Merkel cell carcinoma: literature review

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Merkel cell carcinoma (MCC) was given a such name after the German histopathologist Friedrich Merkel, who first in 1875, described the Merkel cells, as small round or oval basophilic cells located at the end of nerve axons and within the basal layer of the epidermis. The current agreement about the function of Merkel cells they are associated with the nerve terminals acting as mechanoreceptors. MCC is a clinically aggressive uncommon, cutaneous neuroendocrine neoplastic tumour with a high mortality rate. Clinically may be presented as a painless, rapidly growing, dome-shaped red or purplish nodule. Usually in a sun-exposed area of the head and neck or upper limbs. Tremendous effort has been done in the last few years for a better understanding of the pathogenesis behind the MCC and the discovery of the Merkel cell polyomavirus suggests another clue to its pathogenesis. The expression of both epithelial and neuroendocrine immunohistochemical markers in the malignant cells, gives the tumour a unique feature that helps differentiate this neoplasm from other entities.

**Key words:** Merkel cell carcinoma, trabecular carcinoma, Toker tumour, polyomavirus

**Introduction**

Merkel cell carcinoma (MCC) is a highly aggressive neuroendocrine carcinoma of the skin. In spite it is a rare tumour, its incidence is increasing. It is known to have high rates of recurrence and distant metastasis. MCC is a frequently lethal skin cancer with a higher mortality (33%) than melanoma (15%) [1]. This cancer is known with rapid progression course and poor prognosis. British National Cancer Intelligence Network 10 year incidence rate for rare skin cancer across English Cancer Registries (1999–2008) Report revealed evidence for increasing standardised incidence rates of Merkel cell carcinoma (0.1 to 0.2 per 100,000 population). Risk factors include, polyomavirus, UV light, immunosuppression and presence of other cancers as lymphomas.

**Historical background**

Freidrich Sigmund Merkel, a German histopathologist, first described the Merkel cells in 1875 using animal modules. They are clear-staining cells at the dermo-epidermal junction were near myelinated nerve fibers, they acted as mechanoreceptors, other Merkel cells that have no contact with nerve terminals appear to have an endocrine function [2]. Intriguingly, three years later, the term Merkel cell was born by a young anatomist Robert Bonnet who later worked with Dr. Merkel [3]. The first human cases was first reported in 1972 by Toker, who was born in South Africa and worked as a Professor of Pathology at University of Maryland School of Medicine in Baltimore, USA. He used the term “trabecular carcinoma” of the skin to describe a poorly

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differentiated carcinoma of the dermis and subcutaneous tissue [4, 5], this is why some papers called this disease as Toker Tumour.

**Epidemiology, risk factors & pathogenesis**

MCC is a frequently lethal skin cancer with a higher mortality (33%) than melanoma (15%) [1]. This cancer is known with rapid progression course and poor prognosis. British National Cancer Intelligence Network 10 year incidence rate for rare skin cancer across English Cancer Registries (1999–2008) Report revealed evidence for increasing standardised incidence rates of Merkel cell carcinoma (0.1 to 0.2 per 100,000 population). Risk factors include, polymavirus, UV light, immunosuppression and presence of other cancers as lymphomas.

The increased incidence of the disease could be due to actual incidence increase. Other factors are blamed as growing aged population, increased sun exposure (Tropical Holiday Factor), tanning salons, advancement in immunohistochemical diagnostic techniques together with better registration facilities. MCC occurs more often among elderly fare skin patients with somewhat more commonly in males [6]. Most common on sun-exposed areas or artificial light [4, 10, 11]. Predominantly occurred in head and neck area (more than 50%) followed by limbs (40%). The rest 10% reported in the trunk [4]. Non-sun exposed area MCC also has been reported as vulva [12], tongue [13] and gluteal area [14]. In the year 2008, a team from University of Pittsburgh, USA, came with new break through related to the pathogenesis of MCC. It is related to Merkel cell polymavirus (MCV or MCPyV), reports mentioned that it is present in 80% of cases. It is a small novel polymavirus with a genome consisting of double-stranded DNA. Thus, MCV may be a contributing factor in the pathogenesis of MCC [6, 15, 16]. The MCPyV large T antigen contains MCC tumor-specific mutations that withdraw its replication capability, however perpetuate its oncogenic functions, and the small t antigen encourages an environment propitious for carcinogenesis [17, 18].

Immu

**Clinical picture**

Clinical picture could be a reddish blue, firm, non-tender, nodular mass that has grown rapidly over a few weeks or even for months, this may ulcerate. They metastasise to lymph nodes (55%), liver, lung and bones (34–49%) with a local recurrence rate of 40–44% after primary treatment. Rarer sites of metastasis has been described in testis [27], mesentery [28] and tibia [29]. Secondary disease is an indicative feature for poor prognosis.

American Joint Committee on Cancer (AJCC) and the International Union for Cancer Control (UICC) in the year 2010 recommended MCC TNM Staging System. This was based on retrospective study included 5823 from the National Cancer Database registry [30], see Table I.

