

Correspondence:**Oesophageal malignancy with cutaneous metastasis over lower limb: a rare presentation**

Skin metastases are common from breast and lung cancers. Squamous cell carcinoma of the oesophagus is known for its local invasion and lymphatic spread. Oesophageal carcinoma accounts for approximately 6% of all gastrointestinal malignancies.¹ Squamous cell carcinoma is the predominant histopathological subtype, comprising about 70% of cases.¹ Squamous cell carcinoma oesophagus is characterized by extensive local growth and proclivity to lymphnode metastases.¹ Common sites of metastases include lymph nodes, lung and liver.¹ Cutaneous metastases of abdominal malignancies are uncommon, with frequency ranging from 0.7% - 9%.² Skin metastases from oesophageal cancer are even rarer, and affect less than 1% of cases.² The overall survival rate varies from 4.3 to 4.7 months.³ We report a rare case of squamous cell carcinoma of the middle oesophagus presenting with skin metastases.

A 52-year-old female presented with the complaints of difficulty in swallowing of 3 months duration. Upper gastrointestinal endoscopy which showed an ulceroproliferative growth starting at 20 cm from incisors causing complete luminal narrowing at 25 cm. General physical examination and other metastatic work-up did not reveal any evidence of metastases. Contrast-enhanced computed tomography of the chest revealed a heterogeneously enhancing circumferential thickening about 12.7 cm starting from the level of carina extending up to gastro-oesophageal junction and loss of fat plane with aorta focally.

Biopsy from the growth was suggestive of moderately differentiated squamous cell carcinoma (Figure 1). Then patient received definitive concurrent chemotherapy and radiotherapy. On first follow-up the patient had symptomatically improved. She presented again after three months with complaints of swelling over the left lower limb and appearance of one more swelling in the sub mandibular region (Figure 2). On examination a swelling measuring 3 × 2 cm was noted over lateral aspect of left lower limb 4 cm above ankle joint which was non-tender, fixed to the skin but not fixed to underlying structures and one more mobile swelling of 4 × 4 cm size that was palpable over the left submandibular region were seen. Fine needle aspiration cytology (FNAC) from both the lesions was reported as metastatic squamous cell carcinoma deposits (Figures 3 and 4). Then, the patient was started

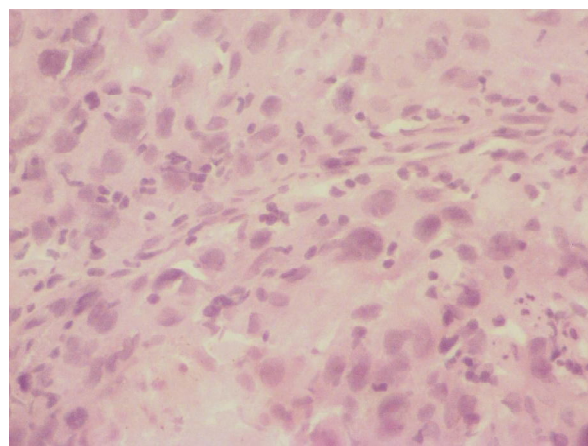


Figure 1: Photomicrograph of biopsy from the oesophageal growth showing sheets of neoplastic squamoid cells (Haematoxylin and eosin, × 100)

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Figure 2: Clinical photograph showing swelling over the left lower limb and one more swelling in sub mandibular region

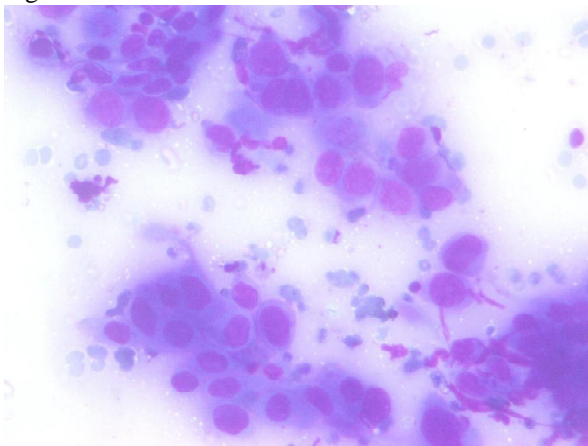


Figure 3: Fine needle aspiration cytology from skin nodule over shin region showing neoplastic squamoid cells in clusters (May - Grunwald- Giemsa, $\times 100$)

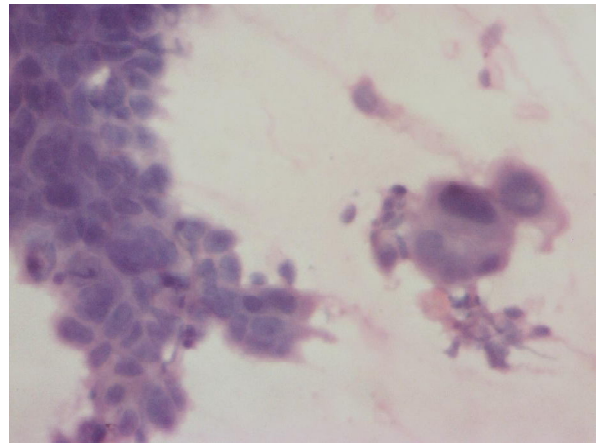


Figure 4: Fine needle aspiration cytology from sub mandibular swelling showing neoplastic squamoid cells with high nucleo-cytoplasmic ratio (Papanicolaou, $\times 400$)

on palliative chemotherapy. Patient is surviving since 10 months with a good performance status.

The cancer types most commonly associated with cutaneous metastases are breast, lung and melanoma.⁴ Metastatic spread to the skin occurs either haematogenously or via the lymphatic system and presents in the form of rapidly growing papules or nodules.^{5,6} In a study⁷ of clinical and necropsy findings of 32 of 2,300 internal carcinomas, the most common primary site was the lung (50%) and oesophagus was the primary tumour site in just one case and this was an adenocarcinoma. The most common sites of skin metastases were on the chest and abdomen.⁷ The most frequent site of cutaneous metastasis from gastrointestinal cancer is skin of the abdominal wall.⁸ The scalp is also a

common site for cutaneous metastatic disease, but the extremities and the face are generally not affected.⁸ Metastases on the limbs are even rarer.⁹ Half of patients with cutaneous metastasis die within the first 6 months after the diagnosis; the prognosis being the poorest with lung carcinoma.¹⁰ Hence, it is prudent to carry out meticulous clinical examination to detect new skin nodules in patients on follow-up. Diagnostic confirmation by cytology or biopsy as early diagnosis helps in planning appropriate management.

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