A Patient of Esophageal Carcinoma Presenting with Fever and Multiple Nodules on Fingers

Yen-Chi Chou     Jing-Yi Lin     Hua-Hsin Chen     Hsin-Chun Ho

CASE REPORT

A 63-year-old man experienced progressive dyspnea of 1-week duration in August 2002. Esophageal squamous cell carcinoma with periesophageal soft tissue invasion had been diagnosed 1 year previously. He had been treated with tumor resection and 3 courses of chemotherapy. Two-dimensional cardiac echography showed large amount of pericardial effusion and a vegetation in the left atrium (Fig.1). After performing pericardiocentesis and sclerosing therapy with mitomycin, his symptoms improved. However, fever and chillness were noted in the following month. Physical examination revealed several 0.5- to 1-cm indurated tender nodules on right thumb and both fourth fingertips (Fig.2). These lesions appeared 1 week before the onset of fever and resembled septic emboli with peripheral erythema. Blood culture showed coagulase-negative staphylococcus and Streptococcus pneumoniae. Endocarditis with septic emboli was diagnosed and the patient was treated with antibiotics. Although his fever subsided, the skin lesions on both hands persisted.

Fig. 1
A vegetation in left atrium was revealed in two dimentional cardiac echography.

Fig. 2
Several 0.5 to 1 cm indurated nodules with peripheral erythema was noticed on fingertips.

From the Department of Dermatology, Chang Gung Memorial Hospital
Accepted for publication: November 10, 2003
Reprint requests: Hsin-Chun Ho, M.D., Department of Dermatology, Chang Gung Memorial Hospital, 199, Tun Hwa North Road, Taipei, Taiwan, R.O.C.
TEL: 886-2-27135211 ext.3397, 3400     FAX: 886-2-27191623
**DIAGNOSIS: Septic Emboli-Like Metastatic Esophageal Carcinoma**

**MICROSCOPIC FINDINGS AND CLINICAL COURSE**

A skin biopsy specimen revealed nests of pleomorphic tumor cells with pale cytoplasm and many mitotic figures (Fig.3), consistent with the histopathology of his primary esophageal carcinoma. The vegetation in his left atrium may be preferred the invasion of esophageal cancer to infective endocarditis but no further tissue-proven study supported that. He died of pulmonary failure 2 weeks after the cutaneous metastasis appeared.

**DISCUSSION**

Cutaneous metastases may originate from different primary tumors. Breast cancer, colon cancer, and melanoma are the most common primary tumors in women, whereas lung cancer, colon cancer, and melanoma are the most common in men. Cutaneous metastasis as the first sign of internal malignancy is most seen in cancers of lung, kidney, and ovary. Skin involvement in esophageal cancer is very rare and accounts for only 3% of all skin metastases. Esophageal carcinoma is uncommon and accounts for 1% of all malignancies. Because of the late onset of symptoms, most patients present with unresectable disease or metastasis at the time of diagnosis. The metastases may appear as widespread cutaneous nodules or as a scalp tumor. Acrometastases are very rare. Four cases of esophageal carcinoma metastasizing to the fingers have been reported. These patients all presented with cellulitis-like erythematous plaque limited to the pulp area of the fingertip. Another patient presented with a painful nodule located in the pulp of the right ring finger. However, in our patient, metastases manifested as multiple nodular lesions on the bilateral fingertips. To the best of our knowledge, this is the first case described in the English literature of a metastatic esophageal carcinoma presenting as septic emboli-like lesions on fingertips.

The clinical appearance of the metastatic skin lesions varies and may be easily misdiagnosed. As in our patient, acral metastasis of esophageal carcinoma was regarded as septic emboli due to the concurrence of fever and a vegetation in the left atrium. Therefore, cutaneous metastases should be considered in the differential diagnosis of inflammatory disease of the hands, and a skin biopsy should be performed in every suspected case.

**REFERENCES**