

LETTERS TO THE EDITOR

Cutaneous Metastases from a Follicular Carcinoma of the Thyroid

Sir,

Cutaneous metastases (CM) represent a specific skin manifestation of an internal malignancy (1). The overall incidence of metastatic disease in the skin is low, and most authors consider the clinical incidence of CM to be 0.7-9% (1). CM of thyroid carcinoma are very rare. Only 31 cases have been reported in the medical literature (2-5). We report a case of CM from a follicular carcinoma of the thyroid gland.

A 57-year-old woman had 12 years previously had a total mastectomy for a breast adenocarcinoma. In 1986 a follicular carcinoma of the thyroid gland was diagnosed. She underwent a total thyroidectomy and was subsequently treated with radioactive iodine (^{131}I) and hormonal therapy. In 1991, a local recurrence was noted. She was treated with total laryngectomy and lymph node dissection and a higher dose of ^{131}I was admin-



Fig. 1. Tumoral lesion on the right retroauricular area.

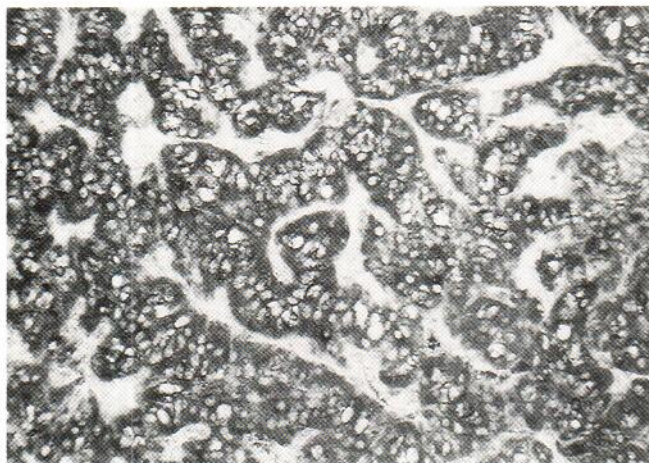


Fig. 2. Cytoplasmic positivity for thyroglobulin in the tumor cords (DAB 150 \times).

istrated. Seven months later, she developed two solid tumors on the right retroauricular area and on the left side of the parietal scalp (Fig. 1). The tumoral lesions were resected. Routine histopathologic study of the skin biopsy specimen revealed an atypical proliferation of epithelial cells, affecting dermis with solid aggregation. Large and dilated vessels could be seen within and around the tumor. Pale-basophilic cytoplasm and hyperchromatic nuclei were observed in the tumoral cells. They were occasionally arranged in microfollicle-like structures with different amounts of eosinophilic deposits (Colloid). Period-acid-Schiff stain showed intense staining of the colloid as well as the cytoplasm of the cells. Immunohistochemical study with polyclonal antibody against thyroglobulin, using the peroxidase-antiperoxidase technique, demonstrated positive stain in the cytoplasm of the tumor cells and in the lumina of some follicles (Fig. 2). Scintigraphy with radioactive iodine did not detect any extrathyroid sites of suspicious metastases. The patient is still alive and is being treated with ^{131}I and substitutional therapy.

In previously reported cases, most lesions present as solitary or multiple painless skin tumors of less than 25 mm. The color is usually violet due to the rich blood supply, and vascular neoplasms are the main differential diagnosis for this reason. CM from thyroid carcinoma are frequently located on the head and neck. CM from carcinoma of the kidney are also often located in the scalp and sometimes the tumor presents with the skin involvement (6). The histopathologic diagnosis of the skin specimens may be difficult. Cutaneous metastatic lesions show occasionally an undifferentiated pattern (6). In some cases, like ours, two different primary tumors may be present in the same patient. Immunohistochemical techniques may be useful in these special cases, in which routine stains do not make clear the primary tumor. Endocrine secretion, if present, will be clear by this technique. In our case, CM from breast adenocarcinoma was ruled out by the use of immunohistochemistry with antithyroglobulin monoclonal antibodies.

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