Chronic unrelieved ulcer on the anterior upper chest of an elderly woman

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A 65-year-old woman presented with complaint of unremitting ulcer between her breasts from 6 months ago. Initially, it was manifested as the development of painless, firm, subcutaneous erythematous nodules that gradually enlarged and evolved into a chronic ulcer. She also had a history of mild weight loss. There was no history of anorexia, fever, cough, hemoptysis, or local trauma.

On physical examination, a 6 by 4 cm ulcer was noted on her anterior upper chest, between breasts, with a little serous discharge and a granulation tissue at the base surrounded by densely erythematous woody margins with some telangiectasia (Figure 1). Breast examination showed a big pendulant breast with no palpable mass. She had also a 2 by 1 cm firm, mobile, non tender left axillary lymphadenopathy. The rest of her physical examination was normal. A previous diagnosis of frictional ulcer was made in her previous visit to the doctor, because she had big pendulant breasts and worn tight-fitting undergarments. She had no improvement with conservative treatments.

Investigation revealed normal levels of complete blood count, ESR, VDRL, plasma glucose, a negative mantoux tuberculin test, and normal chest X-ray. Skin biopsy was performed.

What is your diagnosis?

Figure 1. An ulcer on the anterior upper chest, between breasts, with a granulation tissue at the base surrounded by densely erythematous woody margins with some telangiectasia

Diagnosis

Invasive ductal carcinoma of breast

Microscopic findings

Histological examination of the skin reveals extensive invasion of the fibrotic stroma by pleomorphic groups and cords of tumor cells with abundant cytoplasm, hyperchromatic nuclei and some mitoses. There were marked dilated vessels under the epidermis which consisted of these neoplastic cells and tended to build small ducts and compact cellular cords among the fibrotic tissue. Ulceration of the epidermis in some areas was seen. These findings were consistent with the diagnosis of invasive carcinoma with intravascular carcinomatosis suggestive of invasive ductal carcinoma of breast (Figure 2).

DISCUSSION

Regarding the primary tumors, breast cancer has the highest rates of skin metastases that could occur by direct invasion, lymphatic or vascular spread, or even iatrogenic implantation [1,2]. Cutaneous metastasis could be the initial clinical presentation of breast carcinoma which can present with several morphologies and presentations in different sites of the skin; for example, a palpebral mass on the eyelid- the most common metastatic tumor of the eyelid - or an erythematous nodule at the biopsy site or even rapidly progressive cutaneous metastases which is a presenting sign of breast carcinoma in man [3,4]. The anterior chest wall is the area of greatest predilection as seen in our case [5].

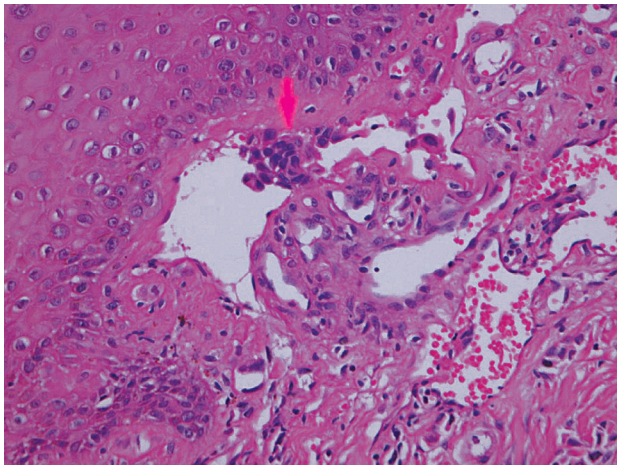

Figure 2. Extensive invasion of the fibrotic stroma by pleomorphic groups and cords of tumor cells with abundant cytoplasm, hyperchromatic nuclei, and some mitoses (H&E*40)

The invasive forms of breast carcinoma have three main types: infiltrating ductal carcinomas, infiltrating lobular carcinomas and other infiltrating carcinomas (special histological types). Patients with invasive lobular carcinoma of the breast have significantly better short- and long-term survival rates and biologically less aggressive than those with invasive ductal carcinoma [6].

We found an abnormal distorted image in her mammography with an irregular, speculated calcification area and mixed solid and cystic components in the in the upper lateral quadrant of her right breast, that was highly suggestive of breast cancer. No distant metastasis was identified in computed tomography and bone scintigraphy. Our case was referred to an oncologist and a surgeon for appropriate treatment including surgery, chemotherapy, and radiotherapy.

In conclusion, we reported a rare case of metastatic carcinoma of the breast in a 65-year-old woman with the clinical feature of a non-healing scrofuloderma-like ulcer on her upper anterior chest, between her breasts. Furthermore, it is important to know that breast metastasis can manifest as a chronic ulcer and physicians should not forget to examine the breasts carefully and to perform appropriate investigations when dealing with these lesions.

REFERENCES

1. Cho E, Kim MH, Cha SH, et al. Breast cancer cutaneous metastasis at core needle biopsy site. Ann Dermatol 2010; 22:238-40.
2. Hu SC, Chen GS, Wu CS, et al. Rates of cutaneous metastases from different internal malignancies: experience from a Taiwanese medical center. J Am Acad Dermatol 2009; 60:379-87.
3. Karakuzu A, Koc M, Ozdemir S. Multiple cutaneous metastases from male breast carcinoma. J Am Acad Dermatol 2006;55:1101-2.
4. Dabski K, Milgrom H, Stoll HL Jr. Breast carcinoma metastatic to eyelids: case report and review of the literature. J Surg Oncol 1985; 29:233-6.
5. Hussein MR. Skin metastasis: a pathologist's perspective. J Cutan Pathol 2010; 37:e1-20.
6. Toikkanen S, Pylkkänen L, Joensuu H. Invasive lobular carcinoma of the breast has better short-and long-term survival than invasive ductal carcinoma. Br J Cancer 1997; 76:1234-40.