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Cutaneous metastases in a patient with adenocarcinoma of the stomach

Sir,

Cutaneous metastasis is a rare manifestation of advanced malignancy which represents 2% of all skin neoplasms.[1] Among males, commonly it is seen from melanoma and carcinoma of colorectum and lung and in females from breast and colorectal carcinoma and melanoma. It can be either an early sign of an underlying malignancy or a late sign of recurrence. Cutaneous metastasis is rare in cases of gastric cancer with the reported incidence being <5%.[2] Here, we report a case of advanced gastric malignancy with cutaneous metastasis to the nape of the neck, which is an extremely rare site.

Case Presentation

A 31-year-old man presented with dysphagia and vomiting, weight loss for the past three months. The routine hematology and biochemistry investigations were normal. Upper gastrointestinal endoscopy was done which revealed an ulcerated lesion in the antrum of the stomach. Histopathological examination of the lesion showed signet ring adenocarcinoma. Metastatic work up with contrast enhanced computerized tomographic scan of chest and abdomen showed primary stomach lesion with no other sites of metastasis. Pre-operative staging laparoscopy was done and it revealed omental deposits indicating metastatic inoperable disease. He was started on palliative systemic chemotherapy. After six cycles of chemotherapy, the patient was found to have a progressive painless, non-pruritic lesion, at the back of the neck. Examination revealed well-circumscribed exophytic growth of diameter 3.5 cm on the lower part of nape of neck the C7 vertebra. The growth had an erythematous fleshy color with a cauliflower-like proliferative central part and a smooth peripheral part [Figure 1]. On palpation, it was firm to hard and nontender.

Figure 1: Exophytic growth was noted on upper back with erythematous fleshy color and proliferative central part with smooth peripheral part.

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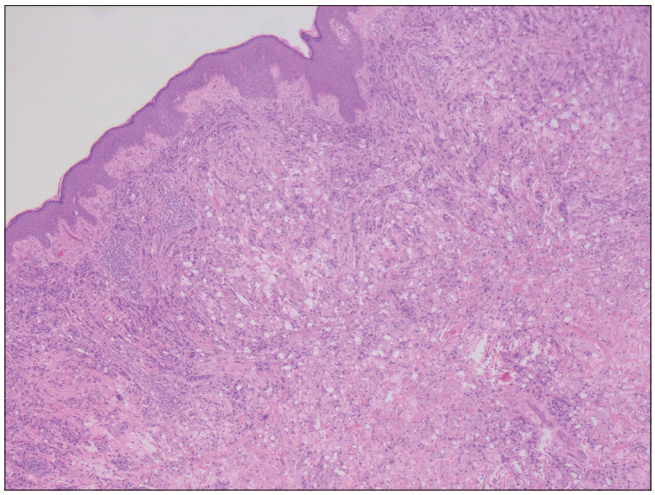

Figure 2a: HPE of exophytic growth showing acanthosis, elongated rete ridges and dermis infiltrated with numerous tumour cells in clusters or scattered singly (hematoxylin and eosin stain x100)

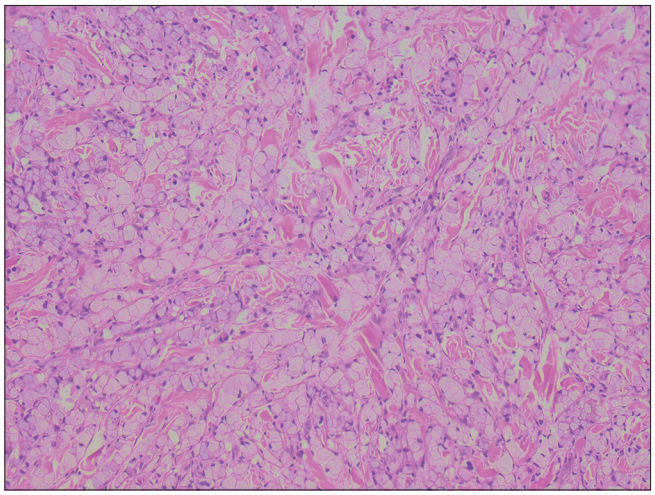

Figure 2b: The tumour cells have abundant cytoplasm and eccentric nuclei and hence called as signet ring cells. (hematoxylin & eosin stain x200)

