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ISOLATED CUTANEOUS METASTASIS IN NECK FROM SQUAMOUS CELL CARCINOMA PENIS: A RARE CASE REPORT

Oncology

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ABSTRACT

Carcinoma of penis is very common in developing countries like India. Main route of dissemination is through lymphatic to inguinal and iliac lymph nodes. Haematogenous metastases are very rare although metastases to distant sites such as lung, liver, bone and brain have been reported. But cutaneous metastasis to distant sites is very rare and very few cases have been reported in literature till now. We are reporting a case of isolated cutaneous metastases in neck from squamous cell carcinoma penis.

KEYWORDS

Carcinoma Penis, Cutaneous Metastasis, Chemoradiation

INTRODUCTION

Penile carcinoma is a rare malignancy even in developing countries like India with an incidence of 07.-2.3 cases/ lac population.[1] Primary dissemination occurs through lymphatic route to the inguino-femoral and iliac lymph nodes. Haematogenous spread is very rare due to the resistance offered by bucks fascia and tunica albuginea. The mainstay of therapy in metastatic disease is chemo-radiation. Patients with penile carcinoma rarely presents with cutaneous metastases. Surgical excision of isolated cutaneous nodule is an acceptable approach in absence of other distant sites of metastases.

CASE REPORT-

A 65 -year -old gentleman presented with a painful swelling over the left side of neck since 2 weeks. The patient had history of partial penectomy with bilateral inguinal lymph node dissection for a high grade (c T2N1MO) squamous cell carcinoma of penis three months back. Final histopathology report was Grade 3 squamous cell cancer, margins free,. The patient had not received any adjuvant chemotherapy in the postoperative period. On examination a solitary, tender, hard lump of 3×2 cm size was noticed on the left supraclavicular region. The overlying skin was fixed to the lump with an area of fluctuation at the summit while the nodule was freely mobile from the underlying structures. The skin nodule very much resembled an inflamed epidermoid cyst (Figure 1).No palpable cervical lymph node was found on both side of neck. No evidence of loco-regional recurrence was found at previous operative site. Fine needle aspiration cytology (FNAC) of the nodule revealed presence of metastatic squamous cell carcinoma (SCC) consistent with the index malignant lesion in the penis. Positron emission tomography scan of whole body showed no evidence of loco-regional recurrence and distant metastasis._The patient insisted for surgical excision due to the persistent pain and cosmetic disfigurement secondary to the skin nodule. Wide excision of the lump with a 1 cm margin was done under local anaesthesia. Histopathology confirmed the FNAC findings of SCC infiltrating the subcutaneous tissue; however, the overlying skin was free from tumour invasion. (Figure 2) He was treated with 3 cycles of TIP (Paclitaxel, ifosfamide, cisplatin) regimen considering it as a metastatic disease. The patient was doing well at his regular follow up at an interval of 3 months till date.

DISCUSSION-

According to the data of National Cancer Institute, penile cancer accounts for less than 1% of cancers in men in the USA. [2] The incidence is more in developing countries of Africa and Asia where it accounts for 10 to 20 % of all malignancies in men.[3] Higher incidences are often attributed to the ignorance of proper local hygiene and lack of practice of circumcision in this population. Metastasis to skin and subcutaneous tissue is scarcely reported (3 patients) in English literature. One report described simultaneous occurrence of cutaneous metastasis in a 65 year old patient of carcinoma penis detected at the time of initial examination.[4]Two other patients developed multiple cutaneous metastases following surgical intervention of the primary lesion and were treated with adjuvant chemotherapy.[5]

In our patient cutaneous metastasis developed three months after the management of primary disease. Clinically it resembled an infected epidermal cyst causing pain and discomfort to the patient. The clinical examination as well as the histopathology report excluded the possibility of lymph node metastasis at the left supraclavicular area. The possibility of a primary cutaneous malignancy was also ruled out as the skin was not found to be involved in the malignant process. The development of a subcutaneous malignant deposit away from the site of primary tumour is quite interesting. The various explanations for such an event can be occult haematogenous metastasis or permeation of tumour cells from the involved lymph nodes.

