

Cutaneous metastasis of endometrial carcinoma with hemorrhagic nodules and papules

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Summary

Background: Endometrium cancer is the fourth most frequent malignancy in women. However, skin metastasis from endometrium cancer is a very rare entity.

Case: A 58-year-old multiparous woman postmenopausal for ten years presented with multiple metastatic, nodular, hemorrhagic skin lesions located at the initial surgery and radiotherapy site 14 months after the original diagnosis was made. Combination chemotherapy was instituted, but the patient died after the second cycle of chemotherapy.

Conclusion: Although endometrial cancer is one of the most frequent malignancies in women, skin metastasis from endometrial cancer is very rare. In reported cases metastasis from endometrial cancer has been most commonly noted at the initial surgery and radiotherapy site. Therefore, the initial surgical and radiotherapy site must be examined carefully for skin metastasis.

Key words: Endometrial carcinoma; Skin; Metastasis; Radiotherapy.

Introduction

Endometrial cancer is the fourth most frequent malignancy in women. In the United States approximately 30,000 new cases are being reported annually [1].

The spread of endometrial cancer occurs by contiguity (most common), through the lymphatics and blood vessels. Predictive prognostic factors are the histologic type of malignant cells, invasion of distant capillary-lymphatics, positive peritoneal lavage cytology and ploidy and kinetics of the tumor. In the treatment of recurrent or metastatic endometrial carcinoma, although there is still controversy, local excision (if feasible), combination chemotherapy, radiotherapy and hormonal therapy is recommended.

We report a case of abdominal skin metastasis from endometrial cancer because of the rarity of this entity.

Case Report

A 58-year-old multiparous woman, postmenopausal for ten years was admitted to the hospital with vaginal bleeding. She underwent probe curettage and pathologic examination of the biopsy specimen revealed the diagnosis of endometrial adenocarcinoma, histologic grade II. Type II hysterectomy, bilateral salpingo-oophorectomy, and bilateral pelvic lymphadenectomy with peritoneal washings were performed. During the operation both of the ovaries and the tubas were macroscopically observed as normal. In the postoperative pathologic evaluation, morphologic classification of the tumor was endometrioid-type endometrial adenocarcinoma, histologic grade 2, Figo Stage IB. While less than 50% of the myometrium was involved by the tumor with a maximum vertical tumor size of 0.7 cm, there was

no endocervical invasion. Peritoneal lavage cytology was negative, vascular invasion was present and reactive hyperplasia was detected in all lymph nodes that were excised. One month later whole pelvic radiotherapy in a dose of 3,500 cG and then brachytherapy were instituted, and the patient enrolled in follow-up. During the follow-up period every three months the patient was admitted to the hospital and besides a physical examination, pelvic, abdomen and thorax computerized tomographies were obtained and evaluated in order to rule out distant metastasis. Fourteen months after radiotherapy the patient presented with multiple fragile, hemorrhagic, nodular, and papular skin lesions varying between 0.5 and 3 cm in diameter, located below the umbilicus at the initial surgery site (Figure 1). Examination of the biopsy specimen obtained from these skin lesions revealed metastasis from endometrial carcinoma (Figure 2). When the skin biopsy documented recurrent disease a metastatic work-up was performed: Thorax, abdomen and pelvic computed tomographies were obtained and while abdomen and pelvic CT's were normal, bilateral multiple metastatic nodules were determined in the thorax CT. Also in the physical examination multiple nodules varying from 1 to 3 ml in diameter were observed in the vaginal cuff. Pathological examination of the biopsy specimen taken from these nodules also revealed endometrial adenocarcinoma.

There is no consensus on endometrial carcinoma about what the optimal therapy in recurrent cases should be. Some authors recommend chemotherapy, while others radiotherapy. However, none of these options have been effective in the treatment and the prognosis remains poor. We chose chemotherapy because the patient had already received radiotherapy and at the time of recurrence distant metastasis was present. Chemotherapy consisted of a cyclophosphamide and adriamycin combination, but the patient died after the second cycle. As we planned to evaluate the response to treatment prior to the third cycle and as the patient died out of hospital, we could not document the exact cause of death. We can only speculate that the patient died due to progression of disease.

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Fig. 1

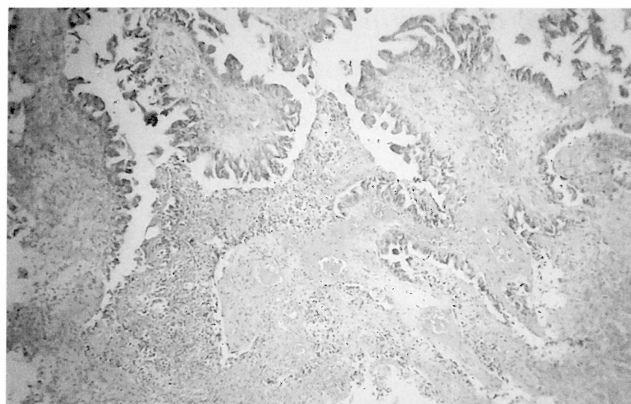


Fig. 2

Figure 1. — Hemorrhagic, nodular and papular skin lesions.

Figure 2. — Atypical endometrial glandular structures.

