



## Case Series

# Would Marjolin see it coming? Two unusual cases of squamous cell carcinoma



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## ABSTRACT

**INTRODUCTION:** Cutaneous squamous cell carcinoma (SCC) is a common skin cancer, second in incidence only to basal cell carcinoma (BCC). The incidence of SCC increases significantly with age; thus, it is rarely diagnosed in young patients. In this paper, we present two cases of young patients who presented clinically with purulent lesions that were later diagnosed as large primary SCCs.

**MATERIALS AND METHODS:** A review of the medical records of two patients who were admitted to the department of plastic surgery with a final clinical diagnosis of cutaneous SCC was conducted. Information of the review included history, physical examination, laboratory tests, imaging studies and histology. A literature review was also conducted and discussed.

**RESULTS:** Two female patients under the age of 45 presented with large, purulent lesions that were initially clinically suggestive of an infectious etiology. The lesions were surgically treated by incision and drainage without sending tissue samples to pathology. Biopsies of the lesions were performed to obtain a tissue diagnosis due to recurrence approximately one year after the initial treatment. Histological evaluation revealed well differentiated squamous cell carcinomas. Surgical intervention with wide excision with adjuvant chemotherapy was recommended based on biopsy and CT scan results.

**DISCUSSION:** Aggressive behavior of SCC in young patients is uncommon. The patients in this report were diagnosed only one year after the first sign of the lesion. One patient was first diagnosed with an abscess, and the other with necrotizing fasciitis. The delayed diagnosis of SCC in these two patients is a potential contributing factor to the aggressiveness of the tumors. Therefore, it is imperative to perform skin biopsies of chronic or persistent purulent lesions to rule out malignancies including Marjolin's ulcer.

**CONCLUSION:** Aggressive SCC should be suspected in cases of persistent and relapsing purulent lesions in all patients.

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## 1. Introduction

Cutaneous squamous cell carcinoma (SCC) is the second most common skin malignancy after basal cell carcinoma (BCC) and can present with a wide variety of clinical manifestations [1,2]. It accounts for approximately 20% of all nonmelanoma skin cancers in the United States [1–4]. The incidence of SCC increases with age and is 5–10 times higher for those 75 years of age or older [5,6]. There are numerous environmental and genetic risk factors that contribute to the development of SCC, which include UV light, radiation, immunosuppression, chronic inflammation, smoking, HPV

infection, drugs, family history, inherited disorders such as xeroderma pigmentosum and others [1,2,7–10].

SCC is most commonly seen in fair-skinned individuals in locations that are frequently exposed to the sun [11]. A thorough and complete physical examination, including lymph nodes, is necessary to detect potential lesions, and the final diagnosis is made by histopathologic analysis of skin biopsy specimens [1,11,12]. Treatment of SCC involves surgical excision, with radiation and systemic therapy in case of a regional or metastatic disease. The patient specific treatment plan is based on a risk assessment for local recurrence and metastasis [13–16]. Regional lymph node involvement and metastases are rare and associated with increased mortality [17–21]. Although the five-year cure rate is greater than 90%, all patients require long term oncologic follow up even after successful treatment.

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**Fig. 1.** The gluteal area showing extensive tumor formation with ulcerative surface.

Marjolin's ulcer refers to a rare but highly aggressive ulcerating SCC, which presents as a non-healing wound or painless ulcer [22]. It is associated with chronic inflammatory states, such as venous ulcers, lupus vulgaris, vaccination scars, snake bite scars, pressure sores, osteomyelitis zones and radiotherapy areas. The majority of purulent Marjolin's ulcer lesions described in the literature are pilonidal abscesses [11,22–24].