The rapid development of subcutaneous nodule following surgery could be attributed to tumour cell permeation into the tissue planes opened up during the dissection. The cells can be trapped by the minute capillaries and lymphatic channels exposed during the surgical procedure increasing the risk of distant metastasis. In other words the surgery controls the macroscopic disease while the risk of post procedure micro-metastasis is reduced by adjuvant therapy. The need of adjuvant chemotherapy following index surgery in penile carcinoma is highlighted in our case. This patient's refusal for adjuvant therapy could have favoured the development metastatic lesions in other parts of the body.

Treatment guideline for metastatic penile carcinoma has not been well established because of the rarity of the disease resulting in dearth of large randomised clinical trials for penile SCC. Though palliative chemotherapy remains the only option in metastatic disease, isolated metastatic lesions as in our patient can be safely treated with surgery to alleviate the local symptoms, prevent future development of complications such as recurrent infection, on healing skin ulceration, and cosmetic disfigurement.

Finally we can conclude that cutaneous metastasis from Squamous cell carcinoma penis is extremely rare. Palliative chemotherapy is primary modality of treatment for metastatic penile carcinoma. Surgery can be an option for symptomatic patient and to prevent development of local complications secondary to a metastatic deposit. The formulation of a guideline supported with evidence based recommendations for

metastatic penile carcinoma is the need of the hour.

Conflict Of Interest: Authors declare not to have any conflict of interest.

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PICTURES

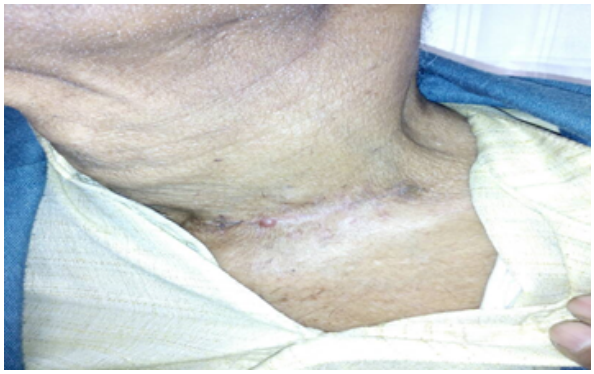

Figure 1: Cutaneous Neck Metastases

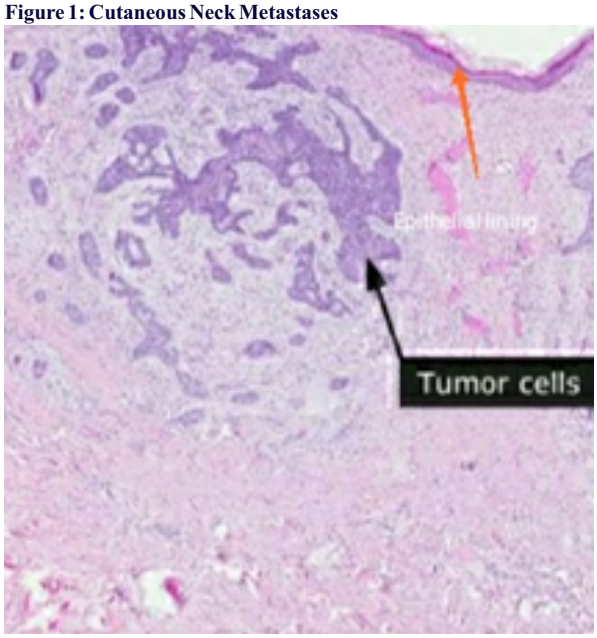

Fig 2 Underlying dermis showing small clusters and nests of Tumour cells showing metastatic disease from penile cancer. Hematoxylin and Eosin stain 200 X magnification.

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