intense, predominantly peripheral enhancement in association with non-enhanced areas[5–7]. Histopathological and immunohistochemical analyzes are necessary to confirm the diagnosis[6].

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Gastric Kaposi's sarcoma

Sarcoma de Kaposi gástrico

Dear Editor,

A male, 29-year-old, homosexual patient presenting with history of 20 kg-weight loss, asthenia, nausea and stomach pain for three months in association with appearance of skin lesions in upper limbs and scrotal sac.

Human immunodeficiency virus (HIV) serology was positive. Double contrast radiological study of the stomach (Figure 1A) demonstrated polypoid lesions. At abdominal computed tomography (Figures 1B and 1C), solid, polypoid nodular masses were observed on the gastric submucosa with endoluminal component and early contrast-enhancement. High digestive endoscopy (Figure 1D) demonstrated erythematous lesions, some of them being violaceous, polypoid and flat, with a normal gastric submucosa. On that occasion, biopsy of the skin lesions and of the lesions in the stomach revealed atypical vascular lesion, and the anatomopathological and immunohistochemical analyses confirmed the diagnosis of Kaposi's sarcoma.

The compromise of the gastrointestinal tract by Kaposi's sarcoma is the most common form of disseminated disease, observed in up to 50% of patients. The disease can involve from the

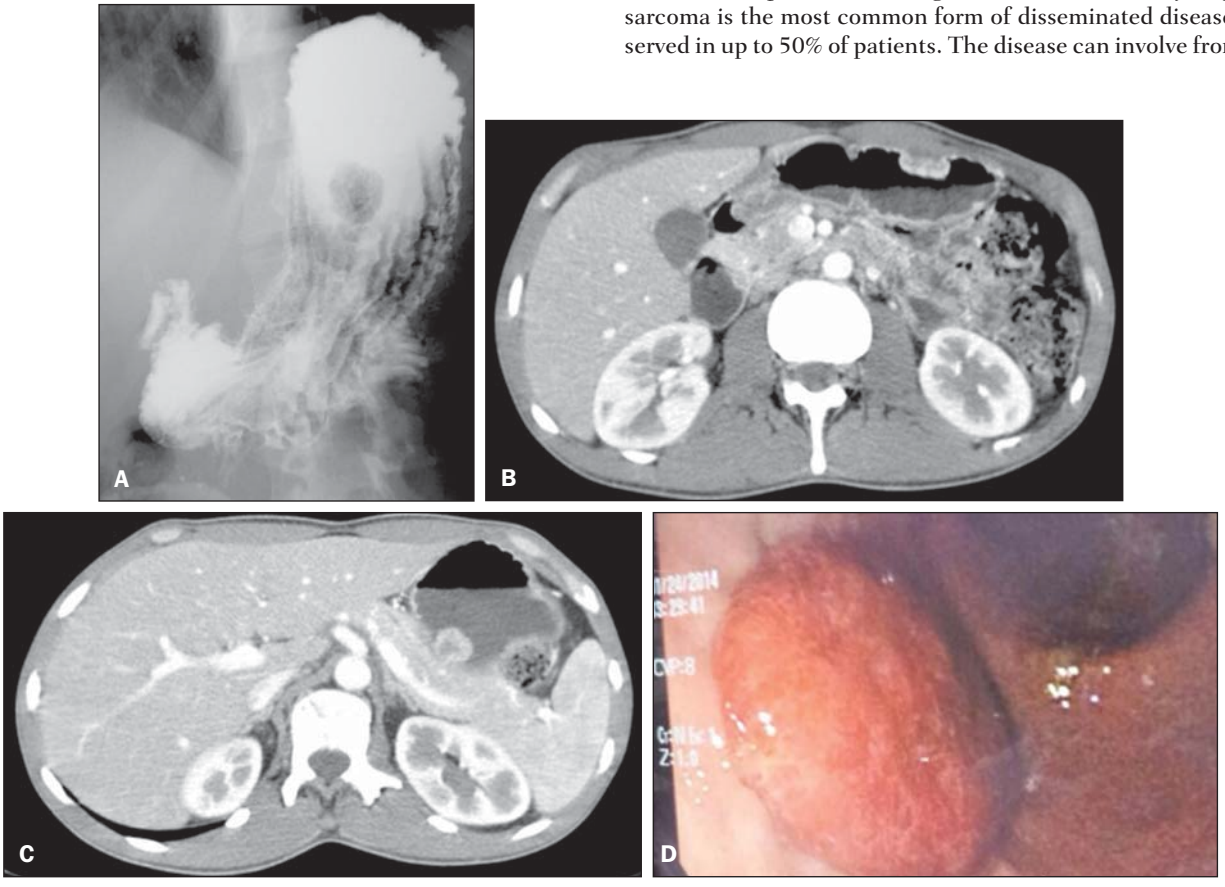

Figure 1. A: Radiographic image of esophagus, stomach and duodenum shows polypoid filling defect. **B,C:** Abdominal CT arterial phase shows subepithelial hypervascular polypoid lesions. **D:** High digestive endoscopy shows the corresponding reddish polypoid lesion.

oropharynx to the rectum, and the duodenum is most frequently affected, followed by the stomach, esophagus and colon[1,2].

