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Case Series

Squamous Cell Carcinoma of the Gluteal Fold: An Unusual Presentation (About Two Cases)

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Abstract

Squamous cell carcinomas represent 30% of skin carcinomas. Perianal localization is rare and should be investigated for HPV infection, a history of pilonidal cyst and visceral metastasis which remains exceptional. We report two cases of squamous cell carcinoma located at the intergluteal fold in two patients. The first patient had already been operated on for a pilonidal cyst, the squamous cell carcinoma was classified as T2N0M0 and the patient underwent tumor resection without recurrence and whose exploration revealed a benign renal tumor. The second patient had no medical history and she also had a squamous cell carcinoma classified as T2N0M0 for which she was operated.

Clinically, perianal squamous cell carcinoma initially presents as an erythematous or flesh-colored nodule on eczematized skin. The tumor extends laterally and in depth to have a vegetative, exophytic "cauliflower" appearance; it may eventually ulcerate. Functional signs include pruritus, discharge, bleeding and pain. A diagnostic delay was estimated in 33% of cases and this following a wrong diagnosis such as eczema, lichen therefore any lesion not responding to conservative treatment should be biopsied. Well-differentiated perianal lesions, without sphincter involvement and non-metastatic (T1T1, N0, M0) are excised locally with wide margins of 1cm. Chemoradiotherapy is indicated for locally advanced tumours, with lymph node involvement or sphincter muscle invasion, while abdomino-perineal resection is reserved for large tumors.

Keywords: *Squamous Cell; Carcinoma; Gluteal Fold; Perianal; Surgery*

Introduction

Squamous cell carcinomas represent 30% of skin carcinomas. They are clinically manifested by ulceration, budding and infiltration. Perianal localization is rare and should lead to a search for HPV infection, a history of pilonidal cyst and visceral metastasis, which remains exceptional. We report two cases of squamous cell carcinoma localized at the level of the intergluteal fold in two patients and whose exploration allowed us to reveal a renal tumor in one of the two.

Case Reports

Case n°1: 62-year-old patient operated on at the age of 35 for a pilonidal cyst, who consulted for a budding tumor of the intergluteal fold that had been progressively evolving for 1 year. On clinical examination, there was a flesh-colored swelling, measuring 2.5 cm by 3 cm,

budding, of firm consistency, centered by an ulceration, resting on a symmetrical erythematous plaque with a circumscribed border on either side of the interfold (Figure 1). On dermoscopy, glomerular and hairpin vessels are found, with whitish areas of keratin. No genital warts or abnormalities on genital examination and no palpable lymphadenopathy (Figure 2). The skin biopsy was in favor of a well-differentiated squamous cell carcinoma: positive anti-P53 antibody and mitotic index estimated at 40% (Figure 3). The biological assessment was unremarkable, in particular renal function, HIV serology and tumor markers. The MRI centered on the tumor objectified a process of the intergluteal fold without locoregional invasion arriving in contact with the coccyx communicating with the cutaneous tissue by a fistulous way. Thoraco-abdomino-pelvic CT showed a well-limited rounded tissue mass of the upper pole of the left kidney near the renal hilum and the tail of the pancreas with no sign of invasion. Rectosigmoidoscopy was unremarkable. This suggested stage T2N0M0 disease, and he was planned for local excision with 1 cm margins. One year after excision, examination and anoscopy revealed no evidence of local recurrence or loss of function to the external anal sphincter.

