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Carcinoma Cervix with Cutaneous Metastasis: A Case Report

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ABSTRACT

Cutaneous metastasis is an uncommon entity in gynecologic cancer. Though carcinoma cervix is the commonest female malignancy in the developing countries, cutaneous involvement of cervical cancer is particularly unusual, even in the terminal stage of the disease. The incidence of cutaneous metastasis in carcinoma cervix ranges from 0.1% to 2%. Here we present a case of cutaneous metastasis to anterior abdominal wall from carcinoma cervix after 18 months of completion of treatment with chemoradiation. She was treated with six cycles of chemotherapy with paclitaxel and carboplatin, followed by external beam radiotherapy to cutaneous presentation area. This case is reported due to its rarity and for documentation.

KEY WORDS- *Carcinoma cervix, cutaneous metastasis, squmous cell carcinoma.*

INTRODUCTION

Carcinoma of cervix is the commonest female genital malignancy in developing countries. Early detection and improved treatment technique have resulted in better tumor control and improved survival. The occurrence of metastatic disease is still a rarity. Cervical cancer spread through direct local and lymphatic pathway[1]. But hematogenous metastasis is relatively rare i.e. to lung, bone and liver[2,3,]. A review of literature of this relatively

rare metastasis shows that, the incidence of cutaneous metastasis from carcinoma cervix range from 0.1% to 2%[4].The most common sites of cutaneous metastasis in carcinoma of cervix in decreasing order are anterior abdominal wall, vulva, anterior chest wall[5].The presence of cutaneous metastasis may be at the time of diagnosis or thereafter.

Here we present a case of carcinoma cervix stage IIB who on follow up presented with an anterior abdominal wall cutaneous metastasis, 18 months after completion of concurrent chemoradiation due to its rarity and needs documentation.

CASE REPORT

52 year old postmenopausal woman clinically presented with history of postmenopausal bleeding and foul smelling watery vaginal discharge of three months duration. Routine gynecological examination revealed a 4cmx4cm exophytic lesion replaces the whole of the cervix to involvement of both parametrium but not up to pelvis. Histopathology of the lesion was moderately differentiated squamous cell carcinoma. Routine hematological parameters were within normal limits. X-ray of chest and ultrasonography of the abdomen and pelvis excluded the possibilities of any metastatic disease. The patient was diagnosed as a case of carcinoma cervix of FIGO stage IIB. Basing upon this information patient was planned for concurrent chemo radiation with 50Gy of external beam radiotherapy in 25 sessions over 5 weeks and weekly cisplatinum 40mg for 5 weeks. High dose rate brachytherapy of 7Gy/# x3 fractions was delivered at weekly interval which was completed in February 2011.Patient had attended complete remission of the disease 3 weeks after completion of treatment. She was on regular follow up without any clinicoradiological disease. On August 2013, she presented with a subcutaneous noduleat the epigastrium. On examination a nodule of size 2x3 cm was palpated deep beneath the upper abdominal wall in the region of epigastrium. Physical examination revealed no evidence of disease anywhere. Fine needle aspiration cytology of the nodule was positive for malignant cells consistent with previous histology of primary disease i.e. Squamous cell carcinoma. She was planned for excision biopsy of the abdominal nodule at that time but was lost for follow up. She presented to Department of Radiation oncology in February 2014 with gradual increase of previous subcutaneous nodule. Clinical examination revealed a subcutaneous nodule present at the epigastrium of size 4x3 cm, which was nontender, mobile and hard in consistency (Figure -1). Punch biopsy of the nodule, was positive for squamous cell carcinoma. Her primary was under control. Her complete hemogram and biochemistry profile were normal. But X-Ray chest P-A view showed pleural effusion. Computed tomography of abdomen and pelvis showed secondary deposit in parietal wall over the rectus muscle (Figure- 2) and left side pleural effusion with nodular pleural deposits. Cytology of pleural fluid was performed which revealed malignant cells. She was successfully treated with 6 cycles of Paclitaxel 175mg/$m^2$and carboplatin dosed to an area under curve of six

(max dose 600mg) on day 2.She received 6 cycles of chemotherapy followed by external beam radiotherapy. Her disease was under control. Evaluation at 6 cycles of chemotherapy revealed complete disappearance disappearance of skin metastasis

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Figure -1 Clinical photograph showing a subcutaneous nodule at the epigastrium.

Figure -2 CECT scan of abdomen showing a cutaneous nodule over the rectus abdominis.

DISCUSSION

Cutaneous metastasis from visceral malignancy is approximately ranges from 0.7 %to 9%[6].A presentation of cutaneous metastasis reminds us the possibilities of primary malignancy of organ like breast, kidney, lung and ovary[7]. But the incidence of cutaneous metastasis in carcinoma cervix is very rare even in late stage of the disease with a reported incidence of 0.1 to 2%.

The most common stage and histopathological pattern reviewed in literatures that produces cutaneous metastasis in cervix is stage IIIB and adenocarcinoma[8].As per Agrawal et al primary squamous cell carcinoma of the cervix was commonest histopathological variety that constitutes 63.8% of cases that produces cutaneous metastasis[9].But the present case had clinical stage IIB with histopathology was of moderately differentiated squamous cell carcinoma.

The site of involvement of cutaneous metastasis may be anterior chest wall, abdominal wall, vulva, but most common site of cutaneous metastasis is abdominal wall which has been observed in our case also.

According to Agrawal et al on analysis of 47 patients of carcinoma cervix with cutaneous metastasis the average time interval between the initial diagnosis and appearance of cutaneous metastasis was 20.7 months. On analysis of stage wise distribution, patient having stage I disease had average interval between diagnosis and appearance of cutaneous metastasis was 37.6 months, in stage II 20.8 months, in stage III 24.9 months and in stage IV 3.4 months[9].In one case the interval between initial diagnosis and appearance of cutaneous metastasis is reported to be 10 years which is largest one till date. However in this case, patient presented with cutaneous

metastasis 18 months after completion of treatment.

The morphological pattern of presentation of cutaneous metastasis varies from nodular, plaquelike, inflammatory and telangiectatic variety. But the present case had nodular type of cutaneous metastasis.

Even though no effective treatment is available till date for this type of presentation, chemotherapy followed by local therapy i.e. surgical resection orexternal beam radiotherapy is considered as the mostsuitable treatment. But our patient had pleural effusion as well as cutaneous metastasis. She was treated with combination of paclitaxel and carboplatin 6 cycles followed by external beam radiotherapy to cutaneous presentation area for which her disease is under control, three months after the completion of the treatment.

CONCLUSION

Cutaneous metastasis in carcinoma cervix is a rare entity. It is the sign of generalized dissemination of the disease and is a reflection of rapidly progressive disease. Hence patients with carcinoma cervix presented with pruritic or non-pruritic nodular or plaque like cutaneous lesion should be given due attention and should undergo biopsy for early diagnosis and early institution of therapy to give a qualitative life to the patient.

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