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Skin Carcinoma in 2 Patients with HIV Infection

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KAPOSI SARCOMA (KS) and high-grade non-Hodgkin lymphomas (NHL) are associated with HIV infection [1, 2]. The identification of other associated malignancies was predictable in view of the impaired T-cell and natural killer cell function in HIV infection. In fact, an increased number of malignant neoplasms, such as Hodgkin's disease (HD), testicular cancer, squamous cell carcinoma of the oral cavity and the anorectum, malignant melanoma, adenocarcinomas of the lung, colon, pancreas and kidney and skin carcinoma have been recorded [1-7]. However, of this wide spectrum of malignancies, only KS and high-grade NHL are frequently associated. With the other tumours, some, such as HD, have unusual clinicopathological characteristics and may be more aggressive in HIV infection [3], although there is no epidemiological link between HD and HIV infection.

3 cases of skin carcinoma have been reported in patients with HIV infection: 2 squamous cell and 1 basal cell carcinoma with somewhat different clinicopathological features compared with those in the general population [8-10]. We report 2 cases of skin carcinoma in HIV patients in our centre in the past 2 years.

Case 1 (M/50, anti-HIV seropositive in 1987 after two negative tests in 1985 and in 1986). ELISA and western blot were positive. An ulcerative lesion in a cicatrix site of a previous wound at the right shoulder appeared at the end of 1987 and increased in size and dimension until August 1989, when biopsy revealed squamous cell carcinoma of the skin. CD4 were 350/ml and a diagnosis of AIDS according to the Centers for Disease Control (CDC) definition was made on the basis of a wasting syndrome. Radiotherapy with 60 Gy over 30 days was given, with a regression of the lesion. In January 1990, the patient was seen for the first time at our centre for evaluation of the ulcerative lesion of 7 × 6 cm at the right shoulder with lifted margins, irregular and cut borders and necrotic tissue at the bottom; also, a lymphonodal mass of 8 × 5 cm diameter was present in the

axillary right cavity. Histological examination of the cutaneous lesion and of the lymphonodal mass confirmed the diagnosis of squamous cell carcinoma of the skin metastasising to lymph-nodes. Two different regimens, vincristine, bleomycin and methotrexate for 5 weekly cycles and 5-fluoruracil and cisplatin for 3 cycles were administered with no response. The shoulder mass increased to 17 cm in diameter, with pain manageable only with major analgesics. The patient died in November 1990 of a haemorrhage from the axillary cavity.

Case 2 (M/46). In December 1989, a retroauricular lesion of 14 × 2 cm diameter was noted. Bleeding was also reported and in February 1990 the lesion was removed with histological diagnosis of basalioma of the skin. ELISA and western blot were positive for anti-HIV. CD4 were 125/ml. In March 1990 the patient underwent lymph-node biopsy in the retroauricular region and histological examination was negative. The patient is being followed up without any evidence of malignancy and without any disease diagnostic of AIDS. The last CD4 count was 121/ml.

Skin carcinoma can be detected in patients with HIV infection without CDC-defined AIDS. While no epidemiological link has been documented between skin carcinomas and HIV infection, it is interesting that both our patients were not intravenous drug users, the predominant group affected by HIV infection in Italy (approximately 70% of all AIDS cases). Clinicians dealing with patients with HIV infection should be aware of the possibility of skin tumours in these patients and early diagnosis and treatment are indicated, with the possibility of good control of the disease, as in our second case. A delay in diagnosis and management, as in our first case, was associated with an unfavourable outcome of the malignancy.

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