



Case Report

Carcinoma Erysipeloides: A rare form of cutaneous metastases from breast carcinoma

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ABSTRACT

We described in this case report a 62 years-old women with a history of modified radical mastectomy for an invasive ductal carcinoma of the left breast 3 years previously (Stage IIIA-Cerb-b2 (+), ER(-), PR %75 (+)). Although the patient has been still receiving Aromatase inhibitor (AI) diffuse erythematous plaques with an erysipel-like appearance occurred located over the left side of the anterior chest wall and extending far from the mastectomy incision through the infraclavicular area, axilla, and back including scapular region. We observed complete clinical response after this chemotherapy regimen. Today the patient has been still under following up since diagnosed with erysipeloid carcinoma without any local recurrences for 24 months.

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1. Introduction

In general, cutaneous metastases of the breast carcinomas can present clinically as nodules, plaques, and tumors. The most common clinical appearance usually presents as nodules. An unusual form of cutaneous metastases is called "carcinoma erysipeloides (CE)" which is actually a tumor infiltration that clinically mimicked a cellulitis (Homler et al., 1986; Nambi and Tharakaram, 1999; Lee et al., 2001; Calka, 2002). It is important to differentiate carcinoma erysipeloides from erysipelas. The latter is an acute cellulitis caused by Group A -hemolytic streptococci and could be seen frequently at any time of the life, at any age and gender. Skin changes are highly similar in both conditions but erysipelas are usually warmer and more tender than the plaques of carcinoma erysipeloides. If proceeding the treatment only as struggle of a skin infection without suspicion of erysipeloides carcinoma, it might have been late for starting the cancer therapy. This is the reason why being aware of this diagnosis is important in clinical practice. So we aimed to share our experience on following up of this unusual entity and to emphasize the differential diagnosis between erysipelas and CE.

2. Case Presentation

We described in this case report a 62 years-old women with a history of modified radical mastectomy for an invasive ductal carcinoma of the left breast 3 years previously (Stage III A-Cerb-b2' (+), ER(-), PR %75 (+)). After the surgical treatment intravenous chemotherapy was given by six cycles comprising cyclophosphamide, methotrexate and 5-flourouracil (CMF) and in total 5000 cGy radiotherapy to the chest wall, peripheral lymphatic including axilla.

After adjuvant chemoradiotherapy, she has taken 1 mg Aromatase inhibitor (AI) daily. Although the patient has been still receiving AI, diffuse erythematous plaques with an erysipel-like appearance occurred located over the left side of the anterior chest wall and extending far from the mastectomy incision through the infraclavicular area, axilla, and back including scapular region (Fig. 1). Initially a course of medical therapy for elimination the diagnosis of erysipelas with acute cellulitis was given but there was not seen any response. Afterwards we performed punch skin biopsy to find out the diagnosis from erythematous plaques. It showed histologically extensive infiltration of the



Fig 1 : Presentation of erythematous plaques with an erysipelas-like appearance located over the left side of the anterior chest wall and extending to the infraclavicular area, axilla, and post chest wall include scapular region

dermis by tumor cells, and a slight perivascular lymphoid infiltrate. These histological findings supported the clinical diagnosis of carcinoma erysipeloides.



Fig 2 : Immediately after she had received a second line chemotherapy; after 5 months from the time of diagnosis of erysipeloid carcinoma

We did not find any other clinical evidence of synchronous distant metastases after clinical evaluation. The patient has received a second line chemotherapy consisting six cycles docetaxel 100 mg/m² weekly intravenous infusion for 6 months. The first day of cycles Capecitabine 1500 mg/m² was given per-orally. We observed complete clinical response after this chemotherapy regimen (Fig. 2). Today the patient has been still under following up since diagnosed with erysipeloid carcinoma without any local recurrences for 24 months (Fig. 3).

