

association of acanthosis nigricans and Leser-Trélat sign.

Regarding the association of this sign with the various kinds of tumors and their sites of origin, the sign has been reported in relation to adenocarcinoma and squamous carcinoma of the lung,³ leiomyosarcoma,¹ melanoma,^{7,8} lymphomas, leukemia, and Sézary syndrome.^{2,5,9-11} Only 1 case of transitional cell carcinoma of the bladder has been reported to date,¹² although the most common tumors are adenocarcinomas, with more than 50 case studies published. These include adenocarcinoma of the stomach and others of the gastrointestinal tract, as well as breast tumors.¹

The course of Leser-Trélat sign usually runs parallel to that of the underlying neoplasm, although in some published cases, the lesions did not remit with satisfactory treatment of the neoplasm. In our patient, the lesions disappeared after appropriate treatment of both neoplasms, an outcome we consider to be an additional argument to believe that this was a true paraneoplastic syndrome.

References

1. Schwartz RA. Sign of Leser-Trélat. *J Am Acad Dermatol.* 1996;35:88-95.
2. Dantzig PI. Sign of Leser-Trélat. *Arch Dermatol.* 1973;108:700-1.
3. Heaphy MR Jr, Millns JL, Schroeter AL. The sign of Leser-Trélat in a case of adenocarcinoma of the lung. *J Am Acad Dermatol.* 2000;43:386-90.
4. Heng MCY, Soo-Hoo K, Levine S, Petresek D. Linear seborrheic keratoses associated with underlying malignancy. *J Am Acad Dermatol.* 1988;18:1316-21.
5. Horiuchi Y, Katsuoka K, Takezaki S, Nishiyama S. Study of epidermal growth activity in cultured human keratinocytes from peripheral-blood lymphocytes of a patient with Sézary syndrome associated with the Leser-Trélat sign. *Arch Dermatol Res.* 1985; 278:74-6.
6. Horiuchi Y, Katsuoka K, Tsukamoto K, Takezaki S. Leser-Trélat associated with Sézary syndrome. *Cutis.* 1985;36: 4009-10.
7. Ellis DL, Kafka SP, Chow JC, Nanney LB, Inman WH, McCadden ME, et al. Melanoma, growth factors, acanthosis nigricans, the sign of Leser-Trélat and multiple acrochordons: a possible role for alpha-transforming growth factor in cutaneous paraneoplastic syndromes. *N Engl J Med.* 1987;317:1582-7.
8. Fanti PA, Metri M, Patrizi A. The sign of Leser-Trélat associated with malignant melanoma. *Cutis.* 1989;44: 39-41.
9. Blázquez E, Fernández-López E, Fernández-Canedo I, de Unamuno P, Martín-Pascual A. Signo de Leser-Trélat asociado a síndrome de Sézary. *Actas Dermosifiliogr.* 2003;94:309-12.
10. Cohen JH, Lessin SR, Vowels BR, Benoit B, Witmer WK, Rook AH. The sign of Leser-Trélat in association with Sézary syndrome: simultaneous disappearance of seborrheic keratoses and malignant T-cell clone during combined therapy with photopheresis and interferon alfa. *Arch Dermatol.* 1993;129:1213-4.
11. Ikari Y, Ohkura M, Morita M, Seki K, Kubota Y, Mizoguchi M. Leser-Trélat associated with Sézary syndrome. *J Dermatol.* 1995;22:62-7.
12. Yaniv R, Servadio Y, Feinstein A, Trau H. The sign of Leser-Trélat associated with transitional cell carcinoma of the urinary-bladder: a case report and short review. *Clin Exp Dermatol.* 1994;19: 142-5.

Gastric Adenocarcinoma Presenting as Generalized Cutaneous Metastases

FJ Nicolás-Sánchez, J Garreta-Messegue, L Fernández-Cabrera, RM Sarrat-Nuevo, ME Nicolás-Sánchez, and J Cabau-Rubies

Servicio de Medicina Interna, Hospital de Santa María, Lleida, Spain

To the Editor:

Cutaneous metastases originating from internal visceral neoplasms are rare, with an incidence among cancer patients of 0.71% to 9%, according to published

series.¹ Only 6% of cutaneous metastases secondary to solid visceral tumors are caused by gastrointestinal carcinomas.²

We describe a 72-year-old man, ex-smoker of 30 cigarettes/d, with a history

of alcoholism (alcohol intake of about 80 g/d). He consulted for several episodes of rectal bleeding, reporting the onset of multiple subcutaneous nodules in the last month, anorexia, and a weight loss



Figure. Multiple subcutaneous nodules on the neck, anterior and posterior parts of the trunk, arm, and abdomen.

of about 22 kg. The physical examination revealed multiple, rubbery subcutaneous nodules on the head, front and back of the trunk (Figure) and limbs. His hemoglobin level was 8.8 g/dL and renal and hepatic enzymes were normal. Carcinoembryonic antigen (CEA) was 251 ng/mL (normal range, 0.2-4 ng/mL) and cancer antigen (CA) 19.9 was above 120 000 IU/mL (normal range, 1-35 IU/mL). The chest x-ray was normal, whereas the computed tomography scan of the abdomen showed massive ascites, with thickening of the gastric wall, a focal lesion of 1 cm in the right hepatic lobe, and enlarged lymph nodes in the pericaval region and between the aorta and vena cava at the level of the renal hila. A gastroscopy of the prepyloric area revealed a mamelonated, ulcerated mass surrounding the pylorus. Antral biopsy showed adenocarcinoma infiltration, and biopsy of the subcutaneous nodules from the arm and chest was reported as adenocarcinoma metastases. The colonoscopy was normal.

