

the production of reactive oxygen species, leading to skin damage.<sup>5</sup>

A further factor to be taken into account in our patient was that she had had atopic dermatitis since childhood. Previous studies have shown an association between atopic dermatitis and UC,<sup>6</sup> and an increased risk of inflammatory bowel disease among patients with atopic dermatitis.<sup>7</sup> However, other studies have not observed a statistically significant increase in the prevalence of atopic dermatitis among patients with UC compared with healthy controls.<sup>8</sup> Possible mechanisms may include an impaired barrier function, potential sharing of type 2 T-helper cell cytokines, and thymic stromal lymphopoietin (TSLP).<sup>9</sup>

In summary, we have described the rare case of a patient with UC who developed concurrent PG and EN not related to the activity of her intestinal disease. Reporting of similar cases will help to clarify the mechanisms of the aseptic neutrophilic disorders, such as the so-called aseptic abscess syndrome.

### Conflict of interests

The authors declare no conflict of interests.

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## Non-AIDS Kaposi sarcoma in the external ear



### Sarcoma de Kaposi del oído externo, no asociado con SIDA

*Dear Editor*

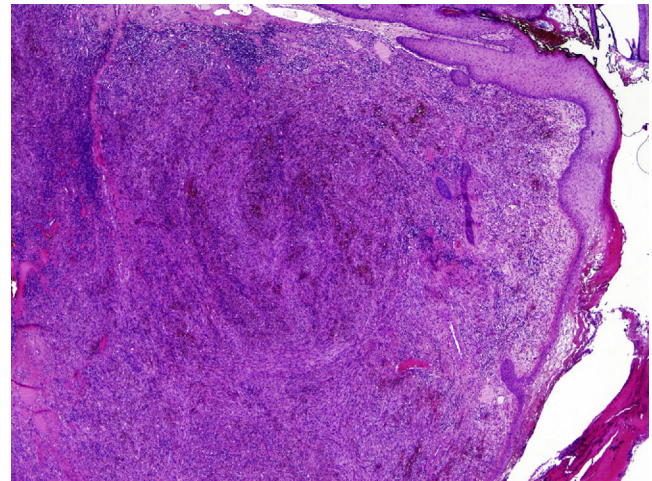
Kaposi sarcoma (KS) is an uncommon, malignant, multifocal systemic disease derived from the proliferation of endothelial cells. The disease has predominant cutaneous involvement and follows a benign course, but in severe cases it can affect other organs, especially the gastrointestinal tract and the lungs. In 1994, Chang et al.<sup>1</sup> demonstrated that human herpesvirus type 8 (HHV-8) infection is involved in the etiology of KS. Its presence has been detected in over 90% of biological tissues affected, and it is now considered a valuable diagnostic marker of the disease. Classic KS (described in 1872 by Moritz Kaposi) is the most common form of KS, and it usually affects elderly males of Eastern European or Mediterranean origin. Clinically, it manifests as red-bluish papules, plaques, and nodules on the lower extremities that exhibit a slow but steady growth. There are 4 types of KS: classic KS, endemic (African) KS, immunocompromised (iatrogenic) KS (related to aggressive immunosuppressive

treatment), and AIDS-related (epidemic) KS. A new variant related to homosexuality was recently described in men who have sex with men: non-human immunodeficiency virus (HIV)-associated KS.<sup>2</sup>

We describe a rare presentation of KS of the external ear in an immunocompetent patient. A 77-year-old woman came to our dermatology department with a firm, slow-growing, red-bluish nodule measuring 1.4 cm in diameter on the anterior helix of the right pinna (Fig. 1). She was otherwise well and had no relevant past history of skin disorders, other medical conditions, or associated immunosuppression. The tumor was painless, and there was no bleeding or lymphadenopathy. It had a vascular appearance, and the tentative diagnosis was pyogenic granuloma, although other diagnoses considered were amelanotic melanoma, epidermoid carcinoma, Merkel cell carcinoma, and atypical fibroxanthoma. The lesion was excised completely, and histologic examination revealed a proliferation of fine, irregular vascular channels, with erythrocyte extravasation and minimal pleomorphism and mitotic activity (Fig. 2). Positive staining of spindle cells with CD31, CD34, and HHV-8 was consistent with a diagnosis of KS (Fig. 3). Laboratory tests only revealed hyperglycemia. Serology and polymerase chain reaction results were both positive for HHV-8. Serology for HIV, cytomegalovirus, herpes zoster virus, Epstein–Barr



**Figure 1** Polypoid lesion of the right ear.



**Figure 2** Proliferation of fine, irregular vascular channels, with erythrocyte extravasation (hematoxylin–eosin staining, original magnification  $\times 20$ ).

virus, HHV-6, and HHV-7 was negative. To rule out gastrointestinal disease, we performed a fecal occult blood test and an endoscopy, but observed no pathological findings. A whole-body computed tomography scan showed no other visceral disease. Screening laboratory tests to evaluate cellular immunity (total lymphocyte count, T-cell, B-cell, and natural killer-cell enumeration using flow cytometry) and functional assessment of helper T (T<sub>H</sub>) cells based on T<sub>H</sub>1 and T<sub>H</sub>2 cytokine production were normal, but early response to stimulation measured by detection of intracellular adenosine triphosphate (ATP) synthesis in T cells (Immuknow, Viracor IBT Laboratories Inc.) was low. This suggested defective T-cell activation because the production of intracellular ATP is one of the first steps in cellular activation. During 2 years of follow-up, no recurrences, new lesions, or new immunosuppressive diseases have been detected.

