SHORT COMMUNICATIONS

SECONDARY CUTANEOUS CARCINOMATOSIS

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Secondary cutaneous carcinomatosis may be the primary menifestation of malignancies. Due to the help of modern investigative techniques primary malignant sites can be detected. But in many circumstances the primary site can not be detected in spite of available investigation. The cases presented here clearly show that the secondary cutaneous menifestation may be the first clue for detecting a hidden primary maligmancy.

Key Word : Secondary cutaneous carcinomatosis

Introduction

Secondary metastasis from internal malignancies may accur in the skin. Many a times the secondary metastasis in the skin gives a clue for a primary site. However, the primary site may not be detected for a long time in spite of repeated sophisticated investigative procedures. The primary carcinomas which metastasize in the skin are breast, liver, prostate, gastro-intestinal tract and melanomas.[1] The route of spread to the skin is either directly through lymphatics or through the blood stream. The secondary lesions are usually asymptomatic and painless. Rarely, cutaneous menifestations are the first menifestations.

Case 1

A 55-year-old male presented with the complaints of chest pain, backache, general debility and multiple swellings on the back of the left side of the chest, and swelling in the front of the chest wall (Fig. 1), loss of appetite and difficulty in swallowing.

Swellings were hard, margin was irregular, non-tender, fixed to the skin, and there was no local rise of temparature. Cardiovascular, respiratory and abdominal examinations were normal. The patient was anaemic, ESR was 150 mm in first hour and other investigations like total count, differential count, blood sugar, alkaline phosphatase, total protein and other blood biochemistry were normal. Skiagram chest, ultrasound abdomen were also within normal limit.

Fine needle aspiration (FNAC) from the swelling of the left side of the back of the chest wall showed blood stained necrotic material with groups of malignant cells with abandant cytoplasm with large vasicular nuclei having 1-2 nuclei suggesting anaplastic carcinoma. FNAC from the hard nodules from the front of the chest wall showed groups of malignant cells.

Case 2

A 50-year-old male presented with the complaints of chest pain, multiple swellings in the chest wall and swelling of the neck for past one month.

The swellings were nodular, dark-coloured, covering the chest wall on both sides, size was 0.5 to 1 cm rounded and oval. Nodules were immobile and adherent to the

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overlying skin, firm in consistancy, painless and non-tender. There was enlargement of the neck glands on the right side of short duration. They were multiple, mobile, pain-less, firm, about 2 to 3 cm in diamater. Left sided neck glands were also enlarged, 1 cm in diameter, firm but fixed. Axillary and inguinal glands were enlarged, firm, painless and mobile. The patient was anaemic but clubbing and cyanosis were absent.

Liver was enlarged, non-tender, firm and nodular. The spleen was not palpable. Cardiovascular, nervous and respiratory systems were normal. ESR was 100 mm in first hour. Other blood biochemistry, liver function tests, total protein, skiagram chest were within normal limits.

Cervical lymph node and axillary lymph node sections showed fibrocollagenous tissue infiltrated by groups of small anaplastic carcinomatous cells. Section of skin nodule showed fibrocollagenous tissue infiltrated by poorly differentiated carcinoma cells.

Discussion

Secondary metastasis in the skin due to primary lesion elsewhere in the body is not uncommon. During the last few years, cases have been found in the hospital presenting with the cutaneous menifestations. Many a times the primary lesion is difficult to find out in spite of available investigative procedures. It has been observed that when the cutaneous menifestations are sole clinical features, it often misleads the physician.

The breast, liver, prostate, gastrointestinal tract and melanomas are the primary sites from where the spread occurs to the skin. The lymphatics and blood stream are the principle routes of spread. Secondary metastasis develops suddenly as solitary or multiple, firm and discrete nodule and occasionally as infiltrated plaques. In the initial stages they are freely mobile, but subsequently adherent to the skin by reactionary inflammation and ulceration. The nodules are asymptomatic and painlesss.

Metastatic carcinomas of the skin from the primary lesions elsewhere may be occasionally mistaken for a primary tumour of the skin.

