

Case 14 A skin tumour

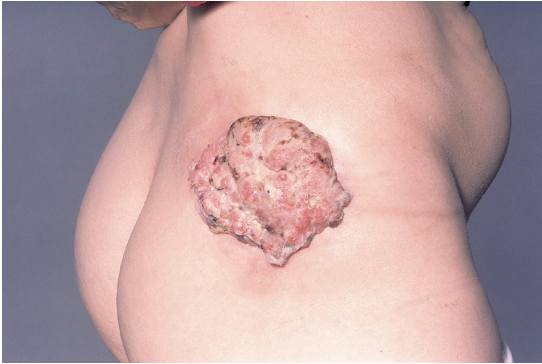


Figure 14.1

This 58-year-old woman actually worked in the kitchen of the hospital canteen. She stated that she had noticed a little lump above her right buttock some 10 years previously. This had slowly but surely enlarged over the years but did not hurt and never bled (Fig. 14.1). She had carefully hidden the lump from her family, including her husband, all this time. Eventually she plucked up her courage and showed her lump to a junior female doctor, who brought her round at once to the surgical outpatient clinic.

What would be your 'spot' diagnosis on looking at this lesion?

It certainly looks like a large squamous carcinoma of the skin.

What would you expect to find on further examination, and where would you examine for evidence of possible metastatic disease?

Sure enough, palpation revealed that the lump was rubbery-hard in consistency, with raised, everted edges. The groins were carefully palpated and enlarged, rubbery-hard nodes were felt on the right side. The rest of the clinical

examination found an otherwise perfectly healthy – but very anxious – woman.

This is a relatively unusual site for this tumour. Where is it more often found?

Squamous carcinoma of the skin usually occurs at sites exposed to sunlight – the face and the backs of the hands.

What are the predisposing factors for the development of this tumour?

Predisposing factors to the development of squamous carcinoma of the skin include, as already mentioned, exposure of white skin to sunshine or to irradiation, exposure to carcinogens (e.g. pitch, tar and soot, malignant change in senile keratosis, lupus vulgaris and chronic ulcers (Marjolin's ulcer*), malignant change in Bowen's disease† (carcinoma in situ) and in patients on long-term immunosuppressive drugs.

Left untreated, what causes death in these patients?

Blood-borne metastases are unusual in this condition. Death occurs from repeated haemorrhages and infection of the mass, when it eventually and inevitably ulcerates, or haemorrhage from ulceration of the involved lymph nodes infiltrating the groin vessels.

How was this patient treated?

The diagnosis was first confirmed by taking a biopsy under local anaesthetic from the tumour edge. This revealed the typical appearances of a moderately well differentiated squamous carcinoma of the skin

*Jean Nicholas Marjolin (1780–1850), surgeon, Hôpital St Eugénie, Paris.

†John Templeton Bowen (1857–1941), dermatologist, Harvard Medical School, Boston.

Part 2: Cases

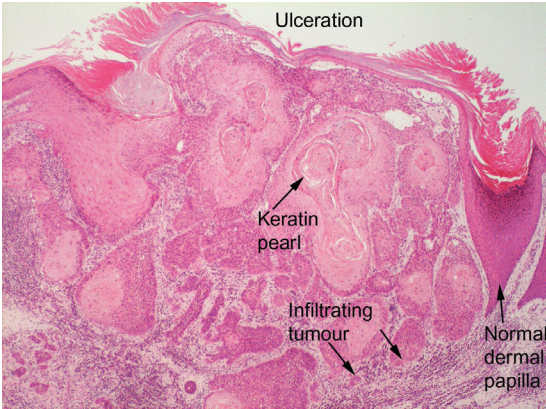


Figure 14.2 Histology of a squamous carcinoma of the skin (magnification $\times 10$, haematoxylin and eosin stain).

(Fig. 14.2). There is ulceration, and tumour is seen infiltrating into the normal adjacent dermis; note the 'keratin pearls' typical of squamous carcinomas.

Wide excision of the primary tumour was performed, with split-skin grafts to the resulting defect, followed by block dissection of the nodes in the groin. She achieved long-term survival!