

## Carcinoma Ovary with Cutaneous Metastases

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A 45 year old cachexic and pale woman presented on 1<sup>st</sup> February, 2001 with complaints of abdominal distension and swelling on the chest wall of one month duration. There were hard, 1.5 cm sized lymph nodes in the supraclavicular region, and multiple lymph nodes in both axillas. There were 6-7 hard, mobile and nontender nodules aggregated into a 8x8 cm swelling on the anterior aspect of the chest wall, the skin overlying the nodules was free (Photograph 1). Abdominal examination revealed ascites and a 12x10 cm hard, fixed and nontender mass in the right iliac fossa whose lower limit was not reachable. Vaginal examination revealed a normal cervix and a hard nonballotable mass in the right adnexa. Chest x-ray showed bilateral pleural effusion and hilar lymphadenopathy. There was ascites and a mass in the pelvic cavity, primarily in the right adnexa on ultrasound examination of the abdomen. Contrast enhanced computed tomography (CT scan) of the chest and abdomen revealed bilateral pleural effusion, hilar and retroperitoneal lymphadenopathy, ascites, and right adnexal mass. Serum CA-125 levels were 1594 units / ml. Pleural fluid cytology was positive for malignant cells. Fine needle aspiration cytology (FNAC) of the cutaneous nodules and the abdominal lump revealed large clusters of pleomorphic hyperchromatic epithelial cells suggesting deposits of an adenocarcinoma. With a diagnosis of carcinoma ovary stage IV she was started on cytotoxic chemotherapy comprising of cisplatin 75 mg/m<sup>2</sup> and cyclophosphamide 750 mg/m<sup>2</sup>, both given on day 1 and repeated three weekly. After three cycles of chemotherapy, the patient was assessed for response and there was complete regression of the cutaneous metastases and lymphadenopathy and partial regression of the ovarian mass which was confirmed on CT scan of the pelvis. Serum CA-125 levels were 78 units / ml. She underwent a total abdominal hysterectomy with bilateral salpingo-oophorectomy and omentectomy on 5<sup>th</sup> May, 2001 and postoperatively she received three more cycles of the same chemotherapy. At one month follow up she was clinically normal, chest x-ray was normal and CT scan of the pelvis and abdomen were essentially

normal. Serum CA-125 levels further declined to 28 mg / dl. Follow up after one year showed that she was asymptomatic with no evidence of disease clinically, as well as on pelvic and abdominal ultrasound, CA -125 levels were 15 units / ml and chest x-ray was normal.

### Discussion

Ovarian cancers commonly spread by transperitoneal route and usually metastasize to liver and lungs. Cutaneous metastases are rare. Synchronous presentation of cancer of the ovary with generalised lymphadenopathy and cutaneous metastases is even more rare<sup>1</sup>. In a review of 146 cases with cutaneous and subcutaneous metastatic deposits from epithelial malignancies the result of FNAC have been reported<sup>2</sup>. The commonest known primaries were those of the breast, lung and gastrointestinal tract and the unknown primaries, detected later, were those of the gastrointestinal tract, lung, prostate and breast. The reported commonest sites of cutaneous and subcutaneous metastatic deposits were on the chest wall, back, abdomen, head, neck, and upper and lower extremities. Patients with such a presentation should commonly be treated by neoadjuvant chemotherapy followed by adequate surgery depending upon the response.



Photograph 1. Cutaneous metastases on the chest wall.

### References

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