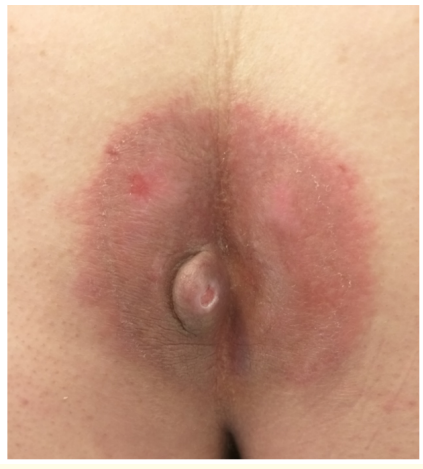

Figure 1: *Flesh-colored swelling, measuring 2.5 cm by 3 cm, budding, of firm consistency, centered by an ulceration, resting on a symmetrical erythematous plaque with a circumscribed border on either side of the interfold.*

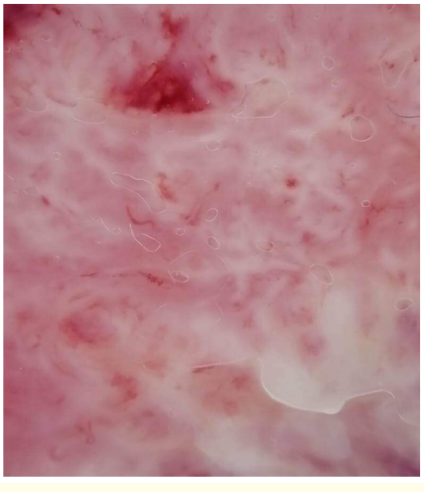

Figure 2: *Dermoscopy, showing glomerular and hairpin vessels with whitish areas of keratin.*

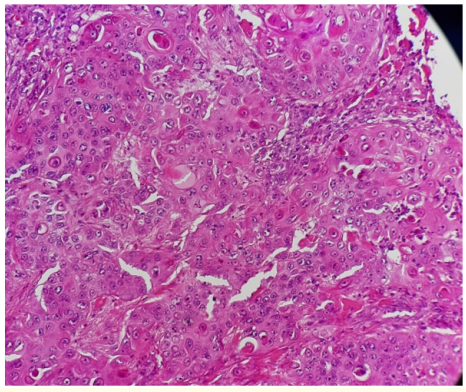

Figure 3: *Skin biopsy was in favor of a well-differentiated squamous cell carcinoma: positive anti-P53 antibody and mitotic index estimated at 40%.*

Case n° 2: 65-year-old patient, with no particular history, who consulted for a tumor of the right buttock that had been evolving for 4 years and gradually increasing in size. On clinical examination, a budding, ulcerated and oozing tumor with irregular boundaries was found, firm, pedunculated with a wide neck, 9.5 cm x 6 cm in diameter, resting on the right buttock (Figure 4). On dermoscopy, glomerular and hairpin vessels were found, with whitish areas of keratin (Figure 5). Examination of lymph node areas was free and loco-regional examination was unremarkable. Histological examination was in favor of a well-differentiated infiltrating and keratinizing squamous cell carcinoma (Figure 6). Local and regional extension assessment were unremarkable. MRI centered on the tumor objectified a budding and ulcerated mass of the right buttock, close to the intergluteal fold, irregular, well limited, in T2 signal, T1 hyposignal, hypersignal diffusion, enhanced heterogeneously after injection, measures 46 x 26 mm. This suggested stage T2N0M0 disease, and he was planned for local excision with 1 cm margins. The patient benefited from excision of the tumor with good postoperative results, but unfortunately the patient was lost to sight.

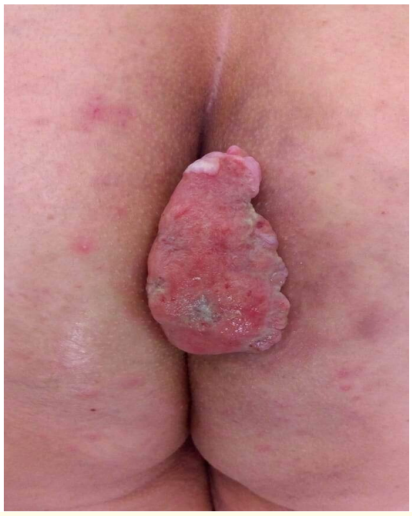

Figure 4: *Budding, ulcerated and oozing tumor with irregular boundaries, 9.5 cm x 6 cm in diameter, resting on the right buttock.*

