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A CASE REPORT: SECRETORY CARCINOMA OF SKIN

General Surgery

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ABSTRACT

Background: Secretory carcinoma of the skin is a rare and aggressive type of skin cancer originating from neuroendocrine cells. It often presents with metastasis upon diagnosis. Risk factors include advanced age, white population, and immunosuppression. Secretory carcinoma typically affects sun-exposed areas. **Case Summary:** A 50 year old female patient came with chief complain of right axillary mass since 3 years which was increasing in size and fungating in nature with foul smelling odour and went to nearby civil hospital where I&D was done with negative fluid analysis for TB, after 3 months there was increase in mass along with purulent discharge and excision biopsy was taken. Patient was diagnosed with secretory carcinoma of skin. **Conclusion:**secretory carcinoma of the skin is a distinct and rare neoplasm that requires awareness. The primary treatment for SCS is surgical excision with clear margins. Regular follow-up is recommended to monitor for recurrence, given the potential for local regrowth.

KEYWORDS

Secretory carcinoma, cutaneous, Prognosis, Malignancy

INTRODUCTION:

Cutaneous secretory carcinomas (CSCs) are primary neoplasms of the skin that share similar pathological characteristics to mammary-analog secretory carcinomas (MASCs) and secretory breast carcinomas (SBCs). This novel tumor has only recently been identified in case reports and case series, first appearing in the literature in 2009 [1]. Although the axilla is the most common location for CSC, its presence throughout the body has been reported [2]. A key genetic identifier in the literature is the (12;15)(p13;q25) translocation which results in the ETS variation transcription factor 6-neurotrophic tyrosine receptor kinase 3 (ETV6-NTRK3) gene fusion, a genetic property present in CSC, MASC, and SBC tumors [3].Secretory carcinoma of the skin is a rare and aggressive type of skin cancer originating from neuroendocrine cells. It often presents with metastasis upon diagnosis. Risk factors include advanced age, white population, and immunosuppression. Secretory carcinoma typically affects sun-exposed areas.

Case History: A 50 year old female patient came with chief complain of right axillary mass since 3 years which was increasing in size and fungating in nature with foul smelling odour and went to nearby civil hospital where I&D was done with negative fluid analysis for TB, after 3 months there was increase in mass along with purulent discharge and excision biopsy was taken. Upon general examination the patient was vitally stable, fairly built and fairly nourished. On local examination approximately 25x20cm² right axillary fungating mass with purulent discharge and foul-smelling, immobile and adherent to chest wall. No involvement of ipsilateral breast and nipple areola complex. Contralateral axillary lymph node not palpable. On Routine blood investigations including CBC, LFT, RFT, blood sugar were unremarkable. On radiological examination ultra sonographic findings suggestive of lobulated lesion with collection. HRCT THORAX suggestive of large multilobulated solid lymphoidal mass approximately measuring 7.9x6.5 cm in right axilla with few necrotic contents and few subcentimeter discrete lymph nodes are seen. Fungating mass with poor generalised condition hampering daily routine , the patient was planned for excision of mass. Intra operatively the mass was found to be lobulated, not adherent to chest wall, superiorly the mass was extending upto clavicle, surrounding axillary vein, the adhesions were removed and mass excised. Grossly the mass appearance was bossalated, the mass was excised and sent for histopathology. Post operatively the patient was kept on negative suction drain. The patient developed wound gap which was healed by secondary intention. The patient after few months presented with malignant pleural effusion, pleurodesis was done. Histological features are suggestive of Mammary Analogue Secretory Carcinoma of Skin.

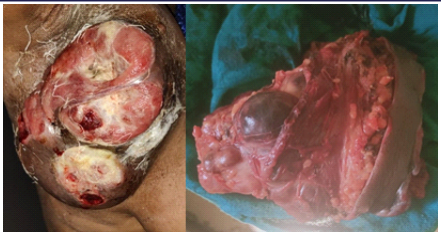

Figure 1. Skin lesion and Intraoperative findings

DISCUSSION:

According to reports, CSCs can exhibit a range of morphological traits, including microcystic, glandular, papillary, ductal, tubular, and solid development patterns. Mild pleomorphisms are reported in just a small percentage of cases (20.8%), and this tumor type regularly reports a low mitotic rate. [4,5] Moreover, necrosis, lymphovascular invasion, and perineural invasion are rarely observed. S100 (83.3%), STAT5 (41.7%), SOX10 (12.5%), MGA (75%), GATA-3 (25%), ER (20.8%), and CK7 (25%) were the most often positive CSCs in the literature that were subjected to immunohistochemical labeling. A common identifier for secretory carcinomas, such as CSC, MASC, and SBC cancers, is the ETV6-NTRK3 gene fusion. In total, the ETV6-NTRK3 has been discovered in 83.3% of CSC reports. [6,7] The main treatment for CSC is surgical excision [8]. Re-excision was carried out on individuals whose first biopsy or excision revealed positive margins. Our patient was treated by having the nodule with negative margins removed and mainly closed. The patient continued wound management after undergoing plastic surgery. Entrectinib, a tyrosine-receptor kinase (TRK) inhibitor, can aid patients with recurrent and metastatic illness and has proven therapeutic in a case of MASC [9], but it is not required for our patient because of negative margins and lack of involvement of sentinel lymph nodes. Given the NTRK3 gene fusion that causes the affected cells to become carcinogenic, TRK inhibitors might be helpful for our patient in the case of recurrence or metastasis. There has only been one confirmed instance of metastasis documented in the past [10], and CSCs are often indolent [11]. The current strategy is for yearly CT scans with surveillance by surgical oncology. Given the uncertain nature of this tumor type, careful monitoring is advised, and preventative imaging is advised to determine whether the tumor originated in the original salivary gland or spread to nearby lymph nodes. There has only been one confirmed metastatic report for CSC and just one for MASC , indicating a good prognosis. [12]

CONCLUSION:

The secretory carcinoma of the skin is a distinct and rare neoplasm that requires awareness. The primary treatment for SCS is surgical excision with clear margins. Regular follow-up is recommended to monitor for recurrence, given the potential for local regrowth.

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