

phototherapy. UVA1-cl therapy rapidly reduced the skin eruptions and a remission was observed which is comparable to that achieved with other phototherapeutic options for SPP (4–7). Owing to the extensive reduction of infrared and erythematogenous wavelengths UVA1-cl phototherapy is an excellently tolerated treatment regimen. Thus, UVA1-cl phototherapy could be a treatment alternative for patients with parapsoriasis who do not tolerate or response to UVB therapy and PUVA. Nevertheless, further clinical trials on a larger study population are required to confirm our results.

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Zosteriform Metastasis of Occult Bronchogenic Carcinoma

Sir,

Lung cancer is the primary cause of cutaneous metastases in males and skin metastases may be the presenting clinical sign of an occult primary pulmonary tumour in these patients. Clinically, cutaneous or subcutaneous metastases lack a uniform or distinctive gross appearance. They present as painless, fixed or mobile, firm or rubbery, solitary or multiple masses, 2–10 cm in size, without notable overlying skin changes (1, 2). Sometimes, exudative ulcers can develop as secondary lesions on the top of previous nodules or plaques. We describe here an unusual presentation of cutaneous metastasis from an occult primary bronchogenic carcinoma appearing as a primitive ulcerative facial lesion with zosteriform distribution.

CASE REPORT

The patient, a 71-year-old man suffering from dyspnoea, dysphagia and declined general health, was admitted with a 5-month history of a primitive indurated ulcer on the right lower part of the face. The lesion, showing a progressive and persistent course, presented a herpes-like, zosteriform distribution because of the unilateral involvement of the right ear, maxilla, mandible, upper labium and chin (Fig. 1). Laboratory investigations were not significant. Histology of a skin biopsy revealed epidermal ulceration and extensive dissemination of tumour cells mainly through the entire dermis. The anaplastic cells, medium or large in size, showed large pleomorphic hyperchromatic

nuclei and varying degrees of differentiation and were mainly arranged in single-row lines or in small groups between the collagen bundles (Fig. 2). In some areas of the upper dermis, the cells seemed to fill dilated lymphatic spaces. Chest X-ray, bronchoscopy and axial tomography revealed diffuse pleural effusion and collapse of the left pulmonary parenchyma because of neoplastic obstruction of the left primary bronchus due to bronchogenic adenocarcinoma. The patient died 3 weeks later from pulmonary failure.



Fig. 1. Extensive ulcerative lesion of the right part of the lower face showing a zosteriform distribution.

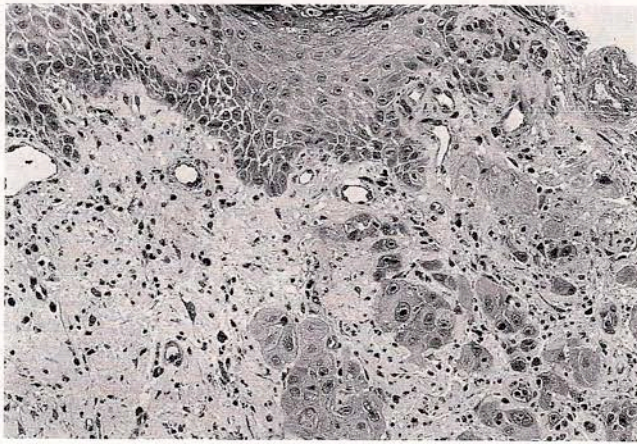


Fig. 2. Spreading of metastatic anaplastic epithelial cells through the dermis (H&E \times 125).

DISCUSSION

Haematogenous or lymphatic metastases are regular complications during the course of lung cancer. Skin metastases are uncommon and less frequent than those to other visceral organs such as suprarenal glands, liver, brain, contralateral lung and bones (1). The reported incidence of cutaneous metastases varies from 2.8 to 7.5% and they always predict an aggressive course of the disease with fatal outcome (2). Among 1,084 patients affected by lung cancer, 34 (31%) developed skin metastases and only in 5 of these latter patients was the cutaneous involvement the first presenting clinical manifestation of the disease (3). Scalp, head, neck and chest are the most common anatomic sites and adenocarcinoma is the most common histology reported (2–4). The development of a solitary skin metastasis in a male patient without a known carcinoma should always raise the suspicion of lung cancer (4). A zosteriform appearance of cutaneous metastases has been described in only a few patients primarily affected by

prostate, lung and transitional cell carcinomas and cutaneous squamous cell carcinoma (5). In our case, the skin lesion was the first presenting sign of the disease. Its unusual clinical presentation, showing a primitive erosive and ulcerative unilateral facial plaque instead of the more common cutaneous or subcutaneous masses, could be explained by the predominant lymphatic dissemination of the neoplastic cells as observed in the histology. Microscopically, the tumour cells mainly showed a superficial growth spread in the upper dermis through the lymphatic vessels. Therefore, a primitive ulcerative indurated lesion should be considered as a possible rare clinical expression of cutaneous metastases from visceral organs.

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