Kaposi's sarcoma is about 300 times more common in AIDS patients than in those with other immunodeficiency types, and generally occurs in the setting of CD4 count below 150–200 cells/mm^3[1].

The diagnosis is made by means of digestive endoscopy and biopsy. The classical endoscopic finding is represented by subepithelial, reddish, ulcerative or non-ulcerative lesions[3].

Barium studies characterize polypoid lesions with smooth contour with sizes ranging from few millimeters to 3 cm. Larger lesions may ulcerate, giving the lesion a "bullseye" or "target" pattern[4].

Computed tomography detects subepithelial polypoid lesions or irregular thickening of gastric folds, which after intravenous contrast injection show hypervascular behavior, with a more marked enhancement than that of the adjacent mucosa in the arterial phase due to the intense vascularization of the tumor. Additionally, peripancreatic lymph node enlargement may be observed in the porta hepatis, mesenterium and retroperitoneum in up 80% of cases[1,3].

Kaposi's sarcoma with visceral involvement is frequently associated with poor prognosis. The treatment includes antiretroviral therapy, radiotherapy, and chemotherapy[5].

The authors conclude that Kaposi's sarcoma should be considered in the differential diagnosis of hypervascular submucosal lesions, particularly in AIDS patients.

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Acute post-tonsillectomy negative pressure pulmonary edema

Edema pulmonar agudo por pressão negativa pós-tonsilectomia

Dear Editor,

A female, 28-year patient was submitted to tonsillectomy and developed respiratory discomfort immediately after the procedure. At the following day, posteroanterior and lateral chest radiography demonstrated coalescent, poorly defined opacities in both lungs, sparing the periphery and characterizing the so called "butterfly wing" pattern, compatible with a diffuse alveolar process. The cardiac image was normal (Figure 1A). Three days after the procedure, without any use of medication, radiographic images (same views) revealed the opacities disappearance (Figure 1B).

Negative pressure pulmonary edema (NPPE) represents a rare occurrence in surgeries (0.094%), most frequently reported in buccomaxillary-facial and oral surgeries due to the probability of upper airway obstruction[1–3]. This condition is divided into two classes, namely, type I NPPE caused by upper airway obstruction such as, for example, post-tracheal extubation laryngospasm, epiglotiditis, tracheal cannula obstruction and postoperative vocal cord paralysis[3–6]. Type II NPPE occurs after corrective surgical procedures for chronic airway obstruction such as tonsillar hyperplasia, sleep apnea, tumors and acromegaly[7,8]. In such cases, the treatment should be aimed at reverting hypoxia and decreasing the pulmonary fluid volume[1–5]. The prognosis is good, with recovery at the first 24 hours.[8].

Radiographic and chest CT findings of NPPE include interstitial edema progressing to alveolar edema in more severe cases. Generally, regression of symptoms and radiological finding is observed within two or three days[6]. Many diseases present with

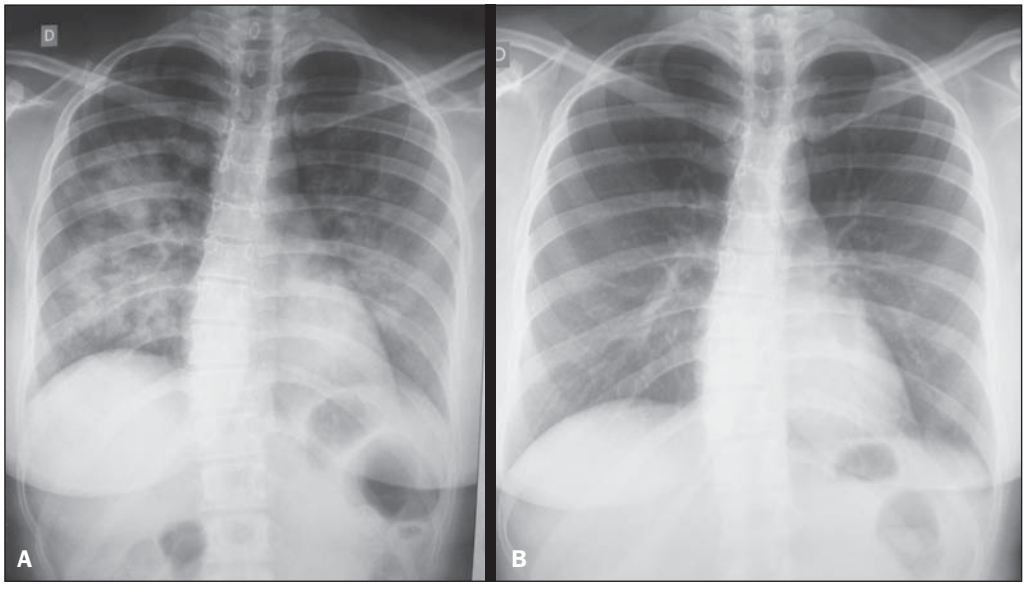

Figure 1. A: Posteroanterior chest radiographic image showing bilateral, coalescent, poorly defined opacities, characterizing the so called "butterfly wing" pattern, which is typical of alveolar process. The cardiac image is normal. These images were acquired on the following day after tonsillectomy. The patient presented with mild dyspnea. **B:** Posteroanterior chest radiographic image acquired three days after the procedure. Complete resolution of the alveolar process demonstrated on the previous images.