Case Report

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

Ayfer Kamali Polat, Ahmet Veyes Polat, Sevil Isik, Sebnem Alpakut, Bulent Gungor

Ondokuz Mayis University, General Surgery Department, Samsun
Ondokuz Mayis University, Radiology Department, Samsun
Ordu University, General Surgery Department, Ordu
Mehmet Aydin Egitim ve Arastirma - Dermatology Department, Samsun

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* Correspondence to:
Ayfer Kamali Polat
Ondokuz Mayis University
Medical Faculty General Surgery Department, Samsun/Turkey
E-mail: ayferkp@yahoo.com

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1. Introduction
In general, cutaneous metastases of the breast carcinomas can present clinically as nodules, plaques, and tumors. The 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 can 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 carcinoma erysipeloides (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 (StageIIA-Cerb-b2 (+), ER(-), PR %75 (+)). Although the patient has been still receiving Aromatase inhibitor (AI) diffuse erythematous plaques with an erysipel-like appearance occured 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). We observed complete clinical response after this chemotherapy regimen (Fig. 2). Today the patient has been still under following up since diagnosed with erisypeloid carcinoma without any local recurrences for 24 months (Fig. 3).
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 dermis by tumor cells, and a slight perivascular lymphoid infiltrate. These histological findings supported the clinical diagnosis of carcinoma erysipeloides.

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-oraly. 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 ‘carcinoma erysipeloides’ 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 erisipel like appearance far from the primary operative scar. CE is found in less than ½ of all breast carcinomas.

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 erysipelias 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 recognize carcinoma erysipeloides rather early.

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

REFERENCES