Posttransplant Kaposi Sarcoma: Staging as a Guide to Therapy and Prognosis

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Dear Sir,

We were very interested to read the letter by Messina et al. [1]. In our view the strategy of therapy should vary according to the extent of disease at presentation.

Since we reported the first case of Kaposi developing in a cyclosporin-treated patient [2], we have had 11 other cases of Kaposi sarcoma developing after transplant [3]. Of the 12, 7 received both azathioprine and cyclosporin at some stage or other after the transplantation (all 7 also received prednisolone), 2 patients received azathioprine and prednisolone and the remaining 3 received cyclosporin and prednisolone.

Based on clinical examination, upper and lower gastrointestinal endoscopy and computed tomography of chest and abdomen, four stages can be recognized:

Stage 1 Localized skin lesion involving one limb only (there was 1 case in this category)

Stage 2 Widespread skin lesions involving more than one limb (there were 2 cases in this category)

Stage 3 Generalized involving viscera and/or lymph nodes and/or skin (there were 5 cases of this category with involvement of lymph nodes, stomach, colon, lung, liver)

Stage 4 Any of the above categories in the presence of either associated life-threatening infection or other neoplastic tumor (there were 4 such cases, 1 with staphylococcal skin abscesses and tuberculosis, 1 with nocardia, 1 with colonic lymphoma, 1 with Pneumocystis carinii and cytomegalovirus pneumonia).

Such staging determined therapy and prognosis. Stages 1 and 2 were treated with reduction of immuno-suppression to about 50% or less. Such management in the 3 cases in stages 1 and 2 led to regression of the Kaposi and preservation of the graft function. Our early experience showed that mere reduction of immunosuppression in stage 3 was not sufficient to halt the progression of the

Kaposi. Our practice now is to stop immunosuppression completely for this stage. For stage 4, beside specific therapy for the infection, immunosuppression was also completely stopped.

Using the above system only 3 patients died and all were from stage 4. Two died from their infection and the third from bleeding after colectomy for colonic lymphoma. Nine are still alive

with complete regression of the Kaposi. Out of these, there are 3 with functioning grafts. They are all from categories 1 and 2.

We feel that there is very little place for cytotoxic therapy in posttransplant Kaposi.

References

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