KAPOSI'S SARCOMA AND TOXOPLASMA GONDII BRAIN ABSCESS IN A SEXUALLY ACTIVE MALE

Sir,—Several outbreaks of Kaposi's sarcoma and serious opportunistic infections among homosexual men have recently been reported in the United States, possibly due to a defect in cellular immunity. In their series Hymes et al. describe one such patient with a frontal lobe mass, suggesting brain metastasis; no necropsy was done.

In October, 1981, a 35-year-old male homosexual was admitted to hospital with a 2-week history of fever, headache, and purple skin lesions on his trunk. Anaemia and weight loss had started 6 months earlier. Six months before admission the first purple skin lesion had appeared. Although he had a stable, one-partner relationship, he visited New York in 1974 and Turkey in 1980 in which he had contacts with different partners. Over the 2 years before admission he had repeated episodes of gonorrhoea. He denied the use of any drug use. He had five purplish cutaneous nodules on the trunk and one on the oral mucosa. There was generalised lymphadenopathy, but no hepatic or splenic enlargement. Routine blood tests were unremarkable and HBsAg negative. Histology of the nodules revealed Kaposi's sarcoma. Fibreoptic endoscopy suggested gastric involvement. While he was in hospital his headache intensified and a computerised tomographic scan revealed a right frontoparietal mass. Left hemiparesis developed. A well demarcated spherical mass 3 cm in diameter was removed, but the patient did not recover consciousness and died 4 days after surgery.

Necropsy was limited to the thorax and abdomen. Both lungs were congested with areas of consolidation. The trachea showed white plaques. Three angiomatous-like nodules (5-15 mm in diameter) were found in the pyloric gastric region. The urinary bladder mucosa was oedematous and there were two ulcerations. No lesions were found in the intestinal tract and other abdominal organs. Histology disclosed Kaposi’s sarcoma in the skin, oral mucosa, stomach, and paraaortic and mediastinal, and abdominal lymph nodes. It was granulomatous angiomatosis with isolated Candida albicans. The eye had oedematous lesions in the adnexa, liver, and lung. The brain mass had a necrotic centre surrounded by a thin border of necrotic granulomatous tissue, with a proliferation of vessels and round cell infiltration. No giant multinucleated cells were found. Round or oval organisms, mostly in large groups, were identified within the necrotic area. They reacted faintly with periodic acid-Schiff and were well visualised with Giemsa and were positive with both silver methenamine. Electron microscopy disclosed the features of cystic and pseudocystic forms of Toxoplasma gondii. Each sporozoan had a double membrane of approximately 40 nm and a clearly visible nucleus, a polar conoid with a few toxonemes, and a crescentic body in the parasitophorous vacuole. The cysts in the subcutaneous tissues resembled one another; granulomas were formed in the lesions. The cysts were surrounded by a single cytoplasmic membrane of the host cell. The toxoplasmosis measured 3-7 μm and were crescent shaped and usually found as large cysts of five or more protozoa (see figure).

Our case is typical of multiple opportunistic infections in a male homosexual with Kaposi's sarcoma without apparent immunosuppressive disease. In a review of U.S. cases of opportunistic infections and Kaposi's sarcoma the main CNS infection was cryptococcal meningitis. Three cases of CNS toxoplasmosis were reported, but the lesions were not described and none of the patients had Kaposi's sarcoma. We know of no previous reports of T. gondii cerebral lesions and Kaposi's sarcoma.

At first we thought of brain metastasis as the cause of the space-occupying lesion. Awareness that in patients with Kaposi's sarcoma neurobiological involvement may be due to a treatable condition such as toxoplasmosis is very important.

Reports of other European cases of opportunistic infections in male homosexuals with or without Kaposi's sarcoma suggest that the international homosexual community as a whole is at risk. A common feature is asymptomatic cytomegalovirus infection transmitted enterally; these could cause immunosuppression.

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MULTIPLE OPPORTUNISTIC INFECTION IN A MALE HOMOSEXUAL IN FRANCE

Sir,—The first cases of acquired cellular immunodeficiency among male homosexuals were reported by the Centers for Disease Control. Since then, several cases of opportunistic infection in Kaposi's sarcoma among male homosexuals have been reported in California and in the East of the U.S. 2,3 In Britain, a homosexual who had been to U.S.A. has also been reported who would like to report the first similar case seen in France.

The patient is a male homosexual, aged 38. His last visit to New York was in February, 1980, when, for the first and only time, he took "poppers" several times. He has never taken drugs before or since. He was referred to Claude Bernard Hospital in 1981, because of continuous high temperature, loss of weight, malaise, and a dry cough. Clinical examination revealed disseminated microlymphadenopathies only. The chest X-ray was normal. The white cell blood count was 4500/μl (47% neutrophils, 10% eosinophils, 33% lymphocytes, 10% monocytes with abnormal forms). The test results for lactic dehydrogenase and IgM antibody were negative. The levels of IgG and IgA were 153 mg/dl and 1190 mg/dl, respectively). IgM levels were low. Circulating immune complexes were present. Tests for antibodies were all negative except for the cytomegalovirus (CMV) which was positive.