Risk of Kaposi Sarcoma Among Immigrants to Sweden

Mousavi, Seyed Mohsen; Sundquist, Jan; Hemminki, Kari

Published in:
Acta Dermato-Venereologica

DOI:
10.2340/00015555-1754

2014

Link to publication

Citation for published version (APA):

General rights
Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

• Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
• You may not further distribute the material or use it for any profit-making activity or commercial gain
• You may freely distribute the URL identifying the publication in the public portal

Take down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.
SHORT COMMUNICATION

Risk of Kaposi Sarcoma Among Immigrants to Sweden

Seyed Mohsen Mousavi1, Jan Sundquist2,3 and Kari Hemminki1,2
1Division of Molecular Genetic Epidemiology, C050, German Cancer Research Center (DKFZ), Im Neuenheimer Feld 580, DE-69120 Heidelberg, Germany; 2Center for Primary Health Care Research, Lund University, Malmö, Sweden, and 3Stanford Prevention Research Center, Stanford University School of Medicine, California, USA. E-mail: smmousavi@yahoo.com
Accepted Aug 28, 2013; Epub ahead of print Nov 8, 2013

Kaposi sarcoma (KS) is a locally aggressive endothelial tumour that is classified into 4 clinico-epidemiological forms: classic KS affecting lower limbs in elderly Mediterranean or East European men; endemic KS occurring in extremities among Equatorial African middle-aged men and children; iatrogenic KS involving lower limbs in immunosuppressive patients; and AIDS-associated (epidemic) KS observed among homo- and bisexual HIV-1-infected young men (1, 2). The world-wide epidemiology of KS has changed by spreading of HIV infection (1). For example, KS represented 7% of all cancers in Sub-Saharan African men in the 1960s, whereas in the 1980s the rate increased to 50%. Furthermore, the age distribution of KS has changed from elderly (in classic form) to the late thirties (in epidemic form). KS is a rare tumour in Nordic countries; the incidence is 0.1–0.2/100,000 according to the Cancer Incidence in Five Continents (CI5) report (3). According to this source, the rate in many Asian countries is < 0.5/100,000, whereas African American men have a rate of 6.2/100,000. The highest rate is in men from Zimbabwe (52.2/100,000) (3).

Human herpesvirus 8 (HHV-8) is the recognised cause of all forms of KS (2). There is discrepancy between the prevalence of HHV-8 and KS incidence in some populations suggesting underreporting of KS or the existence of some unknown protective factors for KS (1). Migrant studies provide data on international differences in cancer rates (4). Furthermore, studies on immigrants may provide supplementary and confirmatory data on the incidence of cancer in countries without local cancer registries. A few available studies on immigrants have focused only on classic KS (5, 6). In the present study, we report mean age at diagnosis and KS rates by site in first-generation immigrants to Sweden.

RESULTS AND DISCUSSION

The Swedish Family-Cancer Database included 552 cases of KS in Swedes and 119 cases in immigrants (Table I). Immigrants were diagnosed at an earlier age (47.5 years) than Swedes (65.6); Eastern Europeans showed a high diagnostic age (60.1). All immigrant groups had increased risks of KS compared to Swedes. Africans (SIR = 9.64) and Latin Americans (5.69) had the highest significant risk. Eastern Europeans (4.32), Africans (15.5), and Middle Easterners (3.73) had an increased KS risk in lower limbs, while the increased risk in upper limbs were observed only among Africans (18.46). Finns (4.44) and Middle Easterners (5.31) had an increased KS risk in face and genitalia; the SIR of 7.94 for Africans was of borderline significance (2 cases).

It is known that all KS forms can involve lower limbs, whereas upper limbs are observed more specifically in endemic form. Children and middle-aged men in Africa are risk groups for the endemic form (2). Our data showed a high KS risk in upper limbs among Africans diagnosed at an mean age of 32 years. Furthermore, we observed a mean age of 50–54 years at diagnosis among Finns and
Table I. Mean age at diagnosis and standardised incidence ratios (SIRs a) for Kaposi sarcoma among immigrants to Sweden by site

<table>
<thead>
<tr>
<th>Birth region</th>
<th>Lower limbs</th>
<th>Upper limbs</th>
<th>Face and genitalia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean age (SD)</td>
<td>SIR (95% CI)</td>
<td>Mean age (SD)</td>
</tr>
<tr>
<td>Birth region</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finland</td>
<td>60.1 (15.0)</td>
<td>2.90 (1.69–4.64)</td>
<td>55.9 (18.2)</td>
</tr>
<tr>
<td>Norway and Denmark</td>
<td>45.7 (17.0)</td>
<td>1.67 (0.84–3.35)</td>
<td>49.9 (15.3)</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>57.5 (15.3)</td>
<td>2.20 (1.56–3.00)</td>
<td>54.7 (17.0)</td>
</tr>
<tr>
<td>Other Europe</td>
<td>54.7 (15.0)</td>
<td>2.20 (1.56–3.00)</td>
<td>52.5 (17.0)</td>
</tr>
<tr>
<td>Middle East</td>
<td>59.7 (15.0)</td>
<td>2.20 (1.56–3.00)</td>
<td>57.5 (15.0)</td>
</tr>
<tr>
<td>Latin America</td>
<td>55.7 (15.0)</td>
<td>2.20 (1.56–3.00)</td>
<td>53.3 (15.3)</td>
</tr>
<tr>
<td>Other immigrants</td>
<td>50.2 (15.0)</td>
<td>2.20 (1.56–3.00)</td>
<td>51.1 (15.4)</td>
</tr>
<tr>
<td>All immigrants</td>
<td>51.5 (15.0)</td>
<td>2.20 (1.56–3.00)</td>
<td>51.1 (15.4)</td>
</tr>
</tbody>
</table>

The ratios were adjusted for age (5-year bands), sex, period (10-year bands from 1958 to 2008), and region (large cities, northern, Southern, and other Swedish regions). Bold type: 95% confidence interval (CI).

Middle Easterners, respectively for KS in face and genitalia. Whether high-risk populations from those countries immigrated to Sweden is an unproven possibility. Furthermore, involvement of face and genitalia are more common in the epidemic form, which is usually observed in the thirties (1). Hence, further studies are warranted to investigate the differences on age at diagnosis of KS by site among different populations.

Our novel findings originated from a nationwide data having information on the birth country, the date of immigration, and the site of KS for all subjects. We found that immigrants had a higher risk than Swedes. An increased KS risk in lower limbs among Eastern Europeans, Africans, and Middle Easterners, in upper limbs among Africans, and in face and genitalia among Finns and Middle Easterners was observed. The overall observed difference in KS risk is in line with that cited in the C5 report (3). We found that Finns, Norwegians, and Danes had an higher KS risk than Swedes, while a study on KS in the Nordic countries before the AIDS epidemic (1980) reported a higher KS rate among Swedes than among other Nordics (10). Whether the risk difference in the Nordic countries were due to the geographical distribution of HHV-8 remains unanswered because most immigrants entered Sweden decades ago (11). Recent serological analyses from Finland showed that the HHV-8 infection is rare in Finland and it may be lower than the infection rate in Sweden (12). A contributing factor to the high KS rates in Nordic immigrants may be their mobile lifestyle which includes frequent visits to the country of origin. Our study most likely shows that the incidence in KS in immigrants may differ from the rate in the country of origin.

ACKNOWLEDGEMENT
This study was supported by Deutsche Krebshilfe, the Swedish Council for Working Life and Social Research, EU FP7/2007-2013 grant 260715 and NCI grant CA054174.

REFERENCES