

Rare metastasis of carcinoma ovary

Amitha Kamat, Sahaja Kittur*, Mallikarjun G. Hiremath, Swetha Dama

Department of Obstetrics & Gynaecology, Karnataka Institute of Medical Sciences, Hubli, Karnataka, India

Received: 28 December 2014

Accepted: 11 January 2015

***Correspondence:**

Dr. Sahaja Kittur,

E-mail: drsahajakittur@rediffmail.com

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

This is a case report of a 64 year old para 5 operated 2 years back for ovarian papillary adenocarcinoma presenting 2 years later with cutaneous metastases over anterior abdominal wall.

Keywords: Skin metastasis, Carcinoma ovary

INTRODUCTION

Epithelial ovarian cancer is one of the leading causes of death. The most common sites of distant metastasis are pleura, liver, lung and lymph nodes. Metastases to skin are relatively uncommon.¹ Skin metastasis occurs in less than 3.5% of patients with ovarian carcinoma.^{2,3} Abdominal wall is the most common site for skin metastases, which is adjacent to the primary tumor.⁴ Some cases have been reported with skin metastases in limbs.⁵

CASE REPORT

A 64 year old post-menopausal P5L5 had presented to the gynaec OPD 2 years back with complaints of pain abdomen and burning micturition.

On examination she was found to have an abdominal mass of 24-26 weeks size, which on ultrasound was revealed to be a right ovarian mass of 15 x12 cm size with both cystic and solid components, the largest cyst measuring 10x9.5 cm. CT scan of abdomen showed mixed density predominantly cystic mass measuring 7x8x10 cm noted in the right side of the pelvis extending into right lower abdomen. The mass showed irregular solid components within the lesion. The lesion showed heterogenous enhancement on contrast. Liver-no-metastasis. Impression was primary right ovarian malignancy.

Patient underwent total abdominal hysterectomy with bilateral salpingo-oophorectomy + intracolic omentectomy (staging laparotomy). Intra operative findings - ascites present. Bilateral ovarian tumor right side measuring 8x9 cm with multiple cystic areas and left side 5x2 cm. Stage 3B with omental deposits with omental adhesion on right side. Specimens were sent for histopathological reporting which showed mucinous cyst adeno carcinoma of ovary. Patient was given chemotherapy with injection carboplatin every 21 days for 6 cycles. Patient did not come for follow up after 6 cycles of chemotherapy.

On 1/7/2014 patient came with history of skin lesions on the abdomen since one & half years, insidious in onset, about 15-20 lesions, gradually increasing in size with foul smelling discharge from the lesions, non-blood tinged. History of reduced appetite and easy fatigability present. Patient's vitals were stable. On perabdominal examination there were multiple erythematous raised skin lesions over the periumbilical region & right iliac region with foul smelling serous discharge (Figures 1 & 2). Mild tenderness present on palpation. USG abdomen showed Liver size 14.4 cm, echo pattern-increased, grade1 fatty liver. Gallbladder partially distended. Spleen, pancreas, bilateral kidneys ---normal.

CT abdomen revealed right para umbilical & supravescial cystic lesions as described s/o cystic metastasis.

Umbilical hernia noted. Post hysterectomy & bilateral oophorectomy status.

CA125 69.57 u/ml. Liver and Kidney Function tests were within normal limits. 2D echo within normal limits.

Biopsy of lesions - cutaneous metastatic papillary adenocarcinoma

Oncologist's opinion was sought and injection paclitaxel + carboplatin every 3 weeks was advised for 6 cycles. At 4th cycle on 26/11/14 patients RBS was 168mg/dl & HbA1C was 6.69%. Since then she is on tab metformin 500mg twice a day. Patient has completed her 5th cycle on 20/12/14 with skin lesions reduced in size & with good recovery status without any new complaints.



Figure 1: Skin metastases of ovarian carcinoma.



Figure 2: Magnified view of skin metastases.

DISCUSSION

Distant metastases in ovarian cancer may occur at any stage of the disease or can arise during the evolution of the disease. They are usually associated with disseminated widespread disease and bad performance status. Several theories have been explained the pathogenesis of skin metastasis in ovarian cancer: direct invasion from underlying growth, contiguous extension of the tumor cells through lymphatics, accidental implantation of the tumor cells during surgical procedures. Cutaneous metastases generally present as solitary or cystic painless hard nodules. Prognosis following skin metastases is poor¹ and most important prognostic factor is the time period between diagnosis of primary tumor and development of cutaneous metastases.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: Not required

REFERENCES

1. Shilpaja J. Karpate, Swarnlata L. Samal, Suchi M. Jain. Recurrent ovarian malignancy presenting as cutaneous metastases. Indian J Dermatol. 2009;54(4):380-1.
2. Dauplat J, Hacker NF, Nieberg RK, Berek JS, Rose TP, Sagae S. distant metastases in epithelial ovarian carcinoma. Cancer. 1987;60:1561-6.
3. Merimsky O, Chaichik S, Inbar M. Skin metastases of ovarian cancer: report of three cases. Tumori. 1991;77:268-70.
4. Brownstein MH, Helwig EB. Metastatic tumors of the skin. Cancer. 1972;29:1298-307.
5. Moon-Kyung Kim, Seo-Hee Kim, Yoo-Young Lee, Chel Hun Choi, Tae-Joong Kim, Jeoung-Won Lee, et al. Metastatic skin lesions on lower extremities in a patient with recurrent serous papillary ovarian carcinoma: a case report and literature review. Cancer Res Treat. 2012;44(2):142-5.
6. Cormio G, Capotorto M, Di Vagno G, Cazzolla A, Carriero C, Selvaggi L. Skin metastases in ovarian carcinoma: a report of nine cases and a review of the literature. Gynecol Oncol. 2003;90(3):682-5.

DOI: 10.5455/2320-1770.ijrcog20150244

Cite this article as: Kamat A, Kittur S, Hiremath MG, Dama S. Rare metastasis of carcinoma ovary. Int J Reprod Contracept Obstet Gynecol 2015;4:243-4.