

DIFFERENT PRESENTATIONS OF SKIN MALIGNANCIES – A CASE SERIES

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Abstract

The most frequent form of cancer in people is skin cancer, and its morbidity rate is rising every year. The prognosis for skin cancer survival is influenced by several demographic and clinical parameters. In this case series, we include 5 cases with different presentations of underlying skin malignancy, as an attempt to study the various clinical presentation of different types of skin cancer. In this case series, we have examined five female cases of skin malignancy. Among all five patients, four patients had an ulcer at or near the affected area and one patient had blackish discolouration of the skin over the umbilical region. Out of five female patients, one was diagnosed with melanoma, two were diagnosed with BCC, and two were diagnosed with SCC after histopathological examination. For the early detection of skin cancer as well as to reduce the morbidity and mortality associated with these cancers, it is essential to understand the fundamentals of skin cancer screening approaches. Since survival and prognosis depend on early detection of skin cancer, general public education and improved clinician awareness of skin cancer is vital for the prevention and treatment of this deadly malignancy.

INTRODUCTION

Skin cancer is the most frequent malignancy occurring in humans and affecting people worldwide. It can be divided into two categories; melanoma and nonmelanoma cancer. Three-quarters of skin cancer-related fatalities each year are caused by melanoma, but the mortality rate for people with nonmelanoma skin cancer (basal cell and squamous cell carcinomas) is quite low. However, nonmelanoma skin cancer has the potential to be extremely disfiguring, cause a functional loss, and be extremely expensive to treat locally. Both melanoma and nonmelanoma skin cancer have a variety of risk factors and warning symptoms. Age over 15 years, fair skin, multiple moles, atypical moles, a history of melanoma in one's own or one's family, sun sensitivity, and extensive sun exposure are risk factors for melanoma. However, older age, pale skin, male sex, difficulty to tan, and protracted redness after sun exposure are risk factors for nonmelanoma skin cancer.^[1,2]

In this case series, we include 5 cases with different presentations of underlying skin malignancy, as an attempt to study the various clinical presentation of different types of skin cancer.

CASE 1

A 60-year-old female patient had no comorbidities and she had presented with complaints of an ulcer over the right side of the forehead for 5 months. The patient had no history of trauma, discharge, pain, or rapid increase in the size of the ulcer. On examination, a 3.5 • 4 cm ulcer was noted in the right supraorbital region with beaded edges. No bleed on touch surrounding infiltration and mobile over the underlying subcutaneous tissue was seen. Edge wedge biopsy detected adenoid cystic basal cell carcinoma (BCC). The procedure done was 3D wide local excision with full-thickness grafting from the ipsilateral preauricular region skin. Post-operative histopathological examination indicated adenoid cystic BCC; margins free of tumour. The patient is on follow-up.



CASE 2

A 55-year-old female patient presented with complaints of an ulcer over the right foot for 1 year. The patient initially noticed a black mole over the right foot which gradually increased in size to reach the present size, with a sudden increase in the size of the swelling for the past 3 months, bleeding on and off from the ulcer, constant pricking pain over the ulcer, and swelling in the right groin for 1 year. Patients had no history of trauma, fever, and family history of malignancy. On examination, ulceroproliferative lesion over right heels edges everted, 2 surrounding skin nodules, mobile not fixed to underlying tissue, and multiple enlarged inguinal nodes largest 4'4cm with extranodal extension free from underlying tissue were observed. Edge wedge biopsy diagnosed melanoma. PETCT scan of the whole body detected malignant melanoma right foot with ipsilateral inguinal node metastasis. The procedure done was wide local excision (WLE) + reverse sural artery flap cover + ilioinguinal block dissection. Post-operative histopathological examination indicated malignant melanoma. Margins were negative pT4aN3Mx. The patient started with adjuvant immunotherapy as per the medical oncologist and the patient is on follow-up.

CASE 3

A 36-year-old female patient complained of an ulcer over the right lower leg for the past 2 years. The patient had post-trivial trauma 2 years back, which was not healing. Now the patient has sudden increase in size for the past 3 months with no associated pain or discharge from the ulcer. The patient had no other complaints. On examination ulceroproliferative lesion of size 4•4 cm in Antero lateral aspect of right thigh 2cm above the ankle and averted edges. Bleeding on touch, surrounding induration of 2 cm all around, surrounding skin hyperpigmented with 2 satellite nodules around, and sub centimetric vertical inguinal nodes multiple non-tenders, mobile was observed. Edge wedge biopsy detected moderately differentiated squamous cell carcinoma. Ultrasound (USG) scan of the right inguinal region indicated multiple nodes largest 2x1 cm with loss of fatty hilum. The guided biopsy of the above nodes was non-significant. PET CT scan of the whole body detected a malignant lesion in the right anterolateral aspect of the lower leg with hypermetabolic inguinal nodes. It detected no metastasis. The procedure done was WLE + split-thickness skin graft (SSG). Post-operative histopathological examination indicated moderately differentiated SCC, with margins negative. The patient is on follow-up.



