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Calcified cutaneous metastatic deposits as an initial manifestation of adenocarcinoma stomach

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Abstract

Skin metastasis is a rare manifestation of internal malignancy. Presence of cutaneous metastasis can be seen in 6.4% of all malignancy at some point in time. Cutaneous metastases as a presentation of upper gastrointestinal malignancy is far less common (<1%). Here we present a case of poorly differentiated adenocarcinoma of the stomach that presented with extensive metastases of skin, liver and the ovaries, bilaterally.

Skin metastasis as an initial manifestation of adenocarcinoma stomach is very rare. That's why this case merits special attention.

Introduction

Presence of cutaneous metastasis can be seen in 6.4% of all malignancy at some point in time [1]. The most common origin of cutaneous metastases is breast cancer in women and lung cancer in men. Whenever the metastasis is from a gastrointestinal primary, the colon is the commonest site followed by stomach, esophagus and small intestine [2]. We are reporting a case where extensive cutaneous metastasis is the presenting feature of an underlying adenocarcinoma of stomach.

Case report

A 42-yrs old, non-diabetic, non-hypertensive housewife presented with nodular eruptions all over the body for the last 3 months associated with generalized weakness, malaise, dyspepsia and anorexia for the same duration. She was amenorrhoeic for the last 2 months. There is no history suggestive of hematemesis, melena, nausea, vomiting, cough, jaundice, night sweats or abdominal pain. On examination she had anaemia, pedal oedema, palpable left sided supraclavicular lymph nodes which was non tender, firm and mobile. Numerous variable-sized skin nodules were present all over the body (face, neck, chest wall, abdominal wall and all four limbs) which were hard and tender; some are erythematous, while others have a purple to black appearance with necrosis and oozing from the tip (Figures 1 and 2). She also had hepatosplenomegaly.

Routine blood test showed anemia (Hb-7.8 gm%). Skin nodule biopsy revealed poorly differentiated metastatic carcinomatous tissue (Figure 3). On abdominal ultrasonography there was low echogenic space occupying lesion (SOL) (measuring 60 mm × 56 mm) at right lobe of liver. Chest X-ray showed cutaneous caicified nodular lesions over the chest wall (Figure 4). Stool for occult blood test was negative. Fine needle aspiration (FNAC) from liver SOL showed scattered atypical cells in a haemorrhagic background, along with few mesothelial cells and benign hepatocytes. FNAC from left cervical lymph nodes revealed reactive lymphoid hyperplasia. CT scan of abdomen showed enlarged liver with well-defined hypodense non-enhancing SOLs measuring 7.45 cm × 5.4 cm and 5.8 cm × 4.7 cm respectively at right lobe with cystic necrotic areas inside. Margins of the SOLs were thick and irregular suggestive of malignant hepatic SOL. Both ovaries were bulky with heterogenous tissue density (Figures 5 and 6). Serum for CA-

Figure 1. Cutaneous nodule over face and chest wall.

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Figure 2. Cutaneous nodule over anterior abdominal wall.

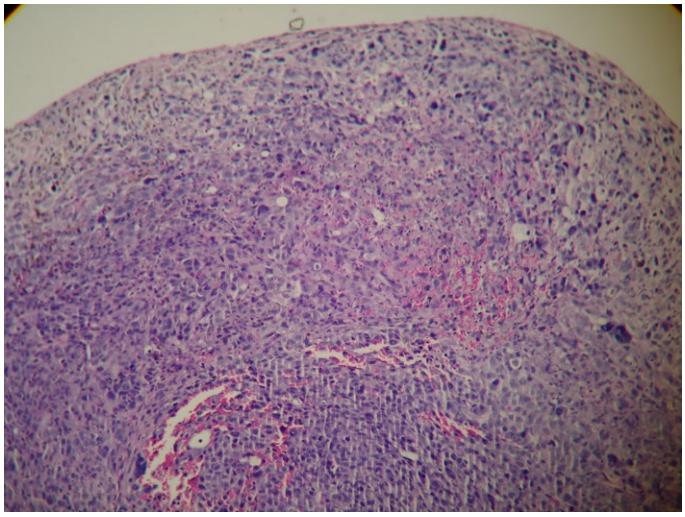

Figure 3. Histopathology of skin nodule showing poorly differentiated metastatic carcinoma.

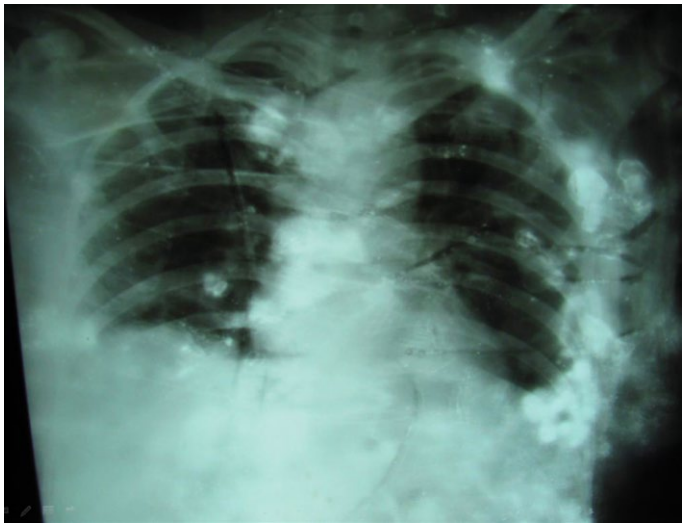

Figure 4. CXR showing multiple calcified cutaneous metastases.