**Histology**

The microscopic features may show Merkel cells with scanty cytoplasm, a small dark polygonal nucleus with granular chromatin and a high mitotic rate [29]. Generally speaking, the histological features of MCC are similar to those of various other tumours, such as metastatic small cell lung carcinoma, blastic haematological malignancies of skin/soft tissue, and melanoma. Usually presented as composed of strands or nests of uniform, small round cells with scanty cytoplasm, round to oval nucleus with powdery dispersed chromatin, and inconspicuous nucleoli [32], see Figures 1 and 2.

**Immunochemistry**

A distinctive histochemical feature of MCC, is the expression of both neuroendocrine and epithelial markers. It is positive for CK-20, which is a sensitive marker for MCC and present in 90–100% of cases. As CK-20 is positive in some cases of extra-pulmonary small cell lung carcinoma (SCLC) it is essential that, the immunological study should include TTF-1 (Thyroid Transcription Factor-1), which expressed in 80–100% of SCLC but negative in MCC [33, 34]. CD56 is a sensitive marker for MCC but not specific [35]. Other immunohistochemical studies are need to confirm the diagnosis as the markers may coincide. One of those markers is CK-7(Cytokeratin-7) may be positive in carcinoid and basal cell carcinoma but negative in MCC. S-100 protein is another marker used to differentiate between malignant melanoma (usually positive) and MCC (usually negative) [36]. Synaptophysin is a trans-membrane channel protein of small pre-synaptic vesicles. MCC consistently shows positive immunoreactions to synaptophysin [37]. A combined features of cutaneous squamous cell carcinoma (SCC) and MCC noticed in some cases. As the MCC component often
Table I. Summary of the 2010 American Joint Committee on Cancer Merkel Cell Carcinoma staging system by SB Edge 2010

| Primary Tumor (T) | Pathologic, after surgery |
|-------------------|--------------------------|
| TX                | TX                       |
| T0                | T0                       |
| Tis               | Tis                      |
| T1                | T1                       |
| T2                | T2                       |
| T3                | T3                       |
| T4                | T4                       |

| Regional Lymph Nodes (N) | Pathologic, after surgery |
|--------------------------|---------------------------|
| NX                       | NX                        |
| N0                       | N0                        |
| cN0                      | cN0                       |
| pN0                      | pN0                       |
| N1                       | N1                        |
| N1a                      | N1a                       |
| N1b                      | N1b                       |
| N2                       | N2                        |

| Distant Metastasis (M) | Pathologic, after surgery |
|------------------------|---------------------------|
| M0                     | M0                        |
| M1                     | M1                        |
| M1a                    | M1a                       |
| M1b                    | M1b                       |
| M1c                    | M1c                       |

| Anatomic Stage - Prognostic Groups |
|------------------------------------|
| Group | Clinical | Pathologic |
|-------|----------|------------|
| 0     | Tis      | 0          |
| I     | T1       | IA         |
| II    | T2/3     | IIA        |
| IIIC  | T4       | IIIC       |
| IIIb  | Any T    | IIIB       |
| IV    | Any T    | IV         |

Note: Isolated tumor nodes should be considered positive nodes.

exists within the dermis, and not in the epidermis, dermis
including biopsies should be carried out when evaluating
potential NMSC (Non-Melanomatous Skin Cancer). This
enables, not to miss an unrevealed deadly neuroendocrine
element with a too superficial shave, causing delays in di-
agnosis and management of this aggressive and often fatal
tumor [38]. Quantitative polymerase chain reaction (PCR)
assay we used to detect MCPyV (Merkel Cell polyomavirus)
DNA, this was found to be positive in 80% of cases [6, 16].
Most of the recurrence appears within the first six to 12
months after the initial diagnosis [25]. Initial management of the patients has a significant impact on disease progression. This depends on the time of the first presentation and initiating the targeted treatment, this factor is decisive to disease prognosis. Immuno-histochemistry staining for cytokeratin 20 needed for diagnosis.

**Treatment**

Current optimal treatment is with radical surgical excision of the primary tumour, sentinel lymph node biopsy, ± regional lymph node dissection, radiotherapy, chemotherapy & immunotherapy [10, 39, 40].

Advanced Merkel-cell carcinoma often responds to chemotherapy, but responses are transient. Interfering with the programmed death 1 (PD-1) immune inhibitory pathway is of interest, because MCC often express PDL1, and MCPyV-specific T cells express PD-1. Using Pembrolizumab to block PD-1 revealed objective response rate of 56%. Responses were observed in patients with virus-positive tumours and those with virus-negative tumours [41]. MCC response to Nivolumab immunotherapy in the current clinical trials is promising [42].

**Future**

A trial of Pazopanib for Merkel cell skin cancer (UKM-CC-01), Phase 2 Recruitment started: 01/12/2012 and ended: 09/02/2016, currently awaiting results.

**Conclusion**

MCC is an aggressive cutaneous malignancy. The incidence of MCC is on the rise, and steadily ascend awareness along with moving forward in immuno-histochemistry staining techniques have greatly facilitated the diagnosis. The published reports heightened awareness of the association between MCC and other cancers. Further research is needed to explore this issue. Also there is a need to implement evidence-based management guidelines for MCC patients, especially that the inadequate initial management of many patients may contribute to the unfavourable disease progression and prognosis.

**Conflict of interest:** none declared

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