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Case Report
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Zosteriform Cutaneous Metastasis from Carcinoma Breast: A Case Report

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Abstract

Breast carcinoma is the main tumor with a high risk of skin metastases followed by lung, colon and ovarian cancer. More than 60% of cutaneous metastases are adenocarcinoma. Zosteriform pattern is rarely seen and there are less than hundred cases declarations in the literature. It is comorbid in 0.7/10% of cancer patients and forms 2% of skin malignancies. Papules, nodules and ulcerations are the most common clinical manifestations of cutaneous metastases.

We report the case of a 55-year-old woman with a history of breast carcinoma, presented with painful erythematous, papulonodular lesions with dermatomal distribution for two-years. She underwent breast surgery with palliative chemotherapy. A biopsy was performed, showed cutaneous localization of a mucinous carcinoma.

Keywords: Breast carcinoma; Zosteriform cutaneous metastases; Skin tumors

Introduction

Cutaneous metastases are skin malignancies which appear as tumor cells spreading over skin directly, lymphatically or hematogenous from primer tissue [1]. Breast cancer in women and lung cancer in men are the most frequent primary for skin metastases [2-5]. Cutaneous metastases from internal malignancies are a rare complication with an incidence of 0.7% to 9%.

However, zosteriform patterns are extremely rare [4]. Herein, we report the case of a 55-year-old female with a history of breast carcinoma, presented with zosteriform cutaneous metastasis.

Case Presentation

A 55-year-old woman presented to the emergency department with a rash on the back. The rash started 2 years ago, initially over the base of the neck and gradually increased in size reaching the scapular region. This was associated with pain and partial functional impotence. The patient was diagnosed in 2011 with mucinous carcinoma of the left breast stage II with lymph node metastases, treated by radical mastectomy and adjuvant chemotherapy escaping all lines. Cutaneous examination revealed multiple erythematous and purple, firm, infiltrated and indurated papulonodular lesions, ulcerated and necrotic in some places and covered with melicera and hemorrhagic crusts, arranged in a dermatomal fashion, extending from the base of the neck to the upper half of the back (Figures 1-3). Histologically, the dermis is the site of a tumor proliferation made up of nests and spans with a few glands, bathed in pools of mucin. Tumor cells are moderately atypical with eosinophilic cytoplasm, nuclei with an eosinophilic nucleolus and sometimes observed in mitosis. The stroma is fibro-inflammatory, compatible with a cutaneous localization of a mucinous carcinoma. The thoraco-abdominopelvic scanner also objectified a secondary cutaneous-muscular localization in favor of a progression of the lesional process.

Discussion

Skin metastases may represent the first sign of internal malignancy, associated with a poor prognosis [3]. Zosteriform presentation is a very uncommon type of cutaneous metastases [2]. The etiopathogeny of the zosteriform pattern remains unknown. Some proposed theories include lymphatic spread, surgical implantation of tumor cells and neural spread through the dorsal nodes [1]. Globally, skin metastases account for 2% of all skin neoplasms and represent 18.6% to 26.5% of patients with breast cancers [2-4]. Breast, malignant melanoma, ovarian and lung cancers are the most common causes in women, and malignant melanoma, head, neck and lung carcinomas

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Figure 1: Clinical aspect: Multiple erythematous and purple, firm, infiltrated and indurated papulo-nodular lesions, ulcerated and necrotic in some places and covered with melicera and hemorrhagic crusts, arranged in a dermatomal fashion.

Figure 2: Clinical aspect: Multiple erythematous and purple, firm, infiltrated and indurated papulo-nodular lesions, ulcerated and necrotic in some places and covered with melicera and hemorrhagic crusts, arranged in a dermatomal fashion.

in men [1].

Clinically, nodular appearance is the most common form [1]. The management of cutaneous metastases consists to define the tumor origin by metastatic nodule biopsy, supported by immunohistochemical study [2].

Figure 3: Clinical aspect: Multiple erythematous and purple, firm, infiltrated and indurated papulo-nodular lesions, ulcerated and necrotic in some places and covered with melicera and hemorrhagic crusts, arranged in a dermatomal fashion.

Conclusion

Skin metastases of all neoplasms carry a very poor prognosis. Zosteriform patterns are rare hence the interest to perform biopsies in such as type of lesions.

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