CASE 4

A 47-year-old female had complained of blackish discoloration of the skin over the umbilical region for the past 6 months and discharge from the discoloured area for 2 months. The patient had no other complaints. Past surgical history with open-on-lay mesh plasty for para umbilical hernia x 7 years back. The patient had a history of laparoscopic sterilization x 20 years back. On examination, a hyperpigmented patch of 2 x 1 cm vertically oval was present over the umbilical region, flushed with skin, well-defined borders, and smooth edges. No bleed on touch, no warmth, and non-tender, and firm consistency was seen. Edge wedge biopsy IHC detected melan A negative and Pigmented basal cell carcinoma. The procedure done was wide local

excision with omphalectomy under SA. The frozen section had margins negative. Histopathological examination indicated pigmented basal cell carcinoma (p T1aNxMx). All margins were free of tumours. Patients are advised routine examinations every 6 months and watch for any new lesions. No role for chemo or radiotherapy.



CASE 5

A 65-year-old female came with ulcerated swelling in the right lateral chest wall x 2 years. Patient had a history of insidious and progressive ulceroproliferative growth in the right lateral chest wall underwent excision in a local clinic twice and half years back. One year back following which patient developed similar swelling in the same site with a sudden increase in size in the past 6 months. Associated with bleeding from the lesion. The patient had no other significant history. On examination, ulceroproliferative growth of 8 x 6 cm approximately 10 cm below the right axilla, pedunculated, stalk – 3 x 2 cm, foul smelling growth, bleeds on touch, 1 cm induration all around, not adherent to the chest wall. No satellite nodules noted were seen. Sub-centimetric axillary node enlargement was seen.



MRI chest detected a large exophytic mass in the right lateral chest wall arising from the skin, infiltrating into the subcutaneous plane up to the muscle plane. R axillary nodes were enlarged. Edge wedge biopsy indicated well-differentiated SCC. PET CT scan indicated metabolically active large enhancing lobulated soft tissue of the right lateral chest wall with metabolically active level I axillary

lymph nodes. No evidence of any distant metastasis (T4N1M0). The procedure done was wide local excision + R Axillary lymph node dissection + primary closure.



DISCUSSION

In this case series, we have examined five female cases of skin malignancy. In order to lower morbidity and death from skin malignancies, early identification is crucial. While patients occasionally can identify the presence of skin cancer warning signs and symptoms, older patients were the ones who had lesions found by medical professionals most frequently. The lack of significant results in the majority of examinations, the low priority given to skin cancer screening in primary care, and the lack of provider knowledge to correctly identify high-risk lesions have historically been the main obstacles to skin cancer identification. The histological analysis of removed tissue serves as the gold standard for diagnosis regardless of the usage of the screening method.^[3] In this case series, one patient was diagnosed with melanoma, two patients were diagnosed with BCC, and two were diagnosed with SCC after histopathological examination. Poorly differentiated carcinomas have a worse prognosis than well-differentiated SCCs, which also have lower rates of metastasis and recurrence. However, it might be challenging to determine whether combinations of characteristics indicate a better or worse prognosis because the prognostic

criteria for SCCs are not usually clearly described in the literature.^[4] Poor histological differentiation has been cited by some writers as a key indicator of metastasis and recurrence, and tumour depth and diameter are adversely correlated with differentiation grade in SCCs. Adenoid basal cell carcinoma is an uncommon lesion and a precise histological diagnosis is essential in the therapy of these cases because prognosis and outcomes vary widely. Non-melanoma skin cancer has excellent survival rates, particularly when detected and treated early. Low social status, poor personal hygiene, fear of diagnosis, and potential repercussions have all been linked to late diagnosis.^[5-7]

The most dangerous type of skin cancer is cutaneous melanoma. Melanoma causes more than 70% of all skin tumour-related deaths but represents less than 5% of instances of skin cancer overall. More people survived melanoma when it was discovered at an early stage and with little depth. Skin melanoma on the back or breast has a worse prognosis than on other anatomic sites. Other prognostic markers, such as age, sex, histology, and location, are associated with melanoma survival in addition to the stage of the disease upon diagnosis.^[8]

CONCLUSION

Understanding the basic skin cancer screening techniques is necessary for the early detection of malignant lesions as well as to prevent the morbidity and mortality caused by these lesions. Education of

the general people and enhanced clinician understanding of the clinical picture of the disease is essential for the prevention and treatment of this lethal malignancy as survival and prognosis depend on early diagnosis of skin cancer.

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