LARGE SUBCUTANEOUS TUMOR OF THE LEFT SHOULDER.

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1. Case

A 66-year-old, otherwise healthy man presented to our clinic with a large tumor on the left shoulder. The patient reported that the lesion had initially been a small, firm nodule that appeared six years before, that enlarged slowly during the following years and more rapidly in the past nine months. At first, the patient did not seek medical attention because of hesitation. On physical examination, a smelling, ulcerated, exophytic tumor, with a cauliflower-like appearance, measuring 20x15x6 cm, was observed on the left shoulder (Fig. 1, panel A). There was no palpable lymphadenopathy or hepatomegaly. The laboratory findings included elevated white blood cell count (29,300/μl) with a left shift, with 93% neutrophils, and anemia (hemoglobin 6.8 g/dl). An elevated C-reactive protein level was also found (16.8 mg/dl). A computed tomography scan showed a heterogeneous soft tissue tumor in the left supraclavicular region and shoulder (13x11x12 cm) with hypodense areas suggestive of necrosis (Fig. 1, panel B).

"What is the diagnosis?"

2. Discussion.

An incision biopsy revealed a squamous cell carcinoma (SCC). Surgical excision of the tumor was done. He had a good immediate postoperative course, and grafting with a pectoral muscle flap was performed with axillary lymph node dissection. The definitive histopathological examination confirmed a moderately differentiated SCC with free surgical margins. Currently, two years after surgery, he remains without evidence of ongoing disease (Fig. 1, panel C).

Squamous cell carcinoma (SCC) is a common cutaneous malignancy that can develop on any cutaneous surface, especially in sites frequently exposed to the sun. Involvement of shoulder is rare, reaching less than 5% of cases (1). SCC frequently manifests as erythematous papules, plaques, or nodules. Hyperkeratosis, ulceration, or hyperpigmentation also may be present. Although clinical findings may strongly suggest a diagnosis of SCC, histopathologic examination is necessary to confirm the diagnosis. For lesions clinically suspected to be invasive, a shave, punch, or excisional biopsy that extends at least into the mid-reticular dermis is preferred. Delay in diagnosis may cause the patient to need radical treatment, which is locally destructive, and to have a complicated surgical reconstruction, as was the case here (2). Surgical excision remains as the gold standard treatment, as it provides means for the histological examination of the entire tumor, and allows the surgeon to achieve tumor-free margins around the lesion and also to evaluate other prognostic factors (3).

3. References.

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Figure 1. Clinical examination at the first visit revealed a large cauliflower-like solid tumor on the left shoulder, exhibiting hemorrhage, necrosis and ulcerations (Panel A). CT scan showing a heterogeneous soft tissue tumor in the left supraclavicular region and shoulder (13x11x12 cm) with hypodense areas suggestive of necrosis (Panel B). Image of the patient's left shoulder, two years after surgery (Panel C).

Figure(s)

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