

Case Report

Saree cancer post wide excision presenting with metastatic lesion in inguinal region. First reported case

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ABSTRACT

Saree is the most common and traditional attire of Indian women which is wrapped tightly on waist. Waist is prone to continuous sweat and soiling and this can cause pigmentation, scaling of the waist which can later transform to malignant lesion in the waist. Here we are presenting a case of saree cancer that was successfully managed with multimodality therapy. A 55 years old female came to our outpatient department with painful nonhealing ulcerative lesion left inguinal region post wide excision of saree cancer in left waist region 3 years back. There was itching and foul smelling discharge from ulcerative lesion (Mets). This lesion was treated with multi-modality and patient survived 1 year without any recurrence.

Keywords: SCC, Saree cancer, Metastasis, Non healing ulcer

INTRODUCTION

Saree is the most common and traditional attire of Indian women which is wrapped tightly on waist. Waist is prone to continuous sweat and soiling and this can cause pigmentation, scaling of the waist which can later transform to malignant lesion in the waist. Tradition of wearing saree is followed by most of Indian women. Wearing saree for 24/7 in hot and humid climate with tight knot on waist, perspiration, sweat, soiling results in pigmentation scaling (Dermatosis) of the waist. Rarely these changes may transform to malignant changes at the waistline and present as squamous cell carcinoma.¹ Previously, just a few cases regarding saree cancers detected among Indian women have been reported in literature and all these cases were managed by wide surgical excision under cover of antibiotics.¹⁻³ Herein we are presenting a case of saree cancer mets at inguinal region, which was successfully managed with multimodality therapy consisting of surgery,

chemotherapy and radiotherapy with patient surviving for a year without any more recurrences.

CASE REPORT

A 55 year old woman from rural area came to our outpatient department with painful nonhealing ulcerative lesion at left inguinal region. There was itching and foul smelling discharge from ulcerative lesion 3 months. Initially there was watery discharge which later turned to pus since last 2 months. Patient was wearing saree for almost 30 years with knot at same place. There was initially irritation at the waistline after that she developed small scaly hyperpigmented patch which turned into foul smelling ulcer and she got operated for it 3 years backs which on histopathology revealed to be squamous cell carcinoma known as saree cancer. Gradually the present lesion (Mets) increased in size. Her past medical history was unremarkable. She had no history of diabetes mellitus, hypertension, cardiovascular disease and any other major illness. Clinical examination revealed a non-

healing ulcer (Figure 1) on left inguinal region measuring 6×3 cm with everted edges, rolled up margins and pus discharge from the thick indurate ulcer bed. On palpation ulcer was firm, tender and bleed on touching, surrounding skin was normal. Wedge biopsy from the lesion showed presence of malignant cells suggestive of squamous cell carcinoma. Magnetic resonance image of pelvis showed multiple conglomerate hyper intense lesions with air foci in subcutaneous plane in anterior abdominal wall in left iliac fossa region measuring. Loss of fat planes with underlying abdominal wall muscle suggested possibility of muscle invasion without imaging signs of peritoneal extension. Few lymph nodes were enlarged in left inguinal region. These findings suggested evidence of ulcerative growth with muscle invasion and lymph node metastasis in left iliac fossa. To downstage the disease we first administered 2 cycles of chemotherapy with paclitaxel and carboplatin before proceeding to surgical management. After thorough diagnostic workup and preoperative evaluation she underwent wide local excision 1 cm margin. Histopathological examination of the specimen confirmed diagnosis of squamous cell carcinoma with tumor free surgical margins moderately differentiated grade II with T3N1M0 stage III. Postoperative period was uneventful. After recovery we proceeded with concomitant chemotherapy with cisplatin and radiotherapy. Our patient tolerated well this management throughout complete course without any adverse event. Now she is in remission state for last 1 year from the completion of treatment.



Figure 1: Mets in left inguinal region.

DISCUSSION

The term of saree cancer among Indian women was first introduced by Patil et al.¹ Saree is a famous traditional Indian costume. But with constant use for longer duration dermatological problems along the waistline have been

recognized by the researchers. Eapen et al.⁴ assessed prevalence and presentation of various dermatoses along the waist in 140 females wearing saree and observed hyper pigmentation and scaly skin changes.⁴ Cutaneous squamous cell carcinoma is developed in chronically diseased skin, long standing ulcers, radiation dermatitis, sinus tracts, osteomyelitis, scars and certain inflammatory disorders. If such lesions remain neglected and untreated for long duration, they transform into malignancy with high risk of metastasis.⁵ Squamous cell carcinomas developing from injured lesions or chronic long standing skin disease are at risk of metastasis by 40%.⁶ Prognosis of cutaneous squamous cell carcinoma depends on site and size of lesion, depth of invasion, histological characteristics and immune status of the patient.⁷ If detected in early stage results in favorable prognosis. Follow up is very important to detect recurrence or persistence of the tumor and presence of new lesion. In the present case muscle invasion and lymph node metastasis were the adverse prognostic factors. But combination of surgery, chemotherapy and radiotherapy in the management of our case achieved locoregional control of the tumor. We recommend practice of multimodality treatment with concomitant chemoradiotherapy after wide surgical excision in high risk skin cancers. Administration of chemotherapy before surgical management decreases tumor load. Addition of chemotherapy for radiosensitization of the tumor improves outcome in patients with advanced disease. Up till now four case reports have been described in literature among Indian women. But all cases were managed with surgical excision and course antibiotics. As our patient presented with metastasis to regional lymph nodes and invasion of muscle by tumor cells, we opted first chemotherapy followed by wide surgical excision and then concomitant radio chemotherapy. Hence our experience suggests that in case of more advanced cases of saree cancer, a combination of surgery, radiotherapy and chemotherapy may be of extra value compared to surgery alone.⁸

CONCLUSION

With more and more cases of saree cancer being reported its awareness will help Indian women prevent a preventable disease. Secondly clinicians can offer best treatment based on multi-modality treatment used here.

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