

Cutaneous Metastasis of An Endometrioid Adenocarcinoma to The Face

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Abstract

Background: Cutaneous metastasis is uncommon in endometrial cancer. Recurrence to the skin has been demonstrated to occur in the abdomen, pelvis and scalp. This is the first case presented of a cutaneous metastasis to the face.

Case: A 60-year-old Nepalese woman stage 1A grade 1 endometrial adenocarcinoma experienced metastasis to her external iliac lymph node 15 months after her initial presentation. After the recurrence was treated with chemotherapy, she experienced cutaneous metastasis of her endometrial carcinoma to her face 34 months after her initial surgery. The patient passed away 3 months after.

Conclusion: Endometrial adenocarcinoma can metastasize to the face and is associated with a poor prognosis

Keywords: endometrial; adenocarcinoma; cancer; facial; metastasis; cutaneous

Introduction

Endometrial cancer is the sixth most common cancer in women worldwide. [1] The most common presenting symptom of endometrial cancer is postmenopausal bleeding. Though nearly 70% of endometrial cancers are limited to the uterus at diagnosis, for the remaining, the most common locations of metastasis include the vagina, pelvic and para-aortic lymph nodes, peritoneum and the lungs. Less commonly, endometrial cancer can metastasize to the skin. [2] There have been several reported cases of cutaneous metastasis, particularly to the abdomen and scalp. [3] There have been no cases reported of endometrial cancer metastasizing to the face. We present a case of endometrial cancer with metastasis to the face.

Case Report:

A 60-year-old Nepalese nulliparous woman initially presented with complaints of intermittent postmenopausal bleeding for one month. Endometrial biopsy was obtained and revealed endometrial adenocarcinoma, endometrioid type, villoglandular variant. The patient underwent a total abdominal hysterectomy, bilateral salpingo-oophorectomy, bilateral pelvic lymph node dissection and appendectomy. Surgical pathology confirmed the diagnosis and noted that the malignancy invaded less than half of the myometrium, with a maximum tumor dimension of 4.5 cm. Lympho vascular

space invasion and perineural space were absent, and no tumor was found in the lower uterine segment, bilateral fallopian tubes and ovaries. Pelvic washings were positive for malignancy. The patient was staged as stage IA grade 1 endometrial adenocarcinoma. Chest X-ray done at the time was within normal limits. Her postoperative course was uneventful, and she was observed with close follow up.

On routine CT imaging 15 months after her initial surgery, the left external iliac lymph node was noted to be enlarged, measuring 21x11mm. The patient underwent 6 cycles of carboplatin and paclitaxel as per request of the patient. Repeat imaging demonstrated a well-defined cystic lesion measuring 4.1x3.6x3.9 cm in the left external iliac region. Fine needle aspiration of the lesion demonstrated metastatic poorly differentiated adenocarcinoma. The patient received an additional 6 cycles of gemcitabine and carboplatin. The choice of chemotherapy regimen was limited by financial constraint. Imaging at this time demonstrated resolution of the lymph node.

The patient continued with close follow-up and at 34 months after her initial surgery (19 months after completion of her second line of chemotherapy), the patient presented with respiratory difficulty and submandibular swelling (Figure 1).



Figure 1: Patient presentation demonstrating facial mass.

CT imaging demonstrated a right mandibular nodular lesion with multiple discrete nodules in the bilateral lungs. Fine needle aspiration of the right cheek mass was positive for malignancy suggestive of metastatic adenocarcinoma (Figure 2).

