MEDIASTINAL LIPOSARCOMA IN A PATIENT INFECTED WITH THE HUMAN IMMUNODEFICIENCY VIRUS

To the Editor:

Infection with the human immunodeficiency virus (HIV) and the subsequent destruction of T4-positive helper cells are associated with the development of infection with opportunistic pathogens and with the development of various malignancies [1]. Patients with acquired immunodeficiency syndrome (AIDS) are also at higher risk for Kaposi's sarcoma and non-Hodgkin's lymphomas [2]. It has been asserted that the increased incidence of these malignancies is associated with alterations in the immune system [3]. If the immune system is truly a factor in protection against malignancy, then HIV-infected patients may be at greater risk for other forms of cancer as well. Liposarcoma is usually a malignancy of later life; it is rarely found as a primary tumor of the thorax. This letter describes the first documented case of a young patient with HIV infection and liposarcoma of the mediastinum.

A 27-year-old man in otherwise good health first noted chest pain and slight hemoptysis in December 1985. The patient was treated with antibiotics for presumed bronchitis and his symptoms resolved. A chest radiograph showed no abnormalities. Several weeks later, the symptoms recurred. Chest radiography revealed a left pleural effusion and a prominent left hilum. Findings on physical examination were normal except for rales heard to the left of the sternum. Results of sputum smears, bronchial washings, bronchoscopy, and bronchial biopsy were negative for mycobacteria, fungi, bacteria, and malignant cells. A serum specimen demonstrated HIV antibodies by enzyme-linked immunoabsorbent assay and Western blot.

Four months later, extensive lymphadenopathy had developed at multiple sites. Computed tomography of the chest confirmed a large left para-mediastinal mass with multiple left upper lobe pulmonary nodules; an abdominal computed tomographic scan was normal. An anergy panel was normal. Lymphocyte studies showed 660 T4-positive cells/mm^3 and 720 T8-positive cells/mm^3 with a T4/T8 ratio of 0.9. Repeat transbronchial biopsy and cytologic examination of bronchial washings showed no abnormal pathologic condition. Left mediastinotomy revealed well-differentiated liposarcoma of the de-differentiated subtype. Subsequent thoracotomy revealed massive tumor invading the pericardium, diaphragm, lung, aorta, pulmonary artery, left main stem bronchus, and carina. The tumor was deemed unresectable.

Liposarcomas are one of the more common soft-tissue malignant tumors in adults. Only rarely are they found as a primary tumor in an intrathoracic location. Of more than 1,000 cases of liposarcoma recorded at the Armed Forces Institute of Pathology between 1970 and 1979, less than 3 percent had an intrathoracic primary site [4]. In addition, liposarcomas more commonly affect older persons; the median age of presentation is 51 years [5].

In light of this tumor's location in a relatively young person, we suggest that there may be an association of liposarcoma with HIV infection.

Note: The opinions and assertions contained herein are the private ones of the authors and are not to be construed as official or reflecting the views of the Navy Department or the naval service at large.

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LYMPHOMA PRESENTING AS ACUTE RENAL FAILURE

To the Editor:

The development of acute renal failure in patients with lymphoma is a common clinical problem. Acute renal failure in these patients is usually the consequence of obstruction to urine flow, toxic effects of chemotherapeutic agents or antibiotics, acute urate nephropathy or the tumor lysis syndrome, and/or associated disease processes such as sepsis, hypercalcemia, and amyloidosis [1]. However, acute renal failure due to lymphomatous infiltration of the kidneys has been described infrequently. The following brief report outlines the course of a patient in whom the primary clinical presentation of disease was acute renal failure secondary to lymphomatous infiltration of the kidneys. The case highlights the value of renal biopsy in

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