Angioma like carcinoma telangiectoides: An unusual presentation of breast carcinoma metastasis

Sir,

Breast carcinoma is the most common tumor associated with cutaneous metastasis in women. Cutaneous involvement can occur by direct invasion, local spread through dermal vessels or as distant metastasis. Morphologically, metastasis can present with various clinical and histopathological patterns. We report a patient who presented with telangiectatic carcinoma with angioma-like papules on the breast and anterior chest wall. This case is being reported to depict uncommon morphology of cutaneous breast carcinoma metastasis.

A 51-year-old woman was diagnosed with carcinoma of the left breast, stage T4N1M1, with metastasis to the opposite breast and skeletal metastasis involving the lumbosacral vertebrae. It was infiltrative lobular carcinoma grade 2, estrogen receptor (ER) negative, progesterone receptor (PR) negative and HER 2 positive. She was on palliative chemotherapy. Initially, she received 6 cycles of epirubicin and docetaxel along with localized radiotherapy for skeletal metastasis, followed by 6 cycles of paclitaxel + herceptin and 6 cycles of herceptin + vinorelbine due to initial relapse after 2 months. Positron emission tomography (PET) scan done after the last regimen change showed response to therapy. Subsequently within the next 2 months, she presented with erythema and itching over both breasts associated with erythematous papules gradually extending in size. On examination, there was partially blanchable erythema over the right breast and adjoining part of the left breast including the upper anterior portion of the chest wall [Figure 1]. Overlying the erythema, there were multiple, 1–2-mm sized erythematous nonblanchable, firm, angiomatous papules [Figure 2]. There was no skin induration and no increase in surface temperature but an ill-defined mass could be palpated in the right breast. There was no regional lymphadenopathy. A skin biopsy obtained from one of the red-colored papules revealed a normal epidermis, and in the upper dermis, there were multiple dilated capillaries containing intravascular metastatic deposits of tumor cells [Figure 3]. The tumor cells were ER and PR negative [Figure 4], and HER 2 positive [Figure 5], similar to the primary breast tumor. CD34 staining highlighted endothelial cells indicating the intravascular location of the metastatic deposits [Figure 6]. A diagnosis of carcinoma telangiectoides mimicking angiomas was made. A repeat PET scan done a month after the detection of cutaneous metastasis showed active residual disease in the right breast, left axillary lymph nodes and the right humerus. This prompted the oncologists to change her chemotherapy to capecitabine and lapatinib to which also she responded poorly.

Cutaneous metastasis comprises 2% of all skin malignancies and occurs in 0.6–10.4% of the patients with internal malignancies. In a series of 164 cases by Mordenti et al., it was shown that cutaneous metastasis from breast carcinoma could manifest as papules and nodules (80%), telangiectatic carcinoma (11.2%), erysipeloid carcinoma (3%), “en cuirasse” carcinoma (3%), alopecia neoplastica (2%) or in zosteriform distribution (0.8%). Erysipeloides carcinomasa usually presents as an erythematous, warm, tender plaque on the breast. Telangiectatic carcinoma manifests with papulovesicles, appearing on an erythematous telangiectatic surface, and histologically tumor dissemination is limited to the superficial lymphatics and blood vessels. Apart from breast carcinoma, carcinoma of parotid and uterus can also present as telangiectatic carcinoma. Although presence of papules of variable size and nodules have been noted in earlier case reports, angioma-like red tiny papules, as seen in our case, has not been reported. Other features in our case such as background erythema and absence of induration resembles the telangiectatic carcinoma subtype of cutaneous metastasis. This was confirmed by the presence of tumor cells within the lumen of cutaneous capillaries. Skin metastasis is usually associated with advanced stage of cancer and prognosis depends on the type and biological behavior of the underlying malignancy. The
5-year survival rate reported in cases with skin metastasis is less than 10%, which can be improved to up to 30–35% with a multimodality approach. Difference in prognosis according to different types of cutaneous metastasis is not known. Our patient received several combination chemotherapy regimens to which she had poor response.

Acknowledgement
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Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

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Involvement of scars in capecitabine induced hand foot syndrome

Sir,

Hand foot syndrome (HFS) is a cutaneous toxic reaction to several chemotherapeutic drugs, and is characterized by symmetrically distributed erythema, edema with or without blisters, and erosions over palms and soles. Most common drugs implicated are pegylated doxorubicin, capecitabine, 5 fluorouracil, cytarabine, docetaxel, sorafenib, and sunitinib, etc. 1, 2 Involvement of atypical sites such as the scrotum and penis have been reported in the literature. 3 Here, we report a case of capecitabine-induced HFS involving old scars in addition to the classical sites. We were unable to find any previous reports of scar involvement in HFS.

A 52-year-old woman of type IV skin with metastatic intrahepatic cholangiocarcinoma was referred to the dermatology department of the Institute of Medical Sciences and SUM hospital for hyperpigmentation on her palms and soles for 10 days. She had received eight cycles of gemcitabine and oxaliplatin. This period was uneventful from the dermatological perspective. However, due to disease progression, the patient was administered a regimen of capecitabine (850 mg/m2) and irinotecan (topoisomerase I inhibitor) (180 mg/m2). Five days after receiving the second cycle of irinotecan and capecitabine, she noticed sudden onset of painful erythema over her palms and soles following a prodrome of tingling sensation. Over the next 5 days, the erythema turned into hyperpigmentation with blistering on finger tips and toes. The pain was severe enough to limit the patient from carrying out self-care activities. Simultaneously, two old atrophic scars on the patient's left arm showed similar changes as that of the palm and sole with painful tingling sensation followed by erythema and hyperpigmentation. Her medical history was unremarkable. There was no history of any topical application, relief on cooling, any constitutional features, or bone marrow transplantation in the past. No similar episodes were present following exposure to any medications. On cutaneous examination, there was well-demarcated tender erythema to hyperpigmentation over convex areas of palm and soles with desquamation at the tips [Figure 1]. Similar changes were present confined to two 2 × 2 cm atrophic scars over the left arm [Figure 2]. Mucosae and nail were normal. Systemic examination did not reveal any abnormalities. Complete blood count showed thrombocytopenia with platelet count of 50,000/µl. From history and clinical findings, a diagnosis of grade 3 HFS caused by capecitabine was made as per the National Cancer Institute criteria [Table 1]. 4 Biopsy from the scar site revealed vacuolar degeneration of the basal layer and increased melanocytes in the epidermis consistent with HFS [Figure 3].

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Received: February, 2017. Accepted: September, 2017.

How to cite this article: Patra S, Khandpur S, Khanna N, Jain D. Angioma like carcinoma telangiectoides: An unusual presentation of breast carcinoma metastasis. Indian J Dermatol Venereol Leprol 2018;84:83-5.