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Cutaneous Metastasis of Endometrial Adenocarcinoma: An Unusual and Dramatic Presentation of two Cases

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ABSTRACT

Skin metastases from endometrial adenocarcinoma, particularly cutaneous lymphangitis carcinomatosis, are rare. We present two cases of endometrial adenocarcinoma that recurred as lymphangitic carcinomatosis after presumed complete resection. Case 1 is a 71-year-old woman with a history of breast adenocarcinoma, who developed painful erythematous lesions and a verrucous plaque in the pubic area three months after surgery for endometrial adenocarcinoma. A skin biopsy confirmed carcinomatous lymphangitis, and she died four months later. Case 2 is a 56-year-old woman with endometrioid adenocarcinoma, who developed erythematous plaques and lymphedema on the left thigh a year after treatment. A biopsy confirmed cutaneous lymphangitis carcinomatosis, and she died five months later. These cases highlight the importance of considering skin metastasis in patients with a history of gynecological cancer presenting with new cutaneous lesions.

KEYWORDS: endometrial cancer, cutaneous metastasis, lymphangitis carcinomatosis, skin cancer, gynecologic cancer

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I. INTRODUCTION

Despite the high incidence of uterine adenocarcinoma, skin metastases from endometrial adenocarcinoma and especially cutaneous lymphangitis carcinomatosis are extremely rare and only a few cases have been reported in the literature [1]. We report two cases of endometrial adenocarcinoma presumed to have been completely resected, which recurred as lymphangitic carcinomatosis metastasis.

II. REPORT OF CASES

Case 1: A 71-year-old woman, with a history of left breast adenocarcinoma treated 7 years previously by mastectomy and left axillary staging, completed by adjuvant radiotherapy and chemotherapy with complete remission. She was diagnosed 1 year ago with endometrial adenocarcinoma and underwent a total abdominal hysterectomy, bilateral salpingo-oophorectomy, and pelvic lymphadenectomy. Three months after her initial therapy, she presented with multiple painful, papulonodular, erythematous lesions, disseminated in the pubic area, creating a verrucous plaque encompassing the entire pubis, with pronounced vulvar hypertrophy (Fig. 1 a). Comparable lesions were observed in front of the left mastectomy scar (Fig. 1 b). The rest of the examination revealed a decrease in vocal vibration of the right hemi thorax, diffuse bone pain with anorexia, loss of weight, and asthenia. A skin biopsy was performed and confirmed carcinomatous lymphangitis secondary to metastases from endometrial adenocarcinoma. The evolution was rapidly fatal, the patient died four months after her admission.

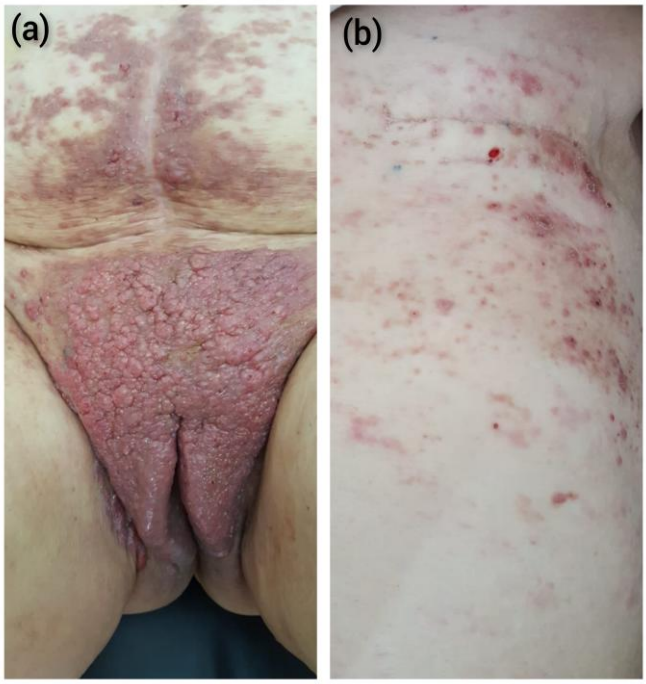

Figure 1: (a): Erythematous, indurated plaque, with papulonodular lesions across the pubic area, accompanied by pronounced vulvar hypertrophy and cutaneous metastasis in the abdominal pelvic wall. (b): Cutaneous metastasis at the site of the left mastectomy scar.