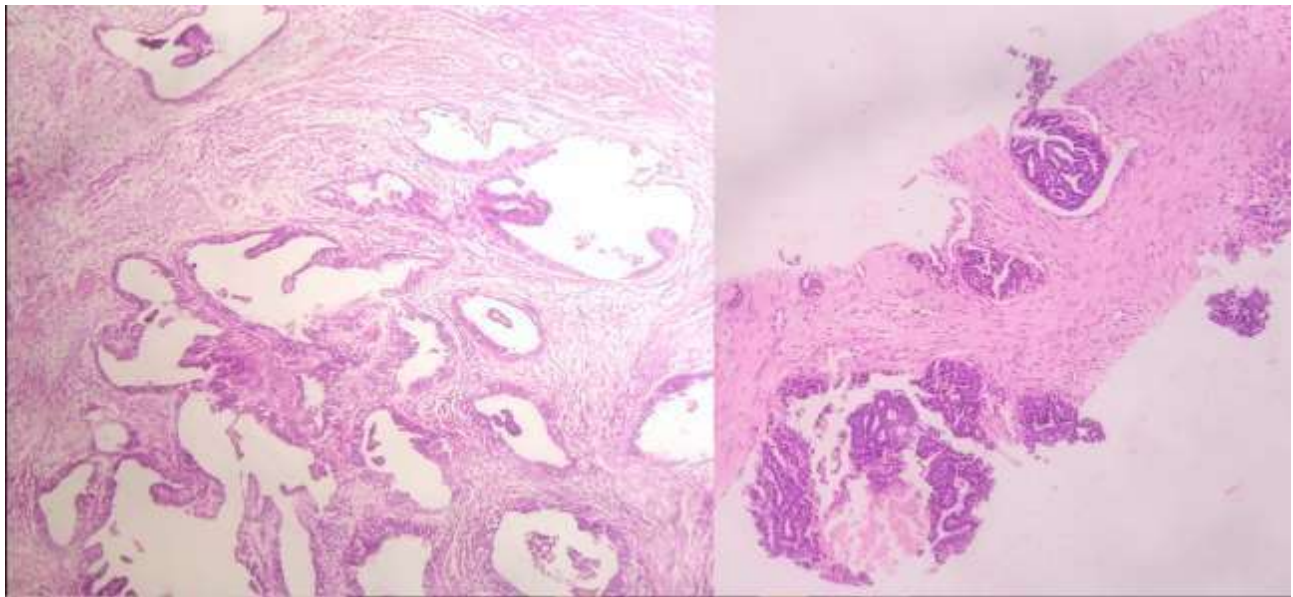


Figure 2: (Left) Histopathology of endometrium demonstrating grade 1 endometrioid adenocarcinoma. (Right) Histopathology of fine needle aspiration of submandibular mass demonstrating adenocarcinoma.

Though the pathology from the original surgery did not match that of facial metastasis, the likelihood of a second primary was low as the patient had no history of tobacco use, betel nut uses or other risk factors. The patient was followed by palliative care and after 3 months, passed away.

Discussion:

Endometrial adenocarcinoma is the most common gynecologic cancer, the five-year survival rate for patients with disease limited to the uterus is up to 95%. For patients with recurrence or disease outside the pelvis, the rate can be as low as 17%. [4] Cutaneous metastasis of endometrial cancer is rare, occurring in <1% of cases. For those with metastasis to the skin, the

prognosis is poor, with the majority of these patients passing away within the next year.

Cutaneous metastasis from endometrial cancer have been found in various sites, most commonly the abdominal wall, umbilicus and scalp. Other reported sites include the external genitalia, surgical site, and lower leg. [3] The lesions often vary morphologically and diagnosis should be confirmed with a tissue biopsy. In most cases, the metastasis is not limited to the skin and the patients present with widespread disease. This is the first reported case of an endometrial adenocarcinoma metastatic to the face. Her unusual site of recurrence in the face highlights the possibility of recurrence not limited to the lymph nodes, abdomen and lungs. In addition to the

cutaneous metastasis, our patient also had metastasis to the lungs and retroperitoneal lymph nodes and after 3 months, succumbed to her disease.

Though this patient received adequate care in a prompt fashion, gynecologic cancer care in Nepal and other resource-constraint countries are not without its challenges. While endometrial cancer may be the most common gynecologic malignancy in the United States, this does not hold true in Nepal (and in low-resource settings) in which the most common gynecologic malignancy is cervical cancer. In Nepal, cervical cancer accounts for 16.4% of all cancer cases and 11.1% of all cancer deaths. [5] This is in stark contrast to endometrial cancer which accounts for less than 1% of all cancers in Nepal.

Patients receiving cancer care in these resource-constraint countries often face long wait times and prohibitive costs. Care is additionally limited by the lack of access to oncologists and health care. Though our patient was able to obtain care in a timely manner, her management plan did not adhere to standard practice due to financial constraints. In addition, her rapid demise after confirmation of her metastasis highlights the need for close follow-up in these patients and the importance of health care access. The poor prognosis in patient with cutaneous metastasis underscores the need for interdisciplinary management and initiation of a goals of care conversation to determine the next treatments, if any, the patient would like to pursue.

Conclusions:

This case underscores the poor prognosis of endometrial carcinoma with metastasis to the skin. Currently, there are no definitive guidelines regarding treatment of endometrial adenocarcinoma with cutaneous metastases; often, patients in this late stage of the disease are treated with radiation and/or chemotherapy. Despite treatment, these patients often do not live past an additional year. The decision to pursue further clinical treatment should be made with a shared decision-making model involving the patient and all his/her healthcare providers. The goals of care should be clearly stated and the treatment plan (or lack thereof) should be made with these goals in mind.

Conflicts of Interest:

The authors declare that there are no conflicts of interest regarding this article.

Author Contributions:

AL and ES contributed to the drafting of this manuscript. SC and LC critically revised and edited the manuscript.

Consent:

Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal on request

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