The Gulf Journal of Oncology

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Genitourinary & Gynecological Cancer
Kuwait Conference

GUG-KC
RECENT UPDATES
14-16 April 2018
State of Kuwait

The Official Journal of the Gulf Federation For Cancer Control
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Case Report

Cutaneous Metastasis of Sigmoid Adenocarcinoma to Face and Scalp at Initial Diagnosis: Case Report

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Abstract

Cutaneous metastases from colorectal cancer are very rare. They appear in less than 0.5% of colorectal metastatic cases at time of initial diagnosis. They indicate disseminated disease and poor prognosis. We describe a case of a 54 years old patient who presented with scalp, face and upper back cutaneous metastatic lesions derived from sigmoid cancer, 9 months prior to his initial diagnosis.

Final diagnosis of cutaneous metastasis of sigmoid carcinoma was made based on fine needle aspiration cytology. An index of suspicion should be maintained with a low threshold for biopsy for any cutaneous nodule in patient with malignancy.

Keywords: scalp metastases, face metastases, sigmoid cancer, adenocarcinoma, cutaneous metastases

Introduction

Skin metastases from visceral cancers are rare and the reported incidence from all visceral cancers is 1.4% to 10%. Skin metastases from colorectal cancers account for only 5% of metastatic skin cancers, among which scalp metastases are very rare (2). Only 0.5% of colorectal patients present with cutaneous metastasis at the time of their initial diagnosis (1). We describe a case of a 54 years old male diagnosed with metastatic sigmoid cancer with synchronous cutaneous nodules in scalp, face and back which were found to be metastatic adenocarcinoma of sigmoid origin. To our knowledge this is the only case reported about cutaneous metastasis to scalp and face of colorectal origin 9 months prior to initial diagnosis.

Case Report

A 54 years old male previously healthy presented in October 2015 with history of weight loss, abdominal pain and constipation. Colonoscopy was done showed ulcers of the ascending colon with histopathology suggestive of poorly differentiated adenocarcinoma of the sigmoid. CT scan showed multiple liver lesions, peritoneal nodules and suspicious bony lesions. During initial assessment for starting him on palliative chemotherapy and on physical examination we found multiple cutaneous nodules on face, scalp and upper back which were noticed by the patient 9 months prior to his initial presentation. There was a 9x7 cm lump of firm texture and smooth surface in the upper back which was evaluated earlier and diagnosed as lipoma based on clinical assessment only in addition to multiple ulcerated facial skin lesions and scalp nodules that were noticed by the patient also prior to initial diagnosis. FNAC of back lesions came suggestive of metastatic adenocarcinoma of colon origin. Patient received radiation for two of the back lumps and on two of the scalp nodules which regressed in size after radiotherapy. Palliative systemic chemotherapy with targeted therapy was initiated in November 2015. Facial cutaneous lesions showed an initial response, but ultimately disease progressed in March 2016 (4 months progression free survival) in terms of ascites and pleural effusion. Further, new lower back cutaneous lesions developed which were treated by hemostatic dose of radiation due to active bleeding. The patient died in April 2016 on best supportive care. To our knowledge this is the 1st case report about scalp, face and upper back cutaneous metastases 9 months prior the initial primary colon cancer diagnosis.

Discussion

Cutaneous metastasis in colorectal cancer patients are rare. They can be seen during the clinical course of the disease as late presentation or as a form of disease recurrence many years after initial diagnosis. Skin involvement can be seen in about 5% of patients with colorectal cancer while scalp lesions are quite rare (5).
Rendi and Damian (2003) found that cutaneous metastatic involvement was the first sign of the previously non evident malignancy in only 0.8% of all cancer patients (10). Therefore, cutaneous metastasis is rarely a sign of initial presentation of malignancy and often serves as an indicator of widespread metastatic disease with poor prognosis (1).

Cutaneous metastasis before initial diagnosis was noticed more in renal and lung cancers. In colorectal cancer cutaneous involvement at the time of diagnosis was present in 0.5% of patients while 3 patients (0.4%) were diagnosed because of cutaneous metastases[11]. One patient presented with inflammatory abscesses of the perineum. In the second patient a metastatic nodule on the scrotum was found 5 months before the primary tumor. A third patient presented with nodules on his chest wall, abdomen, and back (9).

Two cases of rectal cancer with simultaneous scalp metastases at time of diagnosis have been reported and one of them occurred 4 months after diagnosis (5). Another unusual case was reported in which a primary colorectal adenocarcinoma metastasized to the face. This cutaneous lesion occurred 4 years after diagnosis of the primary tumor (11). Our case is the 1st patient reported in the literature with a cutaneous metastasis in face, scalp and back 9 months prior to initial diagnosis of metastatic sigmoid carcinoma.

Colorectal metastatic lesions were most often located in the skin of the abdominal or perineal regions and usually appeared after recognition of the primary tumor (7). Some are reported at different sites through the body such as extremities, head and neck, genitalia and scars from surgery (12). Surgery scars and abdominal skin are the most frequent sites while cervical and thoracic skin metastases are less frequent (12).

Cutaneous metastases may occur due to continuity through the peritoneal cavity or by the interconnected routes of the lymphatic and hematologic systems. The iatrogenic implantation during the surgical primary tumor resection is rare, but considered in literature (9). With the current knowledge on molecular biology, there is not only the possibility of passive dissemination pathway as tumor embolization, but also an easier way through the processes of angiogenesis and angiolymphatic growth factors that help to increase the total surface of blood vessels for tumor cell invasion (3).

Cutaneous metastases are mostly small nodules that resemble epidermal cysts, keratoacanthomas, or pyogenic granulomas. Ulceration occurs in approximately 10% of nodules to the skin (6). Our patient had lipoma like lump in his upper back which was causing him discomfort. Scalp lesions appeared like sebaceous cysts with mild erythema while face lesions were purplish and some of them were ulcerated.

Colorectal metastases usually occur within the first 3 years of follow up, and the median survival of patients after the appearance of cutaneous metastatic lesions is 18 to 20 months (6). Our patient died 15 months after the appearance of cutaneous lesions. Although local lymph nodes, liver, and lungs are the common and initial sites spread from colorectal carcinomas but distant site metastasis without symptoms of colorectal malignancy is unlikely but possible (6). Such vigilance may lead to early diagnosis of an underlying malignancy, which may lead to early intervention and better prognostication (6).

Considering the short estimated survival and probable poor general condition, a surgical biopsy may not be logical for these patients. FNA cytology is an accurate method for diagnosis of skin metastasis in a patient with a known malignancy. Geramizadeh and colleagues reported 25 cases of skin metastasis with no false positive or false negative for FNA results (12, 13).

Treatment almost exclusively is aimed at improving the patient’s quality of life. Given the poor mean survival time, excision and removal of metastases may be warranted to enhance the patient’s quality of life minimizing social embarrassment (4). Simple excision is usually the treatment of choice. Wound care for ulcerated lesions should also be provided because of the risk of infection (4). Our patient received radiation to some of the lesions while other lesions showed partial response to chemotherapy despite of later disease progression and deterioration of general condition.

**Conclusion**

Skin metastasis in colorectal cancer, although rare, is a devastating sign (13). It predicts the systemic compromise of the tumor with multiple metastases and poor prognosis with short estimated survival rate (6). Therefore, atypical or persistent nodular lesions in patients with a history of systemic malignancy should be considered for biopsy to rule out metastasis (4).
References


