

A tropical surprise?

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CASE REPORT

A 56-year-old Surinamese woman with a medical history notable for Crohn's disease presented to our emergency department with unexplained fatigue, fever and severe pain in her right leg for a few weeks. In addition she explained that she had had a small spot on the same leg for the last five years, which she noticed for the first time after a visit to Suriname. It was a reddish skin plaque, which has been slowly growing ever since. In the last few months it had grown explosively and caused severe pain. The vital signs revealed a body temperature of 38.7 °C, a blood pressure of 100/65 mmHg, heart rate of 76 beats/min and a respiratory rate of 18 breaths/min. On physical examination, the right leg revealed an ulcerated lesion with a size of 20 cm long and 10 cm wide, with hard, raised edges, on the lateral side of the lower leg (figures 1 and 2). Chest examination revealed clear and

symmetrical breathing sounds and normal heart sounds. Laboratory examination showed a raised C-reactive protein level of 175 mg/l (normal value 0 to 10 mg/l), leucocyte count of $16.0 \times 10^9/l$ (normal value 3.5 to $10.0 \times 10^9/l$) and a haemoglobin level of 4.4 mmol/l (normal value 7.5 to 9.5 mmol/l) with a mean corpuscular volume of 72 fl (normal value 80 to 100 fl). All the other findings were within normal limits. The microcytic anaemia was successfully treated using a single erythrocyte transfusion and prolonged iron supplementation. The lesion on the lower right leg, however, was still of unknown origin.

WHAT IS YOUR DIAGNOSIS?

See page pagina 328 for the answer to this photo quiz.

Figure 1.



Figure 2.



DIAGNOSIS

To differentiate between framboesia (*Treponema pallidum pertenue*), leprosy (*Mycobacterium leprae*), *Rickettsia* and other causes, radiological imaging was performed and both incision biopsies and serology were taken. Conventional radiological imaging of the lower right leg revealed an abnormal soft tissue contour and lateral proximal tibia of the anterior side. The skeleton showed a normal structure and mineralisation without periosteal response. An MRI of the leg showed staining of the superficial ulcer around the raised edges with slight oedema in the adjacent subcutis. There did not seem to be any growth into the surrounding muscles, tendons or bone. The serology was negative. The biopsies showed a hyperplasia and hyperpigmentation on the basal side advancing in the epithelium showing an abnormal desmoplastic stroma. This eventually confirmed the diagnosis of a well-differentiated squamous cell carcinoma. Squamous cell carcinoma (SCC) is a malignant form of cancer that may occur in many organs, including the skin, lips, mouth, oesophagus, urinary bladder, prostate, lungs, vagina, and cervix and is the second most common cancer of the skin.^{1,2} Sunlight exposure and immunosuppression are

risk factors for SCC of the skin with chronic sun exposure being the strongest environmental risk factor.³ Squamous cell carcinoma can generally be treated by excision or surgery while nonsurgical options for the treatment of cutaneous SCC include topical chemotherapy, topical immune response modifiers, photodynamic therapy, radiotherapy, and systemic chemotherapy. Radiation therapy is a primary treatment option for patients in whom surgery is not feasible and is an adjuvant therapy for those with metastatic or high-risk cutaneous SCC.^{3,4}

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