Image Article
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Histology Confirms Recurrent Poorly Differentiated Metastatic Porocarcinoma

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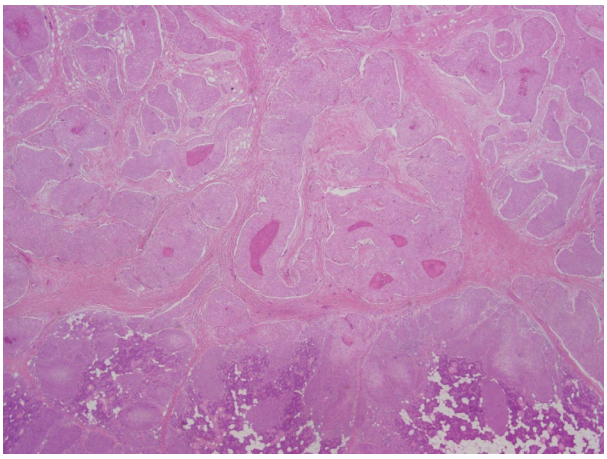

Figure 1. After incisional biopsy, histologic sections were compared to his original parotid excision.

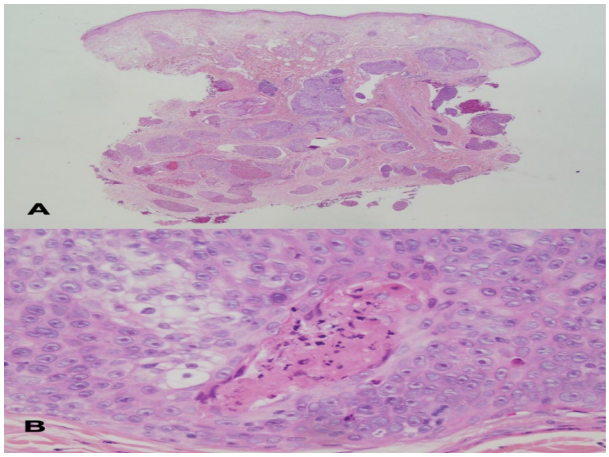

Figure 2. Histology of the current lesion (A) and several mitoses (B).

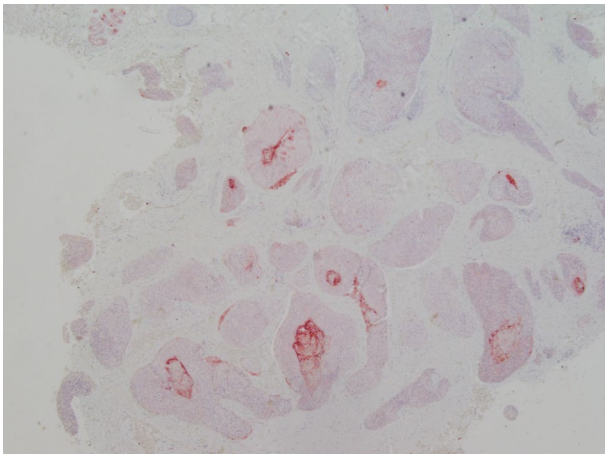

Figure 3. A Carcinoembryonic Antigen (CEA) stain demonstrated focal ductal differentiation.

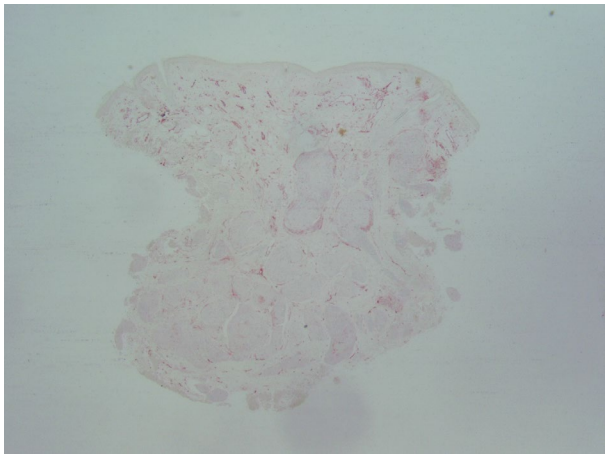

Figure 4. The CD31 stain failed to demonstrate angiolymphatic invasion by the tumor.

Image Article

A 75-year-old white male non-smoker with PMHx of squamous cell carcinoma (SCC) of the tonsils, multiple non-melanoma skin cancers (NMSC), and metastatic porocarcinoma of the left temple treated with resection and radiation therapy (RTX) presented with a 4.3 cm lesion of the left lateral brow. After incisional biopsy, histologic sections were compared to his original parotid excision, with both specimens demonstrated similar morphology (Figure 1). Histology of the current lesion revealed basket weave orthohyperkeratosis with a viable and intact epidermis (Figure 2A). Within the dermis there was a proliferation of epithelioid cells in a nodular configuration. The proliferations focally demonstrated ductal differentiation. There was marked pleomorphism throughout with central necrosis within some proliferations. In addition, there were several mitoses (Figure 2B). The proliferation was situated in a dense fibrotic stroma and in some areas appeared to separate from the surrounding stroma [1-5].

The proliferation involved the peripheral and deep margins. A carcinoembryonic antigen (CEA) stain demonstrated focal ductal differentiation (Figure 3). A CD31 stain demonstrated normal vasculature throughout the proliferation. The CD31 stain failed to demonstrate angiolymphatic invasion by the tumor (Figure 4). He was diagnosed with poorly differentiated carcinoma

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consistent with recurrent porocarcinoma. He underwent radical excision of a 4.3 cm nodule that was 1.2 cm in depth. Two years later, he was diagnosed with subsequent metastatic disease of the left pretragal area. At that time, he received adjuvant chemotherapy with docetaxel anhydrous 30 mg/m^2 and showed significant improvement after one round which allowed for the delay of extensive left neck dissection by two months. Surgery revealed invasive porocarcinoma with lymphovacular (LVI) and perineural invasion (PNI). Notably, the recurrence did not occur in the field of previous RTX. Ultimately, he had multiple recurrences and underwent five additional surgeries until he was finally placed on hospice.

Conflict of Interest

There are no conflicts of interest to disclose.

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