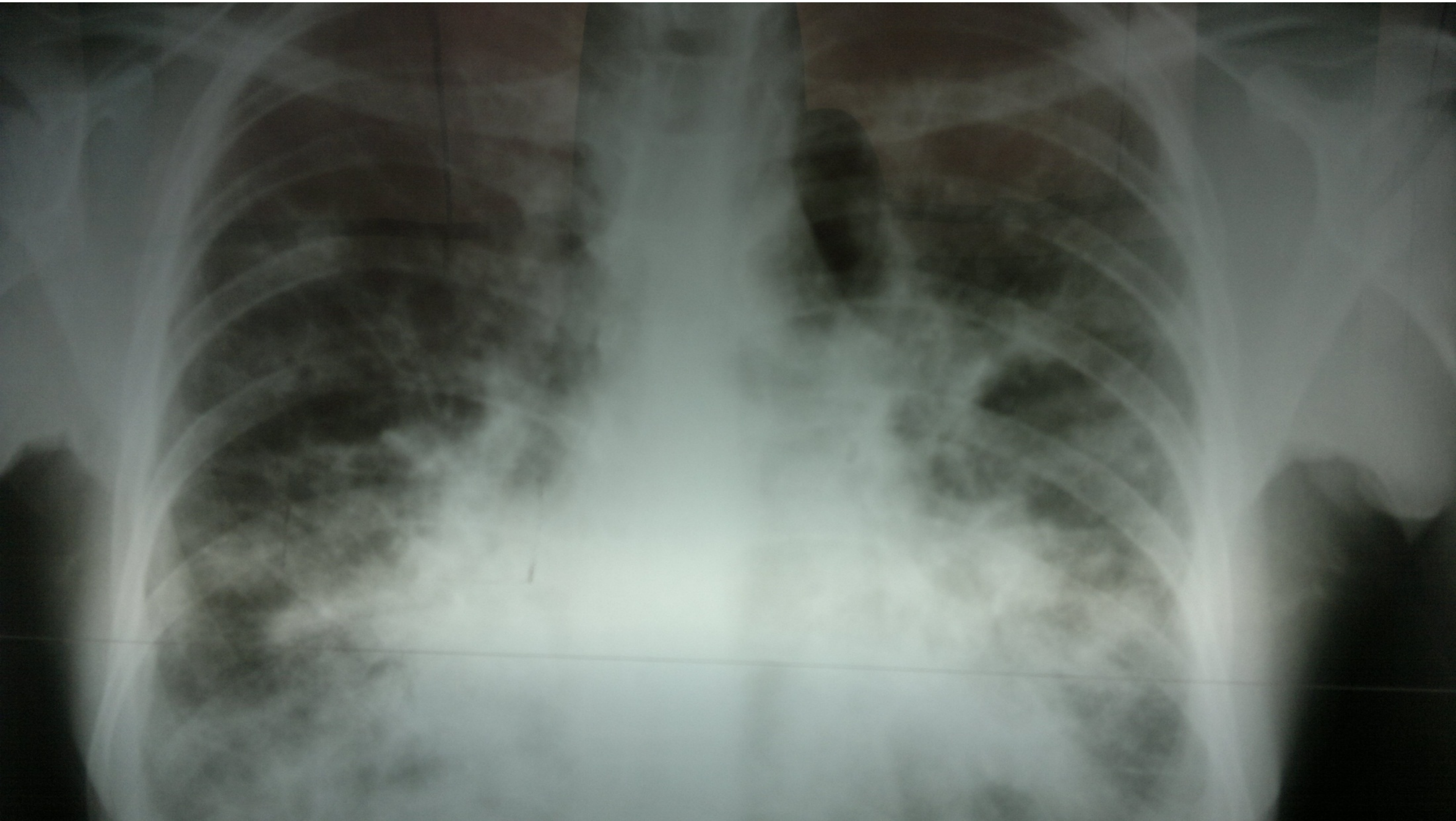
Creatininemia: 0,64 mg/dl

K: 3,1 mmol/l

FyE H: TGO: 14 TGP: 9
FA: 154 GGT: 15
BT 0,31 mg/dl Albúmina: 4,10 g/l

CD4: 6 cel /ml
Carga viral: 214.500 copias log: 5,12

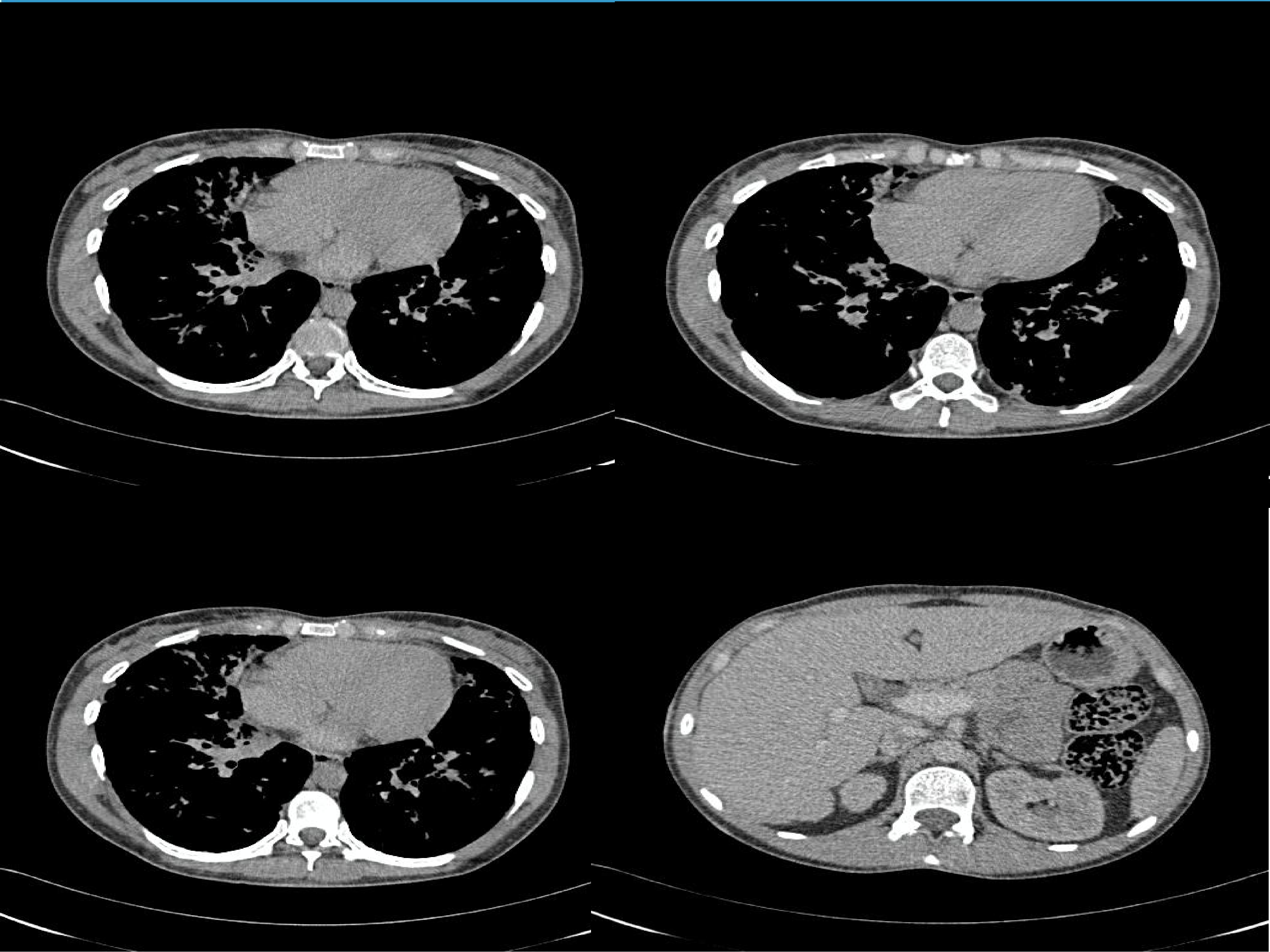
Rx Tx al ingreso



- En suma:

- SF 33 años, VIH/SIDA inmunodepresión severa.
- Sin TARV ni profilaxis.
- Sarcoma de Kaposi.
