Kaposi's sarcoma developing in a HIV-negative Crohn's disease patient shortly after azathioprine and corticosteroid treatment

Dear Sir,

Kaposi's sarcoma (KS) is an unusual malignant vascular tumor principally affecting the skin of the lower extremities. It has four clinical varieties: classic, endemic, epidemic and iatrogenic. The latter is described mostly in organ transplant recipients receiving high-dose and/or long-term (9 to 23 months) immunosuppressive treatment. In addition, KS has been shown as a rare complication in inflammatory bowel diseases (IBD) that should be related to immunosuppression. Oral corticosteroids and immunomodulatory drugs, such as azathioprine (AZA) and 6-mercaptopurine (6-MP) are effective in Crohn's disease, however their use is limited by concerns of toxicity. Here we report a case of 54-year-old HIV-negative man, who developed KS 2 months after initiation of immunosuppressive therapy for Crohn's disease.

A 54-year-old man was admitted to our center with a complaint of newly onset purple colored noduler lesions on his both heels. He denoted that those lesions had been growing rapidly for the last week to a size of 3 × 3 cm. A diagnosis of Crohn's disease had been made 2 months earlier. On his admission he had been taking azathioprine at 150 mg per day and oral corticosteroid at 20 mg per day. Physical and laboratory examinations were normal. Pathologic examinations of the lesion were consistent with KS. An examination of serum samples for HIV by the ELISA method was negative. Computed tomography (CT) of the thorax and abdomen showed no visceral organ involvement. Azathioprine and corticosteroid treatment was stopped. After 1 month, the skin nodules had decreased in size and number. He was instructed to return to the hospital regularly thereafter.

Kaposi's sarcoma should occur in patients receiving immunosuppressive therapy. When the level of immune suppression is greater, symptoms are more aggressive, and the latency period is shorter. In addition to the effect of immune suppression, there are specific characteristics of thiopurines that may promote carcinogenesis by incorporation of 'rogue' thiopurine nucleotides into DNA and promoting mutagenesis. In our case, the interval was two months, which was shorter than that previously reported cases. In prior cases with a short interval, patients had an underlying disease with unique susceptibility to the development of KS such as chronic lymphatic leukemia. However, our patient had no history of these diseases, iatrogenic immunosuppression would appear to be the most probable. In our case KS developed during the reduction of corticosteroid treatment and shortly after the immunosuppressive treatment, thus we believed azathiopurene as the potential cause.

Cases of colorectal Kaposi's sarcoma complicating inflammatory bowel disease should be managed with a conservative approach and discontinuation of the immunosuppressive treatment. In conclusion, it should be kept in mind that KS can develop during immunosuppressive treatment in Crohn's disease, even during the first months of treatment.

Conflict of interest
The authors declare that they have no conflict of interest.

References

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