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Case Report

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Disseminated Cutaneous Malignancy - A Very Rare Presentation

Surabhi Gupta[1*], Neha Sharma[1], Harendra Kumar[2]

[1]Department of Radiotherapy, Sarojini Naidu Medical College and Hospital, Agra, India

[2]Department of Pathology, Sarojini Naidu Medical College and Hospital, Agra, India

[*]**Corresponding author:** Surabhi Gupta, Associate Professor, Department of Radiotherapy, Sarojini Naidu Medical College and Hospital, Agra, India. Tel: +919760025076; Email: mttsurabhi@rediffmail.com

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Abstract

In India, skin cancers constitute about 1-2% of all diagnosed cancers. Basal cell carcinoma of skin is the commonest form of skin cancer worldwide, but various studies from India have consistently reported squamous cell carcinoma of skin as the most prevalent skin malignancy. Various cancer registries in India have reported cumulative incidence of skin cancer varying from 0.5 to 2 per 100,000 populations. Squamous cell carcinoma of skin shows tendency of metastasis mainly in form of in transit metastasis. But distant metastasis, including distal nodal involvement or metastasis to systemic organs is the most feared complication of cutaneous squamous cell carcinoma. Cutaneous metastasis of squamous cell carcinoma of skin is an exceptionally rare finding. We present a case of skin malignancy showing a very rare presentation in the form of distant cutaneous metastasis.

Keywords: Squamous Cell Carcinoma, Cutaneous Metastasis, Skin Cancer

Introduction

Squamous cell carcinoma is the second most common skin cancer, after basal cell carcinoma and its incidence is increasing throughout the world. It is well accepted that cutaneous squamous cell carcinoma arising in previously injured skin (e.g. a burn site, scar, chronic wound or ulcer) have an increased risk of metastasis with a recurrence rate of 58% and an overall five-year survival of 52 % [1]. The most common sites for metastasis are the lung (21%), bone (18%), central nervous system (6%) and liver (4%) [2]. Multiple squamous cell carcinoma of the skin is an exceedingly rare entity. The diagnosis of metastatic cutaneous SCC hinges on the histopathologic evaluation of involved skin. Most patients with primary cutaneous Squamous Cell Carcinoma have an excellent prognosis but Squamous Cell Carcinoma developing as cutaneous metastasis; the long-term prognosis is poor.

Case

We present a case of disseminated cutaneous malignancy in a 46-year-old male who presented to us in Aug 2015 with a painless, non-healing ulcer overlying a warty growth on abdomen persisting for the last 2 years. According to the patient, he developed a non-healing ulcer in his left ankle following thermal burn 4 years back for which he underwent below knee amputation of left lower limb after 2 years of burn. The histopathology report of the amputated limb revealed well differentiated squamous cell carcinoma. (Figure 1)

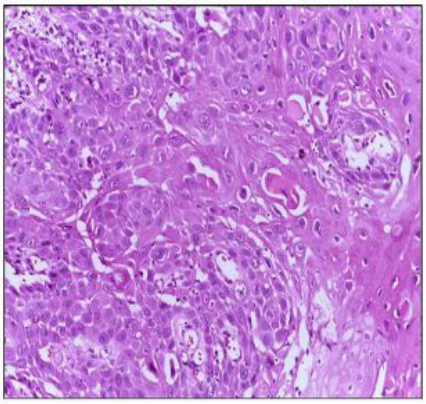

Figure 1: Histopathology from right ankle lesion- revealing well differentiated squamous cell carcinoma.

Following the amputation, he developed non-healing ulcer over the stump and also on right ankle and meanwhile he developed multiple cutaneous lumps all over his body, for which pa-

tient did not receive any treatment. The patient presented to us on 11th Aug 2015 in a very moribund condition (KPS 40) with chief complaints of severe respiratory distress, high grade on and off fever, diffuses body ache and multiple cutaneous lumps (Figure 2). Physical examination revealed multiple non-tender, mobile lumps on multiple sites of the body, i.e. on epigastrium, left hypochondrium, right scapular, right cubital and left clavicular region. Their size varied from 1 cm to 4 cm in diameter. The surface was rough, scaly, margins well defined, raised with few atrophic areas in between and signs of inflammation present over them. (Figure 3)

Figure 2: Cutaneous lump over the abdomen.

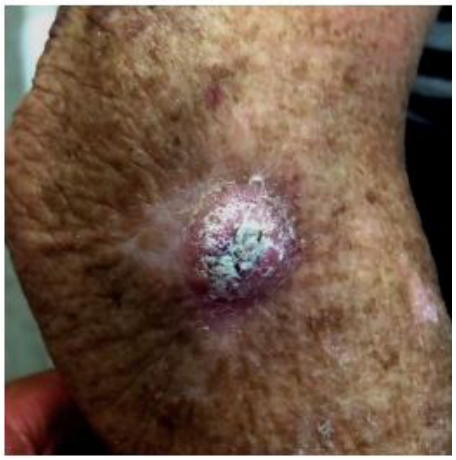

Figure 3: Non-healing ulcer over the right ankle.

