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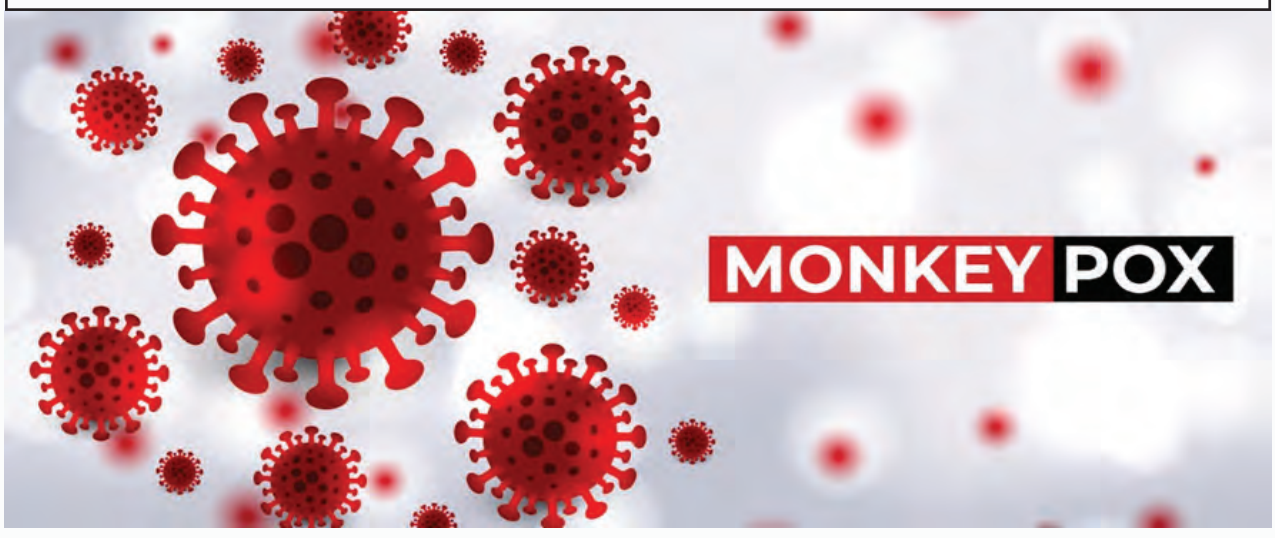


The International Tobacco Control Conference on

The Scourge of Smoking and Conflicts of Interest

October 27-28, 2024

STATE OF KUWAIT



The Official Journal of the Gulf Federation For Cancer Control

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Case report

Synchronous Cutaneous and Brain Metastasis in a Treated Case of Squamous Carcinoma of Left Lower Alveolus: A rare Case report

Prarabdh Singh, Sambit S Nanda, Ashutosh Mukherji

Department of Radiation Oncology, Mahamana Pandit Madanmohan Malviya cancer center /Homi Bhabha cancer hospital, Tata Memorial centre, Varanasi, India

Abstract:

Skin and brain metastasis in head and neck carcinoma (SCC) is extremely rare and contribute to less than 5% of cases. Cutaneous metastases of head and neck cancer usually manifests as papulonodular lesions and brain metastases presents with features of raised intracranial tension. We present a case report of 49–year male diagnosed with synchronous cutaneous and brain metastasis. Intent is usually palliative & prognosis remains poor in these cases marked by poorer outcomes.

Keywords: Head and neck cancer, Brain metastases, Cutaneous metastases

Introduction:

Head and neck squamous cell carcinomas (HNSCC) are notorious for locoregional recurrences. Areas of common sites of metastasis from a primary in the head and neck region include lung, liver, and bone, with the brain being a rare site of metastasis. We present a case report of head and neck cancer with suspected multiple skin nodules which was a biopsy–proven malignancy that coexisted with synchronous brain metastases.

Case Presentation:

A 49–year–old male presented in our institute who was a chronic tobacco chewer for the past 20 years had complaint of a non–healing ulcer in the right lower jaw for the past two months. On examination ulcer proliferative growth was seen in the left lower alveolus involving lower gingivobuccal and gingivolingual sulcus. After doing a routine workup radiological investigation it was staged as cT4a (because of extensive skin involvement) cN0M0 as per AJCC 8th edition staging. The patient received NACT (including two cycles of paclitaxel and cisplatin) for skin involvement. The patient had a partial response to neoadjuvant chemotherapy. Patient underwent left bite composite resection along with selective node dissection with a PMMC flap. Histopathology report revealed ypT4a ypN0M0.Our patient received adjuvant chemoradiation to a dose of 60Gy/30# @ 2Gray /fraction along with concurrent cisplatin by standard practice and institutional protocol. Post completion of treatment after 1 month patient presented in emergency services with complaints of headache, vertigo, and new skin nodules present over the scalp, chest, and axilla area. MRI brain revealed the presence of Intra–axial enhancing lesions measuring 1.2X1.2cm in the left middle frontal gyrus with associated vasogenic edema along with 6x 3mm calvaria Mets. FNAC done from skin nodules revealed Metastatic squamous cell carcinoma. In our case, patient was symptomatic for brain metastases so received palliative radiation as per institutional protocol followed by palliative chemotherapy which was Metronomic chemotherapy with combination of Erlotinib, celecoxib & methotrexate.

