A postoperative case of carcinoma erysipeloides arising from ductal carcinoma of the breast

Sir,

Cutaneous metastases occur in 1%–5% of all patients with internal cancers. Internal malignancies may metastasize to the skin by direct invasion from underlying structures, extension through lymphatics, or by embolization into lymphatics or blood vessels. Cutaneous metastasis from breast cancer can present in varied morphologies such as carcinoma erysipeloides, carcinoma en cuirasse, carcinoma telangiectasia, and carcinoma eburnée.[1]

A 50-year-old woman presented with complaints of a raised reddish skin lesion over her right breast since three months. She had undergone modified radical mastectomy on the same side followed by chemotherapy six months ago for ductal carcinoma of one year onset. Three months after undergoing surgery, the patient noticed a small raised red, asymptomatic lesion over the operation site that gradually increased in size. On examination, there was a well-demarcated, large, indurated, erythematous plaque covering almost the entire right breast. There was no tenderness, or local rise in temperature. There was a linear scar at the suture site [Figure 1]. Examination of the other breast was within normal limits. There were no other significant cutaneous and systemic findings. Routine blood and urine tests were normal. An incisional biopsy specimen obtained from the plaque was subjected to histopathological examination. Hematoxylin and eosin stain of the specimen revealed tumor cell emboli within the lymphovascular tissue, with cells showing features suggestive of ductal carcinoma [Figure 2a and b]. Based on the past history of breast cancer, clinical presentation, and histopathological findings, a diagnosis of carcinoma erysipeloides arising from a ductal carcinoma of the right breast was made. The patient was referred to an oncology centre for further management.

Cutaneous metastasis may occur by direct extension from an underlying malignancy, through lymphatic channels or embolization through lymphatics and blood vessels. Cutaneous metastases account for 0.7%–9% of all metastases and may be the first evidence of internal malignancy or a sign of recurrence and are considered a grave prognostic sign.[2]

Carcinoma erysipeloides occur due to massive lymphatic obstruction by the metastasizing tumor cells. It presents as an erythematous patch or plaque with an actively spreading border resembling erysipelas and is most commonly associated with breast carcinoma.

A case of purpuric plaque on the neck with underlying breast carcinoma was reported by Adelzadeh *et al*. in 2014.[3] Canpolat *et al*. in 2010 reported another case

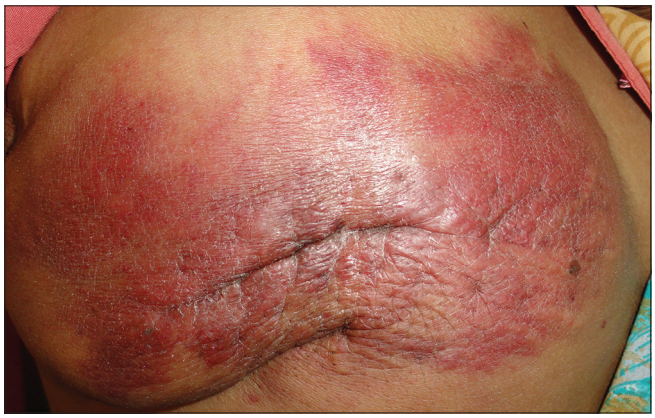

Figure 1: A large, indurated, erythematous plaque over right mammary area

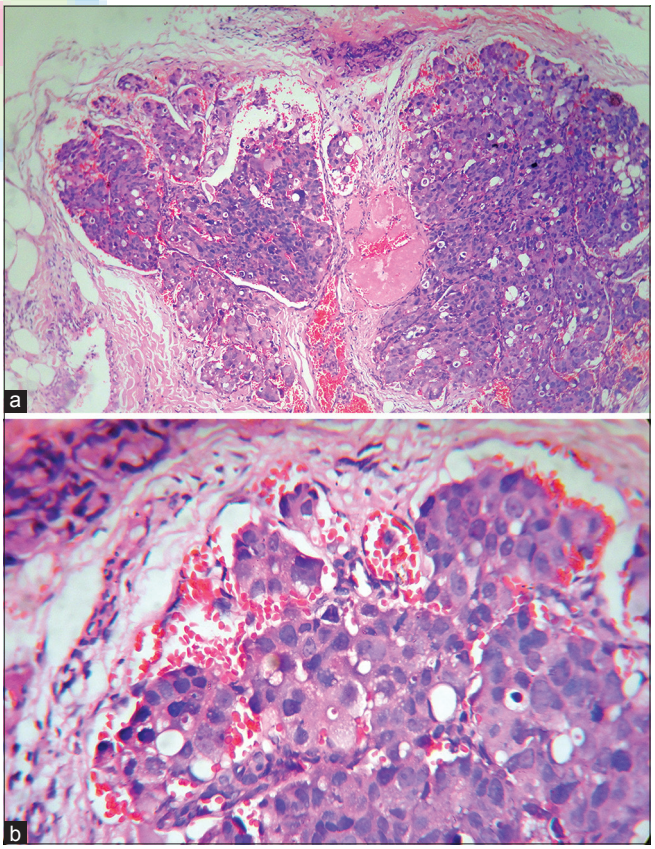

Figure 2: (a and b) Tumor cells embolizing the lymphovascular tissue in dermis and subcutis, tumor cells suggestive of ductal cell carcinoma

of carcinoma erysipeloides in a 44-year-old woman two years after radical mastectomy.[4] Another similar case was reported by Gaffar *et al*.[5] Apart from the breast, carcinoma erysipeloides arising from tumours at other sites such as lung, thyroid, ovary, stomach, and prostate have been reported.

Cutaneous metastasis from internal malignancies may present in varied and confusing forms. Carcinoma erysipeloides is one such presentation that mimics erysipelas, cellulitis, and mastitis at first glance. Hence careful history-taking, clinical and histopathological examination play an important role in diagnosing this condition.

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Quick Response Code:

Website: www.idoj.in

DOI: 10.4103/2229-5178.169710