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Cutaneous Metastases after Cystoprostatectomy: A Case Report

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Abstract **Case Report**

Cutaneous metastases are an atypical secondary location for bladder tumors. Through this observation, we report the case of a patient presenting with cutaneous metastases 3 months after a cystoprostatectomy with bilateral cutaneous ureterostomy, which was preceded by neoadjuvant chemotherapy.

Keywords: Cutaneous Metastases, Tumor, Bladder.

INTRODUCTION

Cutaneous metastasis is a rare and severe manifestation of bladder tumors, which are primarily accompanied by pulmonary, hepatic, and lymph node dissemination. Knowledge of this clinical aspect is essential as it appears late after the primary location.

CASE REPORT

This is a case of a 68-year-old male patient, a chronic smoker with a 10 pack-year history who quit smoking 10 years ago. He was initially admitted to our facility for anemia due to total clotting hematuria, which had been progressing for 8 months without medical consultation. The patient underwent transurethral resection biopsy, which revealed a large tumor with a broad base. The pathological study concluded it was a muscle-invasive urothelial carcinoma classified as pT2. A staging CT scan of the thorax, abdomen, and pelvis showed no distant metastasis. The patient then received 4 sessions of neoadjuvant chemotherapy, followed 4 weeks later by cystoprostatectomy with extended bilateral ilio-obturator lymph node dissection and bilateral cutaneous ureterostomy.

The patient was lost to follow-up and presented again 3 months later at the urology clinic with a deteriorated general condition. Clinical examination revealed ulcerated maculopapular cutaneous lesions with an inflammatory plaque on the neck, chest, and lumbosacral region **(Figure 1).** The cutaneous ureterostomies were functional. A skin biopsy showed secondary localization of urothelial carcinoma. The patient was then referred to the oncology department for further management, including a new staging PET scan with 18 FDG to search for other secondary localizations.

Figure: A

Figure: B

Figure: C

Figure 1 (A, B, C): Ulcerated maculopapular cutaneous lesions with an inflammatory plaque

DISCUSSION

The first case of cutaneous metastases secondary to a bladder tumor was reported in the literature in 1909 [1]. Such cases are rare, with an incidence of 0.84% in a series by Block *et al*., [2]. The incidence of bladder tumor metastases is directly related to the degree of tumor infiltration, size, and grade, although infiltration remains the most significant factor [3]. However, metastases can also appear in superficial tumors [3].

Cancer cell dissemination to the skin occurs through four mechanisms: contiguous spread, hematogenous spread, lymphatic spread, or iatrogenic manipulation (site at the scar) [4]. Cutaneous metastases typically appear late after the surgical procedure [5]. Schmiedecke *et al*., reported an average appearance time of 18 months, with a case of cutaneous metastasis occurring 10 years after the initial site discovery [5].

The clinical aspect of metastasis can take several forms. Brownstein *et al*., described three main clinical aspects: nodular lesion, sclerosing lesion, and inflammatory lesion (which represents our patient's case) [6]. Cutaneous metastases preferentially occur on the face, neck, trunk, and extremities [3].

A biopsy, a simple procedure, allows the diagnosis to be established, but confirming urothelial origin can sometimes be challenging [7]. Differential diagnosis mainly includes lymphatic malformations, herpes zoster, cellulitis, lymphoma, and radiation dermatitis. Anatomopathological study shows nests of malignant cells with eosinophilic cytoplasm. Most of these cells express cytokeratins 7 and 20 in immunohistochemical studies. Recent studies have shown that uroplakin III is detected in 50 to 60% of primary urothelial carcinomas and metastatic carcinomas of urothelial origin [8]. The prognosis is poor, with a life expectancy of less than one year [3]. Given the few cases reported in the literature and the limited survival, it is difficult to establish a therapeutic regimen.

The treatment of choice is chemotherapy, which remains a palliative treatment. Several drugs can be used: methotrexate, cisplatin, and gemcitabine. Surgery is indicated for small localized lesions, while the use of radiotherapy for palliative care has not yet been studied [3].

In conclusion, cutaneous metastasis is a rare dissemination of bladder tumors, making its management challenging due to the lack of an effective therapeutic regimen.

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