

## A Peristomal Tumour

HANNE NYBÆK AND GREGOR. B. E. JEMEC

*Department of Dermatology, Faculty of Health Sciences University of Copenhagen, Roskilde Hospital Denmark, Koegevej 7-13, DK-4000 Roskilde, Denmark. E-mail: hany@regionsjaelland.dk*

A 73-year-old woman who had had a permanent colostomy performed 5 years previously as a result of colonic stenosis following preoperative radiotherapy for cervical cancer, presented with a 3 × 4 cm peristomal tumour, which had gradually increased in size over the past 2 years (Fig. 1). There had been no ulcer or wound prior to the lesion, which had begun as a few small red papules at the mucocutaneous junction and had expanded rapidly to an epidermal tumour. The patient had no pain or bleeding from the lesion, and did not consider it abnormal or consult a doctor. However, she entered a study of peristomal skin problems at our department and was examined by a dermatologist. On questioning, the patient stated that the lesion was obstructive to regular use of the stoma appliance, resulting in her increasingly having to cut the bag aperture larger, in order to avoid leakage (Fig. 2). As she increased the size of the bag aperture, the lesion expanded accordingly. A skin biopsy was taken from the lesion for microscopic analysis.

**What is your diagnosis?**



Fig. 1. Peristomal skin: tumour



Fig. 2. Stoma equipment

## Diagnosis

Over-granulation.

## Microscopic and laboratory findings and clinical course

Skin biopsy revealed proliferation of the endothelial cells, chronic inflammatory cells and islands of bowel metaplasia.

## Discussion

The occurrence of a peristomal tumour in a patient who has been treated for cancer naturally raises the suspicion of metastasis. Differential diagnoses of “neoplasm”, e.g. hernia, foreign body granulomas, over-granulation, infection or scar tissue exist and should always be considered, as this case illustrates. A number of peristomal skin complications have been described (1–3). Over-granulation is a common peristomal skin problem with an estimated prevalence of 8% (1). Peristomal adenocarcinoma is extremely rare (1). Similarly, reports of cutaneous metastases from solid internal tumours, e.g. urogenital tumours or primary adenocarcinomas of abdominal peristomal sites, are exceedingly rare (1, 4–6).

Faecal irritation is speculated to be the principal aetiological factor in over-granulation, and it is supported by the fact that new lesions of over-granulation may occur in previously normal skin if the aperture of the stoma bag is cut too large, exposing skin to soiling.

Most over-granulation is asymptomatic; however, some patients experience pain or bleeding. The patient's main concerns are most often either of a cosmetic nature, cancer phobia, or simple obstruction of normal use of the stoma appliance.

The aim of intervention is to alleviate the symptoms, achieve peace of mind for the patient, and to provide a better surface for adhesion of stoma appliances to avoid additional soiling. There are a number of treatments available: silver nitrate coated sticks to press on to the lesions for a few seconds resulting in chemical destruction of the tissue; photocoagulation



Fig. 3. Peristomal skin at follow-up

using lasers; topical corticosteroids; or cryotherapy with liquid nitrogen. Our patient had a large lesion of over-granulation tissue mimicking an epidermal tumour. The biopsy, and the fact that she had cut the bag aperture larger, thereby exposing the skin to soiling, and the lesion expanding accordingly, allowed accurate diagnosis and treatment of the lesion. Sufficient improvement was achieved by equipment adjustment alone (Fig. 3), which supports the suggestion that the principal aetiological factor in peristomal over-granulation is skin soiling.

## References

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## Recommended answers for CME–24:

1. B, C, D, E.
2. B, C
3. B, C