- Compromiso pulmonar por sarcoma de Kaposi
- A descartar Infección respiratoria baja asociada.

- Conducta:
- FBC c/LBA
- TC de tórax
- Ingreso a sala para completar valoración.



Puntos a discutir.

- Protocolo de estudio de SK
- Opciones de tratamiento
- Inicio de tratamiento oncoespecífico
- Inicio de TARV

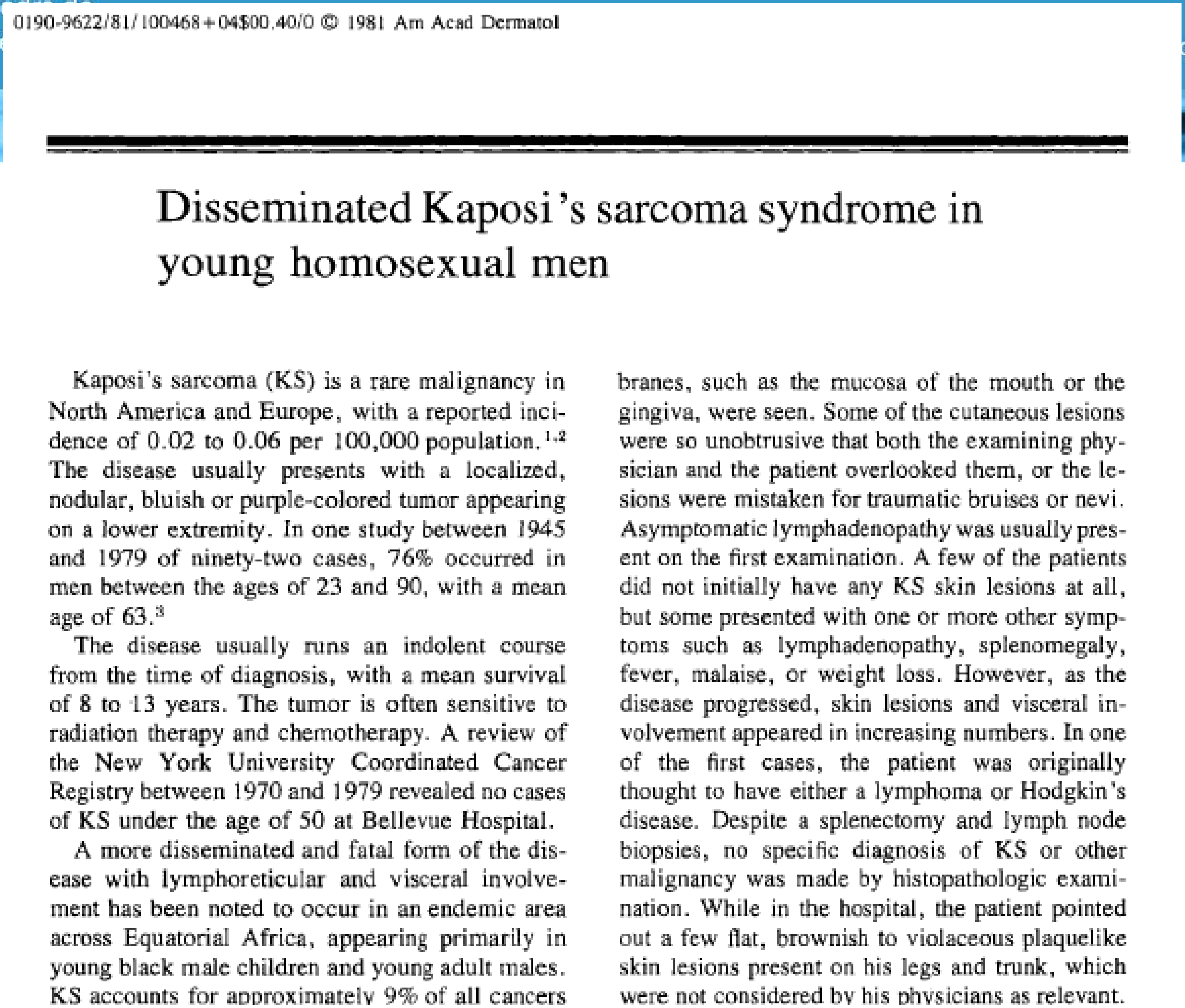
Revisión

Sarcoma de Kaposi.