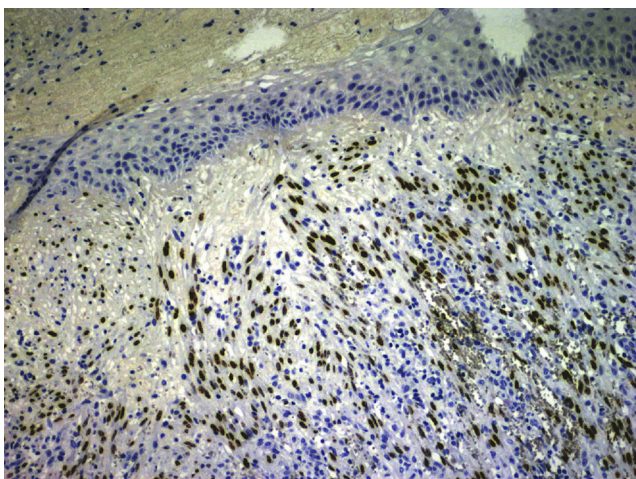
The head is a common site for multiple lesions in HIV patients with KS. However, the presence of a solitary lesion on the ear of an immunocompetent patient is a very rare

finding, and very few cases of KS have been reported on the pinna in patients without a history of immunodeficiency (Table 1). Like our patient, most of the patients described in the literature are elderly, with the exception of a healthy 36-year-old white man. We do not know why certain vascular proliferations, such as angiolymphoid hyperplasia with eosinophilia, have a special predilection for the pinna, but we hypothesize that the sum of certain traumatic/infectious factors in an acral area with complex, fine, and insufficient vascularization could make access difficult for immune cells. All these conditions could favor the occurrence of these vascular tumors in certain individuals with immune dysfunction that has not been adequately studied. We highlight the importance of contemplating KS in the differential diagnosis of tumors with a vascular appearance involving the ears in immunologically competent individuals.

**Table 1** Cases of Kaposi sarcoma involving the external ear of patients without AIDS.

Author(s)	Year	Age, y	Sex	Geographic/ethnic origin	No. of lesions/location	HIV	HHV-8
Naunton and Stoller <sup>3</sup>	1960	68	Male	North American	1/Right helix 1/Lip	ND	ND
Gibbs <sup>4</sup>	1968	73	Female	North-American	Multiple nodules on each ear 1/Left foot	ND	ND
Stearns et al. <sup>5</sup>	1983	66	Male	Indian	1/Left external auditory meatus	ND	ND
Babuccu et al. <sup>6</sup>	2003	36	Male	White	1/Left pinna	HIV <sup>-</sup>	HHV-8 <sup>+</sup>
Colletti et al. <sup>7</sup>	2009	57	Male	White	1/Right pinna	HIV <sup>-</sup>	HHV-8 <sup>+</sup>
Izquierdo Cuenca et al. <sup>8</sup>	2012	81	Male	White	2/Right pinna	HIV <sup>-</sup>	HHV-8 <sup>+</sup>
Busi et al. <sup>9</sup>	2014	72	Female	White	1/Right right pinna and external auditory canal Multiple lesions on right arm and left leg	HIV <sup>-</sup>	HHV-8 <sup>+</sup> (also HHV-4 <sup>+</sup> and EBV <sup>+</sup> )
Our case	2013	77	Female	White	1/Right pinna	HIV <sup>-</sup>	HHV-8 <sup>+</sup>

EBV, Epstein–Barr virus; HHV, human herpes virus; HIV, human immunodeficiency virus; ND, not determined.



**Figure 3** Nuclear positivity for human herpes virus 8 (hematoxylin–eosin staining, original magnification  $\times 20$ ).

### Conflict of interests

The authors declare no conflict of interest.

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## Patient with disseminated tuberculosis and rare perianal involvement



### Paciente con tuberculosis diseminada y un raro compromiso perianal

Dear Editor

#### Case description

A 59-year-old homeless male patient presented to the emergency department with a 3-month history of a rapidly enlarging, painful perianal mass associated with rectal bleeding. He also reported nocturnal sweats, fever, weight loss, and a chronic productive cough. The patient had no past medical history of note and was not on any medication, but he was a smoker and consumed marijuana on a daily basis. He stated that he had unprotected sex with occasional women, but denied anal sex.

On inspection, the patient was cachectic, with a weight of 45 kg. Physical examination revealed numerous enlarged cervical lymph nodes, some measuring over a centimeter in diameter, and chest auscultation was abnormal. In the perianal area, multiple skin-colored nodules had coalesced

into a larger mass associated with a well-defined, indurated, painful, hemorrhagic perianal ulcer (Fig. 1). Serology for HIV and hepatitis was negative, and kidney and liver function was normal. Chest X-ray and high-resolution computed tomography revealed widespread reticulonodular opacities in both lung fields (Fig. 2). Sputum bacilloscopy was positive for acid-alcohol-fast bacilli, confirming the diagnosis of active pulmonary tuberculosis. The GeneXpert MTB/RIF test on material from a biopsy of a cervical lymph node was positive for *Mycobacterium tuberculosis* DNA. On colonoscopy an isolated ulcer with positive bacilloscopy for acid-alcohol-fast bacilli was discovered in the cecum. Biopsy of the perianal lesion revealed caseous necrosis and a granulomatous inflammatory process with positive bacilloscopy for acid-alcohol-fast bacilli and a GeneXpert MTB/RIF test that was positive for *M. tuberculosis* DNA, with a negative rifampicin resistance test (Fig. 3). Based on this information we made a diagnosis of disseminated tuberculosis (TB) with pulmonary, lymph node, intestinal, and perianal involvement. The patient started treatment with rifampicin, isoniazid, pyrazinamide, and ethambutol daily for 2 months, followed by rifampicin and isoniazid 3 times a week for 7 months (total treatment duration, 9 months). A good response was achieved after completing the first phase, with a decrease in the size of the perianal lesion (Fig. 1) and resolution of the systemic symptoms.