FNAC from left hypochondrial lump and left clavicular lump showed smears that were cellular comprising tumor cells arranged in loose clusters & dispersed single and individual tumor having high N:C ratio with hyperchromatic nuclei. Numerous bizarre tumor cells seen features suggestive of metastatic poorly differentiated carcinoma. (Figure 4)

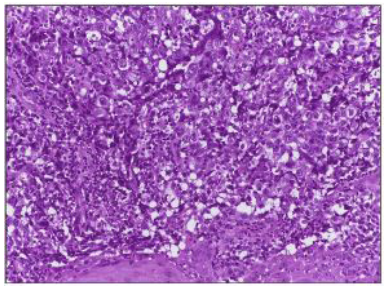

Figure 4: FNAC from the cutaneous lump-metastatic poorly differentiated carcinoma.

On USG Abdomen- sub diaphragmatic hypoechoic deposits were seen likely metastatic deposits and on chest X- ray (PA view) revealed multiple secondaries in bilateral lung fields. (Figure 5)

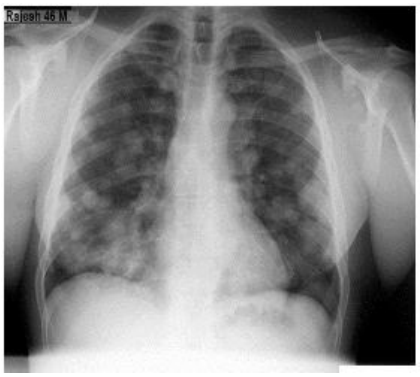

Figure 5: X-Ray Chest (PAview)-multiple secondaries in B/L lung fields.

Blood investigation: Hb--, TLC--, DLC, P.count---, B.Urea---, S.creatinine--, SGOT---, SGPT---. Patient's condition was not suitable for any oncological intervention and was admitted in our department only for conservative treatment and after 3 days patient expired due to cardiopulmonary arrest.

Discussion

Cutaneous squamous cell carcinoma is the second leading cause of death after melanoma. It usually occurs in the sun exposed areas of the skin, i.e head, neck and arms but can also develop in trunk and buttocks. Cutaneous squamous cell carcinoma has been reported in immunodeficient persons particularly after organ transplantation, HIV patients, leukemia and IFN gamma-2 receptor deficient. Apart from this, exposure to oral psoralens, arsenic, coal tar products, UV-A photo-chemotherapy and HPV infection

has been associated with these tumors [3]. Cutaneous squamous cell carcinoma tends to arise in damaged skin for example thermal burns, radiation or chronic inflammation (ulcer) [4].

Cutaneous squamous cell carcinoma usually grows by expansion and infiltration. When the tumour reaches muscle, cartilage or bone, it may spread laterally under normal skin along the fascial or capsular planes, muscles, perichondrium and periosteum. It may also spread along the course of nerve and vessels. Local metastasis occurs primarily via the lymphatic drainage (first superficial then deep lymph nodes). Distant metastasis occurs by haematogenous spread commonly to lung, liver brain, skin or bone. Cutaneous metastasis occurs usually in 0.7-0.9% of all malignancies [5]. In Lookingbill and colleagues' study [6], the most common primary sources of metastatic carcinoma to the skin in males were malignant melanoma (32%), lung (12%), large intestine (11%), carcinoma of the oral cavity (9%), larynx (5.5%) and kidney (5%). In females, breast is by far the most common source (70%), followed by melanoma (12%), ovary (3%), large intestine, lung and oral cavity, each accounting for 1.3% to 2.3% of the cases. In recent years, the incidence of carcinoma of the lung has increased dramatically in females, resulting in a corresponding rise in the incidence of cutaneous metastatic lung carcinoma deposits in females [7]. Other carcinomas that metastasize to the skin include thyroid, pancreas, liver, gallbladder, urinary bladder, endometrium, prostate and testis. However, these are quite rare [8]. The diagnosis of cutaneous metastasis of squamous cell carcinoma hinges on histopathological evaluation of involved skin. Tumour may show characteristics of underlying tumors or they may have more anaplastic appearance. Squamous cell carcinoma developing in cutaneous metastasis, the prognosis is very poor. In the present case study, the indolent multiple warty lesion was showing the poorly differentiated variant, which as such carries a very poor prognosis, simultaneously patient was having multiple bilateral lung secondaries with very low Oxygen saturation so was not in condition to receive any oncological intervention and was kept only on palliative care.

Conclusion

Although in-transit metastasis in cutaneous squamous cell carcinoma is a unique presentation of metastatic Squamous Cell Carcinoma and till date only one case is reported in English literature. It is associated with poor prognosis. Disseminated cutaneous metastasis is an unusual presentation and its management is still undefined.

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