

Coalescing Papules on the Pubis in an Ovarian Carcinoma: A Quiz

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A 79-year-old woman was referred to our dermatology department with a 15-day history of erythematous, infiltrated, and painful papules with a burning sensation, coalescing on the pubic and suprapubic areas. A fungal infection was initially suspected and treated with topical antimycotics, without success. She had a history of high-grade serous ovarian adenocarcinoma diagnosed 6 years earlier, with pulmonary and lymph node metastases unresponsive to successive lines of chemotherapy. At the time of consultation, she was undergoing fifth-line treatment with enfortumab vedotin, an anti-Nectin 4 monoclonal antibody conjugated with monomethyl auristatin E.

On physical examination, there was an erythematous infiltration of the pubis extending to the labia majora (Fig. 1A). Multiple infiltrated scattered papules were observed on the suprapubic area (Fig. 1B).

What is your diagnosis?

- 1: Deep fungal infection
- 2: Mycobacterium infection
- 3: Cutaneous metastases
- 4: Enfortumab vedotin side effect

See next page for answer.

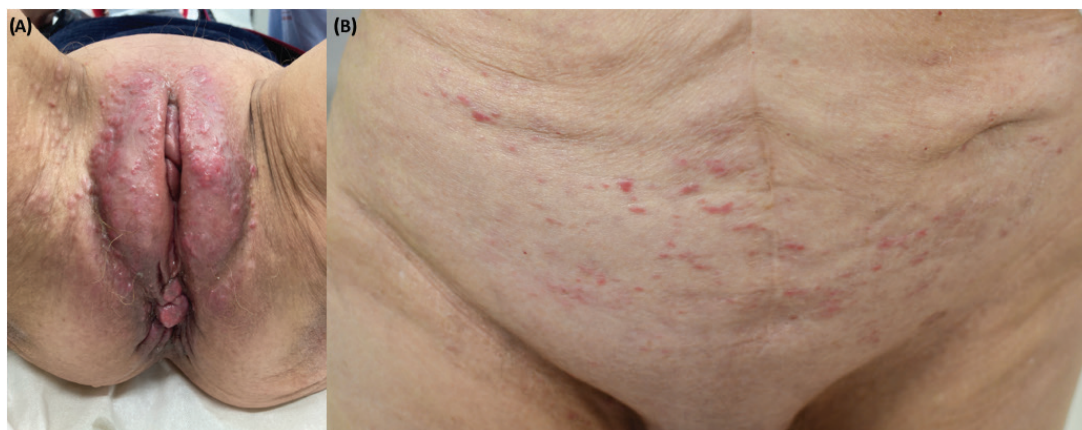


Fig. 1. Clinical presentation. (A) Erythematous and infiltrated, coalescing papules on pubis. (B) Multiple infiltrated scattered papules were observed on the suprapubic area. The patient expressed no objection to the publication of her clinical case.

ANSWERS TO QUIZ

Coalescing Papules on the Pubis in an Ovarian Carcinoma: A Commentary

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Diagnosis: Carcinoma en cuirasse as a manifestation of cutaneous metastases from ovarian cancer

A skin biopsy (Fig. 2A) revealed the presence of a dense dermal infiltrate composed of large tumoral cells arranged in papillary, labyrinthine (with slit-like spaces), and glandular architectures. The nuclei were large and markedly atypical with numerous atypical mitoses. Immunohistochemistry showed diffuse expression of WT1 (Wilm's tumor 1), CK7 (cytokeratin 7), and PAX8 (Paired Box 8) (Fig. 2B), while oestrogen and progesterone receptor expression was heterogeneous. The p53 expression followed a wild-type pattern. These histopathologic and phenotypic presentation was suggestive of cutaneous metastases from the ovarian cancer.

A total-body CT scan revealed concomitant neoplastic progression in the bladder, new peritoneal effusion, and axillary lymph node involvement. Despite a new therapeutic line with irinotecan, the patient's general condition deteriorated rapidly, leading to death within 2 months after the initial appearance of cutaneous metastases.

This case is informative in several ways. First, cutaneous metastases are uncommon in ovarian cancer, with an estimated incidence of 3.5% (1). They are typically classified as umbilical region metastases (Sister Joseph's nodules) and non-umbilical metastases, which frequently develop on surgical scars (1), with a different presentation from that of our patient.

Second, carcinoma *en cuirasse* is a rare form of cutaneous metastasis named for its resemblance to a piece of armour due to extensive tumoral infiltration and fibrosis. It is most commonly observed in breast cancer, where it remains rare (~3%) (2). Other reported cases include pulmonary, renal, and digestive cancers (3). When associated with breast

cancer, carcinoma *en cuirasse* usually appears on the thorax or abdomen within a mean of 3 years after the diagnosis of cancer, but can occasionally be the first sign of malignancy. In all cases, it is associated with therapeutic resistance and poor prognosis (4).

Our case represents a typical presentation of carcinoma *en cuirasse*, characterized by massive tumoral infiltration and a rapid, unfavourable outcome. However, the localization on the pubis and its ovarian origin are exceptional. A literature search revealed only one reported case of vulvar carcinoma *en cuirasse* associated with cervical cancer (5). Moreover, histological examination in our case did not show interstitial infiltration between collagen fibres, fibrosis, or vascular changes, which are usually characteristic of this entity. This could be attributed to the short duration of evolution before biopsy (15 days) in our case, insufficient for significant fibrosis development.

This case underscores the importance of histological and immunohistochemical analysis of any new cutaneous lesion arising in oncology patients. Carcinoma *en cuirasse* can mimic benign dermatoses, leading to delayed diagnosis and management. Early recognition is crucial, as this manifestation is associated with a poor prognosis and requires urgent therapeutic intervention.

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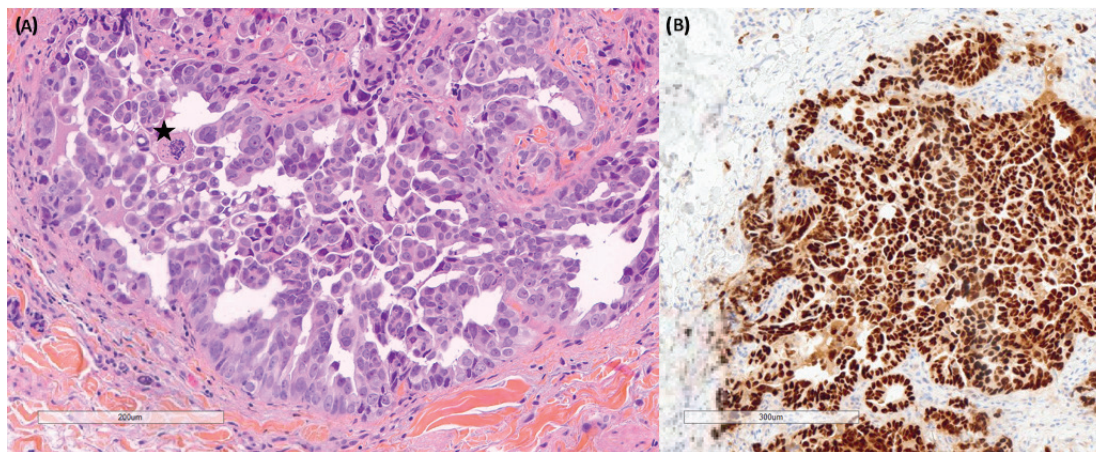


Fig. 2. Skin biopsy. (A) Papillary and labyrinthine architecture of the tumour. Note the atypical mitosis (black star) (HES, x10). (B) PAX8 immunostaining with strong nuclear expression in all tumour cell nuclei (x8).