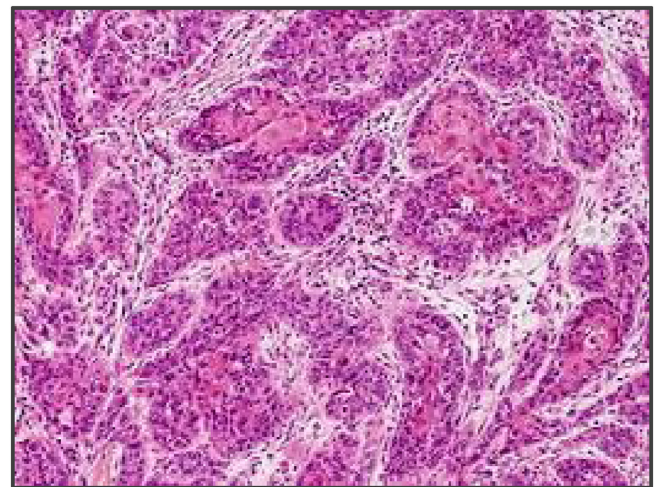
Here we discuss two cases of rare Marjolin's ulcer in northern Israel.

## 2. Case reports

### 2.1. Case 1

A thirty-two-year-old female presenting with a left-sided gluteal abscess was hospitalized in the general surgery department. Her medical history included spina bifida (meningocele) with resultant paraplegia and urinary retention requiring self-catheterization. During the hospitalization, she underwent debridement of the involved gluteal skin and received intravenous antibiotics. However, a biopsy of the affected gluteal tissue was not taken, hence a histopathologic analysis was not performed. The patient was offered a diverting colostomy to keep the abscessed area clean to facilitate healing, however, this intervention was declined. On the second post-operative day, the patient became septic despite receiving intravenous antibiotics. A subsequent CT scan revealed multiple abscesses, which were then incised and drained in the operating room. The patient was discharged following an uneventful postoperative course.

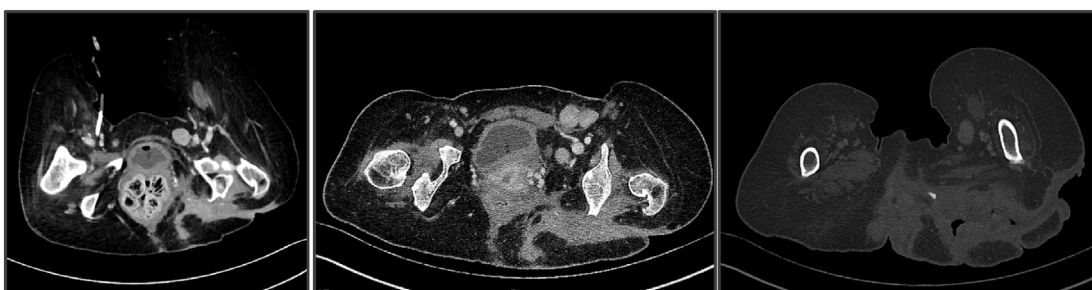
Eight months later, the patient was admitted to our hospital and diagnosed with necrotizing fasciitis in the same left-sided gluteal region. She refused any definitive surgical treatment but agreed to a biopsy, which revealed a well-differentiated squamous cell carcinoma (see Fig. 1). An initial CT scan showed multiple bur-



**Fig. 3.** Histological biopsies confirmed the diagnosis of a well differentiated squamous cell carcinoma.

rows and enlarged lymph nodes (see Fig. 2a–c). Additional CT scans of the thorax and abdomen demonstrated no evidence of distant metastases. Repeat biopsies of the lesion were performed, and the diagnosis of a well differentiated squamous cell carcinoma was confirmed (see Fig. 3).

A multidisciplinary team including plastic surgeons, orthopedic oncologic surgeons, general surgeons and medical oncologists advised her to undergo extensive surgical intervention including hemipelvectomy, abdominoperineal resection (APR) and colostomy. The patient refused any surgical intervention. She was then referred for chemotherapy and began treatment with a regimen of cis-platinum, 5-fluorouracil (5FU), and Erbitux (cetuximab). This chemotherapy was unsuccessful, and the patient passed away



**Fig. 2.** a–c: CT scan showed multiple burrows and enlarged lymph nodes.

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