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Case Report

An unusual case of multiple head and neck carcinoma with cutaneous metastasis

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ABSTRACT

The clinical presentation of multiple head and neck primary carcinomas is rare and may lead to the wrong diagnosis and treatment. The present case was of a 62 year old male who developed infiltrating squamous cell carcinoma of larynx and got treated with radiotherapy and chemotherapy. Subsequently after 3 years, he developed carcinoma tip of the nose. During work up for the same, there was accidental discovery of tonsillar adenosquamous carcinoma. The patient was treated for laryngeal carcinoma with radiotherapy and chemotherapy. Nasal tip carcinoma was treated with wide local excision with local flap reconstruction. Based upon histopathological examination and positron emission tomography (PET) scan for tonsillar adenosquamous carcinoma, the patient was referred for intensity modulated radiation therapy (IMRT). Patients with head and neck carcinoma should be inspected thoroughly with any history or development of new lesions since prognosis in such patients is very poor. However treatment and management is always palliative and should be individualized to the patient.

Keywords: Cutaneous metastasis, Laryngeal carcinoma, Nasal tip carcinoma, Tonsillar carcinoma

INTRODUCTION

A non-healing new skin lesion in a patient with a history of carcinoma could be a cutaneous metastasis, particularly if it presents in an area of the body overlying the visceral malignancy.[1]

The morphology of cutaneous metastases may vary and lesions may also be found at distant sites. A retrospective review of 4,020 patients with metastatic cancer revealed that 10% of the patients developed cutaneous metastases, the most common malignancies manifesting with cutaneous metastases were breast cancer and melanoma. Squamous cell carcinoma of the tonsil, which represents 10% of head and neck malignancies, may also manifest with cutaneous metastases.[1]

The correct diagnosis is crucial as the uncommon clinical presentation of these cutaneous metastases may lead to the wrong diagnosis and treatment.[2]

CASE REPORT

A 62 year old male patient came to the outpatient department of otorhinolaryngology, Lok Nayak hospital on May 2019 with the chief complaint of ulcer on right posterior palatal region since 2 months. The patient had a history of smoking bidi, 1 bundle (12 bidis) per day since 10 years.

Patient presented with chief complaint of change in voice 3 years back and on examination there was a ulceroproliferative growth involving laryngeal surface of epiglottis obliterating the view of endolarynx. However, vocal cords appeared to be normal. Patient was further evaluated with direct laryngoscopy and biopsy, which

came to infiltrating squamous cell carcinoma grade 2 with clinical staging T3N0M0.

Ultrasound abdomen did not reveal any metastasis. He was treated with IMRT using 4 point head and neck overfit caste with 70 grey dose divided in 35 fractions over 7 weeks along with weekly cisplatin 65 mg was given for a period from 21 January 2016 to 8 March 2016. He tolerated the treatment well with grade 2 skin rash and grade 2 mucositis.

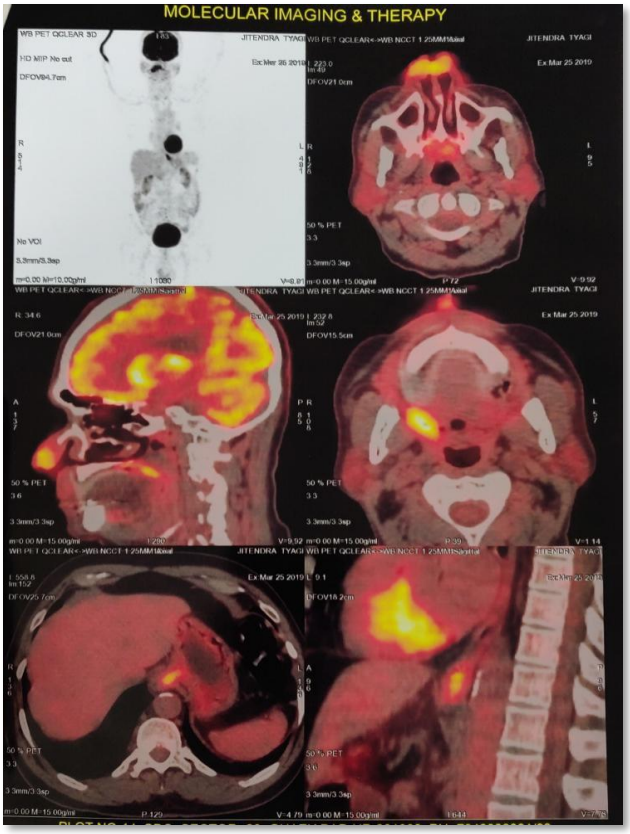

Figure 1: PET scan showing metabolically active, ulcerative soft tissue density lesion involving tip of the nose; increased FDG uptake in right tonsillar fossa can also be seen.

