

Commentary Article

Cutaneous Metastasis of an Urothelial Carcinoma

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The most common sites of metastases of urothelial carcinoma are the lymphatic system, bone, lungs and liver. The cutaneous localization is anecdotic. The aim of this paper is to push clinicians to be vigilant in patients being followed for cancer when a skin lesion appears. We report the case of Mrs. M.B., 62 years old, smoker, previously operated for a muscle-invasive bladder tumor, whom underwent an open pelvectomy with Bricker urinary diversion in 2016. The surgical procedure took place without incident. The inguinal fold is not included in the surgical field. She received neither neoadjuvant nor adjuvant chemotherapy. After a 3 years follow-up with no recurrences on CT-scans and a conserved general condition, an ulceration appeared in the inguinal region (Figure 1). At clinical examination, it was a hard and painful tumefaction, with inflammatory signs, bleeding at any manipulation. The patient received antibiotics (amoxicilline) for 8 days, with no improvement. An 18-FDG pet-scan showed an area of hypermetabolic activity in the same region (Figure 2). We have proceeded to biopsies of this lesion. Histological study showed carcinomatous proliferation compatible with an urothelial carcinoma (Figure 3). The patient is now declared in Stage IV disease, and received a cisplatin-based chemotherapy.

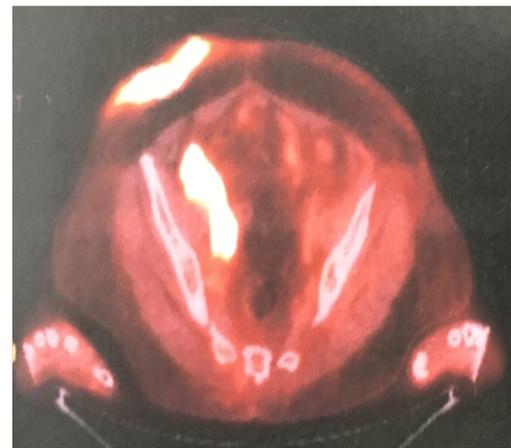


Figure 2.Hypermetabolic areas in the 18-FDG Pet-scan



Figure 1.Ulceration of the inguinal region

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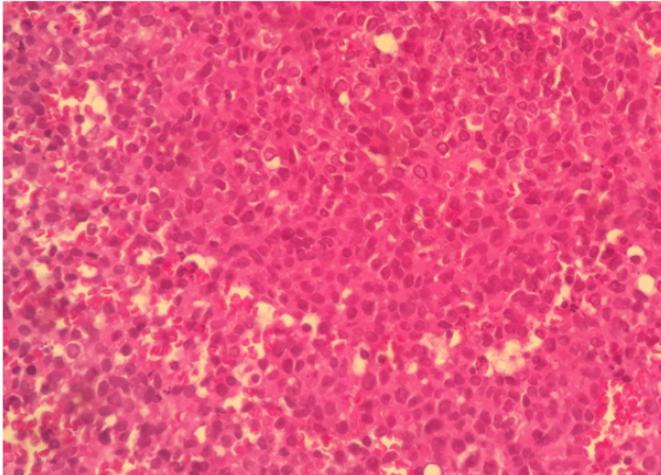


Figure 3. Histology of the biopsy (x100)

Metastatic cutaneous infiltration may have several origins: direct tumor invasion, hematogenous or lymphatic spread, or iatrogenic tumor implantation during surgery. In front of any suspicion of cutaneous metastasis, a biopsy is required. The prognosis is poor with a limited survival, despite a cisplatin-based chemotherapy (GC, MVAC). In fact, cutaneous metastasis are rarely isolated, and indicates the presence of an advanced and aggressive disease.