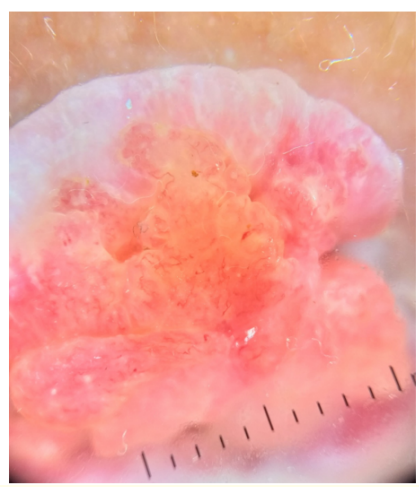

Figure 5: *Glomerular and hairpin vessels with whitish areas of keratin.*

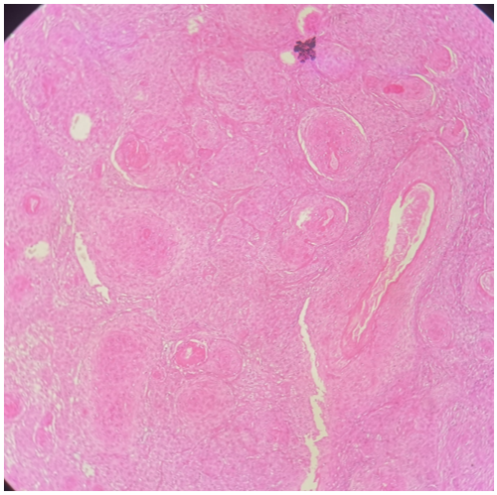

Figure 6: *Well-differentiated infiltrating and keratinizing squamous cell carcinoma.*

Discussion

Squamous cell carcinomas are tumors developed from the keratinocytes of the spinous layer of the epidermis or the squamous mucous membranes, hence the name "spinocellular" exposed. Localization at the level of the inter-gluteal fold is rare [1].

Squamous cell carcinomas do not generally appear de novo, but on precancerous lesions, such as condyloma (HPV 6 AND 11), lichen planus, inverse acne, Crohn's disease, or lichen sclerosis and atrophic. Immunosuppression is also a factor favoring tumor development. Squamous cell carcinoma after a pilonidal sinus in the pre-sacral space is extremely rare [2].

Clinically, perianal squamous cell carcinoma initially presents as an erythematous or flesh-colored nodule on eczematized skin. The tumor extends laterally and in depth to have a vegetative, exophytic "cauliflower" appearance; it may eventually ulcerate. Functional signs include pruritus, discharge, bleeding and pain [3].

Clinical examination should look for inguinal lymphadenopathy.

The evolution is slow with a late infiltrating phase and a risk of local extension to neighboring structures. Bone involvement is not uncommon; estimated at 10%; and mainly affects the iliac wing. The risk of lymph node metastases is common, while visceral metastases are exceptional affecting the anus, rectum, rectovaginal septum, cervix, kidneys and urinary tract [4].

A diagnostic delay was estimated in 33% of cases and this following a wrong diagnosis such as eczema, lichen therefore any lesion not responding to conservative treatment should be biopsied.

Well-differentiated perianal lesions, without sphincter involvement and non-metastatic (T1T1, N0, M0) are excised locally with wide margins of 1 cm [5]. Chemoradiotherapy is indicated for locally advanced tumours, with lymph node involvement or sphincter muscle invasion, while abdomino-perineal resection is reserved for large tumors [6].

The prognosis depends on several factors such as the size of the tumour, the primitive character or secondary, the presence of metastases, the histological differentiation and the patient's immunity [7].

Conclusion

Squamous cell carcinoma is a frequent, potentially aggressive malignant epithelial tumor with metastatic risk. Localization of the level of the intergluteal fold is rare with a risk of local recurrence likely to be approximately 65%, hence the need for regular monitoring.

Conflict of Interest

None disclosed.

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