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Kaposi's Sarcoma: Chronology and Simulators

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Clinically, the early cutaneous lesions of Kaposi's sarcoma (KS) begin as flat, pink to purple macules (and patches). In time, some lesions become elevated to form papules (and plaques). Still later, there is nodule formation. This chronological sequence is not unique to KS and may be seen in other cutaneous neoplasms, including mycosis fungoides and malignant melanoma.

At each stage of development, the microscopic appearance of KS is distinctive, although the features of flat, macular lesions are quite different from those seen in nodules. In the late 1970's and early 1980's, before the phenomenon of AIDS became well known, the diagnosis of KS that was occurring in young homosexual men was not always arrived at, in part because of atypical clinical presentation, but also because of the unfamiliarity on the part of many pathologists with the histologic features of the early macular and papular lesions. Those features are as follows:

**Macules** - vasocentric (especially upper reticular dermis)
- bizarre, thin-walled, jagged vessels (sometimes "promontory" sign)
- "pseudogranulomatous" pattern
- little or no atypia
- few if any mitoses
- plasma cells often
- few siderophages

**Papules** - any of the changes seen in macular lesions
Nodules - may involve entire reticular dermis
- interstitial oval and spindle cells forming small, pointed vascular spaces and/or rudimentary fascicles with erythrocytes in the interstices between spindle cells
- plasma cells often
- usually little or no cytologic atypia
- few mitoses, if any
- occasionally erythrophagocytosis and eosinophilic globules

Nodules - anywhere in dermis
- interweaving fascicles or spindle cells with erythrocytes in interstices
- atypia, mitoses and necrosis maybe prominent
- erythrophagocytosis and eosinophilic globules
- plasma cells and siderophage often
- features of macular or papular lesions sometimes at the periphery

Numerous benign and malignant neoplasms as well as some inflammatory processes may be clinical and/or histologic simulators of KS. There are simulators of patch, plaque and nodular lesions, and some of the more important and common examples will be shown. Because of the numerous clinical simulators and the current high index of suspicion for KS in population groups at risk for AIDS, the number of biopsies submitted to "rule out KS" has increased dramatically in certain population centers. It is then the job of pathologist to recognize histologically the simulators of KS. Often this is a simple task. Other times, strict adherence and application to the histologic criteria just described is necessary to ensure a correct diagnosis.