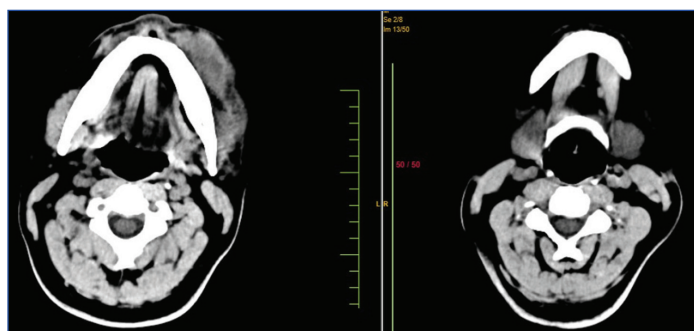


Uncommon Cutaneous Spread of Oral Cavity Cancer: A Clinical Image

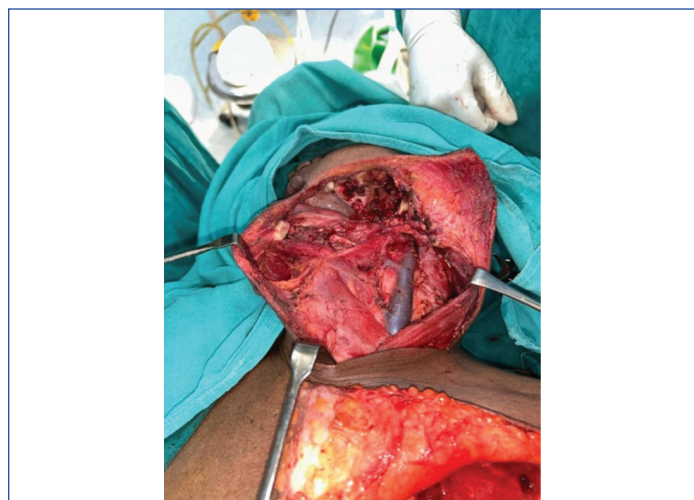
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Keywords: Cutaneous metastases, Extranodal extension, Moderately differentiated squamous cell carcinoma, Oral cavity squamous cell carcinoma

A 55-year-old man presented with a non-healing ulcer on the left mandibular region, which had gradually enlarged over six months from a pea-sized lesion to approximately 3×2 cm, with associated extraoral fungation. He reported sticky, thick saliva and hypersalivation for one month, along with restricted mouth opening of 15 mm. The patient had a history of chronic kharra chewing for approximately 10 years, consuming it three to four times daily, but had recently discontinued this habit. There was no history of smoking and alcohol consumption. The patient had no known medical comorbidities such as diabetes mellitus, hypertension, cardiac disease, or pulmonary tuberculosis. Mastication had been difficult for three months; however, there was no history of pain, dysphagia, or burning sensation. On intraoral examination, a 4×3 cm deep ulcer was noted arising from the left gingivobuccal sulcus, extending from tooth 34 to 38. Teeth 12 and 13 exhibited grade I mobility, while tongue, palate, uvula, and floor of mouth were free of tumour involvement. Contrast-enhanced computed tomography demonstrated a 3×2×2.6 cm soft-tissue mass involving the buccal mucosa and Retromolar Trigone (RMT), with infiltration into the overlying skin and masticator muscles. Multiple cervical lymph nodes were noted, the largest measuring 2×1 cm at level IB 1 [Table/Fig-1].



[Table/Fig-1]: Contrast-enhanced CT face showing left buccal mass, RMT, muscle invasion, with skin infiltration.



[Table/Fig-2]: Intraoperative photograph.

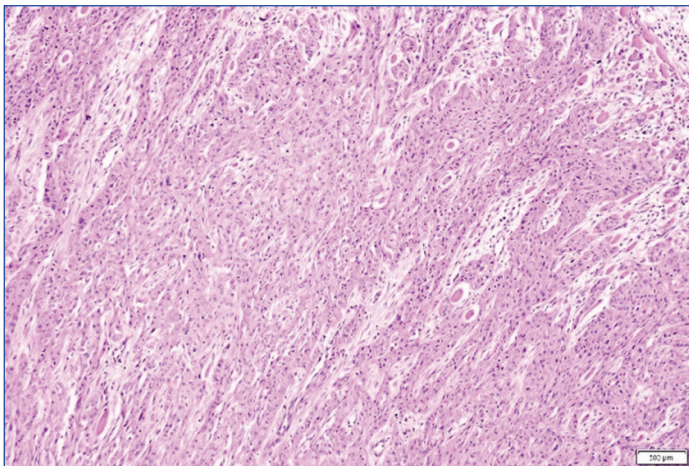
The patient underwent composite resection, including segmental mandibulectomy (teeth 33, condyle-sparing), maxillary alveolectomy (teeth 24-28), and modified radical neck dissection (type II, left side). Reconstruction was performed using a bipaddled pectoralis major myocutaneous flap [Table/Fig-2].

