

Cutaneous metastasis- A marker of hidden malignancy with an atypical presentation of neck nodules: A diagnostic challenge

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Abstract

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Cutaneous metastases are rare but an indicator of internal malignancies, often presents with a wide spectrum of clinical appearances that usually cause diagnostic confusion. We report a 67-year-old male who presented with an indurated plaque over the anterior neck for six months, initially observed as hyperpigmented skin changes that progressively evolved into a firm, sclerotic plaque, studded with multiple flesh-colored nodules with a cobblestone-like texture associated with itching and restricted neck mobility. Early clinical and histopathological evaluation favoured dermatofibrosarcoma protuberans; however, subsequent tissue examination revealed an infiltrative epithelial malignancy. Immunohistochemistry (IHC) showed positivity with cytokeratin and CK7, favouring the diagnosis of cutaneous metastasis. Comprehensive systemic workup identified gastric carcinoma with skeletal dissemination. This case highlights the deceptive presentation of metastatic skin disease and emphasizes the importance of reassessment and repeat biopsy in managing the atypical and recalcitrant cutaneous lesions.

Keywords Cutaneous metastases; Dermatofibrosarcoma protuberance; Immunohistochemistry.

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Introduction

Cutaneous metastasis is an infrequent dissemination of malignant cells to the skin originating from internal malignancies, with an incidence of 0.7-0.9% approximately.

Some cutaneous metastases may serve as primary herald of an underlying tumour, highlighting the significance of early diagnosis.¹ The morphology of cutaneous metastases is variable, commonly presenting as subcutaneous nodules. However several other clinical patterns like indurated plaques, ulcerative lesions, erysipeloid lesions, alopecia

neoplastica, sclerodermoid lesions, and zosteriform distributions can also be seen frequently leading to diagnostic delay.²

The primary tumour with cutaneous metastases varies according to gender. Lung carcinoma, colorectal carcinoma, and melanoma are among the most frequently reported ones in males, whereas breast carcinoma is the most common source in women. Less common malignancies are gastric carcinoma and renal cell carcinoma, but head and neck cancers have also been reported.³

Because these lesions typically signify advanced stage disease and carry a guarded prognosis, prompt histopathological verification is mandatory. Here, we analyze a challenging case where unusual nodular neck lesions masked an underlying systemic malignancy, illustrating the diagnostic hurdles faced by clinicians.⁴⁻⁶

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Case Report

A 67-year-old male from Azad Kashmir presented with a six-month history of progressive hardening and thickening of the skin over the anterior neck. He was normotensive, normoglycemic, smoker and had ischemic heart disease with poor compliance to medications. Initially, he developed localized hyperpigmentation and induration, which gradually extended from the right submandibular region to the left, eventually involving the entire anterior neck. This resulted in a firm, non-mobile, woody hard plaque strictly confined to the front of the neck. Over the last two months, the patient developed multiple skin coloured, firm nodules arranged in clusters over the right side of the neck (**Figure 1**). These gradually increased in size and number and were associated with severe pruritus (7/10). He also experienced marked restriction of neck mobility due to extensive hardening. Associated epigastric discomfort was reported. Before presenting to dermatology, he had been treated by an ENT specialist as a presumed case of cellulitis/Ludwig's angina. He took oral Augmentin and Linezolid but no improvement. The patient also experienced significant unintentional documented weight loss of 10kgs during this period but denied fever, cough, or night sweats. Clinical examination revealed a thick, hyper pigmented, indurated plaque involving the entire anterior neck, with firm clustered cobblestone appearing nodules predominantly on right side and crossing midline towards left side. There was pronounced skin stiffness and reduced cervical

mobility. No lymph nodes were palpable.

Differentials were cutaneous mets with some underlying malignancy, scleromyxedema, dermatofibrosarcoma protuberans, nodular mycosis fungoides, atypical B cell lymphoma. Keeping differentials in mind we started from baselines which were normal. Thyroid function showed subclinical hypothyroidism. USG abdomen was also unremarkable. Ultrasound neck showed skin thickening of 1.1cm and no lymph nodes or mass seen. On MRI neck there was thickening of the subcutaneous tissue and skin in the submandibular region and anterior neck. Oedematous changes were seen in the floor of the mouth. No abscess formation or airway involvement was seen. On CT CAP there was smooth antral mass measuring 2cm in thickness and 9cm in length. Lymph nodes enlargement was not observed. Lytic lesions were present in the vertebral bodies at the level of D 10-12. No other abnormalities were seen in any other organs. We performed two skin biopsies with few weeks' interval. First histopathology report of the lesion demonstrated a storiform proliferation of uniform spindle cells infiltrating the dermis and subcutis. Mild pleomorphism noted and peripheral collagen trapping seen consistent with dermatofibrosarcoma protuberans (DFSP). Second biopsy report revealed an infiltrative malignant epithelial neoplasm involving the dermis. The tumor cells were arranged in fascicles and sheets and exhibited pleomorphic nuclei, high nuclear-cytoplasmic ratio and mitotic figures (**Figure 2**). IHC showed positivity with



Figure 1 Localized hyperpigmented and indurated plaque studded with multiple skin colored, firm nodules arranged in clusters on the neck.

