SKIN METASTASIS OF FACE WITH PRIMARY CARCINOMA OF BUCCAL MUCOSA – A CASE REPORT

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ABSTRACT

Distant metastases in squamous cell carcinoma of head and neck cancer (SCCHN) are most often to the lung, liver and bone. SCCHN rarely metastasis to skin sites. We encountered a 53-years-old male patient who initially presented with carcinoma of the right buccal mucosa with T3N2aMO disease treated by surgery followed by radiotherapy. After about two months, he developed multiple skin lesions in the lower eyelid region, which was initially treated for some infective pathology of skin. But due to no response, cytological examination was performed which turned out to be moderately differentiated squamous cell carcinoma supposed to be metastasis from buccal mucosa carcinoma. The persent case report describes the rare event along with highlighting some of the important issues which to be considered under such conditions.

Key Words: *squamous cell carcinoma, SCCHN, metastasis.*

INTRODUCTION

According to Eugene Meyers the survival rate is very poor in case of distant metastasis, also the regional dermal metastasis usually results from aberrant lymphatic spread rather than from hematogenous seeding of skin, and this finding also portends an extremely poor prognosis. Incidence of distant metastasis is 15-20%. The common sites are lung (66%), bone (22%), and liver (9.5%). More than 90% of patient die of their disease within 2 years of diagnosis of distant metastasis.[1] A case of skin metastasis in the lower eye lid after the surgical management of carcinoma of buccal mucosa is presented.

CASE REPORT

A 58 years old male, chronic smoker, beetle chewer and alcoholic presented to our OPD in september 2010 with chief complaints of pain during swallowing of 6 months duration and unilateral neck swellings of 4 months duration. He was well built with a unilateral, hard, discrete, partially mobile nodes present with normal overlying skin adhering to the lower border of mandible. Biopsy taken from growth showed well-differentiated squamous cell carcinoma. All the basic investigations were done. They were well within normal limits. In view of the above findings patient was diagnosed as a case of carcinoma of right buccal mucosa with T3 N2a MO (stage III). He was treated with Composite resection with modified Radical Neck Dissection and reconstruction with Pectoralis major Myocutaneous Flap. Followed by radiotherapy with a dose of 70 Gy in 35 fractions in 7 weeks on Cobalt-60 tele therapy machine using lateral opposing fields to face and neck with concurrent cisplatin based weekly chemotherapy. Patient tolerated chemo-radiotherapy well and was advised to attend head and neck cancer clinic regularly for follow up. He was disease free for about two months, and in December 2010 he reported with the complaint of multiple subcutaneous nodules in the right lower eye lid region. Initially he was given a course of antibiotic considering some infective pathology of skin, as there was no sign of recurrence at the local or nodal site. Despite the antibiotic treatment his skin nodules kept on increasing in size. Hence fine needle aspiration cytology performed from the nodules, which revealed a metastatic squamous cell carcinoma consistent with primary squamous cell carcinoma buccal mucosa. As these nodules were not fixed to underlying structures a wide local excision was done,

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which further confirmed the diagnosis as Moderately differentiated squamous cell carcinoma. Considering the metastatic nature of the disease, patient was put on cisplatin based palliative chemotherapy.

Patient's response was poor, he developed headache and multiple nodule over the right side of face occurred and the patient expired on 24th January, 2011.

DISCUSSION

The frequency of skin metastasis from internal malignancies varies from 0.7% to 9% of all cancer patients.[2] The most common sites of distant metastases in head and neck cancers are usually lung (70-75%), liver (17-38%) and bone (23-44%).[3] Skin metastasis has been reported to occur in 0.8-1.3% of patients with squamous cell carcinoma of head and neck.[4] There are very few reports in the literature about the skin metastasis from head and neck cancer. Available reports suggest that skin metastasis is a rare event and most common sites were usually neck, scalp and over the chest wall that is near to primary site.[5,7,8]

We report the occurrence of skin metastasis in the lower eyelid, which is extremely unusual. The exact mechanism of skin metastasis in oral cancer is incompletely understood. There are three possible mechanisms namely direct spread, local spread and distant spread.[7] Skin metastasis thought to involve hematogenous spread where pulmonary circulation and filtration can be theoretically bypassed via the azygous venous and vertebral venous system via Batson's plexus, allowing skin implantation. Though it is general assumption that skin metastasis indicates poor prognosis for the patient, information is lacking regarding the survival and the proper treatment of this group of patients. Berger in their study reported that length of survival was approximately three months after skin metastasis become clinically evident in head and neck cancer. The treatment of skin metastasis is inconclusive. Being the metastatic nature of disease, the treatment of these patients is, in general, palliative. Options available are surgical excision, chemotherapy, external beam radiotherapy, or combination of these. Whatever the nature of the primary lesion, the course of the disease or the treatment(s) administered, it appears that skin metastasis is an equalizing factor for all patient groups in carcinoma of the head and neck; all patients do poorly and succumb rapidly to their disease.

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