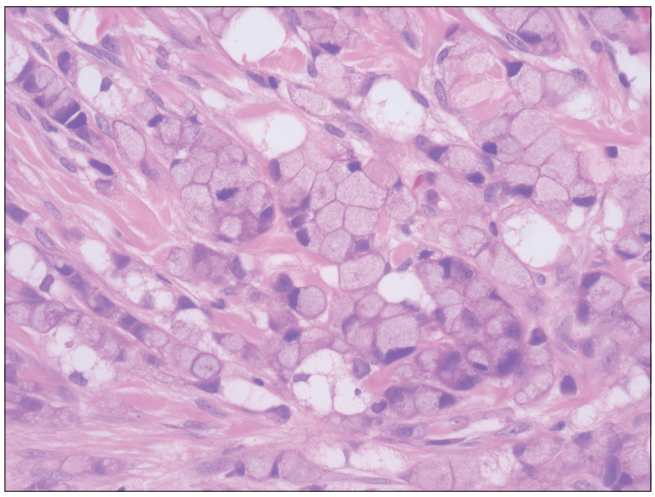

Figure 2c: Further maginification was used to highlight mucin in the cytoplasm of tumour cells. (hematoxylin and eosin stain x400)

Incisional biopsy from the skin lesion showed that dermis was infiltrated with tumor cells. Special stain with mucicarmine highlighted the mucin in the cytoplasm of the tumor cells. Histopathological examination of the lesion was consistent with metastatic signet ring adenocarcinoma [Figures 2a-c].

Repeat contrast enhanced computerized tomographic scan of chest and abdomen revealed the presence of disease in the omentum as well as liver. At present, second line chemotherapy with weekly paclitaxel is being planned for the patient.

Discussion

Skin is an uncommon site of metastasis from the visceral organs with a reported incidence of 0.7–10%.[3] Most commonly, metastasesarise from melanoma and cancers of breast, colorectum and lung. Of all the skin metastases, origin from gastric cancer ranges from 6% in males to 1% in females.

The common sites of metastase from gastric cancer are liver, regional lymph nodes and peritoneal cavity, with skin being a less reported site. The most common site of skin metastasis is the abdominal wall where it is known as Sister Mary Joseph nodule, with less reported sites being scalp, eyelids, fingertips, neck and trunk.[4] They usually present as erythematous or violaceous lesions which are most commonly painless nodules.[4] Less reported types are erysipelas or cellulitis like lesions, lesions with zosteriform pattern, scarred lesions, plaques, epidermoid cyst, wart- like lesions and even non-specific dermatitis.[2] Our patient had a unique patterned cauliflower- like proliferative central part which was surrounded by a smooth erythematous ring. Even after extensive literature search, we could not find a similar presentation of cutaneous metastasis. Skin biopsy and a proper Histopathological examination will show the characteristic presence of malignant cells which can be confirmed with immunohistochemical studies or with special stains. Prognosis of cancer patients with skin metastases is usually dismal.[5]

Skin metastass from gastric cancer is rare but possible. Proper clinical examination and a high level of suspicion followed by a thorough histopathological examination are required to diagnose these lesions. Early diagnosis can lead to timely intervention which may help in improving the quality of life of the patient.

Acknowledgment

Patient's consent was taken before usage of his clinical picture.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent.

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Conflicts of interest
There are no conflicts of interest.

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Langerhans cell histiocytosis presenting as blueberry muffin baby with associated mediastinal mass

Sir,

Langerhans cell histiocytosis (LCH) is an abnormal growth of immature dendritic antigen presenting cells positive for S100 and CD1a on immunostaining and characterized by Birbeck granules on electron microscopy. It is one of the rare causes presenting as blueberry muffin baby, which is characterized by purple, erythematous macular, or papulonodular lesions reflecting dermal hematopoiesis.[1]

A term newborn, delivered through caesarean section, was referred to the department of dermatology at Geetanjali Medical College, Udaipur, with multiple red-brown papulonodular lesions of varying sizes over the face, trunk, and extremities [Figure 1]. General condition of the neonate was well, with birth weight of 2.6 kgs and Apgar score of nine at one minute. The antenatal records revealed a mediastinal mass on fetal ultrasound of mother at 28 weeks of gestation. The baby was delivered through caesarean section anticipating the respiratory distress at the time of parturition due to mediastinal mass. The intranatal and postnatal period was uneventful without any complications. Antenatal records of mother were non-reactive for human immunodeficiency virus (HIV) and *Toxoplasma gondii*, other agents, rubella, cytomegalovirus, and herpes simplex virus (TORCH) infections.

The child was screened negative for birth anomalies, ophthalmic, and auditory defects. Radiological and

Figure 1: Multiple red-brown papulonodular lesions on the face, trunk, and extremities

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