An unusual presentation of a squamous cell carcinoma of bronchus as an ulcer at the tip of the nose

S V Paranavithane[1], C Siriwardena[2], K Satgurunathan[3]

Sri Lanka Journal of Dermatology, 2008, **12**, 28-29

Abstract

The occurrence of cutaneous spread of internal malignancies is quite rare despite the fact that the skin is the largest organ in the human body[1]. When present, it is an indicator of poor prognosis as the patient usually dies within three to six months of diagnosis[2]. Here, we report a patient with bronchogenic carcinoma, who had metastatic ulceration of the tip of the nose as the presenting feature.

Case report

A 74 year old non smoking male presented with painless ulceration of left nostril for two months and erythematous swelling of nose for two weeks.

He also had loss of appetite and weight for one month and right sided pleuritic chest pain for five days. He didn't have haemoptysis or dyspnoea.

On examination he had a poorly defined ulcer (0.5cm X 1.5cm) involving the left nostril extending to the tip of the nose. It had irregular margins and a shallow, erythematous base with contact bleeding. There was surrounding induration and erythema (Figure 1).

General examination revealed an enlarged, hard, solitary, right scalene lymph node and grade III clubbing.

Air entry in the mid zone of right lung was diminished. The rest of the respiratory system examination was normal.

Investigations included an ESR of 89 mm in the first hour. Chest x ray showed a right mid-zonal opacity with ill defined upper margin; reported as a hilar mass (Figure 2). The biopsy from ulcer edge revealed moderately differentiated squamous cell carcinoma. FNAC of scalene lymph node showed atypical squamous cells suggestive of a secondary deposit. Contrast CT of the thorax, head and neck region revealed a soft tissue mass confined to nasal alae, with no evidence of cartilage invasion and an enlarged right supraclavicular lymph node. A large soft tissue mass with central necrosis involving almost whole right upper lobe and superior segment of lower lobe of the lung was noted obliterating the right main bronchus. There was a right sided moderate pleural effusion. Enlarged lymph nodes were identified in the pretracheal group as well.

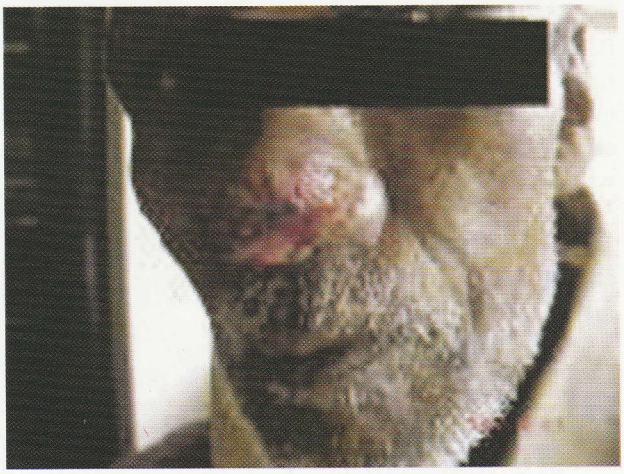

Figure 1.

On clinical diagnosis of carcinoma of bronchus with lymph node and cutaneous secondary deposits, he was started on palliative local radiotherapy and adjuvant chemotherapy as advised by the oncologist.

However he developed rapidly increasing dyspnoea. A repeat chest X ray taken two months after presentation showed a large right sided pleural effusion (Figure 3).

He succumbed to the disease before the second cycle of chemotherapy, within three months of presentation.

[1]*Senior Registrar in Dermatology,* [2]*Registrar in Dermatology,* [3]*Consultant Dermatologist, National Hospital of Sri Lanka.*

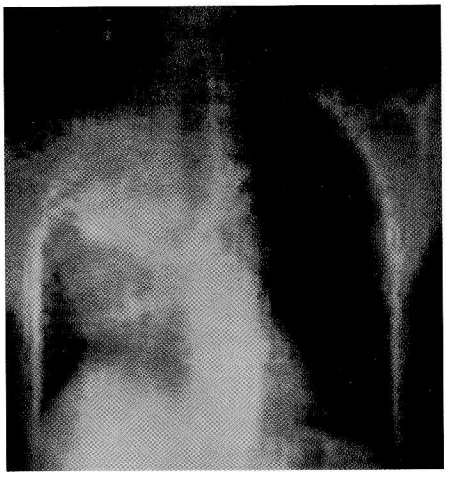

Figure 2.

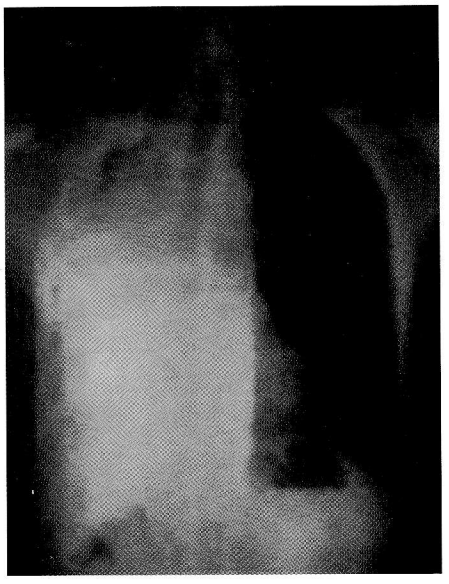

Figure 3.

Discussion

Although lung carcinoma is the commonest malignancy (24%) leading to secondary cutaneous deposits in males, (especially over 40 years of age)[3], diagnosis of a secondary cutaneous deposit prior to identification of the primary tumor is rare. Secondary cutaneous deposits on the face are relatively uncommon. The most common site for cutaneous metastasis from bronchial carcinoma is, the chest followed by abdomen and back. Other areas (in decreasing order of frequency) include the scalp, neck, face, extremities and pelvis[4]. Cutaneous metastases of bronchogenic carcinoma commonly present as, solitary or multiple, firm to hard, skin coloured or reddish purple nodules. Fixation to underlying tissue and ulceration are rare[5]. Hence the presentation of our patient with bronchogenic carcinoma as an ulcer at the tip of the nose is unusual.

References

1 Brenner S, Tamir E, Maharshak N, Shapira J. Cutaneous manifestations of internal malignancies. *Clin Dermatol* 2001; **19**: 290-7.

2 Braverman IM. Cancer: skin signs of systemic disease, 3rd Ed. Philadelphia: WB Saunders Company; 1998, p1-71.

3 Tharakram S. Pattern of cutaneous metastasis (analysis of 50 cases). *Ind J Dermatol Venereol Leprol* 1986; **52**: 149-51.

4 Helm TN, Lee TC. Metastatic carcinoma of the skin. www.emedicine.com

5 Inamadar AC, Palit A, et al. Inflammatory cutaneous metastasis as a presenting feature of bronchogenic carcinoma.