Sarcoma de Kaposi.

- Descrito en 1872 por dermatólogo Kaposi.
- Incidencia baja hasta 1950, luego aumento en transplantados
- 1981: descripción de varones con SK vinculado al VIH
- Neoplasia más frecuente asociada al VIH
- 1994: identifican Herpes virus humano tipo 8 en lesiones de SK.
- Transmisión por vía sexual, saliva y otras no determinadas.
- Presentación x 20 veces en HSH VIH + vs VIH + no HSH.

- Cornett PA, et al. Malignant Diseases in Human Immunodeficiency Virus Infection .En: GL Mandell et al. .Mandell, Douglas, and Bennett's Principles and Practice of Infectious Diseases, 7th ed. Philadelphia: Churchill Livingstone Elsevier; 2010. p 1765-1779
- Di Lorenzo G, et al. Management of AIDS-related Kaposi’s sarcoma. Lancet Oncol 2007; 8: 167–76



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Disseminated Kaposi's sarcoma syndrome in young homosexual men

Kaposi's sarcoma (KS) is a rare malignancy in North America and Europe, with a reported incidence of 0.02 to 0.06 per 100,000 population.[1,2] The disease usually presents with a localized, nodular, bluish or purple-colored tumor appearing on a lower extremity. In one study between 1945 and 1979 of ninety-two cases, 76% occurred in men between the ages of 23 and 90, with a mean age of 63.[3]

The disease usually runs an indolent course from the time of diagnosis, with a mean survival of 8 to 13 years. The tumor is often sensitive to radiation therapy and chemotherapy. A review of the New York University Coordinated Cancer Registry between 1970 and 1979 revealed no cases of KS under the age of 50 at Bellevue Hospital.

A more disseminated and fatal form of the disease with lymphoreticular and visceral involvement has been noted to occur in an endemic area across Equatorial Africa, appearing primarily in young black male children and young adult males. KS accounts for approximately 9% of all cancers

branes, such as the mucosa of the mouth or the gingiva, were seen. Some of the cutaneous lesions were so unobtrusive that both the examining physician and the patient overlooked them, or the lesions were mistaken for traumatic bruises or nevi. Asymptomatic lymphadenopathy was usually present on the first examination. A few of the patients did not initially have any KS skin lesions at all, but some presented with one or more other symptoms such as lymphadenopathy, splenomegaly, fever, malaise, or weight loss. However, as the disease progressed, skin lesions and visceral involvement appeared in increasing numbers. In one of the first cases, the patient was originally thought to have either a lymphoma or Hodgkin's disease. Despite a splenectomy and lymph node biopsies, no specific diagnosis of KS or other malignancy was made by histopathologic examination. While in the hospital, the patient pointed out a few flat, brownish to violaceous plaquelike skin lesions present on his legs and trunk, which were not considered by his physicians as relevant.

Sarcoma de Kaposi:

- Franca disminución de su incidencia vinculado al uso del TARV
- Metaanálisis de 47.936 pacientes se constató que la incidencia del SK descendió desde 15,2 por 1.000 pacientes/ año en la era pre-TARV hasta 4,9 por 1.000 pacientes/año en la era TARV (P <0,0001). RR de SK de 0,32 (intervalo de confianza del 99%: de 0,26 a 0,40) en la era TARV, en comparación con la era previa al TARV.

- Historia natural de SK/SIDA variable y difícil de predecir. Puede ocurrir en pacientes con recuentos muy variables de linfocitos CD4+, pero su frecuencia crece a medida que la función inmunitaria se deteriora.

- Groopman JE. Classic Kaposi sarcoma: Epidemiology, risk factors, pathology, and molecular pathogenesis. En: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Consultado el 20 de mayo de 2014).
- Di Lorenzo G, et al. Management of AIDS-related Kaposi’s sarcoma. Lancet Oncol 2007; 8: 167–76

Manifestaciones clínicas:

- Afectación hombre/mujer: 2:1
- Tumor vascular multicéntrico.
- Afecta típicamente a la piel, se manifiesta en forma de lesiones que aumentan de tamaño, pasando de manchas a placas y más tarde a nódulos
- Inicialmente color violáceo y luego amarronado por depósito de hemosiderina.
- Las lesiones suelen comprometer cara, genitales y cavidad oral

- Groopman JE. AIDS-related Kaposi sarcoma: Clinical manifestations and diagnosis. En: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Consultado el 20 de mayo de 2014).
- Di Lorenzo G, et al. Management of AIDS-related Kaposi’s sarcoma. Lancet Oncol 2007; 8: 167–76

Manifestaciones clínicas:

- Quiescente durante muchos meses y luego aumento brusco de la actividad, con aparición de numerosas lesiones nuevas y crecimiento de las existentes
- Afectación visceral frecuente, sobre todo cuando la enfermedad progresa, y pueden encontrarse lesiones en casi cualquier lugar, sobre todo en el aparato digestivo.
- Existe correlación entre la afectación oral y la del aparato gastrointestinal. Afectación de la cavidad oral hasta un 30%
- La obstrucción linfática es frecuente y puede dar lugar a un intenso edema, que suele afectar a las extremidades inferiores o a la cara.

- Groopman JE. AIDS-related Kaposi sarcoma: Clinical manifestations and diagnosis. En: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Consultado el 20 de mayo de 2014).
- Di Lorenzo G, et al. Management of AIDS-related Kaposi’s sarcoma. Lancet Oncol 2007; 8: 167–76

Manifestaciones clínicas:

- Diseminación visceral del SK con participación del aparato digestivo rara vez provoca síntomas, se han descrito casos de obstrucción, perforación y hemorragia digestiva
- Afectación pulmonar: complicación potencialmente mortal del SK suele ser sintomático y se manifiesta por tos seca, broncoespasmo y disnea.
- Tiende a aparecer en pacientes con SIDA avanzado, que en su mayoría tienen recuentos de linfocitos CD4+ inferiores a 100/mm3.

- No suele ser la causa de la muerte de los pacientes con VIH, salvo en los casos con afectación pulmonar difusa.
- Previo TARV sobrevida 2-6 meses.

- Groopman JE. AIDS-related Kaposi sarcoma: Clinical manifestations and diagnosis. En: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Consultado el 20 de mayo de 2014).
- Arruda É, et al. Consensus of the Brazilian Society of Infectious Diseases and Brazilian Society of Clinical
- Oncology on the management and treatment of Kaposi's sarcoma. Braz J Infect Dis. 2014. http://dx.doi.org/10.1016/j.bjid.2014.01.002

Evaluación inicial:

- Extensión del tumor:

1. Exploración completa de la piel y también hay que inspeccionar con cuidado la cavidad oral.
2. Sangre oculta en heces (SOH): sugiere compromiso digestivo.

- Endoscopía: si SOH positivo; si paciente estadío S1 recomendado FGC y FCC; si presenta sintomatología.

3. Rx Tx: para valorar compromiso respiratorio.

- FBC: si RxTx anormal; si presenta síntomas; si paciente S1 sin importar presencia de síntomas.

- Groopman JE. AIDS-related Kaposi sarcoma: Staging and treatmen. En: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Consultado el 20 de mayo de 2014).
- Arruda É, et al. Consensus of the Brazilian Society of Infectious Diseases and Brazilian Society of Clinical Oncology on the management and treatment of Kaposi's sarcoma. Braz J Infect Dis. 2014. http://dx.doi.org/10.1016/j.bjid.2014.01.002

Estadificación:

- Sistema más utilizado desarrollado por ACTG.
- Divide los pacientes en bueno o mal pronóstico teniendo en cuenta tanto la infección por VIH como el SK.

	Buen pronostico	**Mal pronóstico**
Extensión del tumor. (T)	T0: enfermed confinado a piel y/o ganglios linfáticos, y/o enfermedad oral mínima	T1: Linfedema, compromiso oral extenso, y/o visceral
Status Inmune	IO: CD4>200 cel/ml	I1: CD4<200 cel/m
Severidad de síntomas sistémicos	S0: Sin elementos de S1.	S1: Inf oportunista previa, síntomas B.

- Adapted from: Krown, SE, Metroka, C, Wernz, JC. Kaposi's sarcoma in the acquired immune deficiency syndrome: a proposal for uniform evaluation, response, and staging criteria. AIDS Clinical Trials Group Oncology Committee. J Clin Oncol 1989; 7:1201
- El Amari EB, et al. Predicting the evolution of Kaposi sarcoma, in the highly active antiretroviral therapy era. AIDS. 2008;22(9):1019.

Tratamiento:

Objetivos: Paliar de síntomas, prevenir progresión, disminuir edema asociado, compromiso visceral además de carga psicológica.

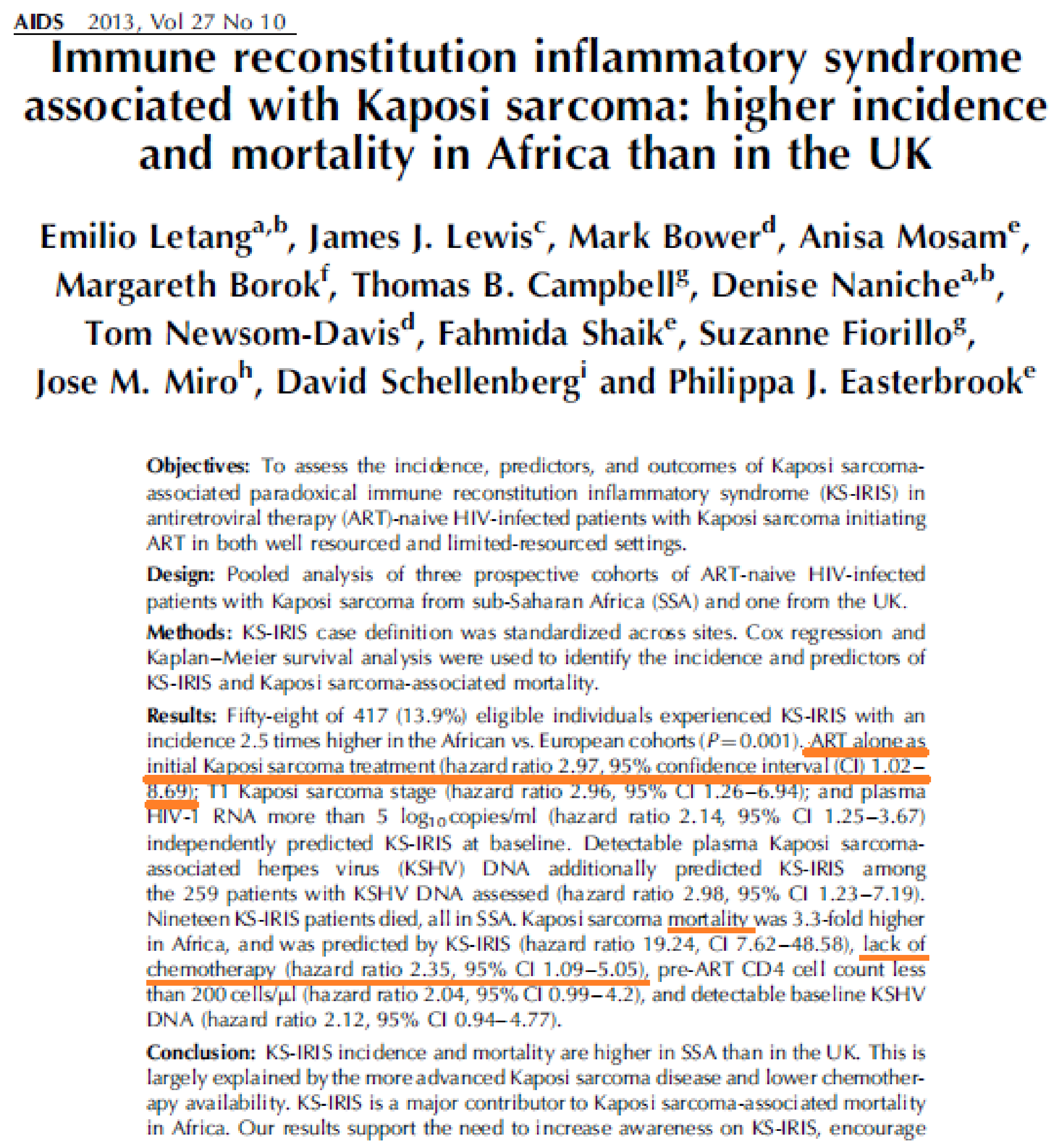
Dos pilares:

1. TARV
2. Tratamiento específico tumoral.

TARV:

- Franca disminución de incidencia desde inicio de TARV, así como de severidad de presentación.
- Sin diferencias en cuanto a combinación utilizada.
- Síndrome Inflamatorio de reconstitución inmune: presente en hasta un 7% en diferentes series. Mayor riesgo asociado a: extensión tumoral, carga viral elevada, uso de TARV sin quimioterapia.

- Groopman JE. AIDS-related Kaposi sarcoma: Staging and treatment. En: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Consultado el 20 de mayo de 2014).
- Letan E, et al. Immune reconstitution inflammatory syndrome associated with Kaposi sarcoma: higher incidence and mortality in Africa than in the UK. AIDS. 2013 Jun;27(10):1603-13.



AIDS 2013, Vol 27 No 10

Immune reconstitution inflammatory syndrome associated with Kaposi sarcoma: higher incidence and mortality in Africa than in the UK

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Objectives: To assess the incidence, predictors, and outcomes of Kaposi sarcoma-associated paradoxical immune reconstitution inflammatory syndrome (KS-IRIS) in antiretroviral therapy (ART)-naive HIV-infected patients with Kaposi sarcoma initiating ART in both well resourced and limited-resourced settings.

Design: Pooled analysis of three prospective cohorts of ART-naive HIV-infected patients with Kaposi sarcoma from sub-Saharan Africa (SSA) and one from the UK.

Methods: KS-IRIS case definition was standardized across sites. Cox regression and Kaplan–Meier survival analysis were used to identify the incidence and predictors of KS-IRIS and Kaposi sarcoma-associated mortality.

Results: Fifty-eight of 417 (13.9%) eligible individuals experienced KS-IRIS with an incidence 2.5 times higher in the African vs. European cohorts ($P = 0.001$). ART alone as initial Kaposi sarcoma treatment (hazard ratio 2.97, 95% confidence interval (CI) 1.02–8.69); T1 Kaposi sarcoma stage (hazard ratio 2.96, 95% CI 1.26–6.94); and plasma HIV-1 RNA more than 5 $\log_{10}$ copies/ml (hazard ratio 2.14, 95% CI 1.25–3.67) independently predicted KS-IRIS at baseline. Detectable plasma Kaposi sarcoma-associated herpes virus (KSHV) DNA additionally predicted KS-IRIS among the 259 patients with KSHV DNA assessed (hazard ratio 2.98, 95% CI 1.23–7.19). Nineteen KS-IRIS patients died, all in SSA. Kaposi sarcoma mortality was 3.3-fold higher in Africa, and was predicted by KS-IRIS (hazard ratio 19.24, CI 7.62–48.58), lack of chemotherapy (hazard ratio 2.35, 95% CI 1.09–5.05), pre-ART CD4 cell count less than 200 cells/μl (hazard ratio 2.04, 95% CI 0.99–4.2), and detectable baseline KSHV DNA (hazard ratio 2.12, 95% CI 0.94–4.77).

Conclusion: KS-IRIS incidence and mortality are higher in SSA than in the UK. This is largely explained by the more advanced Kaposi sarcoma disease and lower chemotherapy availability. KS-IRIS is a major contributor to Kaposi sarcoma-associated mortality in Africa. Our results support the need to increase awareness on KS-IRIS, encourage

Tratamiento:

Tratamiento específico:

1. Tratamiento local.
2. Tratamiento sistémico.

Tratamiento local:

- Quirúrgico.
- Terapias con laser.
- Crioterapia: eficacia >70% para lesiones pequeñas, puede causar hipopigmentación y solo se usa para lesiones leves.
- Radioterapia
- Quimioterapia intralesional
- Aliretinoina.

- Groopman JE. AIDS-related Kaposi sarcoma: Staging and treatmen. En: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Consultado el 20 de mayo de 2014).
- Arruda É, et al. Consensus of the Brazilian Society of Infectious Diseases and Brazilian Society of Clinical
- Oncology on the management and treatment of Kaposi’s sarcoma. Braz J Infect Dis. 2014. http://dx.doi.org/10.1016/j.bjid.2014.01.002

Tratamiento:

- **RADIOTERAPIA:**
- Radiosensible.
- Efectiva para paliar síntomas .
- Útil para SK no pasible de QT intralesional pero no tan extenso para QT sistémica.
- Habitualmente bien tolerada.
- Control de lesiones para el SK clásico mayor al 80% y mayor al 90% para SK asociado al HIV
- Toxicidad en aprox 7% de ptes usualmente limitada a dermatitis, fibrosis, úlceras, habitualmente transitorias.

- Groopman JE. AIDS-related Kaposi sarcoma: Staging and treatmen. En: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Consultado el 20 de mayo de 2014).
- Arruda É, et al. Consensus of the Brazilian Society of Infectious Diseases and Brazilian Society of Clinical
- Oncology on the management and treatment of Kaposi’s sarcoma. Braz J Infect Dis. 2014. http://dx.doi.org/10.1016/j.bjid.2014.01.002

Tratamiento:

- **QUIMIOTERAPIA INTRALESIONAL:**

- Vinblastina tiene eficacia de aprox 70%
- Otros utilizados bleomicina, vincristina.
- Mayoría de datos en SKC pero existen datos en SKHIV **.**
- En SKC respuestas de 60-98%
- Desventajas incluyen dolor en sitio de inyección hiperpigmentación, síntomas gripales, edema perilesional y celulitis.

