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Cutaneous Metastases of Infiltrating Ductal Breast Carcinoma: A Case Report

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Abstract: Cutaneous metastases can have variable clinical appearances and can mimic benign skin lesions. Breast carcinoma metastasis is the most common carcinoma encountered by dermatologists and it presents in various morphological and histological forms. A 52-year-old woman with a history of infiltrating ductal breast carcinoma grade SBR III treated 7years before, presented an ulcerative lesion on the chest. The biopsy confirmed the cutaneous metastasis of the breast cancer. Although cutaneous Metastases are rare in clinical practice, every practitioner should be highly suspicious of acute-onset, persistent, ulcerative, firm papulonodules, thus their detection may contribute to reduce associated morbidities and mortality .
Keywords: Cutaneous metastases, skin lesions, Breast carcinoma.

INTRODUCION

Breast cancer is defined as the most common cause of cancer-related deaths among women worldwide. About 1/5 of women with early breast cancer will develop metastases most commonly to liver, bone and lung[1].

Cutaneous metastatsis (CM) generally represent an advanced stage of cancerous disease and are rarely indicative of underlying neoplasia. Excluding melanoma, breast cancer is the malignant tumor that gives the most cutaneous metastases [2].

The cutaneous involvement is by direct extension from nearby or by vascular extension including lymphatic. The clinical diagnosis of cutaneous metastasis secondary to breast carcinoma is based on pathological reports of biopsy specimen. These breast cancer MCs usually occur several years after the end of treatment, but the evolution can be faster.

This is the case of our patient who had a cutaneous metaseries 7 years after the end of the treatment

CASE REPORT

A 52-year-old patient with a history of infiltrating ductal breast carcinoma grade SBR III treated 7 years earlier by mastectomy and left axillary lymph node clearance with adjuvant radiotherapy and chemotherapy, consulted for a painful ulceration over the right chest and loss of 5 kg over 4 months.

Clinical examination revealed indurated erosive erythematous plaque with well-defined margins and superficial erosions and crusting with purulent papules with keratotic surfaces of angiomatous appearance suggestive of angiokeratomes, measuring 2 to 3 cm. There was tenderness and local rise in temperature over the lesion.

A cutaneous biopsy performed on these lesions showed the dermis infiltrated by an atypical neoplasm formed by epithelial cells with abundant cytoplasm. Results were consistent with a cutaneous localization of an infiltrating breast carcinoma with presence of vascular lymphatic emboli.

Further work-up revealed bone metastasis. She is now on paclitaxel chemotherapy for the metastatic disease and the skin lesions are regressing.

Fig-1: Large erosion with purulent exudate and surrounding firm skin-colored nodules seen over the right chest measuring 2-3 cm in average

DISCUSSION

Metastasis could be defined as a neoplastic lesion arising from another neoplasm with which it is no longer in contiguity or is not in close proximity with the same tissue. The most common tumor to metastasize to the skin is breast cancer.

Cutaneous metastatic breast carcinoma must be distinguished from a wide variety of other malignant and benign neoplasms using histology. They are often seen in patients with advanced disease, but they can be the presenting lesion [3].

Breast carcinoma is the most common malignancy with skin metastases encountered in clinical practice. CM account for 0.7-9% of all metastases [4]. They occur in close proximity to the area of primary tumor.

About 20% of women with a history of early breast cancer will ultimately develop metastases [5]. CM are one of the most distressing presentations of recurrent breast cancer [6]. The chest is the most common site of CM. CM can have variable clinical appearances and can mimic benign skin lesions.

There are numerous morphological variants, with the most common being solitary to multiple erythematous infiltrating papules and nodules or ulcerative lesions. There are some rare variants such as carcinoma erysipeloides, carcinoma en cuirasse, carcinoma telangiectaticum, alopecia neoplastica, metastasis to the inframammary crease [7] and zosteriform pattern.

Accounting for less than 1% of the total metastases, Carcinoma erysipeloides is a relatively rare variant of CM and is usually associated with intraductal breast carcinoma [8]. Bullous lesions are another form of cutaneous metastatic breast cancer, but their appearance is uncommon.

Due to lymphatic spread of tumor cells Most of the metastasis could occur. A biopsy of the skin helps in confirming a diagnosis of tumor. The microscopic appearance suggests most of the time the likely tissue of origin. Generally, the histological features of the metastases are similar to the primary tumor, although metastases may be more anaplastic and exhibit less differentiation.

Immunohistochemical staining, especially with Cathepsin D an aspartic protease that is predominantly revealed in breast metastases is of diagnostic value [9]. We could also see pan cytokeratins, epithelial membrane antigen and carcinoembryonic antigen in most cases. Other point is the immunoreactivity of the metastatic tumor to androgen receptor which is a pointer towards the primary being a breast carcinoma [10].

The prognosis of cutaneous metastasis depends primarily on the pathology and biological behavior of the primary neoplasm and its response to treatment.

Cancer breast with CM occurs late and respond poorly to treatment. Effective treatment depends on treatment of the underlying tumor. Palliative treatment in the form of chemotherapy is usually the only option in such cases and the patient must be advised to keep lesions clean and dry and debriding the lesions if they are bleeding or crusted.

Electrochemotherapy[11], a new treatment that uses electrical impulses to enhance effectiveness of bleomycin or cisplatin injected into tumors.

In many cases, skin metastasis causes disfigurement and discomfort. Removal of skin lesions by simple excision could enhance the patient's quality of life but has little effect on the final outcome that is decided by the primary cancer.

CONCLUSION

Cutaneous metastasis is a common manifestation of breast cancer. The clinical diagnosis of cutaneous metastasis secondary to breast carcinoma is based on histological result of biopsy. The prognosis of cancer breast with CM depends primarily on the pathology and biological behaviour of the primary

tumor and its response to treatment. Their treatment must be early, adequate and especially combining second-line chemotherapy.

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