3. Discussion

In 1931, Rasch introduced the term CE to denote the erysipelas like development of red indurate skin with white sharply demarcated borders in association with skin metastases (Nambi and Tharakaram, 1999; Lee et al., 2001). Erysipelas like aspect of CE can be misleading as cellulitis (Homler et al., 1986; Calka, 2002). The clinical progression usually involves rapid enlargement of the affected area without skin ulceration (Homler et al., 1986; Lee et al., 2001; Calka, 2002; Gutierrez and Rodriguez, 2007). CE is most commonly caused by breast carcinoma, but it has also been related to other malignancies; thyroid,

bladder, lung, gastric (Homler et al., 1986; Lever, 1991; Lookingbill, 1993; Wnamaker et al., 1993; Schwartz, 1995; Nambi and Tharakaram, 1999; Hamamoto et al., 2001; Calka, 2002; Gutierrez and Rodriguez, 2007). Cutaneous metastases occur in 1% to 5% of patients with visceral malignancies (Hamamoto et al., 2001; Lookingbill, 1993). Between 10% and 35% of women with operable breast cancer will experience an isolated locoregional recurrence following their primary treatment. Many of them are seen on the chest wall or nearby incision scar. In a rare condition these locoregional metastases may be seen as erysipelas like appearance far from the primary operative scar. CE is found in less than 2% of all breast carcinomas.



Fig 3 : The appearance of the patient who is at 24 th month following up after diagnosed with erysipeloid carcinoma without any local recurrences.

As a result of diffuse invasion of dermal lymphatic blockage, edema and erythema occurs (Homler et al., 1986; Schwartz, 1995; Nambi and Tharakaram, 1999; Lee et al., 2001). Dissemination is most likely to have occurred via a direct spread from the affected lymph nodes to cutaneous lymphatic (Lever, 1991; Cox, 1994; Schwartz, 1995; Nambi and Tharakaram, 1999).

Surgery for CE does not appear to improve life expectancy. The average life expectancy is about 2 years (1-34 months) from the time of diagnosis (Lever, 1991; Gutierrez and Rodriguez, 2007). Today, the patient we presented is at 24th month after diagnosed as CE and without any local recurrences.

4. Conclusion

We would like to emphasize of such erysipelas like skin lesions which are concerned cutaneous malignant metastases. Differentiate of this entity is important as it may be taken in process for erysipelas and cellulitis in clinical practice by mistake. We experienced in our case that early treatment with chemotherapy could result in meaningful palliation. So, it is important to recognition carcinoma erysipeloides rather early.

In conclusion, mostly Dermatologist and all other clinicians need to be aware of the probability of inflammatory manifestations of such erysipelas-like cutaneous metastases resulted from breast carcinomas and other malignancies.

REFERENCES

- Calka, O., 2002. Karsinoma Erizipelatoides. *Türkderm.* 36, 64-67
- Cox, S.E., 1994. A spectrum of inflammatory metastasis to skin via lymphatics: Tree cases of carcinoma erysipeloides. *J. Am. Acad. Dermatol.* 30, 304-313
- Gutierrez, J.W., Rodriguez M.A., 2007. Carcinoma erysipeloides associated with breast carcinoma. *Int. J. Dermatol.* 46, 613-614
- Hamamoto, Y., Nagai, K., Ichimiya, M., 2001. Regressive effect of intralesional injection of a moderate dose of recombinant interleukin-2 on carcinoma erysipeloides from gastric carcinoma. *Clin. Exper. Dermatol.* 26, 42-44
- Homler, H.J., Goetz, C.S., Weisenburger, D.D., 1986. Lymphatic cutaneous metastases from lung cancer mimicking cellulitis: Carcinoma erysipeloides. *West. J. Med.* 144, 610-612
- Lee, S.Y., Chang, S.E., Bae, G.Y., 2001. Carcinoma erysipeloides associated with anaplastic thyroid carcinoma. *Clin. Exp. Dermatol.* 26, 671-673
- Lever, L.R., 1991. Carcinoma erysipeloides. *Br. J. Dermatol.* 124, 279-282
- Lookingbill, D.P., 1993. Cutaneous metastases in patients with metastatic carcinoma: A retrospective study of 4020 patients. *J. Am. Acad. Dermatol.* 29, 228
- Nambi, R., Tharakaram, S., 1999. Carcinoma erysipeloides as a presenting feature of breast carcinoma. *Int. J. Dermatol.* 38, 367-376
- Schwartz, R.A., 1995. Cutaneous metastatic disease. *J. Am. Acad. Dermatol.* 33, 161
- Wnamaker, J.R., Kraud, D.H., Eliachar, I., 1993. Manifestations of metastatic breast carcinoma to the head and neck. *Head Neck.* 5, 257-262