In February 2019 the patient developed a lesion on tip of the nose for which was biopsied and the histopathology revealed a hyperplastic epithelium with infiltration of dysplastic cells in sub epithelium with keratin pearls. There was no vascular or lymphatic invasion. The diagnosis of infiltrating squamous cell carcinoma grade 2 was given.

Further, MRI face was done on 16 March 2019 which showed lobulated mass with altered signal intensity on tip of the nose with involvement of nares, anterior most part of nasal septum which was more neoplastic than inflammatory. Patient underwent PET scan on 25 March 2019 which showed metabolically active, ulcerative soft tissue density lesion involving tip of the nose which was neoplastic. There was increased FDG uptake in right tonsillar fossa (Figure 1). Biopsy from lesion present on the tonsillar fossa was taken at the same time and the diagnosis of adenosquamous carcinoma of tonsil grade 2 was made.

The patient was treated for nasal tip carcinoma with wide local excision with local flap reconstruction under GA. Post surgery histopathological examination of specimen from nasal tip was suggestive of dermal adnexal tumor with focal squamous cell carcinoma of nose.

Figure 2: Intraoral clinical picture of the patient showing ulceroproliferative growth was present over right tonsil extending to right anterior faucial pillar and soft palate.

Figure 3: Patient profile (a) front view; (b) vortex view; (c) right side; (d) left side; surgical scar mark was present over tip of the nose and forehead with no evidence of ulceration.

After 2 months he visited Lok Nayak hospital for further treatment. On examination, ulceroproliferative growth was present over right tonsil extending to right anterior faucial pillar and soft palate (Figure 2).

On indirect laryngoscopic examination, no abnormality was seen. Surgical scar mark was present over tip of the nose and forehead with no evidence of ulceration (Figure 3). No palpable lymph node was present in the neck. Based upon histopathological examination and PET scan, the patient was referred to department of radiotherapy for IMRT.

DISCUSSION

Cutaneous metastases commonly appeared as round, discrete and painless nodules, which can have a firm, rubbery or fixed consistency. They can occur as a single lesion or multiple lesions anywhere on the body but were found predominantly on the anterior trunk or on the head and neck region. The average survival time of patients with cutaneous metastasis was a few months. Cutaneous metastases occured in 0.7 to 9% of all patients with cancer and the most common primary tumors associated with skin metastasis were breast cancer in women and lung cancer in men. Head and neck SCC rarely metastasizes to any areas of the skin. The most common sites were the chest wall (28.4%) and abdomen (20.2%).[3]

Hematogenous metastases to the head and neck region were rare and occured predominantly in late tumor states. Distant metastases to the facial skin and the scalp were even more uncommon and were usually a sign of very advanced disease. Infrequently squamous cell carcinomas of the esophagus cause cutaneous metastases only about one percent of the distant metastases grew in the skin. However, on rare occasions they can be the first sign of a disease. Moreover, they suggested a rapid disease progression and impending generalized metastatic spread.[2]

The differential diagnosis of tumors or non-healing ulcerative growth of the external nose and the nasal vestibule was extensive. It included local infections, benign tumors like fibromas, chondromas, cysts, hemangiomas, rosacea and rhinophyma as well as granulomatous changes occurring in tuberculosis or sarcoidosis. Moreover, malignant lesions of the skin like basal and squamous cell carcinomas as well as lymphomas, chondrosarcomas, carcinomas of the nasal vestibule and on rare occasions distant metastasis to the facial skin need to be considered.[2]

However, literature review pointed to very limited cases of cutaneous metastasis of esophageal and laryngeal carcinoma.[2,4-6] Ours was a unique case in terms of accidental discovery of tonsillar adenocarcinoma grade 2 during workup of cutaneous metastatic lesion of laryngeal carcinoma.

CONCLUSION

Patients with head and neck carcinoma should be inspected thoroughly with any history or development of new lesions since prognosis in such patients is very poor. However treatment and management is always palliative and should be individualized to the patient. It should be noted that prompt diagnosis and treatment may affect the eventual outcome.

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