- Groopman JE. AIDS-related Kaposi sarcoma: Staging and treatmen. En: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Consultado el 20 de mayo de 2014).
- Arruda É, et al. Consensus of the Brazilian Society of Infectious Diseases and Brazilian Society of Clinical
- Oncology on the management and treatment of Kaposi's sarcoma. Braz J Infect Dis. 2014. http://dx.doi.org/10.1016/j.bjid.2014.01.002

Tratamiento sistémico:

- Enfermedad avanzada o rápidamente progresiva.
- Estudios randomizados pequeños TARV+QT vs TARV solo, respuesta 66 vs 39% y 76 vs 20%
- De primera línea antraciclinas liposómicas (Doxorubicina liposomal pegilada, Danorubicina liposomal). Otros agentes utilizados son Paclitaxel y Vinorelbina.

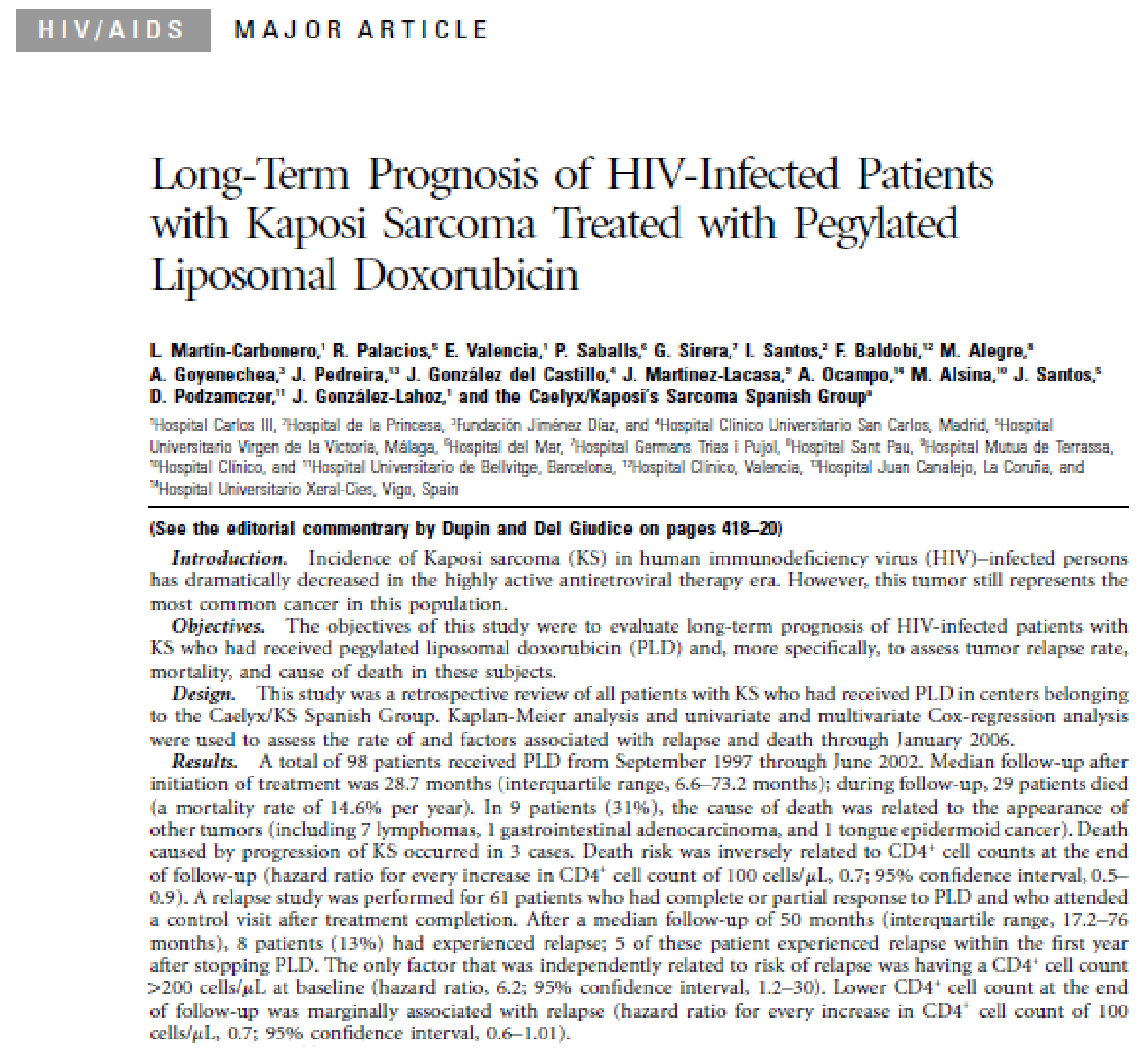
Indicaciones:

- Extensión cutánea >25 lesiones
- Compromiso cutáneo que no responde a tto local.
- Compromiso visceral sintomático..
- SIRI
- Progresión bajo TARV.
  - Groopman JE. AIDS-related Kaposi sarcoma: Staging and treatmen. En: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Consultado el 20 de mayo de 2014).
  - Arruda É, et al. Consensus of the Brazilian Society of Infectious Diseases and Brazilian Society of Clinical Oncology on the management and treatment of Kaposi's sarcoma. Braz J Infect Dis. 2014. http://dx.doi.org/10.1016/j.bjid.2014.01.002

Antraciclinas Liposomales:

- Mejor opción para tto de SK diseminado.
- Eficacia y tolerabilidad al ser administrados en conjunto con TARV
- Doxorrubicina: dos ensayos randomizados mostraron superioridad vs ABV (46 vs 25%, p<0,001), así como una respuesta más temprana y menor cantidad de efectos adversos; y vs BV (59 vs 23% p<0,001) sin diferencias en cuanto a mortalidad.
- Doxorubicina superior a Danorrubicina en ensayos con número pequeño de pacientes.
- Efectos adversos: menores que con planes tradicionales, menor incidencia de neuropatías y neutropenia. Menor cardiotoxicidad que con preparaciones no liposomales.

