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Cutaneous metastasis of rectal carcinoma: a rare phenomenon with poor prognosis

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Abstract

Cutaneous metastasis from colorectal carcinoma is an uncommon clinical finding. It typically signifies widespread disseminated disease and is associated with a very poor prognosis. A 75-year-old male presented with multiple, progressively increasing, painful genital lesions. His history was significant for rectal adenocarcinoma. Cutaneous examination revealed multiple tender, erythematous, and skin-colored papules and nodules on the scrotum and perineal area. A skin biopsy confirmed the diagnosis of metastatic adenocarcinoma with dermal infiltration of atypical cells arranged in a glandular pattern. This case highlights the importance of considering metastatic disease in any patient with a history of malignancy who presents with new cutaneous lesions. Such metastases often appear years after the primary diagnosis and indicate disease progression, necessitating a thorough evaluation and a shift to palliative management strategies.

Keywords: Adenocarcinoma; Cutaneous Metastasis; Perineal Nodules; Prognosis; Rectal Carcinoma

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Introduction

Cutaneous metastasis from internal malignancies is a relatively rare phenomenon, observed in an estimated 0.7% to 9% of all cancer patients.[1] In the specific context of colorectal carcinoma (CRC), the incidence is reported to be around 3-5%.[1,2] These metastases represent hematogenous or lymphatic dissemination of the primary tumor and are a marker of advanced, stage IV disease. Consequently, the prognosis is invariably poor, with limited survival post-diagnosis.[3,4] The most common sites include the abdominal wall, surgical scars, and the perineal region.[2,5] We present a case of cutaneous metastasis from rectal adenocarcinoma presenting in the perineal region three years after initial treatment, underscoring its clinical significance as a harbinger of widespread disease.

Case Report

A 75-year-old male presented to the dermatology outpatient department with a chief complaint of painful skin lesions in the genital area that had been gradually increasing in number over several weeks. The patient reported the appearance of small bumps on his scrotum and perineum approximately two months prior. The lesions were initially mistaken for a local infection or folliculitis. They failed to respond to topical antifungal and antibiotic creams prescribed by his primary care physician. The lesions progressively increased in number and size, becoming increasingly tender and causing significant discomfort during sitting and daily activities. There was no history of any other chronic illnesses. On examination, the patient was afebrile and his vital signs were stable. Dermatological examination revealed multiple, well-defined, firm, tender papules and nodules ranging from 0.5 to 1.5 cm in diameter over the scrotum and perineum, Figure 1.

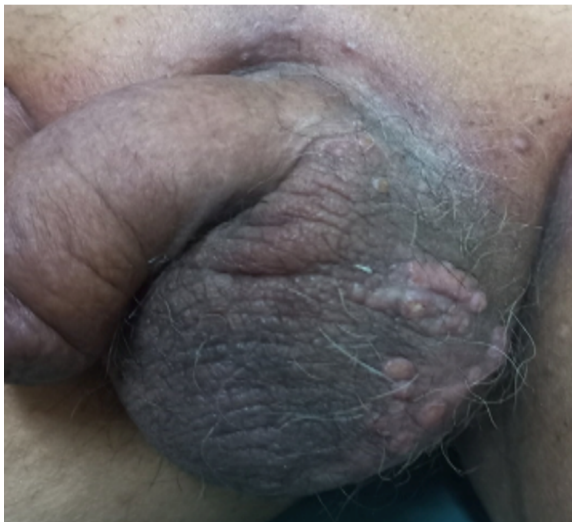

Figure 1. Clinical photograph showing multiple erythematous and skin-colored papules and nodules on the scrotum and perineum

The lesions were predominantly erythematous, with some appearing skin-colored. There was no associated ulceration or discharge. No similar lesions were found on the abdominal wall, extremities, or other parts of the body. General physical and systemic examination did not reveal any hepatomegaly or other significant findings. Given the clinical history and presentation, metastatic adenocarcinoma was the primary differential. A 4-mm punch biopsy was taken from one of the nodules.

Histopathological examination revealed unremarkable epidermis with the dermis infiltrated by nests and glands of atypical columnar cells with hyperchromatic, pleomorphic nuclei and prominent nucleoli, glandular pattern suggestive of metastatic adenocarcinoma, Figure 2.

