Cutaneous Secondaries from Carcinoma Larynx

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Abstract:
Cutaneous secondaries from carcinoma larynx are very rare. Distant metastases in squamous cell carcinoma of larynx have an incidence of five to six percent. It most commonly involves lungs, liver and bone. We present a case of a male patient with cutaneous deposits from carcinoma larynx in Anterior Abdominal wall and his left ring finger. This case is presented for its rare occurrence. 45 year old male patient presented to a hospital outside in April 2009 with complaints of hoarseness of voice. He was investigated for the same. DL scopy showed growth in the right glottis. Biopsy of the same was reported as moderately differentiated (Grade III) Squamous cell Carcinoma. His clinical Staging was T3N1N0. Patient received concurrent Chemo radiation for the same. He was given 60 Gray of external RT with weekly cisplatin 40 mg per meter square. He was apparently normal till March 2010. After which he developed local recurrence for which he underwent total laryngectomy in April 2010. He was given six cycles of chemotherapy with Carboplatin and paclitaxel. He was normal till November 2010 when he presented to us with Anterior Abdominal wall swelling. Cytology of the same proved to be metastatic carcinomatous deposits. As the patient had already received twelve cycles of platinum compounds, we managed him with single agent Methotrexate. He responded well to our treatment for five months, after which the disease progressed.

Keyword: Carcinoma Larynx, Cutaneous Secondaries

INTRODUCTION:
It is estimated that 12,740 men and women (10,160 men and 2,580 women) will be diagnosed with and 3,560 men and women will die of carcinoma larynx in 2011 by SEER data. (1) In India the incidence of laryngeal cancer is 8.5 per one lakh males and accounts to 7.4% of all malignancies in them. (2) It usually has loco regional spread with rare distant spread. Many of the patients die of their loco regional disease before distant spread occurs. Even if distant spread.
occurs, it mainly spreads to lungs. In our patient, as he had cutaneous metastasis we are presenting this case for its rarity.

**PATIENT DETAILS:**
45 year old male patient presented to a hospital outside in April 2009 with complaints of hoarseness of voice. He was investigated for the same. DL scopy showed growth in the right glottis Biopsy of the same was reported as moderately differentiated (Grade III) Squamous cell Carcinoma. His clinical Staging was T3N1N0. Patient received concurrent Chemo radiation for the same. He was given 60 Gray of external RT with weekly cisplatin 40 mg per meter square. He was apparently normal till March 2010. After which he developed local recurrence for which he underwent total laryngectomy in April 2010. He was given six cycles of chemotherapy with Carboplatin and paclitaxel. He was normal till November 2010 when he presented to us with Anterior Abdominal wall swelling. Cytology of the same proved to be meta static carcinomatous deposits. As the patient had already received twelve cycles of platinum compounds, we managed him with single agent Methotrexate. He responded well to our treatment for five months, after which the disease progressed. During the treatment time the nodule never ulcerated and is maintained.

![Cutaneous Secondary before Treatment CT Abdomen Showing Abdominal Wall Secondaries](image1)

![After treatment Secondary in Left Ring Finger](image2)
DISCUSSION:
Skin, or cutaneous, metastasis refers to growth of cancer cells in the skin originating from an internal cancer. In most cases, cutaneous metastasis develops after the initial diagnosis of the primary internal malignancy (e.g. breast cancer, lung cancer) and late in the course of the disease. In very rare cases, skin metastasis may occur at the same time or before the primary cancer has been discovered and may be the prompt for further thorough investigation. Cutaneous metastases are quite uncommon. The frequency of cutaneous metastasis from internal carcinomas ranges from 0.7 to 10% according to different authors. Metastases to the skin occur in up to five percent of patients who have an internal malignancy. The route to the skin is usually one or more of the following:
1. Direct invasion. 2. lymphatics. 3. Vascular emboli. 4. iatrogenic (surgical implantation )

The most frequent carcinomas metastasing to skin are as follows:

The sites of predilection when metastases involve the skin are:
3. Abdomen (peri-umbilical) – from gastrointestinal system. 4. Lower abdomen – from genitourinary system.

Cutaneous metastasis is associated with the type of primary cancer and sex of the patient. In males from melanoma 32%, lung 12%, intestine 11%, carcinoma of oral cavity 10%, carcinoma larynx 5.5% and Renal cell carcinoma 5%.In females it is mainly from carcinoma Breast 70%, melanoma 12%, ovary 3% and other malignancies like lung, large intestine, oral cavity account for 2.3%.

Most skin metastasis occurs in a body region near the primary tumour. Metastatic lesions in the skin are usually hard, non-tender, non-ulcerated nodules. They are most often flesh coloured or pink to brown, but may even be black. Less commonly, metastases present as ulceration or plaque of alopecia A cellulitis-type of inflammatory response is occasionally seen. When the primary is from lung or kidney and spreads to the skin, the metastatic lesion is found before the existence of the primary is known in about half the cases.

The diagnosis of metastasis can be confirmed by cytology or biopsy. Usually cytology will do for establishing diagnosis. On histological examination, the secondary cutaneous localization appeared to be more dedifferentiated compared to the primary tumour. Metastatic lesions will often demonstrate retained characteristics of the site of origin on biopsy examination. Stoma recurrences, permeation nodules and cutaneous metastases in the head and neck or trunk areas from nearby head and neck cancer are by far the most common. Conversely, distant cutaneous metastases to the lower part of the body are exceedingly rare. Very few case of distant cutaneous head and neck SCC (HNSCC) metastases have been described and are usually multiple.

Distant metastases in laryngeal carcinoma are rare and when present, most commonly involve the lung. This tumor originates from glottis (59%), supraglottis (40%) or infraglottis (1%) (8)

To treat the cutaneous metastasis, the underlying primary tumour needs to be treated. However, in most cases where skin metastasis has occurred,
the primary cancer is widespread and may be untreatable. A large number of conventional single agents have been investigated in the past in patients with recurrent disease. The four most active and most extensively used agents are methotrexate, cisplatin, 5-fluorouracil (5-FU) and bleomycin. These drugs produced a 15 – 30% response rate of short duration, 3 – 5 months, and only rarely complete response (9,10). Methotrexate has significantly improved the quality of life of patients 38.8% of patients show good response with decrease in the tumour bulk by more than 50% and other 39% of patients have stable disease when Injection Methotrexate is given.(11) Also, palliative care is given and includes keeping lesions clean and dry. Debridement can be done if lesions bleed or crust has to be done. Other therapies that may be helpful include:

Imiquimod Cream – may lead to regression of metastasis in some cases of melanoma.

Liquid nitrogen cryotherapy

Photodynamic therapy

Excision

Carbon dioxide laser therapy

Pulsed dye laser therapy

Intralesional chemotherapy and cytokines

The prognosis of any patient is very poor ranging from 3 to 34 months from the time of diagnosis of metastasis.

REFERENCES:


