



Squamous Cell Carcinoma at an Unusual Site – A Rare Case Report

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ABSTRACT

Cutaneous squamous cell carcinoma (SCC) is the second most common form of skin malignancy. It is usually seen on the sun exposed areas of the skin, at the site of chronic irritation and in immunosuppressed individuals. A SCC developing on the waist line is quite uncommon. However awareness of such a lesion developing is important especially in those practicing in rural areas. A case of SCC developing on the waist line is reported along with a brief review of literature.

INTRODUCTION

Cutaneous squamous cell carcinoma accounts for 20% of cutaneous malignancy.¹ These usually arise at the site of sun exposure, chronic irritation or in immunosuppressed individuals.

Wearing tight constricting clothing is commonly seen in rural Indian women. This causes severe irritation at the site of contact of the clothing with the skin leading to depigmentation and latter ulceration. This ulceration if allowed to persist for long can undergo malignant change.

A case of SCC developing at the waist is reported along with a review of literature.

CASE REPORT

A 35 year old female patient presented with a growth over left iliac crest region for the past two and half years which started as 2 x 2 cm growth, insidious in onset and gradually progressed to present size (10 x 8 cm) with an ulceration and fungating growth; not associated with pain / fever and considerable weight loss present

On examination an ulcero-proliferative growth of size 10 * 2 cm, oval in shape, irregular surface and borders which bleeds on touch, restricted mobility vertically and horizontally. Vertical group of lymph nodes are enlarged, 3 in number largest being 2 * 1 cm, mobile, firm in consistency. Metastatic workup revealed no distant metastasis. Biopsy confirmed it as moderately differentiated squamous cell carcinoma (g2). Wide excision with reconstruction was done with 2cm margins. Tumor free margins are achieved and was confirmed by histopathological examination.



Fig 1-Preoperative Exophytic growth of Squamous cell carcinoma over waist

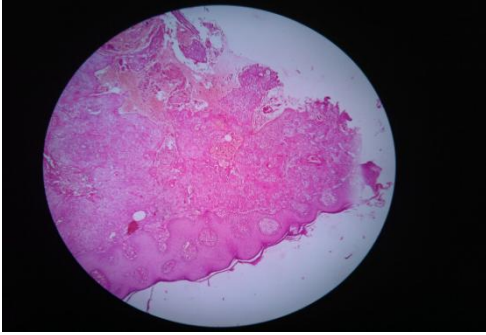


Fig 2- Histopathological picture showing Moderately differentiated squamous cell carcinoma



Fig 3- Postoperative picture of wide local excision & Split skin grafting

DISCUSSION

Cutaneous squamous cell carcinoma (SCC) is the second common form of skin cancer. A multitude of risk factors are associated with the development of squamous cell carcinomas.^{2,3,4,5} Of all these actinic keratosis, chronic ulceration and patients who have undergone solid organ transplants are more at risk of developing SCC.

SCC is a malignant tumor of epidermal keratinocytes. Most squamous cell carcinomas arise from sun induced precancerous lesions known as actinic keratosis. The lesion starts as a squamous cell carcinoma in situ defined histologically by atypical cells involving the full thickness of the epidermis but not penetrating the basement membrane. Clinically these in situ lesions range from scaly pink patches to thin keratotic and papules. Most cutaneous squamous cell carcinomas are capable of local infiltration. The overall risk of metastases to lymph nodes is 2-6%.⁶ However rates as high as 47% have been reported for cases with extensive perineural invasion.⁶

The typical clinical presentation is a raised firm, flesh colored papule or plaque usually in the sun exposed areas. Majority cutaneous squamous cell carcinomas usually occur in the upper part of the body. It is unusual to find a SCC on the waist as in the case reported which makes this presentation rare.

Cutaneous SCC is staged according to the American Joint Committee on Cancer guidelines which uses the TNM classification system. Most SCC lesions are non metastatic at the time of initial presentation. Therefore the staging used is usually based on characteristics of the primary tumor.

Diagnosis of SCC is confirmed by skin biopsy taking utmost precaution to ensure that the biopsy specimen reaches the level of the mid dermis to detect the presence or absence of invasive disease.⁶

Radiological investigations have limited role in the staging of squamous cell carcinomas. They are usually indicated in patients with regional lymphadenopathy or neurologic symptoms suggestive of perineural involvement. CT scanning, MRI, USG or PET scanning can be done.

Treatment of cutaneous SCC includes surgical and non surgical modalities. However conventional surgery still remains the best option. This involves excision of the lesion along with a minimum 4-6mm margin of normal adjacent tissue.⁷ This gives excellent cure rates. In areas such as the face where normal tissue needs to be conserved Moh's surgery is performed.⁸

Nonsurgical options include topical chemotherapy with 5 FU, Topical immune response modifiers such as Imiquimod which enhances cell mediated immune responses via the induction of proinflammatory cytokines.^{9,10} Photodynamic therapy involves application of a photo sensitizer (either topically or systemically) followed by exposure to a light source. The resulting photochemical reaction causes inflammation and destruction of targeted lesions. This method is of specific use in treating actinic keratosis.¹¹

Radiotherapy offers cure rates for early lesions; however the side effects may at times outweigh the benefits of treatment. It is therefore used as an adjunct to surgery especially in patients with nodal metastases.¹² In patients on immunosuppressive therapy the dosage of the immunosuppressive therapy needs to be reduced.¹³ This could lead to increased rate of rejection. Hence for such cases surgical modality of treatment is the best option.

Cryotherapy with liquid nitrogen can be used for superficial lesions. However its use is limited by its inability to penetrate deeper tissues.¹⁴

Awareness of such type of a lesion developing at an unusual site is important for early diagnosis and prompt treatment. Surgery remains the best option with excellent disease free rates for early lesions. Other modalities of treatment may be used as adjuncts to surgery in advanced cases.

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