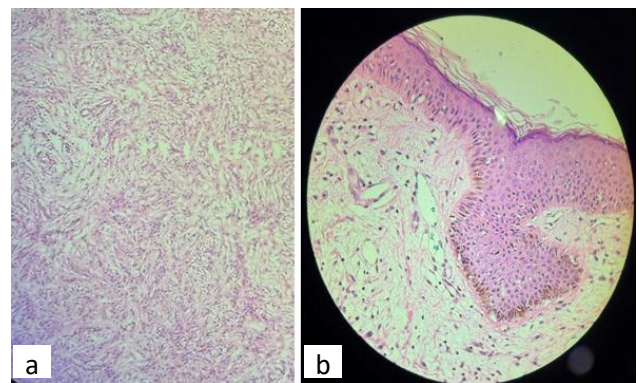


Figure 2 a) Tumor cells arranged in fascicles and sheets and showing pleomorphism (b) pleomorphic changes and mitotic figures.

cytokeratin and CK 7. Gastric biopsy showed signet ring cell consistent with gastric adenocarcinoma.

Discussion

Usually, internal malignancies do not metastasize to skin but few of them can. Cutaneous metastases may occur via lymphatics, blood, direct extension or from iatrogenic implants. Skin biopsy is the gold standard and IHC helps in confirmation. Gastric adenocarcinoma most commonly metastasizes to the liver, peritoneum, and lymph nodes, while involvement of the skin is unusual.¹ Cutaneous metastasis from gastric carcinoma may present as firm dermal or subcutaneous nodules, most commonly on the abdomen, chest wall, or umbilical region. However, atypical morphologic presentations may occur and can mimic various conditions, making clinical diagnosis challenging.² In our patient, the lesion presented as a woody hard indurated plaque with multiple cobblestone-like nodules over the anterior neck, an unusual presentation that initially raised suspicion for infiltrative dermatoses and cutaneous neoplasms. Cutaneous metastases with underlying malignancy, scleromyxedema, mycosis fungoides, and primary cutaneous adnexal tumors were kept in differentials.

Scleromyxedema was considered due to indurated skin and nodular lesions, but the absence of waxy papules, lack of generalized involvement, and absence of mucin deposition on histopathology argued against this diagnosis.⁷

Similarly, nodular mycosis fungoides was unlikely due to the absence of preceding patch or plaque stage lesions and lack of epidermotropism or atypical lymphoid infiltrates on histopathology.⁸

Histopathological examination of the skin biopsy demonstrated an infiltrative malignant epithelial neoplasm composed of atypical cells arranged in fascicles with increased nuclear-cytoplasmic ratio and mitotic activity. Immunohistochemistry showed positivity for cytokeratin and CK7, supporting an epithelial origin. Negative staining for CD34, S100,

TTF-1, GATA-3, PAX8, and NKX3.1 helped exclude several primary cutaneous and metastatic tumors. Furthermore, CT chest, abdomen and pelvis with contrast showed smooth 9cm long and 2cm thick mass in gastric antrum along with lytic lesions in vertebral bodies from D10-12. Upper gastrointestinal endoscopy demonstrated severe antral gastropathy with erosions and pre-pyloric edema, and biopsies were obtained to evaluate for gastric malignancy. These findings strongly suggested cutaneous metastases from gastric carcinoma. Cutaneous metastases may occasionally be the first manifestation of an underlying internal malignancy and may precede the diagnosis of the primary tumor. The clinical morphology can be highly variable, including nodules, plaques, inflammatory lesions, or sclerodermoid induration, which may mimic benign dermatologic conditions. Therefore, persistent indurated plaques or nodular lesions of unclear etiology warrant early biopsy and thorough systemic evaluation.⁴⁻⁶ Our case is notable for the unusual clinical presentation of cutaneous metastases from gastric carcinoma as a woody indurated cobblestone plaque over the anterior neck, which initially mimicked primary cutaneous neoplasms and infiltrative dermatoses. Diagnosing the atypical presentation is important for timely and appropriate oncological management.

Conclusion

This case shows an unusual and atypical presentation of cutaneous metastasis which involves the anterior neck with indurated plaque and clustered cobblestone nodules mimicking inflammatory and lymphoproliferative conditions. Early biopsy of persistent indurated plaques is necessary for exact diagnosis and prompt management.

Declaration of patient consent Authors certify that they had obtained all appropriate patient consent.

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Author's contribution

MS: Substantial contribution to Identification, diagnosis and management of the case, manuscript writing and critical review of the manuscript.

RM,ST: Substantial contribution to diagnosis and management of the case, manuscript writing.

MA,AS: Substantial contribution to management of the case. Critical review of the manuscript.

All authors have given final approval of the version to be published and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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