Case 2: A 56-year-old woman, was diagnosed with FIGO Stage IIB, endometrioid adenocarcinoma, and underwent a total abdominal hysterectomy, bilateral salpingo-oophorectomy, completed by adjuvant radiotherapy and chemotherapy. One year after her initial treatment, she exhibited stage II dyspnea and developed an erythematous, purpuric, and indurated plaque primarily on her left thigh, extending to the left knee and up to the umbilicus (Fig. 2). This was accompanied by pruritus and significant lymphedema in the left leg. No pelvic mass was palpable. A biopsy was performed and confirmed carcinomatous lymphangitis secondary to metastases from endometrial adenocarcinoma. A positron emission tomography scan highlighted the presence of multiple pelvic iliac and lumboaortic lymphadenopathies. The patient's condition continued to worsen progressively, and she died five months later.

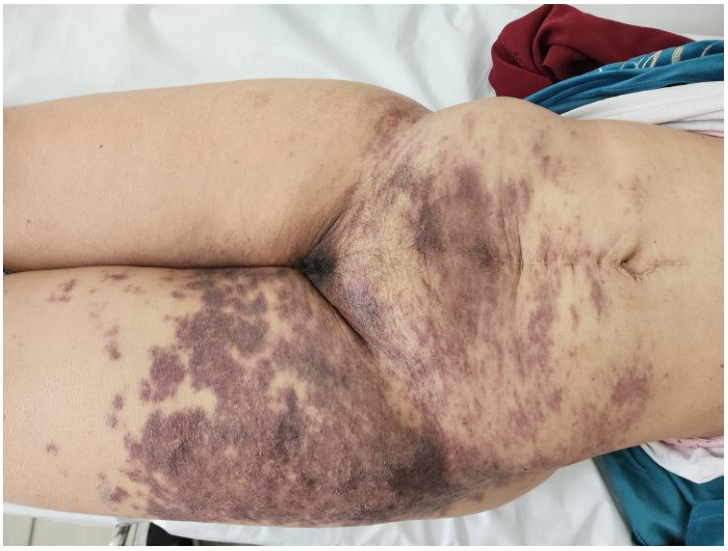

Figure 2: Erythematous-purpuric, indurated, and ecchymotic plaque affecting the anterior surface of the left thigh, extending up to the umbilicus, associated with lymphoedema of the left lower limb.

III. DISCUSSION

Cutaneous lymphangitis carcinomatosis is an uncommon form of skin metastases, representing about 5% of all cutaneous metastases [1]. Breast carcinoma is by far the most common primary neoplasm resulting in skin involvement, while endometrial cancer uncommonly

metastasizes to the skin, with a reported frequency of 0.8% [1,2]. It is caused by cancer cells occluding the lymphatic channels of the dermis [2].

Cutaneous Lymphangitis carcinomatosis is notable for its polymorphic presentation, which includes erythematous plaques, nodules, cellulitis, bullae, and sometimes even ulcerations [3,4]. This variability can complicate diagnosis, as these lesions may mimic benign dermatological conditions. The subtlety of these signs necessitates a high index of suspicion, especially in patients with a known history of endometrial adenocarcinoma. Moreover, the prognosis associated with cutaneous metastasis from endometrial adenocarcinoma remains poor. This aggressive form of metastatic spread is often indicative of advanced disease, correlating with a decline in overall survival rates [3,5].

Due to its rarity, no effective treatment has been established for this particular type of metastasis. However, treatment approaches have been informed by experiences with other forms of metastasis [5]. For most patients, care is palliative, and while chemotherapy and radiotherapy are frequently administered, they often prove ineffective [5].

IV. CONCLUSION

Our two patients represent a dramatic form of skin extension of a common disease. Dermatologists should be aware of the similarities between cutaneous lymphangitis carcinomatosis and other inflammatory skin conditions. Every cutaneous lesion in a patient with a history of cancer should alert the clinicians to the possibility of a cutaneous metastasis and a skin biopsy must be done.

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