Discussion

The lung remains the most common site for distant metastases in head and neck cancer [1]. Cutaneous malignancies are rare but they have increased prevalence due to longer patient survival with increased effective therapies [2]. The presence of cutaneous metastases is often marked by poorer survival outcomes [3]. The primary site for SCC metastases might vary as per the site of primary involvement [4]. Breast carcinoma is more likely to present with cutaneous metastases while prostate carcinoma is

Corresponding author: Dr. Prarabdh Singh, Senior resident, Department of Radiation Oncology, MPMMCC/HBCH, Tata Memorial Centre, Varanasi, Contact number: 91–9452268306, Email ID: prarabdh3008@gmail.com

least likely to show them. [5]. With increasing numbers of human papillomavirus (HPV)–mediated head and neck cancers, it is important to address the role of HPV in the progression of metastasis. Literature suggests that HPV–mediated SCCs of this region involve a greater number of sub–sites and metastatic sites. Moreover, metastases occur later after chemotherapy as compared to HPV–negative disease [6]. Irrespective of the origin, cutaneous metastasis has a poor prognosis, hence treatment aims to relieve patients' symptoms and improve their quality of life [7]. Treatment intent remains palliative in this setting. Likewise, outcomes of brain metastases are very dismal with survival outcomes of about 2.3–7.1 months [8]. Primary HNSCCs spread locally and have high rates of locoregional recurrences. Meanwhile, they can metastasize distantly in 10%–30% of cases, more commonly in the lung, liver, and bone, and extremely rarely to the brain [9]. The overall incidence of intracranial metastases is only about 0.4% overall, and 2–8% for those patients who already have distant spread to the lungs or other extracranial sites [10]. BM secondary to HNSCCs is more likely due to perineural invasion; therefore, any pain, paresis, or paresthesia in the distribution of cranial nerves should raise the alarm for BM in HNSCC patients. MRI can diagnose perineural invasion better than CT scans. BM secondary to HNSCC is difficult to treat, and the overall patient status must be considered before planning treatment. The two possible mechanisms of spread to the brain are a hematogenous and perineural invasion of the tumour with retrograde intracranial deposits. It is postulated that a tumour with perineural invasion leads to intracranial metastasis by seeding the intrafunicular spaces of the nerves which have direct communication with the subarachnoid spaces [11]. Outcomes of both brain and cutaneous metastases are palliative and with a dismal prognosis. In our case study, brain metastases were incidental findings currently there is a paucity of literature reporting both brain and cutaneous metastases.

Conclusion:

Occurrences of cutaneous and brain metastases in head and neck cancer are rare. We report this rare case in which the patient presented with both skin and brain Mets simultaneously with atypical locations including the presence of calvaria and scalp metastases. Moreover, these metastases came in a short span of 1 month which denotes the probability of the presence of occult metastases at the time of diagnosis. Skin lesions were initially mi squandered as a benign skin disease which was later proven malignancy by FNAC which denotes the importance of the latter.

Acknowledgement:

Not appreciable



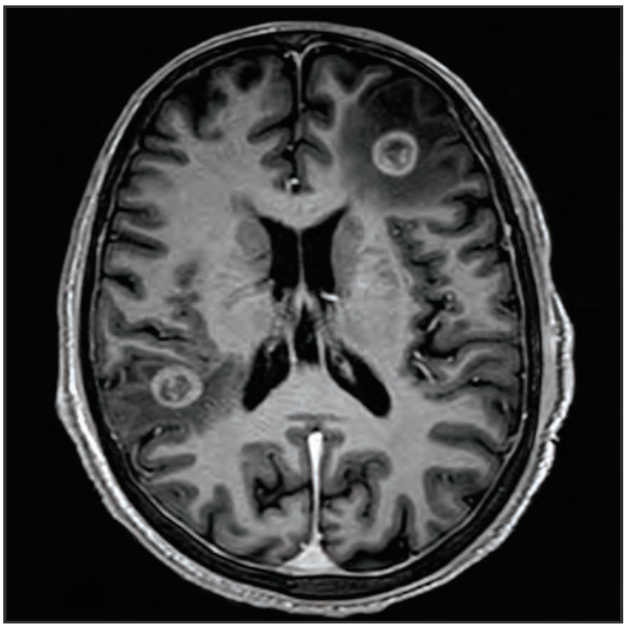
A) Skin nodules present in abdomen



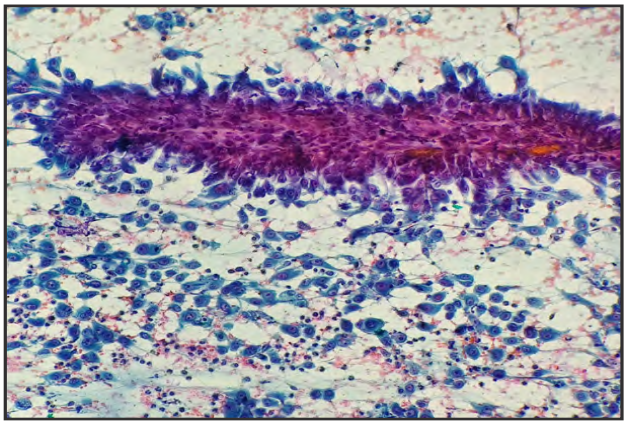
B) Skin nodules present in back



C) Impending ulcerating nodule in scalp



d) MRI (3DFSPGR Axial sequence) showing brain metastasis



E) Cytology from skin nodules showing increased nucleo–cytoplasmic ratio in malignant cells

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Conflict of interests:

The author declares that there is no conflict of interest regarding the publication of this paper.

Ethics statement:

Ethics committee review was not applicable due to the case report design.

Consent:

Written informed consent was obtained from the patient to publish this report by the journal's patient consent policy.

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