

## Incisional Site Metastases of Cervical Carcinoma: A Rare Case Report

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### Abstract

Cervical cancer is the fourth most common cancer in women both in terms of incidence and mortality. Its spread is mainly direct locoregional and to pelvic lymph nodes and uncommonly to liver, lung, and bone via hematogenous route. Still rare is the incisional site or abdominal wall metastases of cervical cancer with reported incidence of 0.1% to 2%. It is associated with poor prognosis and mortality within a year of diagnosis. It is more common in women who do not receive post operative radiotherapy or who receive incomplete radiotherapy. We here report a case of undiagnosed cervical cancer operated earlier for a benign cause and presenting three years later as incisional site metastases.

**Keywords:** Radiotherapy; Cervix; Metastasis

### 1. Case Report

A 51-year-old Para 4 postmenopausal woman presented to gynaecology outpatient department with the complaints of bleeding and unhealthy vaginal discharge and a foul-smelling ulcer on the abdomen for one month. There was an infraumbilical abdominal swelling for the past one year when it gave way and converted into an ulcer (FIG. 1). She underwent abdominal hysterectomy for irregular vaginal bleeding 3 years back of which no records were available. On examination, vitals were stable and there was a 6 cm by 7 cm fixed ulcerative mass occupying the midline infra-umbilically at the previous incision site with sinuses and foul-smelling discharge. The genital examination showed a 4 cm irregular growth at the vault extending to upper 1/3 of vagina, bilateral parametrium involvement up to the lateral pelvic wall and free rectal mucosa. Routine haematological and biochemical investigations were normal. Cervical biopsy showed non keratinizing squamous cell carcinoma. A biopsy from abdominal ulcer showed fibrocollagenous tissue lined with stratified squamous epithelium showing full thickness dysplasia and nuclear disarray. MRI findings correlated with PET CT which showed a hypermetabolic mass in pelvis involving

urinary bladder and another hypermetabolic mass lesion in the anterior abdominal wall with invasion of skin subcutaneous tissue complex and underline muscle.



FIG. 1. A) show the pretreatment view of abdominal ulcer. B) indicates the post therapy contraction in size of the ulcer. C) & D) are the PET Scan images. E) & F) show the histopathology of biopsy from the abdominal ulcer.

She received 6 cycles of chemoradiation with inj Paclitaxel and inj Carboplatin. There was a good response to therapy as the abdominal ulcer showed marked contraction in size, but she succumbed to her disease due to multiorgan failure within 11 months of presentation. The written informed consent for publication of this case was taken from the patient's son.

## **2. Discussion**

Gynaecological malignancies rarely give rise to metastatic deposits on the skin. Cutaneous metastases in cervical cancer have been reported to the abdominal wall, vulva, lower extremities, chest wall and rarely to scalp and face [1].

In a large case series, the incidence of skin metastasis according to the initial tumour stage was 0.8 % in stage I and increased to 4.8% in stage IV. It was higher in patients with adenocarcinoma and undifferentiated carcinoma than in patients with squamous cell carcinoma [2]. Possible theories of metastatic occurrence at the incision site are direct tumour seeding occurring at the time of surgery or fibrin platelet deposits in microcirculation of the wound which may trap circulating tumour cells.

The potential risk factors include immunoreactions, wound hypoxia, acidosis leading to angiogenesis and hematogenous spread. Advanced stage of the disease, adenocarcinoma cell type, peritoneal carcinomatosis and lymph node disease are associated with increased risk. Mechanical port irrigation and direct implantation by instruments and gloves may also contribute to metastatic implants.

Treatment of metastatic disease is mainly palliative and includes chemotherapy, radiotherapy, or wide surgical excision. Reconstruction of the abdominal wall with a latissimus dorsi musculocutaneous flap and mesh have been successfully tried [3]. Platinum based chemotherapy is usually recommended while fluorouracil or topotecan have also been used.

Prognosis in such cases depends upon the time interval between the initial diagnosis of primary malignancy and the appearance of abdominal wall metastasis. The earlier the metastasis, worse is the prognosis. Prognosis is poor because of systemic involvement of the disease, the mean survival being 3 months and survival for more than 1 year is seen in only 20% of patients [4].

## **3. Conclusion**

Careful and close follow up including examination and imaging with special attention to incisional, port, or drain sites is proposed to identify such recurrences. Further case series are required on the role of including incisional site post operative radiotherapy to prevent metastases.

## **4. Author Contribution**

All the authors have contributed in the preparation of this manuscript and there are no conflicts of interests among the authors.

## **5. Disclosure**

The authors declare that they have no conflict of interests.

## REFERENCES

1. Brady LW, O'Neill EA, Farber SH. Unusual sites of metastases. *Semin Oncol.* 1977;4(1):59-64.
2. Imachi M, Tsukamoto N, Kinoshita S, et al. Skin metastasis from carcinoma of the uterine cervix. *Gynecol Oncol.* 1993;48(3):349-54.
3. Neven P, Shepherd JH, Tham KF, et al. Reconstruction of the abdominal wall with a latissimus dorsi musculocutaneous flap: a case of a massive abdominal wall metastasis from a cervical cancer requiring palliative resection. *Gynecol Oncol.* 1993;49(3):403-06.
4. Behtash N, Mehrdad N, Shamshirsaz A, et al. Umbilical metastasis in cervical cancer. *Arch Gynecol Obstet.* 2008;278(5):489-91.