In male, carcinoma of the lung, colon, malignant melanoma and the carcinoma of the oral cavity are the common sources of skin infiltration. In female, breast, colon and lung are the important causes of skin metastasis. Apart from carcinomas skin infiltration may also occur in case of lymphomas (lymphoma cutis) and leukaemias (leukaemia cutis).

Acknowledgement

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Reference

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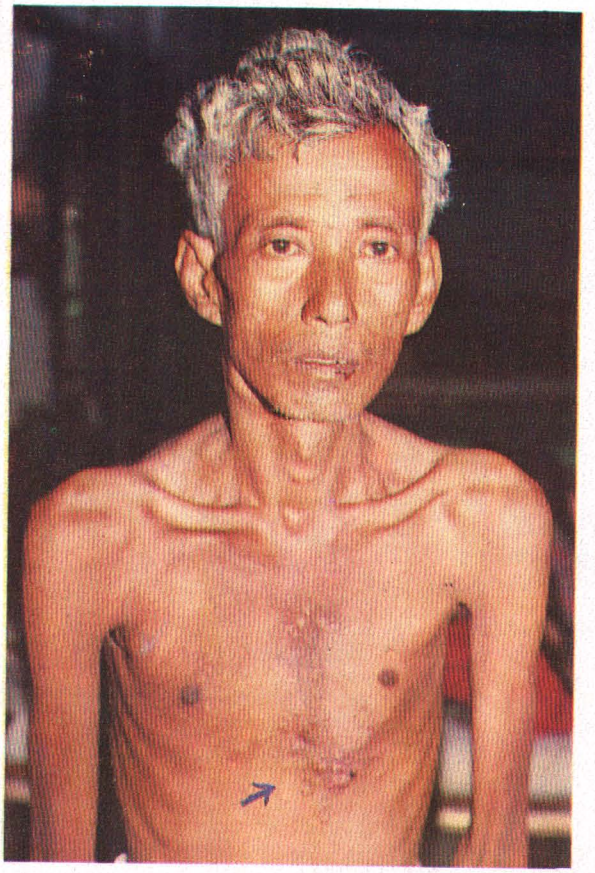

FIG. I

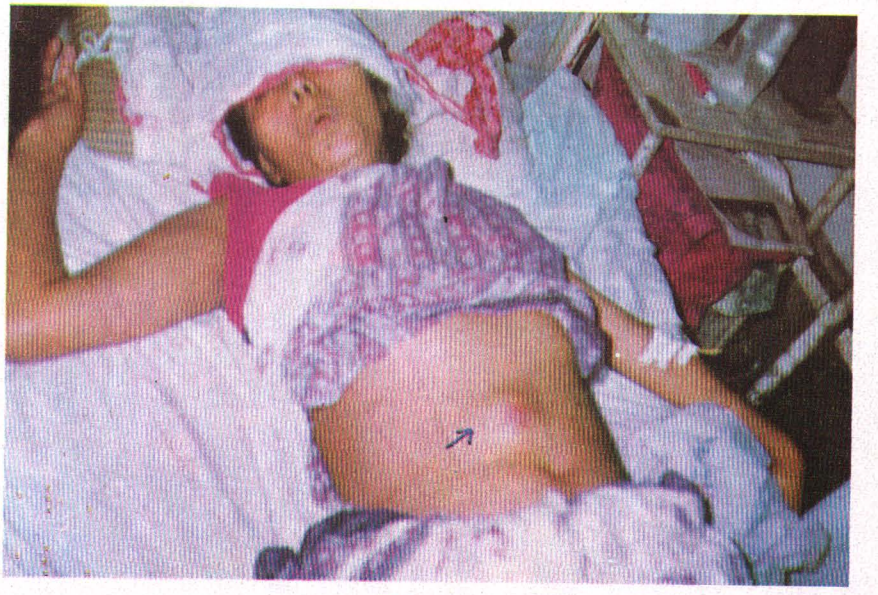

FIG. II