MANAGEMENT OF EPIDEMIC KAPOSI'S SARCOMA: A RECENT CONCERN IN DENTISTRY.

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INTRODUCTION:
Kaposi's Sarcoma in its classic endemic form has never been a concern in dental practice. Since early this decade the medical practice has witnessed an ever increasing new form of the same sarcoma in its more aggressive form called the epidemic Kaposi's Sarcoma. The clinical presentation of this disease, while showing certain similarities with the endemic one, does have some unique aspects. Both diseases commonly involve skin and mucous membranes, however, oral presentation typically remains the domain of the epidemic Kaposi's Sarcoma. Not uncommonly victims of endemic Kaposi's Sarcoma have presented to the dentist with oral Kaposi's Sarcoma lesion as the first complaint be it the only site or part of many sites of disease presentation. It is appropriate, therefore, that medical professionals in dentistry field be made aware of the management possibilities for this recent form of Kaposi's Sarcoma.

In this paper we will review our experience at the Tanzania Tumor Centre in the management of epidemic Kaposi's Sarcoma.

METHOD AND MATERIALS:
Since May 1985 we have seen a total of 46 patients with Acquired Immune Deficiency Syndrome related Kaposi's sarcoma referred for X-ray therapy. Their ages ranged from 18 to 58 years, most of the patients being between 30 and 45 years of age 12 of these patients were females. Two thirds of the patients were from rural Tanzania with predominantly peasant agricultural occupation. Most of the patients presented with stigmata of skin Kaposi's lesions of unusual distribution alerting the clinicians to possible HIV infection. All cases were laboratory confirmed for HIV infection. The Kaposi's sarcoma lesions predominated in the lower limbs, (60%), presenting as gross limb edema with eczematous fluid ooze or with multiple bluish plaques mixed with nodular lesions in some cases. The nodular lesions tended to ulcerate and where the instep was involved intefered with ambulation. In 7 patients the eczematous lesions were extensive and involved most of the body including the scalp. Generalized peripheral llymphadenopathy athy was demonstrable in 30% of the patients.

Other stigmata of Immunodeficiency syndrome included diarrhoea (15 patients) cough (17 patients) weight loss (22 patients), fever (15 patients), herpes zoster (12 patients). Palatal ulcers were seen in 7 patients and in 3 of the 7 this was the only manifestation of Kaposi's sarcoma. Pain was a significant symptom in 6 patients.

Treatment involved irradiation of half the body starting with the half with most of the clinically demonstrable disease. For upper body the area from the umbilicus cronially was treated and for the lower body caudal half from the umbilicus was treated. These radiotherapy sesions were delivered from Theratron 780 telecobalt radiotherapy machine with the patient placed on the floor. Anterior and posterior ports were used each port receiving 300 rads calculated to the midline. Pretreatment preparation included an adequate hemogram. Antiemetics were used postirradiation in patients who experienced nausea and vomiting. Most of the patients were inpatients at the Tumor Centre. In case of the outpatients an overnight observation in the ward was required.

Objective results of treatment were scored at the time of maximum response as CR (complete disappearance of disease), PR (greater than 50% reduction of the lesion), and NR (Less than 50% reduction in the lesion). Subjective response was graded as CR (complete relief of symptoms), PR (partial relief), or NR (no relief). Patients were discharged when maximal relief was deemed obtained and given a follow up appointment date. Most patients (58%) received 2 treatments either on one half or both halves of the body. 18% received only one treatment and the rest had more than two treatments as determined from response. Longest follow up is 38 months.

RESULTS/RESPONSE:
All the 46 patients got at least one treatment with half body irradiation.. Further treatment had to be discontinued due to deterioration in 4 patients, (9%). As majority of the patients had multiple site disease distribution objective response was scored as the average response for all the clinically detectable lesions. For the 42 patients who got the intended treatment total objective response was 82% (34 patients). Of these 7 patients were complete responders and the rest.

Edema responded better than other disease manifestations (91% total response). Regression of plaque was 56%, nodules 76% and eczematous oozing and itching only 30%. Palatal lesions were either stable (60%), or progressed. No remarkable regression of any palatal lesion was seen in this series.

Subjective response was achieved in 93% of the patients who completed treatment. Pain was relieved in most of the patients and lesion in the instep regressed sufficiently enough for the 5 patients to walk again.

TOXICITY:
Blood count was taken before treatment and on the fourteenth day after each treatment. No hematologic toxicity requiring intervention was witnessed in this series. One patient experienced what was suspected to be a radiation pneumonitis but this was never confirmed by tests.

No adrenal crisis wos documented in this group of patients.

DISCUSSION:
Although HIV with its clinical manifestations was retrospectively traceable to the early 1980's in Tanzania, laboratory confirmation of the disease was only possible in 1985. In that same year the first cases of HIV related Kaposi's sarcoma, or a typical