AIDS DEFINING NEOPLASIA

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Introduction

- Malignancy develops in approx 20% ofpts with HIV
- Often is the first evidence of HIV infection
- Leads to 28% of HIV pts death

	Standard incidence	Ratio
Tumor	Pre-HAART	HAART
Kaposi's sarcoma	52900	3640
NHL	79.8	49.5
Burkitt lymphoma	57.4	49.5
DLBCL	98.1	29.6
PCNSL	5000	1020
Cervix	7.7	5.3
HL	7.0	13.6
ANUS	18.3	19.6

KAPOSI'S SARCOMA

- First described by Moritz Kaposi in 1872 as indolent
- It is now clinically aggressive
- Common in young pts
- Associated with human herpes virus-8

Treatment

- HAART is fundamental
- Local therapies: RT, penretin gel, 3% Na+ tetradodecyl sulphate
- ABV
- Paclitaxel
- Liposomal daunorubicin/peg liposomaldoxorubicin
- RT for limited disease

NHL

- DLBCL: ‘B’ symptoms are common
  Presents with L/adenopathy with/out splenomegaly
  Can present with CNS involvement
  Staging – like any other NHL

- Poor prognostic features:
    - stage 4
    - PS
    - CD4 Count ≤ 100 and high viral load
    - Hx of OI

- Treatment: CHOP

  CDE/EPOCH

  Relapse: ICE/ESHAP/PBSCT
- BURKITT LYMPHOMA: in the era of HAART

  treat like in HIV negative.

  Be aware of BL-like NHL

- PCNSL: prognosis is poor

  Treatment: HD MTX, WBRT, Steroids

Anal carcinoma

- No improvement in the risk even in the era of HAART
- Don’t require immune suppression
- Not AIDS defining
- Treatment depends on PS, CD 4 count, and stage:
  - Chemo-RT – may need adjustments
    - Chemotherapy - 5FU/cisplatin or
      5FU/Mitomycin – advanced stage
    - ? Palliative RT alone?

Thanks

REFERENCES

1. DeVita, Hellman, and Rosenberg's CANCER: Principles & Practice of Oncology, 8th Edition
2.
3.