The patient was treated with docetaxel trihydrate, cisplatin, and 5-fluorouracil. The size of the cutaneous metastases decreased; however, he presented multiorgan failure and died.

The family did not consent to an autopsy.

Cutaneous metastases tend to manifest as round or oval nodules of 1 to 3 cm that are raised above the skin surface.³⁻⁵ They can appear at any age, are uncommon in visceral carcinomas, and generally occur in the final stage of neoplastic disease,^{6,7} but may sometimes be the first manifestation of a malignant tumor.⁸

The appearance of cutaneous metastases on a specific area of the body depends on whether dissemination is lymphatic or hematogenous, as well as adhesion to target tissue and number of circulating neoplastic cells. Metastases probably develop on formation of clusters of more than 6 or 7 neoplastic cells because most circulating cells in the bloodstream are eliminated by the immune system.⁹ A primary metastasis may give rise to secondary metastases. Cutaneous metastases of the gastrointestinal tumors are usually located on the anterior wall of the abdomen.¹⁰ In our patient, the cutaneous metastases appeared on the head, anterior and posterior part of the trunk, arms, and legs. A CA 19.9 level above 1000 U/mL in the laboratory workup indicates that the tumor is irresectable in 90% of cases.¹¹ High CEA is also associated with metastasis.¹² In the case described, the levels of CA 19.9 and CEA were elevated. Chemotherapy may be beneficial in some cases.⁸ In our patient, the disease presented as generalized cutaneous metastases, eventually leading to diagnosis of the primary neoplasm.

References

- Seed S, Keehn CA, Morgan MB. Cutaneous metastasis: a clinical, pathological, and immunohistochemical appraisal. *J Cutan Pathol.* 2004;31: 419-30.
- Ozakkyol AH, Saricam T, Pasaoglu O. A rare entity: cutaneous metastasis from gastric carcinoma. *Am J Gastroenterol.* 1999;94:1118-9.
- Toné J, Bonaut B, Sanz C, Martínez C, Torrero MV, Miranda Romero A. Metástasis cutáneas de adenocarcinoma de recto con distribución herpetiforme. *Actas Dermosifiliogr.* 2006; 97:206-7.
- García-Arpa M, Salamanca J, Ortiz PL, Rodríguez-Peralto J, Martín-Gallardo, Iglesias L. Metástasis cutáneas de leiomiomas de útero. *Actas Dermosifiliogr.* 2003;94:666-8.
- Martínez-Menchón T, Mahiques L, Pérez-Ferriols A, Sánchez-Ballester, Fortea JM. Metástasis cutáneas en linfoma primario testicular. *Actas Dermosifiliogr.* 2004;95(6):382-4.
- Segura Huerta A, Pérez-Fidalgo JA, López Tintero P, Gironés Sarrío R, Aparicio Urtasun J. Supervivencia de trece años en una paciente con metástasis cutáneas aisladas de adenocarcinoma gástrico. ¿Ante qué enfermedad nos encontramos? *An Med Interna.* 2003;20:251-3.
- Muino Minguez A, Polo Casado A, Donis Sevillano E, et al. Metástasis cutáneas como presentación de cáncer de origen desconocido. *An Med Interna (Madrid).* 1986;10:442-3.
- Loockbill DP, Spangler N, Sexton FM. Skin involvement as the presenting sign of internal carcinoma. A retrospective study of 7,316 cancer patients. *J Am Acad Dermatol.* 1990; 22:19-26.
- Folkman J. Tumor invasion and metastasis. In: Holland JF, Frei E III, editors. *Cancer Medicine.* 2nd ed. Philadelphia: Lea & Febiger; 1982. p. 167-77.
- Powell FC, Cooper AJ, Massa MC, Goellner JR, Su WP. Sister Mary Joseph's nodule: a clinical and histologic study. *J Am Acad Dermatol.* 1984; 10:610-5.
- Trape J, Molina R, Sant F. Clinical evaluation of the simultaneous determination of tumor markers in fluid and serum and their ratio in the differential diagnosis of serous effusions. *Tumour Biol.* 2004;25:276-81.
- Goldstein MJ, Mitchell EP. Carcinoembryonic antigen in the staging and follow-up of patients with colorectal cancer. *Cancer Invest.* 2005; 23(4): 338-51.