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# UNUSUAL PRESENTATION OF CUTANEOUS METASTASIS TO THE NECK FROM THE PRIMARY GASTRIC ADENOCARCINOMA - A CASE REPORT

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***Abstract***

Cutaneous metastasis to the neck from gastric adenocarcinoma is an unusual site of presentation.

This is a case report of a 70 year old male who underwent gastrectomy for a gastric adenocarcinoma one year ago. He is now presenting with cutaneous metastasis over the neck as nodules and sclerodermal plaques. FNAC from the nodules revealed signet ring cell adenocarcinomatous deposit.

This case has been reported for its unusual presentation. Since Gastric adenocarcinoma usually metastasis to the anterior abdominal wall, perineum and the umbilicus ( Sister Mary Joseph nodule) and the cutaneous metastasis to the neck is an unusual site of presentation.

***Keywords****: Cutaneous metastasis, Gastric adenocarcinoma, Signet ring cell.*

## Introduction

**Case report**

Here is a case of a 70 year old male, farmer presented with the complaints of diffuse swelling over the anterior aspect of neck as nodules and sclerodermatic plaques associated with pain of 2 months duration. The lesion measures about 8x 5 largest and smallest measuring 2 cm dm. There was a past history of gasterctomy done one year ago for unknown cancer, reports were not available.

Fine needle aspiration study was performed, which revealed hyper cellular smear composed of discohesive clusters of malignant cells with signet ring cell morphology.Signet ring cells are cells with intracytoplasmic mucin which pushes the nucleus to the periphery.

Hence the diagnosis of cutaneous signet cell adenocarcinomatous metastatic deposit to the neck probably from the stomach was made.

## Discussion

Cutaneous metastasis from stomach and pancreas usually occur before the discovery of the primary tumor. The usual site of metastasis from gastrointestinal carcinomas are the abdominal wall, perineum and umbilicus (sister Mary Joseph nodule).In one series 10 % of metastasis to abdominal wall occurs in the umbilicus and 28% of those tumors were of gastric origin [(1)].

Esophageal carcinomas occasionally metastasize to the skin. These are usually squamous cell cacinomas that metastasize to the upper trunk and neck as single or multiple nodules. Metastasis of the oseophageal adenocarcinomas have also been reported [(2)].

Adenocarcinomatous deposits are by far the most commonest variant of cutaneous metastasis with the breast being the most frequent source of (up to 23% of cutaneous metastasis most of which occur in women)[(3)]
Lung and large intestine are also important sources of metastatic adenocarcinoma deposit. Other primary sites include the stomach, prostate, pancreas, endometrium, thyroid gland, ovaries and endocervix. They present as

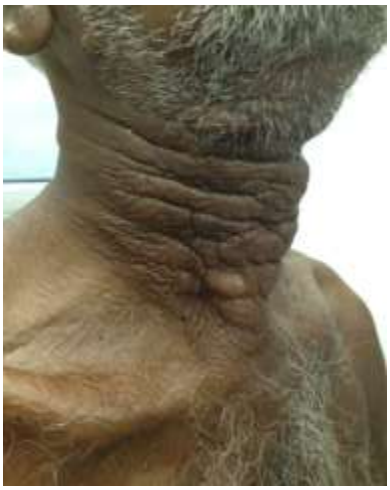
nodular deposit composed of diffuse infiltrate of undifferentiated cells or can present with epidermotrophism and confusion with a superficial spreading melanoma can ensue [4].

Typical of a breast metastasis is the presence of linear dissection of tumor cells between adjacent collagen bundles (stacked penny appearance)
Similar appearances may be seen with a number of other tumors including those of the prostate, stomach, pancreas and small cell carcinoma.
Cutaneous metastasis is defined as deposition of tumor in the skin from a distant location.
It represents approximately 2% of all cases.
Scalp is considered the most common site of metastasis because of its rich vascularity.
The metastasis could be the cutaneous manifestation of an underlying disorder, then it is termed as precocious metastasis. Synchronous metastasis is defined as metastasis occurring at the same time as development of primary disease and metachronus metastasis is defined as the metastasis occurring months or year after the development of primary malignancy.
Clinically most metastasis is seen as nodules or plaques. Most often the metastasis is seen adjacent to the primary site.
Melanoma appears to be the most common primary tumor to metastasize. Other primary sites of carcinomas such as lung, breast, GIT, thyoid are also well known to metastasize to the skin.
Clinically most metastasis is seen as nodules or plaques. Most often the metastasis is seen adjacent to the primary site.
Melanoma appears to be the most common primary tumor to metastasize other primary sites.
Metastasis from gastric carcinoma may occur at any distant site, but the umbilical region is perhaps more common.
Signet morphology may present in stomach Gastric, pancreatic and gall bladder carcinomas that metastasize to skin usually present as nodules, sclerodermoid plaques or Sister Joseph nodules.

## Conclusion

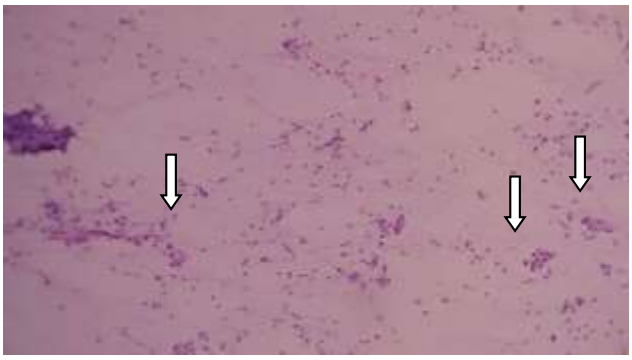
Stomach metastasis are usually anaplastic, infiltrating carcinomas with variable cellularity, a loose stroma and varying proportion of signet ring cell may be seen.
Metastatic adenocarcinomatous deposit from stomach to the neck is an unusual site.

FIGURE 1



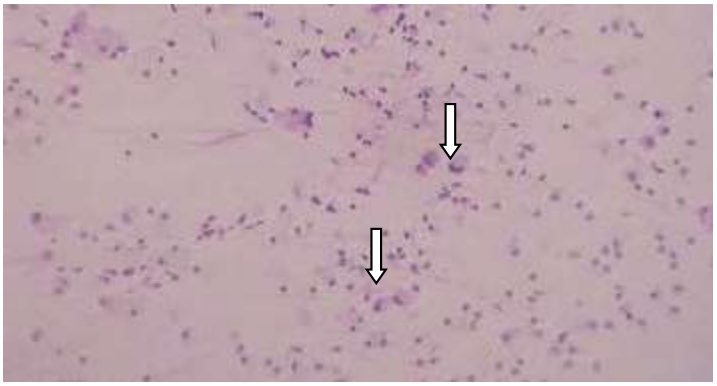
***Diffuse neck swelling presenting as nodules and sclerodermoid plaques.***

FIGURE 2:



***Low power view H&E,X100: Hypercellular smear composed of discohesive cells with signet ring cell morphology. Arrow indicates glandular structures.***

FIGURE 3:



***High power view H&E,X400: Arrow indicating signet ring cells.***

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