

## CARCINOMA ERYSIPELOIDES FROM BREAST CANCER MIMICKING AS RADIODERMATITIS: REPORT OF A CASE

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### ABSTRACT

Carcinoma erysipeloides (CE) is an uncommon metastatic pattern arising from visceral carcinoma. As a consequence of lymphatic blockage by the tumor cells, erysipel like appearance can occur. It may be confused with erysipelas and other inflammatory lymphedemas. We report a case of CE in a woman previously treated by mastectomy for locally advanced breast carcinoma. The lesion was clinically mimicked a radiation dermatitis.

**Key words:** Carcinoma erysipeloides, breast cancer, radiation dermatitis

### MEME KANSERİNE BAĞLI GELİŞEN VE RADYASYON DERMATİTİNİ TAKLİT EDEN ERİZİPEL KARSİNOM: OLGU SUNUMU

#### ÖZET

Erizipel karsinom, visseral kanserlerin nadir bir metastazıdır. Lenfatik blokaj sonucu erizipel benzeri bir görünüm oluşmaktadır. Bu da erizipel ve diğer inflamatuvar lenfödem durumlarıyla karışabilmektedir. Biz bu olgu sunumunda, lokal ileri meme kanseri nedeniyle mastektomi yapılmış ve sonrasında erizipel karsinom gelişmiş bir kadın hastayı sunmayı amaçladık. Lezyon, klinik olarak radyasyon dermatitini andırmakta idi.

**Anahtar sözcükler:** erizipel karsinom, meme kanseri, radyasyon dermatiti

Carcinoma erysipeloides (CE) is an uncommon metastatic pattern arising from visceral carcinoma. This metastasis is the clinical representation of the rapid spread of the tumour cells along deep dermal lymphatic vessels. As a consequence of lymphatic blockage, erysipel like appearance can occur. Although CE is often related to breast carcinoma, it can rarely be observed during the course of other malignant tumors such as lung (1), thyroid (2,3), stomach(4), prostate (5) and colon (6) cancers.

### Case Report

A 60-year-old woman had a modified radical mastectomy for left locally advanced breast carcinoma. Pathology showed grade II infiltrating ductal carcinoma, measuring 4 cm and 19/20 positive axillary lymph nodes. She had negative estrogen receptor while her progesterone receptor was positive (%95) accompanied by weak positive C-erb with immunohistochemistry. After surgical treatment, six cycles of adjuvant chemotherapy (epirubicin 75mg/m<sup>2</sup> and docetaxel 75mg/m<sup>2</sup>) followed by 5000 cGy radiotherapy were administered. She also received hormonotherapy (tamoxifen 20mg/day). After 8 months of her initial operation, she was admitted for a symptomatic lesion that covered the incision scar, extending to the infraclavicular and left shoulder areas. On examination, there was erysipelas-like lesion characterized by large, erythematous and edematous plaque with irregular margins lacking clear borders which was considered

as radiation dermatitis initially (Figure 1). We performed punch skin biopsy to establish diagnosis and her pathology report disclosed carcinoma erysipeloides (Figure 2). In further examination, we also revealed contralateral breast mass, 5 cm in diameter. A biopsy taken from this mass revealed metastatic involvement of the right breast. The patient was started on second line chemotherapy consisting of gemcitabine 1250mg/m<sup>2</sup> and paclitaxel 175mg/m<sup>2</sup>. Although we observed well clinical response and the lesion became gradually smaller (Figure 3), there was no pathological response at the 4. month of chemotherapy regimen. Six cycles of chemotherapy was completed and right mastectomy was performed for metastatic contralateral breast carcinoma, which did not respond to chemotherapy, completely. On the contrary, it progressed rapidly and got in characteristics of severe inflammatory carcinoma in a few days, after the cessation of chemotherapy. After 15 days of this operation, she had third line chemotherapy consisting of oral capecitabine 1250mg/m<sup>2</sup>/day per-oral and skin electron beam radiotherapy. Unfortunately, the patient died 1 month later because of metastatic involvement of pleura and severe pulmonary failure.

### Discussion

Cutaneous metastases of the breast malignancies can present clinically as nodules, plaques, and tumors, while the nodular pattern is the most common clinical aspect (7,8). CE which is characteri-



Figure 1. Carcinoma erysipeloïdes that covered the incision scar

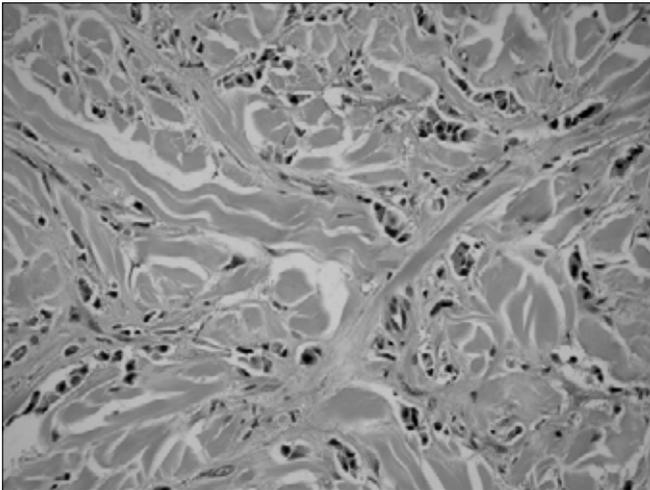


Figure 2. There are strands and groups of tumor cells between collagen bundles and in dilated lymphatics

zed by warm, painful erythematous plaques has the worst prognosis and a less common prevalence rate among them (7). CE is a comparatively rare complication of internal malignancies and is often related to breast carcinoma. Nevertheless, it is found only in less than 2% of all breast carcinoma (9). It can either be primary or secondary (after treatment of a primary breast carcinoma). The latter is observed much commonly (7). The most common localization area of CE is anterior chest wall. The other possible sites are

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Figure 3. The lesion after 4 cycles of chemotherapy regimen

contralateral breast, incision scar, arms and facial skin (7,10). We observed that the lesion was located on the anterior chest wall and covered incision scar, in our case.

Although it has been reported that cutaneous metastases of the breast carcinomas are commonly discovered long after the diagnosis of the primary tumor (7), in our one case, we observed CE 8 months after the initial diagnosis and only 1 month later than the completion of her radiation therapy. Generally, dermatitis and erysipeloïd appearance related to radiotherapy develop during radiotherapy and tend to resolve soon after the completion of such treatments. However, these skin lesions may also continue, even after the completion of radiation therapy (11-13). Consequently, this phenomenon might be confused as radiation inducing dermatitis, easily.

The surgeon must be aware of this condition because CE may be confused with erysipel or other inflammatory lymphedemas such as radiation dermatitis which is a common condition after radiotherapy in breast cancer treatment. In this situation, biopsy of such lesions may lead to establish the exact diagnosis, precluding delay of the already limited treatment options.

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