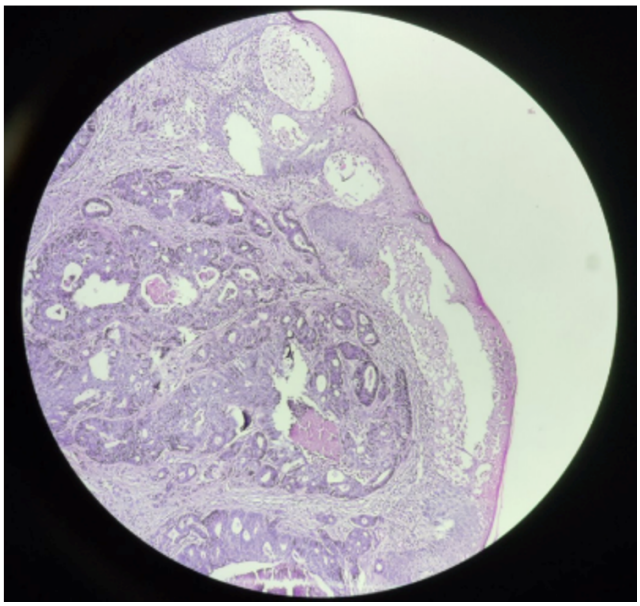

Figure 2. Photomicrograph of skin biopsy (H&E stain, 20x magnification) showing the dermis infiltrated by atypical gland-forming cells (adenocarcinoma structure), consistent with metastatic disease

In light of the disseminated stage IV disease, the patient was not a candidate for curative therapy. The goal of treatment was to control disease progression, alleviate symptoms, and improve quality of life. Palliative chemotherapy was initiated, but the patient's condition worsened. The patient was transitioned to best supportive care and hospice for end-of-life symptom management, focusing on pain control for his tender cutaneous lesions.

Discussion

This case exemplifies a classic, albeit rare, presentation of cutaneous metastasis from rectal adenocarcinoma. It demonstrates several key teaching points consistent with the existing literature.

Firstly, the incidence of cutaneous metastasis from CRC is low, ranging from 3% to 5.6% in large autopsy series, making it an uncommon clinical occurrence.[1,2]

Secondly, the latency period can be highly variable. While our patient presented three years after his initial resection, cases have been reported to appear anywhere from concurrent with the primary diagnosis to over five years later, emphasizing the need for long-term vigilance.[2,4]

The perineal location in this case is a recognized pattern, particularly for carcinomas of the lower rectum and anus, likely due to the mechanisms of spread. Metastases to this region can occur via retrograde lymphatic spread, hematogenous dissemination, or iatrogenic implantation during surgical resection of the primary tumor.[2,5] The clinical morphology of the lesions—multiple, firm, tender nodules—is highly characteristic of cutaneous metastases, though they are often misdiagnosed initially as benign conditions, as in our case.[1] The most critical aspect of this presentation is its prognostic implication. The appearance of cutaneous metastasis is an unequivocal sign of widespread hematogenous dissemination. Studies consistently show a dismal prognosis, with a median survival ranging from 4 to 18 months post-diagnosis.[3,4] Our patient's rapid clinical decline is, unfortunately, a common outcome. Management is purely palliative, aimed at controlling local disease symptoms and systemic progression, though responses are often limited.[3]

This case underscores the vital role of dermatologists and oncologists in recognizing these lesions. Any new, unexplained cutaneous eruption in a patient with a history of cancer, regardless of the time elapsed, warrants a low threshold for biopsy. Early and accurate diagnosis is crucial for appropriate staging, patient counseling, and initiating timely palliative care interventions to optimize the patient's remaining quality of life.

Conclusion

Cutaneous metastasis from rectal carcinoma is a rare but serious sign of advanced, disseminated disease. It carries a grave prognosis and often presents a significant diagnostic challenge, masquerading as benign skin conditions. This case serves as a critical reminder for clinicians to maintain a high index of suspicion for metastatic disease in oncology patients who develop new cutaneous lesions, even several years after successful primary treatment. Prompt recognition through biopsy allows for accurate staging, appropriate palliative intervention, and realistic counseling for the patient and family regarding the disease course and outcomes.

Acknowledgement

None

Conflict of Interest

None

Funding

None

Patient Perspective

The patient and his family were informed of the poor prognosis. They expressed a desire for comfort and quality of life over aggressive intervention, leading to the decision to transition to hospice care.

Informed Consent

Informed written consent was obtained from the patient's next-of-kin for the publication of this case report and accompanying images.

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