Discussion

Cutaneous metastasis from endometrial carcinoma is rare and portends a poor prognosis [2, 3]. Up to today there have been about 20 cases reported in the literature [4]. The majority of skin lesions have been located in the trunk and the extremities. These lesions may appear in several forms such as inflammatory lesions, discrete nodules or plaque. Cutaneous metastasis may vary in number from a single nodule to several nodules, such as in our case. At the time of recurrence generally the disease is widespread and given the poor response to therapy patients usually die within six months. Metastasis appears within an interval of one month to several years after the original tumor has been diagnosed. This interval was 14 months in our case. Carcinoma reaches the skin by a variety of mechanisms including direct extension, lymphatic or hematogenous spread, and through implantation in surgical scars. Implantation in surgical scars is more common than hematogenous spread [5]. Treatment in recurrent cases is miscellaneous. Given the poor prognosis some authors recommend symptomatic treatment only, while others propose hormonal therapy or chemotherapy. However, no dramatic change in survival has been noted with any particular treatment [3]. Consequently, the initial surgery field is a common site for metastasis from endometrial carcinoma as reported in the literature. Also metastasis to a previous

radiotherapy field has been reported [4]. Therefore, this should be kept in mind and during routine physical examinations, physician must be careful when inspecting previous surgical and radiotherapy sites in order to determine probable skin metastasis earlier.

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Letter to the Editor

THE USE OF THUMBTRACKS TO STOP SEVERE PRESACRAL BLEEDING: A SIMPLE, EFFECTIVE, READILY AVAILABLE AND POTENTIALLY LIFE-SAVING TECHNIQUE.

Dear Editor,

The review by Wydra, Emerich, Ciach and Marciniak [1] was informative and thorough with one notable exception - the offhand way in which it dismisses the use of thumbtacks.

In our case history report and literature review [2], we reported a case where the use of standard thumbtacks was found to be a simple, effective, readily available and potentially life-saving technique in severe presacral bleeding. Further, our review of the literature documented 14 other reports of successful use of thumbtacks, in many of which it was stated that the use of sterile thumbtacks was now, or would become, the standard method of controlling severe presacral bleeding in the reporting institution.

Our opinion remains that the thumbtack technique should be considered in any episode of severe presacral bleeding which cannot be controlled by simple methods involving direct pressure.

Your sincerely,

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Authors' Reply

To the Editor,

We thank Dr. M. Harma and M. Harma for their interest in our publication relating to the management of massive presacral bleeding in patients with gynaecological malignancies and their comments [1]. They commented on our lack of consideration for the use of thumbtacks to stop severe presacral bleeding. We have read their article on the subject with great interest and would like to assure them that the thumbtack method has indeed been considered and used by our medical university. They may be interested in the following case histories. Recently five patients with advanced rectal cancer undergoing surgery suffered massive bleeding

from the sacral venous plexus damaged presacral bone fascia. Two of the patients, after unsuccessful attempts to control the bleeding, were packed with large laparotomy sponges. After 48 hours a relaparotomy was performed. Although haemostasis was confirmed they required numerous transfusions of erythrocyte concentrate and fresh frozen plasma. Three further patients were treated by the use of long tacks. The lesions were packed with the synthetic coagulant Surgicel (Johnson and Johnson, Ethicon, USA) fixed to the sacral bone by long surgical steel tacks (Figure 1). One of the three patients was initially treated with a packing of Spongostan (gelatin sponge) but this proved ineffective due to the elasticity of the gelatin. Additionally after insertion of Surgicel, pelvic packing using surgical gauze was applied for up to 60 minutes. In all cases it allowed us to achieve haemostasis and complete the surgery without the need for relaparotomy at a later time.

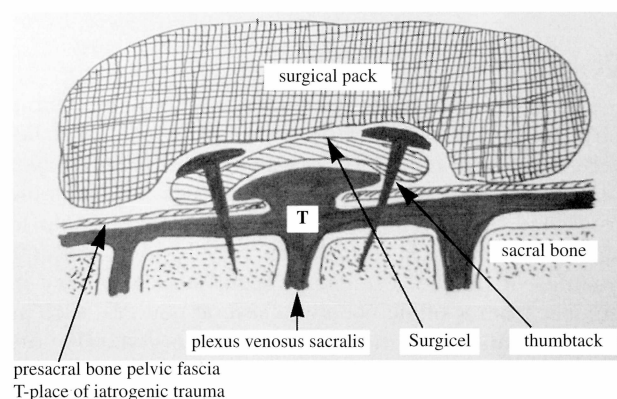


Figure 1. — Scheme of use the thumbtacks to stop presacral bleeding.

However, we have also witnessed massive bleeding in a case of total pelvic exenteration in a 42-year-old patient with recurrent cervical cancer. Bleeding was a result of damage to the venous plexus surrounding the urethra. In such case there are not enough solid structures in the immediate vicinity of the urethra to which thumbtacks can be attached. Therefore pelvic packing was the first and effective method used.

We find that the use of thumbtacks is a very useful method in the control of massive bleeding, especially during oncological pelvic surgery, obviating the need for relaparotomy. While in our opinion it is not appropriate in every case of pelvic bleeding, it should be considered because of its simplicity, cost effectiveness and potentially life-saving qualities.

In reading Harma's *et al's*. [2] case report we would be interested to know what material was used to occlude the bleeding in conjunction with the thumbtacks as the report does mention this.

Yours sincerely,

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Editor's Comment

I thank both Dr. Harma *et al.* and Dr. Wydra *et al.* for the interesting question and answer about a very important topic like severe presacral bleeding in radical operations for pelvic cancer. I agree with the conclusions of the authors who wrote articles on "The use of thumbtacks to stop severe presacral bleeding" and "The management of massive presacral pelvic bleeding in patients with gynecological malignancies: Review of the literature". In my surgical experience in gynecologic oncology I have sometimes had problems in stopping presacral bleeding and careful attention must be paid to this site. I think thumbtacks are useful in cases of severe presacral bleeding.

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