A man in his thirties living with HIV presented with two weeks of rectal pain, straining and liquid leakage through the anus. The patient had been diagnosed with HIV infection one year before with a baseline RNA viral load of 692,000 copies/mL and CD4+ count of 65 cells/µL. VDRL, hepatitis B surface antigen and hepatitis C antibody were negative. The decision was made to start cART with EFV/FTC/TDF but HIV RNA levels below the lower limits of detection were not achieved. A genotypic resistance test was performed revealing the following mutations: K65R, M184V for NRTIs; L100I, K103N for NNRTIs; and M36I/M, A71V/I for PIs. Eight weeks prior to the patient’s present illness cART was changed to ATV/r+3TC/AZT. M184V for NRTIs; L100I, K103N for NNRTIs; and M36I/I, A71A/V for PIs. Eight weeks prior to the patient’s present illness cART was changed to ATV/r+3TC/AZT. On physical examination mild hypogastric tenderness without rebound was present. No dermatological lesions were observed. Anal tone was normal, no rectal masses or irregularities were identified, with diffuse tenderness starting at 3 cm from the sphincter. An MRI was obtained (figure 1) and an anoscopy was performed where diffuse violaceous irregularities were identified, with diffuse tenderness starting at 3 cm from the sphincter. An MRI was obtained (figure 1) and an anoscopy was performed where diffuse violaceous irregularities were observed and biopsied. Kaposi’s sarcoma was diagnosed (figure 2) but the lesion was ulcerated and vascular structures were surrounded by inflammatory cells (figure 3). Warthin–Starry and anti–Treponema pallidum immunohistochemistry were obtained and were positive for the presence of spirochetes (figure 4).

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Kaposi’s sarcoma gastrointestinal involvement can occur in the absence of cutaneous disease. Risk factors for developing KS-IRIS include advanced tumor stage, an HIV viral load >5 log10 copies/mL, and initiation of cART without concurrent chemotherapy. Kaposi’s sarcoma diagnosis represents a challenge in the absence of dermatologic abnormalities and is usually delayed. Prozone phenomenon, biological false positive and delayed appearance of seroreactivity have been reported in patients living with HIV when VDRL is used to rule out syphilis. CDC guidelines recommend alternative tests when clinical findings are suggestive of syphilis, but serologic tests are nonreactive. The clinician and the pathologist must have a high index of suspicion when diagnosing patients infected by HIV since illness like syphilis can occur covertly in the context of another opportunistic infection.

References


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