
CASE REPORT

Hepatocellular Carcinoma Metastasizing to The Skin: An Unusual Presentation

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ABSTRACT:

Hepatocellular carcinoma is a common malignancy, however skin metastasis is rare. We report a 65years old male farmer, who presented with a recurring anterior chest wall mass, of several months duration. He had an ulcerated, spontaneously bleeding exophytic tumour on his anterior chest wall, over the lower sternum and upper abdomen. Histologic diagnosis was metastatic hepatocellular carcinoma. The case serves as an example that unusual presentations can occur for hepatocellular carcinoma, necessitating a thorough preoperative assessment of cases presenting similarly.

Keywords: Hepatocellular, Carcinoma, Metastasis

INTRODUCTION

Hepatocellular carcinoma (HCC) is the fourth most common cancer worldwide.¹ The World Health Organization(WHO) reports it as the 7th most common cancer in males and the 8th in females.² Aetiological factors include infection with Hepatitis B, and C viruses, cirrhosis, exposure to aflatoxins, and metabolic disorders like tyrosinosis.^{1, 3} The typical tumour grossly, grows as a unifocal, multifocal or diffuse lesion in the liver.^{2,3} Microscopically, the tumour grows as a conventional or special type. The conventional type of tumour is trabecular, pseudoalveolar, or solid. The fibrolamellar type is a special form of the tumour with a more favorable outcome.

Frequent sites of metastasis include the lungs, lymph nodes, adrenal glands, and bone. Sites of skeletal metastasis usually include vertebrae, ribs, and long bones, though reports of hepatocellular carcinoma manifesting as

mandibular and scapular masses are not uncommon.⁴ Prognosis is universally poor, with most cases dying within a few months after diagnosis. The fibrolamellar type is said to carry a better prognosis if discovered early.

CASE REPORT

We report a 65years old male farmer, who presented with a recurring anterior chest wall mass, of several months duration. He had had a lumpectomy done from the site, about 3 months before presentation. The lump was said to be slowly growing and painless. He did not smoke cigarette or ingest alcohol. His other social histories were not significant. On examination, he was emaciated, moderately pale, dehydrated, anicteric and afebrile. He was fully conscious and oriented, with a raised blood pressure. He had an ulcerated, spontaneously bleeding exophytic tumour on his anterior chest wall, over the lower sternum and upper abdomen, measuring 10 X 4 X 3.5 cm. A clinical impression of squamous cell carcinoma was made, and he was prepared for surgery. The surgery consisted of a wide excision. Intraoperatively, it was observed that the tumour extended into, and destroyed the lower sternum. The wound was packed and dressed daily, with a second surgery involving skin grafting, done 4 weeks later. The

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graft which took and healed well initially later developed nodules. An abdominopelvic ultrasound scan done 8 weeks after the excision biopsy, showed an echogenic mass in the right lobe of the liver measuring 8.9 X 9.3cm, continuous with the area of the chest wall tumour anteriorly. There was also ascitis; however, the other abdominal viscera were within normal limits. Histopathological report of the biopsied lesion, revealed an ulcerated infiltrative tumour growing in sheets, nests pseudoalveolae and trabeculae. It is composed of large hepatoid cells, with vesicular to hyperchromatic, round to oval nuclei, occasional prominent nucleoli and abundant eosinophilic cytoplasm. Occasional greenish granular pigments both intra- and extra- cellularly is seen. Tumour emboli and a moderately inflamed stroma are also noted. A diagnosis of moderately differentiated hepatocellular carcinoma was made. The patient however, was lost to follow up.

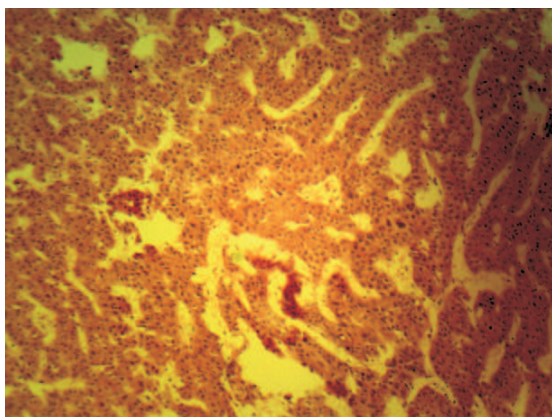


Figure 1: Note malignant hepatoid

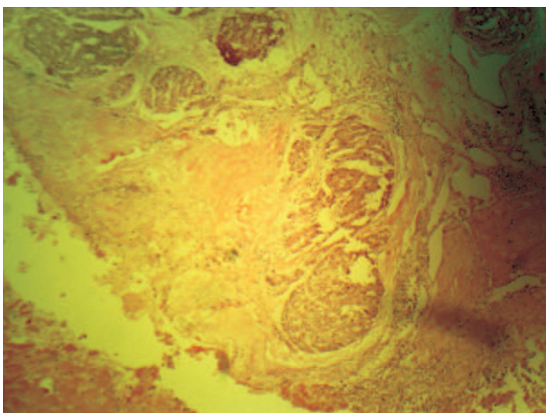


Figure 2: Showed metastatic cells arranged in trabecular pattern. H&E x100 nests. H&E x40

DISCUSSION

Hepatocellular carcinoma is one of the most common primary hepatic malignancies worldwide. Incidence is especially high in China, Japan, Korea, and sub-Saharan Africa, where hepatocellular carcinoma ranks as one of the top four malignancies in adults and has an annual incidence as high as 150 cases per 100,000 population.⁴

This case is rather unusual in the presentation of hepatocellular carcinoma especially, since the tumour is not known to permeate the Glisson's capsule and infiltrate the anterior abdominal wall, presenting as an ulcerated cutaneous lesion. Reported cases in the literature, mention the occurrence of the cancer in the posterior abdominal wall,⁵ along needle tracts;⁶ and also presenting for the first time as a cutaneous mass^{7, 8, 9} or, as a soft tissue mass in the gluteal region⁴.

Some investigations needed to be done in this patient were HBsAg, HCV and α -Fetoprotein assays, these were not done because the clinician had not entertained the diagnosis of hepatocellular carcinoma. The patient was lost to follow-up after discharge from hospital admission and further investigations not done. As a form of ancillary investigation, tumour markers that are relevant in evaluating adenocarcinoma of potential hepatic origin include carcinoembryonic antigen (CEA), alpha-fetoprotein (AFP), vimentin, and anticytokeratins AE1, AE3, and CAM 5.2.^{1, 4}

Once a liver mass is suspected in patients at risk of developing hepatocellular carcinoma, imaging becomes critical in the evaluation of these patients.¹ These imaging techniques include abdominal ultrasound scan, computed tomographic scan and magnetic resonance imaging.

CONCLUSION

This case is instructive in appreciating how difficult working in a resource-poor setting can be especially, considering the fact that the patient's preoperative work up was poor and also, postoperatively, he was lost to follow up. The case also serves as an example that unusual presentations can occur for hepatocellular carcinoma, necessitating a thorough preoperative assessment of cases presenting similarly.

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