Remission of metastatic primary mucinous carcinoma of the skin with anastrozole.

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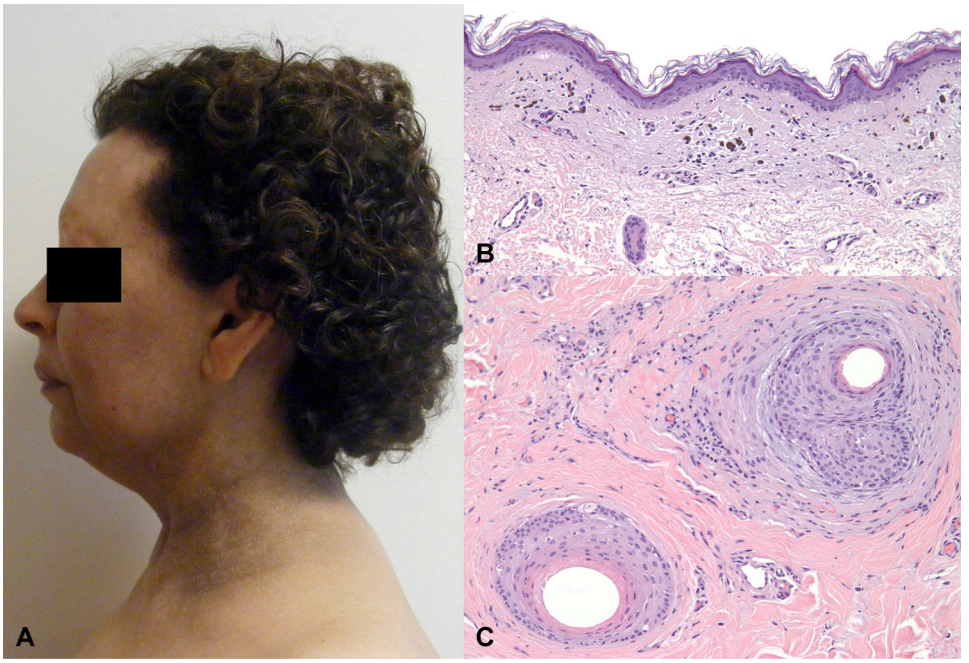

Fig 1. A, Lichen planus pigmentosus and frontal fibrosing alopecia. Diffuse hyperpigmentation of upper chest, neck, and cheeks with loss of eyebrow hair and recession of frontal hairline. **B**, A punch biopsy demonstrates an atrophic lichenoid dermatitis with many perijunctional necrotic keratinocytes and melanophages, as is typical of lichen planus pigmentosus. **C**, Transverse sectioning of a punch biopsy of the scalp demonstrates concentric perifollicular fibrosis, limited compound follicle formation, and a modest lymphocytic infiltrate. This combination is diagnostic of a lymphocyte-mediated primary cicatricial alopecia, and clinicopathologic correlation favored a diagnosis of frontal fibrosing alopecia.

Conflicts of interest: None declared.

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Remission of metastatic primary mucinous carcinoma of the skin with anastrozole

To the Editor: An 80-year-old woman with a recurrent primary mucinous carcinoma of the scalp presented for Mohs surgery (Fig 1). After several stages of Mohs surgery, the tumor was deemed unresectable because of its depth and the extent of bone involvement. Clinical exam, computed tomography, positron emission tomography (PET) scan, and lymph node biopsy revealed mucinous carcinoma in the cervical, hilar, and mediastinal lymph nodes, as well as lung parenchymal involvement. The tumor cells were strongly positive for estrogen receptors (ERs), negative for progesterone receptors (PRs), GCDFP, and CK20. The patient underwent local radiation of the scalp and neck over 6 months. The patient was also started on anastrozole (Arimidex), an aromatase inhibitor, 1 mg daily due to the tumor cells' strong ER positivity. Follow-up PET scan showed no hypermetabolic focus on the scalp, neck, or chest. Five years after diagnosis, no signs of scalp recurrence or metastatic progression can be detected on physical exam or PET scan. Mammography and colonoscopy results continue to be negative. She continues to

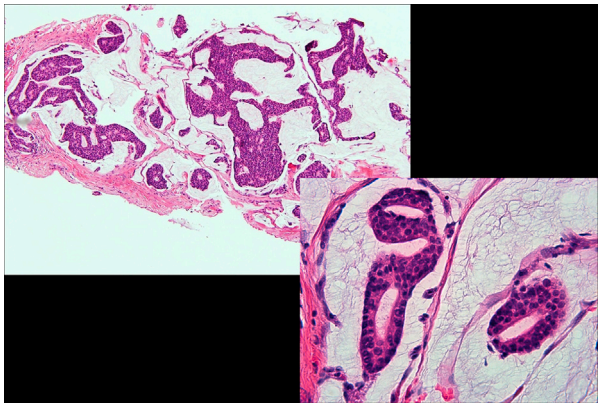

Fig 1. Hematoxylin-eosin stain of primary mucinous carcinoma of the skin.

take and tolerate anastrozole therapy, which was complicated only by a slight decrease in bone density that was stabilized with weekly alendronate (Fosamax).

Mucinous carcinoma of the skin can be locally invasive and approximately 30% recur after excision, but has low rate of regional metastasis through lymphatic spread (9.6%) and only 2% of cases are fatal.[1] It is recommended that patients undergo wide local excision, but recent data have shown Mohs micrographic surgery to be valuable in establishing clear margins and decreased recurrence.[1,2] Unfortunately, as in our case, the tumor is not completely resectable even using Mohs micrographic technique.

Primary mucinous carcinoma of the skin (PMCS) can appear clinically and histologically identical to metastatic adenocarcinomas from other sites such as lung, breast, and colon.[3] It is important to distinguish between the 2 because of the differences in prognosis and treatment. Therefore, the use of imaging studies, immunohistochemical staining of biopsied specimens, and collaboration with oncology staff is often required. Unfortunately, PMCS and cutaneous metastases of mucinous breast adenocarcinoma can be immunohistochemically identical, making differentiation between the 2 impossible without clinical identification of a primary breast carcinoma. Similarities between ER-positive breast carcinomas and ER-positive PMCS, as in our case, suggest that aromatase inhibitors may be beneficial in PMCS. There are 2 major risk factors seen with aromatase inhibitors that should be carefully monitored: osteoporosis with fracture[4] and cardiovascular events due to increased lipids.[5]

In order to prevent local invasion, recurrence, and the rare metastasis, the antiestrogenic medications may be beneficial in PMCS given its similarities to primary mammary mucinous carcinoma and the strong ER positivity found in these tumors.[5] We suggest testing for ER/PR expression in PMCS and advocate for the potential use of aromatase inhibitor therapy in advanced disease.

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