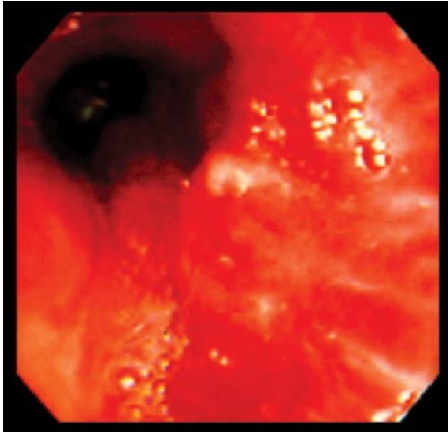


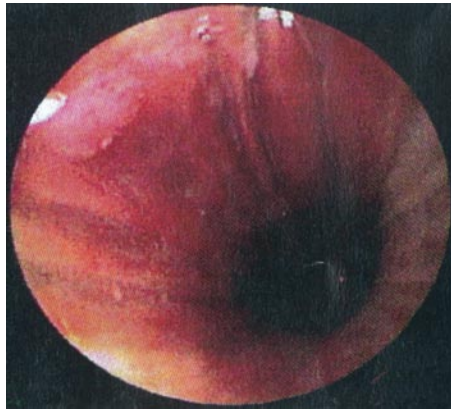
## Endobronchial Kaposi's Sarcoma

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A



B

**A** 31-year-old man with a history of AIDS with a CD4 cell count of 200 cells/ $\mu$ L presented to the emergency department with dyspnea at rest, cough, night sweats, and hemoptysis. The patient was afebrile. Evaluation revealed symmetrically widespread raised purplish plaques on his back, diffuse rhonchi on chest auscultation, bilateral infiltrates on chest radiograph, and a CD4 cell count of 9 cells/ $\mu$ L. He was treated for community-acquired pneumonia and *Pneumocystis carinii* pneumonia with no improvement. Bronchoscopy was performed and revealed erythematous lesions in the large airways (**Image A** and **Image B**) consistent with endobronchial Kaposi's sarcoma (EKS). The patient was started on antiretroviral therapy (ART), which resulted in significant improvement (CD4 cell count of 100 cells/ $\mu$ L).

Kaposi's sarcoma is an AIDS-defining illness and is the most common malignancy affecting persons with HIV infection.<sup>1,2</sup> EKS may cause radiographic infiltrates and respiratory symptoms that mimic a variety of other infectious and neoplastic processes, including pulmonary tuberculosis, lung malignancy, community-acquired pneumonia, and *P. carinii* pneumonia.<sup>1,3</sup> Thus, EKS should be considered as a differential diagnosis in im-

munocompromised patients with respiratory symptoms. The incidence of EKS is uncertain due to its nonspecific presentation; prior to widespread use of ART, pulmonary Kaposi's sarcoma was reported in approximately 10% of patients with AIDS.<sup>2</sup> Diagnosis of EKS is made by bronchoscopy, which demonstrates the erythematous lesions of Kaposi's sarcoma in large airways. ART is associated with regression in size of existing EKS lesions.<sup>4</sup> **HP**

### REFERENCES

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