ABSTRACT

Educational Objective: At the conclusion of this presentation, the participants should be able to recognize a patient with primary laryngeal Kaposi’s Sarcoma and guide its management.

Objectives: Kaposi’s Sarcoma (KS) is a malignancy seen more commonly in patients with Acquired Immune Deficiency Syndrome (AIDS) or immunosuppression. KS has also been linked to Human Herpesvirus-8 and is predominantly seen as violaceous lesions of the skin. Head and neck manifestations of KS have been reported in the literature and predominantly are seen in the skin and mucous membranes of the oral cavity. More rarely seen is laryngeal involvement of KS, with the majority presenting with airway obstruction or hoarseness in the setting of concurrent skin lesions. We present a case report of a rare occurrence of laryngeal KS in a patient without concurrent skin lesions.

Study Design: Case report

Methods: Case report and literature review

Results: A 37-year-old male with poorly controlled AIDS presented with hoarseness without airway obstruction. Flexible laryngoscopy revealed a large vascular lesion anterior to the right true vocal cord. The patient did not have concurrent KS lesions of the skin. After tissue diagnosis by biopsy, the patient was successfully treated in the operating room with two CO₂ laser excisions and with better control of his AIDS.

Conclusion: Laryngeal KS, while uncommon, should be considered in AIDS patients presenting with hoarseness or difficulty breathing even without the presence of concurrent skin lesions.

INTRODUCTION

Kaposi’s Sarcoma (KS) is a malignancy seen in patients with Acquired Immune Deficiency Syndrome (AIDS) or immunosuppression. KS has also been linked to infection with Human Herpesvirus-8. The most common manifestations of KS include mucocutaneous violaceous macular lesions of the lower extremities, face, trunk, genitalia and oropharynx. KS also commonly involves visceral organs, such as the liver and GI tract, and lymph nodes. Head and neck manifestations of KS have been reported in the literature and predominantly are seen in the skin and mucous membranes of the oral cavity and oropharynx. Specific subsites frequently involved include the hard palate, gingiva, and buccal mucosa. More rarely seen is laryngeal involvement of KS. The majority of patients with laryngeal KS present with airway obstruction, hoarseness, or dysphagia with signs of cutaneous or visceral KS already present.

OBJECTIVE

To present a case of laryngeal Kaposi’s Sarcoma in a man with AIDS with no prior manifestations of KS

METHODS

Case report and review of the literature

REFERENCES


CASE

A 37-year-old male with poorly controlled AIDS (CD4 ~43,000) presented with hoarseness. He denied any difficulty breathing, dysphagia or odynophagia. He did not have stridor on exam. The patient did not have concurrent lesions of any kind of skin or mucocutaneous sites. Flexible laryngoscopy revealed a large vascular lesion anterior to the right true vocal cord. The lesion did not cross the midline, and appeared to be filling the right ventricle. An attempt was made to remove the lesion intraorally using a 532 nm laser, however the patient did not tolerate the procedure in the office. Consequently, the patient was taken to the operating room for a Microdirect laryngoscopy with CO₂ laser excision. Intraoperatively, the lesion was noted to be extremely friable. A combination of cupped forceps and CO₂ laser at 5 watts was used to completely excise the lesion. The patient was sent home and urged to comply with his antiretroviral regimen. Surgical pathology was sent and returned consistent with HHV-8 positive KS. Follow-up at 1 week showed healing granulation at the excision site with no obvious recurrence of disease. His voice had improved and a mucosal wave was appreciated bilaterally, with slight limitation on the right side. The patient returned for follow-up after 1 month with complaints of recurrent hoarseness without dysphagia or respiratory distress. Flexible laryngoscopy revealed isolated recurrence at the site of his prior KS. The patient was then taken to the operating room for a repeat CO₂ laser excision and sent home with better follow-up of his AIDS. Follow-up at 1 week showed typical post-operative changes with no evidence of recurrence. The patient’s hoarseness had improved since the procedure. At last follow-up, he was free of KS, had a near normal voice quality and has achieved much better control of his AIDS (CD4 ~214, VL ~23,000).

REVIEW OF LITERATURE

A comprehensive literature review yielded a total of 28 reported cases of laryngeal KS. 64% of these cases occurred in patients with prior cutaneous manifestations of KS. The most common site of involvement was the supraglottis (71%). The most common presentations of disease were hoarseness and airway obstruction. A variety of treatments were used across the population, including chemotherapy, radiation, and various methods of excision (laser, cold knife). Of the 9 patients with outcome data, 7 (78%) remained free of disease at last follow up.

CONCLUSIONS

Laryngeal KS, while uncommon, should be considered in AIDS patients presenting with hoarseness or difficulty breathing even without the presence of concurrent skin lesions. In addition to better control of AIDS with medical management, laser excision of KS lesions of the larynx is an effective method of treatment.