Penile Metastases from Bladder Carcinoma

Sir,
Cutaneous metastatic lesions, on the penis are extremely rare (1–3). Typically, they are associated with an advanced stage of the disease and a poor prognosis. A recent review of the literature showed that 75% of the primary tumours are of genitourinary origin, the most frequent site being the bladder (2). However, carcinomas of the gastrointestinal and respiratory tracts, lymphomas and bone tumours have also been reported to metastasise to the penis (2, 4). We describe one additional case of penile metastases arising from bladder carcinoma.

CASE REPORT
A 60-year-old man presented with nodular, non-ulcerated, violaceous lesions on the penis. One year earlier, bladder carcinoma (ST T3b, G3) had been diagnosed and he was treated with total cystectomy. Physical examination revealed pea-sized, hemispherical, firm, asymptomatic nodules, two of which were located on the glans and one on the shaft of the penis (Fig. 1). Ingualn lymph nodes were not enlarged.

Microscopic examination of one of the nodular lesions revealed a dense diffuse infiltrate throughout the entire dermis. Neoplastic cells showed no tendency to epidermotropism. Higher magnification detected cytomorphic features of large cells with eosinophilic cytoplasm and large basophilic nuclei, and foci of squamous metaplasia (Fig. 2). Vascular spaces were extensively infiltrated by neoplastic nests. The mitotic rate was high. Results of immunohistochemical staining (immunoperoxidase technique) with monoclonal antibodies against tissue polypeptide antigen (TPA), pan-cytokeratins (CKs), CK8, CK18 and CK19 were positive. Carcinomembranotypic antigen reaction was negative.

At this time, the patient complained of progressive weakness, anaemia, lumbar and lower extremities pain. Magnetic nuclear resonance of the spinal backbone showed hypodense, irregular areas located on L2-L5, D12 and D11 vertebrae, consistent with a diagnosis of bone metastases. Computed tomographic scans of the chest and abdomen were negative.

Based on clinicopathological findings, a diagnosis of penile metastases was made. The patient died of widespread disease 2 months after our observation. An autopsy was not performed.

DISCUSSION
Clinical features of metastasis to the penis are diffuse penile induration, single or multiple, rarely ulcerated, nodules (2, 3). The lesions usually involve the shaft of the penis; less often, as seen in our patient, they are located on the glans (3–8). Signs and symptoms of penile metastases consist of urinary retention, dysuria, haematuria, priapism and penile pain. The clinical differential diagnosis may include primary tumours of the penis, true priapism, Peyronie’s disease, tuberculosis and unspecific inflammatory lesions. In our patient, the past medical history was remarkable for bladder carcinoma.

Urinary bladder tumours are most frequently of epithelial origin. Approximately 93% of the primary bladder cancers...
The Sarcoïdosis-Lymphoma Syndrome: Acceleration of the Cutaneous Sarcoïdosis during Chemotherapy of the Lymphoma

Sir,

The sarcoïdosis-lymphoma syndrome is characterised by a lymphoproliferative disorder that develops after the onset of sarcoïdosis. We report here a patient with this syndrome who developed a low grade B cell non-Hodgkin’s lymphoma (NHL) after sarcoïdosis. During treatment of the lymphoma his cutaneous sarcoïdosis became rapidly worse.

CASE HISTORY

A 36-year-old man presented an annular lesion over his presternal region (Fig. 1). Diascopy suggested a granuloma and histological examination of a skin biopsy confirmed the clinical diagnosis of sarcoïdosis. At this stage all haematological and biochemical investigations, including an angiotensin converting enzyme level, were normal. However, a chest X-ray demonstrated bilateral hilar lymphadenopathy.