- Groopman JE. AIDS-related Kaposi sarcoma: Staging and treatmen. En: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Consultado el 20 de mayo de 2014).
- Di Lorenzo G, et al. Management of AIDS-related Kaposi's sarcoma. Lancet Oncol 2007; 8: 167–76



HIV/AIDS MAJOR ARTICLE

Long-Term Prognosis of HIV-Infected Patients with Kaposi Sarcoma Treated with Pegylated Liposomal Doxorubicin

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(See the editorial commentrary by Dupin and Del Giudice on pages 418–20)

Introduction. Incidence of Kaposi sarcoma (KS) in human immunodeficiency virus (HIV)–infected persons has dramatically decreased in the highly active antiretroviral therapy era. However, this tumor still represents the most common cancer in this population.

Objectives. The objectives of this study were to evaluate long-term prognosis of HIV-infected patients with KS who had received pegylated liposomal doxorubicin (PLD) and, more specifically, to assess tumor relapse rate, mortality, and cause of death in these subjects.

Design. This study was a retrospective review of all patients with KS who had received PLD in centers belonging to the Caelyx/KS Spanish Group. Kaplan-Meier analysis and univariate and multivariate Cox-regression analysis were used to assess the rate of and factors associated with relapse and death through January 2006.

Results. A total of 98 patients received PLD from September 1997 through June 2002. Median follow-up after initiation of treatment was 28.7 months (interquartile range, 6.6–73.2 months); during follow-up, 29 patients died (a mortality rate of 14.6% per year). In 9 patients (31%), the cause of death was related to the appearance of other tumors (including 7 lymphomas, 1 gastrointestinal adenocarcinoma, and 1 tongue epidermoid cancer). Death caused by progression of KS occurred in 3 cases. Death risk was inversely related to $CD4^+$ cell counts at the end of follow-up (hazard ratio for every increase in $CD4^+$ cell count of 100 cells/μL, 0.7; 95% confidence interval, 0.5–0.9). A relapse study was performed for 61 patients who had complete or partial response to PLD and who attended a control visit after treatment completion. After a median follow-up of 50 months (interquartile range, 17.2–76 months), 8 patients (13%) had experienced relapse; 5 of these patient experienced relapse within the first year after stopping PLD. The only factor that was independently related to risk of relapse was having a $CD4^+$ cell count >200 cells/μL at baseline (hazard ratio, 6.2; 95% confidence interval, 1.2–30). Lower $CD4^+$ cell count at the end of follow-up was marginally associated with relapse (hazard ratio for every increase in $CD4^+$ cell count of 100 cells/μL, 0.7; 95% confidence interval, 0.6–1.01).

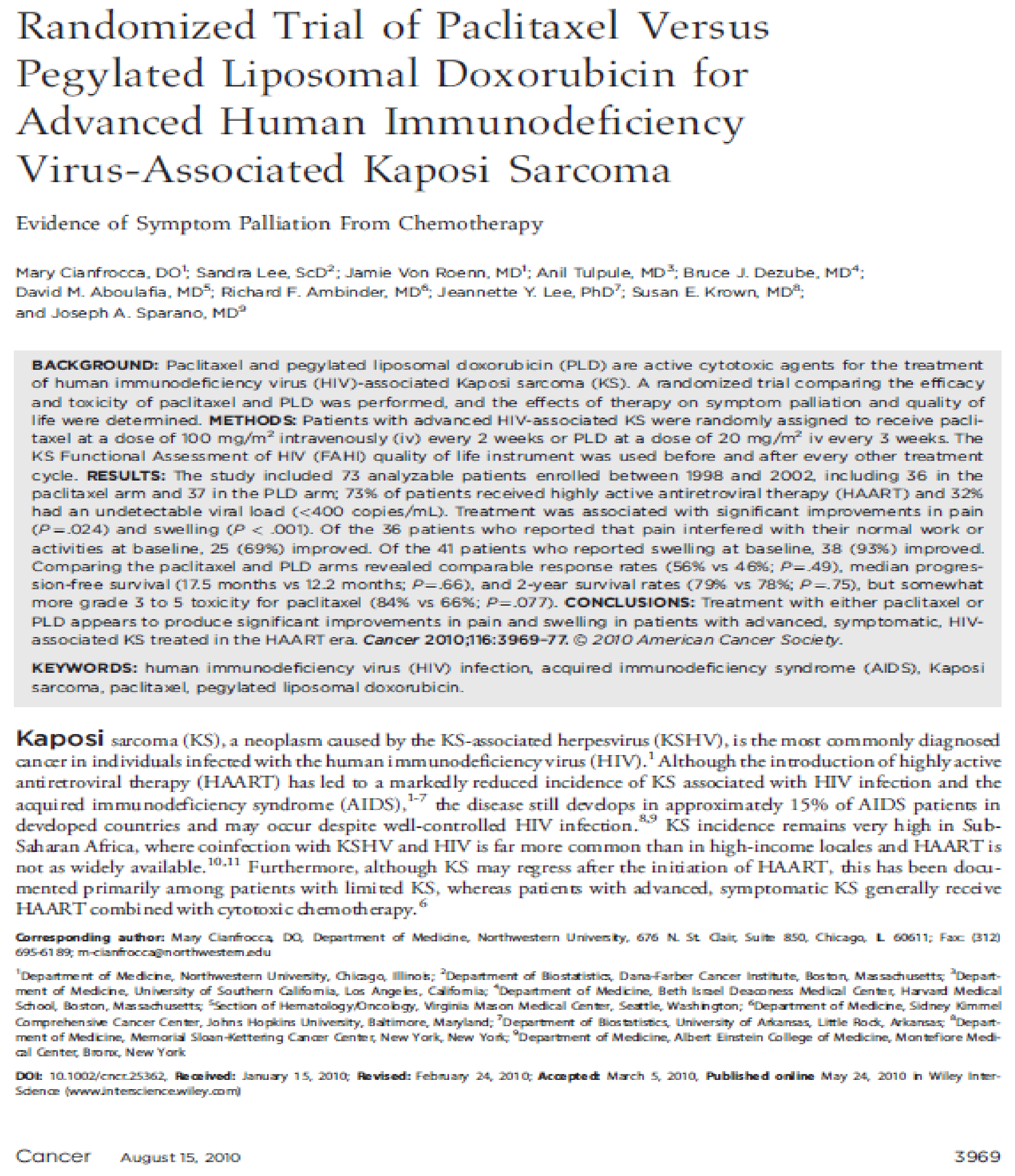
Paclitaxel:

- Mayor toxicidad que antraciclinas liposomales.
- Eficaz como tratamiento de segunda línea en pacientes sin respuesta a antraciclinas, o como tratamiento alternativo.
- Tasas de respuesta 56-71%
- Duración media de respuesta 8.9-10.4 meses.
- EA más frecuente: neutropenia y reaccione alérgicas.
- Importante:

- Requiere uso de corticoides.

- Interacción con TARV, sobre todo con IP e INNTI

- Groopman JE. AIDS-related Kaposi sarcoma: Staging and treatmen. En: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Consultado el 20 de mayo de 2014).
- Di Lorenzo G, et al. Management of AIDS-related Kaposi’s sarcoma. Lancet Oncol 2007; 8: 167–76



Randomized Trial of Paclitaxel Versus Pegylated Liposomal Doxorubicin for Advanced Human Immunodeficiency Virus-Associated Kaposi Sarcoma

Evidence of Symptom Palliation From Chemotherapy

Mary Cianfrocca, DO[1]; Sandra Lee, ScD[2]; Jamie Von Roenn, MD[1]; Anil Tulpule, MD[3]; Bruce J. Dezube, MD[4];
David M. Aboulafia, MD[5]; Richard F. Ambinder, MD[6]; Jeannette Y. Lee, PhD[7]; Susan E. Krown, MD[8];
and Joseph A. Sparano, MD[9]

BACKGROUND: Paclitaxel and pegylated liposomal doxorubicin (PLD) are active cytotoxic agents for the treatment of human immunodeficiency virus (HIV)-associated Kaposi sarcoma (KS). A randomized trial comparing the efficacy and toxicity of paclitaxel and PLD was performed, and the effects of therapy on symptom palliation and quality of life were determined. **METHODS:** Patients with advanced HIV-associated KS were randomly assigned to receive paclitaxel at a dose of 100 mg/m^2 intravenously (iv) every 2 weeks or PLD at a dose of 20 mg/m^2 iv every 3 weeks. The KS Functional Assessment of HIV (FAHI) quality of life instrument was used before and after every other treatment cycle. **RESULTS:** The study included 73 analyzable patients enrolled between 1998 and 2002, including 36 in the paclitaxel arm and 37 in the PLD arm; 73% of patients received highly active antiretroviral therapy (HAART) and 32% had an undetectable viral load (<400 copies/mL). Treatment was associated with significant improvements in pain ($P = .024$) and swelling ($P < .001$). Of the 36 patients who reported that pain interfered with their normal work or activities at baseline, 25 (69%) improved. Of the 41 patients who reported swelling at baseline, 38 (93%) improved. Comparing the paclitaxel and PLD arms revealed comparable response rates (56% vs 46%; $P = .49$), median progression-free survival (17.5 months vs 12.2 months; $P = .66$), and 2-year survival rates (79% vs 78%; $P = .75$), but somewhat more grade 3 to 5 toxicity for paclitaxel (84% vs 66%; $P = .077$). **CONCLUSIONS:** Treatment with either paclitaxel or PLD appears to produce significant improvements in pain and swelling in patients with advanced, symptomatic, HIV-associated KS treated in the HAART era. *Cancer* **2010;116:3969-77.** *© 2010 American Cancer Society.*

KEYWORDS: human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS), Kaposi sarcoma, paclitaxel, pegylated liposomal doxorubicin.

Kaposi sarcoma (KS), a neoplasm caused by the KS-associated herpesvirus (KSHV), is the most commonly diagnosed cancer in individuals infected with the human immunodeficiency virus (HIV).[1] Although the introduction of highly active antiretroviral therapy (HAART) has led to a markedly reduced incidence of KS associated with HIV infection and the acquired immunodeficiency syndrome (AIDS),[1-7] the disease still develops in approximately 15% of AIDS patients in developed countries and may occur despite well-controlled HIV infection.[8,9] KS incidence remains very high in Sub-Saharan Africa, where coinfection with KSHV and HIV is far more common than in high-income locales and HAART is not as widely available.[10,11] Furthermore, although KS may regress after the initiation of HAART, this has been documented primarily among patients with limited KS, whereas patients with advanced, symptomatic KS generally receive HAART combined with cytotoxic chemotherapy.[6]

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Otros tratamientos:

INMUNOTERAPIA:

- Disponible varios años antes que antracicicinas.
- Respuesta al IFNa 20-40%; mejor en ptes con >200 CD4/ml.
- No es útil en pacientes con compromiso visceral ni con enfermedad rápidamente progresiva.
- Efectos adversos frecuentes.

ANTIVIRALES:

- Viremia por HVH8, asociada a mayor riesgo de SK, sin embargo el tratamiento de este no ha demostrado claros beneficios.
- Sensible a Cidofovir, Ganciclovir y en menor medida Aciclovir.
- Antivirales útiles contra población en fase lítica, no contra fase latente que es la predominante.

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Conclusiones

- Mujer VIH + con inmunodepresión severa
- Problema psico-social fundamental
- Refuerzo de la adherencia, red familiar y social
- EO: Sarcoma de Kaposi de mal pronóstico (T1, I1, S1)
- FBC con LBA descartó infección respiratoria concomitante
- Reinicio de TARV
- Reinicio de tratamiento oncoespecífico.
- Necesidad de enfoque multidisciplinario.