Histopathological examination revealed a 4.5×1.5×1.5 cm Moderately Differentiated Squamous Cell Carcinoma (MDSCC) with a Depth of Invasion (DOI) of 15 mm. The pattern of invasion was classified as POI-4, and the worst pattern of invasion was WPOI-1. Lymphovascular invasion and perineural invasion were present. The lingual mucosal margin was positive. Five of 21 cervical lymph nodes (levels IB-IV) showed metastatic deposits with extranodal extension. Decalcified bone sections confirmed tumour infiltration. The disease was staged as pT4aN3bM0, (Stage IVB). Adjuvant chemoradiotherapy was advised. The planned regimen was 66/60 Gy in 33 fractions with weekly cisplatin-(40 mg/m²). The patient received 29 fractions and five cycles of cisplatin (55 mg). During treatment, raised erythematous lesions developed on the left chest and shoulder [Table/Fig-3A-C].



[Table/Fig-3]: Postoperative clinical photographs demonstrating the primary surgical site with multiple cutaneous metastatic nodules. (A) Frontal view showing the operative site with cutaneous metastases; (B) Lateral view depicting the operative site with metastatic nodules; (C) Close-up view showing cutaneous metastatic nodules involving the left chest wall and shoulder region.

Local examination revealed more than 10 erythematous nodular lesions distributed over the left chest and shoulder region. The cutaneous lesions varied in size, ranging from subcentimetric nodules to larger lesions measuring approximately 1-2 cm in diameter. On palpation, the nodules were firm to hard in consistency, non-tender, and immobile, being fixed to both the overlying skin and underlying tissues. The surface was smooth with no ulceration, crusting, or discharge. The surrounding skin appeared normal, with no evidence of cellulitis. Systemic examination revealed no evidence of hepatomegaly, pulmonary nodules, or skeletal tenderness. Fine-needle aspiration cytology from one of the larger nodules confirmed metastatic deposits of MDSCC [Table/Fig-4].



[Table/Fig-4]: Haematoxylin and Eosin (H&E)-stained section (40x) showing epithelial islands and cords infiltrating the connective tissue stroma, with moderate keratinisation, intercellular bridges, nuclear pleomorphism, and increased mitotic activity, consistent with Moderately Differentiated Squamous Cell Carcinoma (MDSCC).

At the time of writing this report, the patient is receiving palliative chemotherapy comprising weekly intravenous paclitaxel (80 mg/m²) and carboplatin (AUC 2). He is also receiving regular wound care and analgesic management as part of supportive care. To date, he has completed six cycles of the aforementioned chemotherapy regimen and remains under regular follow-up. Cutaneous metastasis from Oral cavity Squamous Cell Carcinoma (OSCC) is rare, with a reported incidence of 0.7–2%. GLOBOCAN 2022 reported nearly 390,000 new cases of lip and oral cavity cancer worldwide, predominantly in Asia; however, cutaneous metastasis remains uncommon [1]. Pitman KT

and Johnson JT identified 19 cases (0.76%) of skin metastasis among 2,491 patients with squamous cell carcinoma, typically occurring within six months, with a median survival of approximately three months. The presence positive resection margins, multiple nodal deposits, and extranodal extension predisposes to such recurrence or distant spread [2]. Emanuel H and Emanuel P reported that squamous cell carcinoma and thyroid carcinoma are the most frequent noncutaneous head and neck primaries to metastasise to the skin [3]. Cole RD and McGuirt WF observed poorer survival with intradermal lymphatic spread (approximately 3 months) compared with direct extension (approximately 7 months) [4]. All major risk factors were present in this case. The development of cutaneous metastatic deposits during adjuvant therapy underscores the aggressive biological behaviour of the tumour. Once cutaneous metastasis occurs, the prognosis is poor, and management remains largely palliative; however, isolated surgical excision may provide symptomatic relief in selected cases [5].

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