125 and CEA were 65.7 U/ml and 1.82 ng/ml respectively. Her upper gastrointestinal endoscopy showed a large nodular mass on antral area with superficial ulceration. Biopsy from that lesion suggested poorly differentiated adenocarcinoma of stomach (Figure 7). Lower gastrointestinal endoscopy was normal.

On the basis of these reports she was diagnosed as a case of poorly differentiated adenocarcinoma of stomach with extensive calcified skin, liver and bilateral ovarian metastases. Then patient was on chemotherapy but she died after 2 months.

Discussion

Cutaneous metastases may be the first presentation, along with other symptoms, or occur during follow-up. Among the patients with cutaneous metastasis primaries arising from upper GI tract are far less common (less than1%) [3]. Cutaneous metastasis may occur in one of the following ways: (1) direct spread from underlying tumors (2) direct spread through lymphatics, for example, carcinoma en cuirase (3) dissemination through lymphatics (4) dissemination through

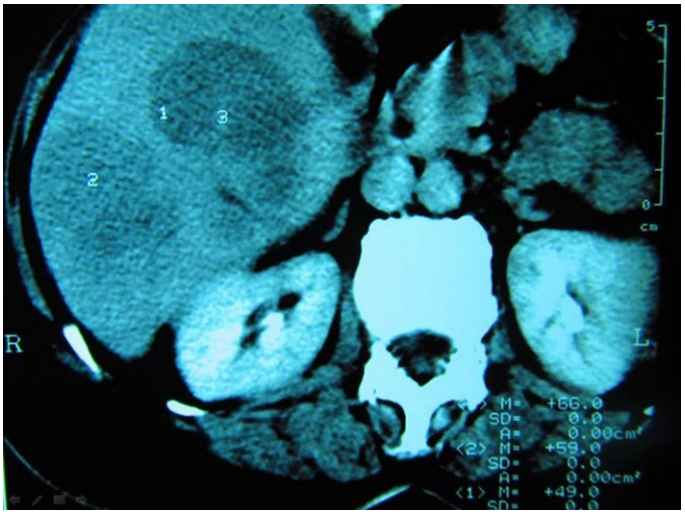

Figure 5. CT scan abdomen showing hepatic metastasis.

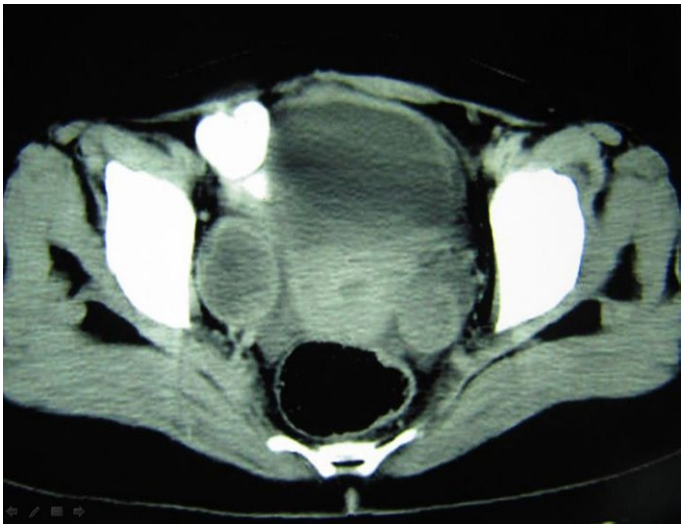

Figure 6. CT scan abdomen showing ovarian metastases bilaterally.

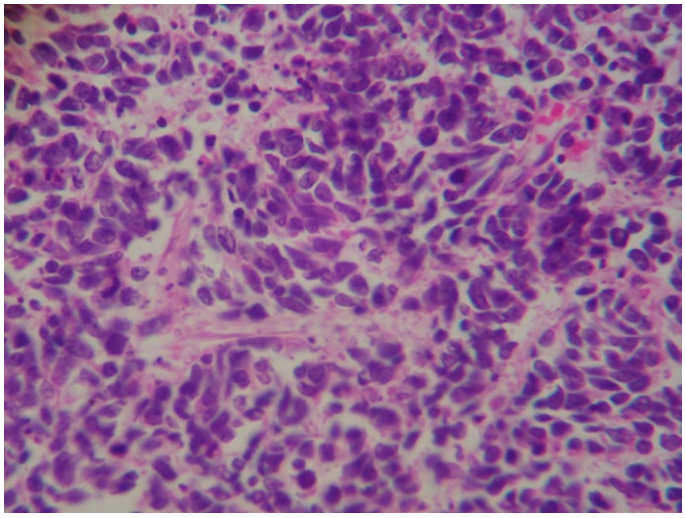

Figure 7. Histopathology of stomach growth showing poorly differentiated adenocarcinoma of stomach.

blood stream [4]. Various patterns of cutaneous involvement have been reported in literature which include, nonspecific painless dermal or subcutaneous nodules which is the commonest presentation, and occasionally inflammatory metastatic carcinoma, scarring alopecia, carcinoma erysipelatoides (ill-defined area of warm, tender, erythematous and edematous skin often reported with carcinoma stomach) [5]. Generalized cutaneous metastasesare relatively rare with gastric adenocarcinoma and occur most commonly on the abdominal wall [6]. In the present case, the patient had skin nodules all over the trunk, face, both upper limbs as well as lower limbs, which is extremely rare. Presence of cutaneous metastasis typically signifies widespread disease with median survival of 3 months, after the detection of metastasis [7]. Therefore, the aim of treatment is palliative in most of the instances. In this case also the patient had short survival.

From the above discussion we can conclude that persisting cutaneous nodules must be biopsied in order to diagnose cutaneous metastases and early recognition of them enables prompt therapy with antitumor agents before the occurrence of massive visceral metastasis.

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