



SKIN METASTASES FROM LUNG CANCER: A CASE REPORT

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ABSTRACT

This case is about a 65 year old Indian male, who is a smoker and who presented to us with erythematous nodules.

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INTRODUCTION

Lung cancer is one of the most common malignancies which (Rolz Cruz, 2008). Can metastasize in almost all organs, but more frequent sites are hilar nodes, liver, adrenal glands, bones and brain (Goljan, 2006). Metastases from lung cancer may be the first sign of lung cancer and clinically cannot be distinguished from skin metastases originated from other organs (Dreizen, 1986). Clinically, skin metastases occur as painless nodules, firm and usually skin-colored (sometimes red) They may rarely appear in the form of solitary or grouped papules, plaque-like, zosteriform, erysipelas-like or as cicatricial alopecia on the scalp (Estariol, 2006). The occurrence of cutaneous metastases from lung cancer is a poor prognostic indicator (Estariol, 2006).

Coexistence of skin metastases with other extracutaneous metastases decreases the average survival time to approximately three months (Schoenlaub, 2001).

Case Presentation

Sixty five years old Indian male, smoker, presented to our department with eruption of multiple erythematous nodules localized in the head, neck, back and chest since 4 weeks.

The nodules were firm, mildly tender, skin-colored and measured 5-50 millimeters in greatest dimension (Figure 1). Some of the nodules showed ulceration with serosanguinous discharge (Figure 2).

In addition, the patient exhibited signs of weight loss, anorexia and fatigue, but no symptoms related to respiratory system. FNAC was performed to one of the lesions which confirmed metastatic nature of the lesion namely, malignant tumor of lung consistent with adenocarcinoma.

The pattern consisted of grouped malignant cells, large hyperchromatic nuclei, prominent nucleoli with altered N: C ratio with acini formation (Figure 3). Subsequently, chest X-ray (CXR) showed nodular densities in the perihilar zones (Figure 4). Ultrasonography of liver revealed hypoechoic lesions (Figure 5). Computed tomography of chest revealed multiple nodular opacities scattered in bilateral lungs and mediastinal lymphadenopathy. Computed tomography of abdomen revealed multiple necrotic lymphadenopathy in mediastinal, peri pancreatic and paravertebral regions. The patient was referred to oncology department in a tertiary care hospital and was lost to follow up



Figure 1. Clinical picture showing firm, mildly tender, erythematous to skin-colored and measured 5-50 millimeters in greatest dimension

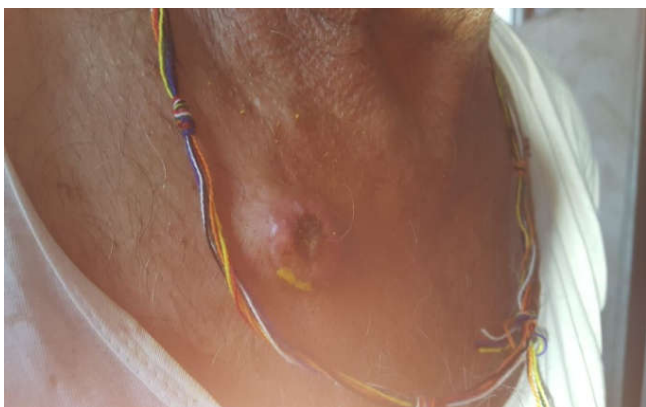


Figure 2. Clinical picture showing ulcerated nodules with serosanguinous Discharge

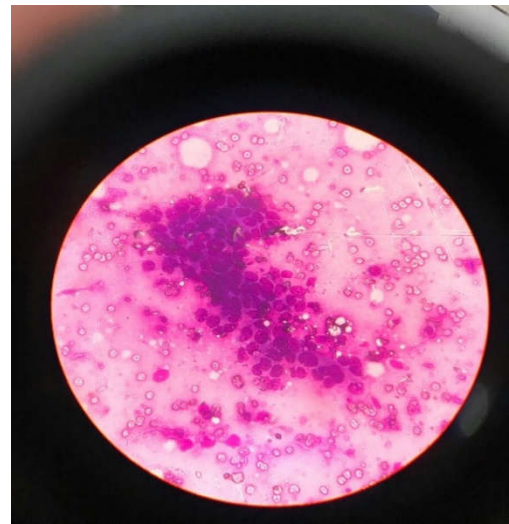


Figure 3. 40X FNAC was performed to one of the lesions which confirmed metastatic nature of the lesion namely, malignant tumor of lung consistent with adenocarcinoma



Figure 4. Chest X-ray showing densities in the perihilar zones



Figure 5. USG showing hypoechoic lesions in liver

REFERENCES

- Rolz Cruz, G., Kim, C.C. 2008. Tumor invasion of the skin. *Dermatol Clin.* 26:89–102. doi: 10.1016/j.det.2007.08.004.
- Goljan, E.F. 2006. Rapid Review Pathology. 2. St. Louis: Mosby; pp. 321–4.
- Dreizen, S., Dhingra, H., Chiuten, D., Umsawasdi, T., Valdivieso, M. 1986. Cutaneous and subcutaneous metastases of lung cancer. *Postgrad Med.*, 80:111–6.
- Estarrinol, M.H., Goday, M.R. 2006. Cutaneous Metastases of Small-Cell Lung Cancer. *N Engl J Med.* 354:2583. doi: 10.1056/NEJMicm031071.
- Schoenlaub, P., Sarraux, A., Groshans, E., Heid, E., Cribier, B. 2001. Survival after cutaneous metastasis: a study of 200 cases. *Ann Dermatol Venereol.* 128(12):1310–5.