We report the case of a 76-year-old Caucasian man, smoker, admitted to the emergency department with a clinical history of progressively worsening dyspnea, cough and bilateral pleuritic chest pain, asthenia and anorexia, with 6-months evolution. On physical examination, observations were normal, except increased respiratory rate. On inspection and palpation, a hard and painful mass on the right anterolateral hemithorax was detected. Laboratory investigations were normal except for a high lactate dehydrogenase (LDH 944 U/L). Chest X-ray revealed bilateral pulmonary opacities and left enlargement of the superior mediastinum. Chest computed tomography (CT) showed three pulmonary masses, one with 6.1 cm in the right inferior lobe and two in the left superior lobe (with 5.8 and 2.9 cm). The patient also had a pre-vascular solid mass with 9 cm in the superior mediastinum (Fig. 1A) and a 7.9 cm diameter lytic mass involving the anterior portion of the 7th right rib (Fig. 1B). Eco-guided transthoracic core needle biopsies of the rib lesion were performed and the

Fig. 1. (A) Chest CT showing a pre-vascular solid mass with 9 cm in the superior mediastinum (white arrow). (B) Chest CT showing a lesion in the anterior portion of the 7th right rib with 7.9 cm and bone destruction (white arrow). (C) Photomicrograph illustrating small-sized round cells with scanty cytoplasm. Stain: hematoxylin and eosin (HE); magnification: 20×. (D) Immunohistochemistry photomicrograph showing tumor cells positive for CD99; magnification: 20×.
Kaposi Sarcoma and Lung Transplant: Two Case Reports

*Cardos de Kaposi y trasplante pulmonar: dos casos clínicos*

**Dear Editor,**

Solid organ transplant recipients have an increased risk of developing malignancies, particularly lung transplant recipients, being one of the leading causes of morbidity and mortality.1,2 Certain viral infections are related with the development of tumours, both in immunocompetent and immunosuppressed patients.3,4 In the latter, the permanent state of immunosuppression, makes them more susceptible to new infections or reactivations1,3 such as by human herpesvirus 8 (HHV-8), which is associated with Kaposi Sarcoma (KS) and can manifest in very different ways,2,5 as it will be described. The first case refers to a 63 years old male patient, former smoker, submitted to bilateral pulmonary transplant (BPT) when he was 61 years old. Eleven months after transplant, on a routine visit, two small purpuric skin lesions in the patient’s chest were identified. He was referred to the Dermatology outpatient department and clinical vigilance was decided. Five months later, due to progression of the skin lesions, (Fig. 1a), he was submitted to cutaneous biopsy whose pathology revealed morphological features and HHV-8 positive cells, compatible with KS, and its digestive tract involvement was excluded. Meanwhile, he showed functional decline and the diagnosis of bronchiolitis obliterans was made, leading to changes in his immunosuppression from mycophenolate mofetil 1250 mg bid to everolimus 0.5 mg bid. Afterwards, he presented clinical worsening with dyspnea, bilateral pulmonary infiltrates and respiratory failure without response to non-invasive ventilation, all portrayed as a possible pulmonary involvement by KS, associated with transplant rejection (Fig. 1b). The patient died two days after these symptoms began, without having started specific therapy for KS.

The second case describes a 35 years old male patient with bronchiectasis of unknown aetiology, submitted to BPT at the age of 30. Regarding post-transplant complications, the authors emphasise acute rejection with progression to bronchiolitis obliterans with functional stability without respiratory failure. He begun immunosuppression with everolimus 0.5 mg bid and tacrolimus 4.5 mg bid. Fifty months after transplant, he was hospitalized for both prostatitis and acute cholecystitis. During that period the patient presented

### Bibliografía


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http://dx.doi.org/10.1016/j.arbes.2017.03.024
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