Cutaneous metastasis from colon cancer is rare, occurs in less than 6% of patients and its associated with poor prognosis. Most often it presents in the abdomen, inguinal or perineal regions, supraclavicular area, and less commonly on the face, neck, scalp, and prior surgical sites. We present a case of a 41-year-old female with colon cancer who developed cutaneous metastases to the scalp, and was treated with topical 5-FU and radiation therapy. Treatment options for cutaneous metastases usually include systemic therapy, topical chemotherapy, surgical excision, or radiation. Our case is probably the first report who was treated with topical 5-FU in addition to radiation therapy. This treatment modality is easy to use and we would recommend clinical trials to be conducted to further study the use of topical 5-FU.

Keywords: Adenocarcinoma, cutaneous metastasis, colon cancer, fluorouracil imiquimod, skin-directed treatment, synergy, synergy of topical and systemic treatments, topical treatment, 5-FU
obstruction. Intraoperative peritoneal fluid pathology was negative for malignant cells. Further imaging with MRI abdomen showed a complex cystic right adnexal lesion most consistent with primary ovarian cancer. She was evaluated by gynecologic oncology who recommended against biopsy due to high risk of rupture because of its cystic nature. Genetic analysis of the colon cancer showed KRAS and TP53 mutations. No loss of nuclear expression of mismatch repair proteins. She had homozygous wild-type polymorphism for UGT1A1 (UDP glucuronosyltransferase family 1 member A1).

In the setting of stage IV colorectal cancer and suspicion of ovarian cancer, she was started on chemotherapy with FOLFIRINOX (5-FU without bolus, leucovorin, irinotecan and oxaliplatin) and completed 12 cycles. Following that she underwent total abdominal hysterectomy and bilateral salpingo-oophorectomy for suspected ovarian cancer. The pathology was consistent with metastatic adenocarcinoma of colonic origin. Her follow up CT scan showed progressive metastatic disease. She initiated second line treatment with FOLFIRI (Irinotecan with 5-FU and folinic acid) with bevacizumab.

During this treatment, she noticed a non-healing cyst-like lesion on the posterior right parietal scalp, which was slowly growing over one year (Fig. 1). The lesion was sometimes painful with spontaneous serosanguineous discharge. She was evaluated by dermatology followed by resection of her right parietal scalp 2.5x2.2 cm lesion. An MRI of the head (Fig. 2) was done to assess the depth of the lesion and deep tissue involvement. The pathology was consistent with adenocarcinoma of colonic origin with positive positive. Palliative radiation therapy (PRT) was recommended in case of worsening symptoms such as bleeding or pain. Patient received 24 Gy in 3 fractions.

Due to progression of the scalp lesion, topical 5-FU twice daily was started. Her scalp lesion started showing signs of healing with scab formation starting at week 4 with decreased in size and dramatically improved in 8 weeks (Fig. 3).

Five months after initiation of topical 5-FU the patient reported increasing frequency of local symptoms including a sharp stabbing pain, increased headache and tender to touch with deep aching. She also developed a palpable small nodule in the right sub-occipital region with concern for a new metastatic lesion. MRI head revealed a soft tissue lesion in the right parietal scalp, measuring 2.4 cm (previously 1.6 cm) with a new 1 cm enhancing soft tissue lesion in the right sub-occipital scalp.

Despite the numerous systemic treatments including FOLFIRI with bevacizumab, Regorafenib, MIRI (mitomycin-
C, irinotecan), FOLFOXIRI (folinic acid, 5-fluorouracil, oxaliplatin and irinotecan) and bevacizumab and topical 5-FU her scalp lesion progressed. Palliative radiation therapy was started. Following radiation therapy with concurrent 5-FU her scalp lesions remained stable and her symptoms improved.

Her overall systemic disease continued to progress while on therapy and after significant decline in functional status, the patient was transitioned to comfort measures.

**Discussion**

Colon cancer rarely metastasizes to the skin and occurs in less than 6% of patients. Cutaneous metastases occur concurrently with widespread metastatic disease to other sites such as liver, peritoneum and lung. Most frequent sites of cutaneous metastasis are the abdomen, inquinal or perineal regions, and prior surgical sites, and occur with less frequency on the face, neck and scalp. Adenocarcinoma has the highest rate of cutaneous metastasis compared to other histologic subtypes. The skin metastasis can appear as sessile, pedunculated, single or multiple nodules, as a mass with ulceration, or as a cyst.

The mechanism is thought to be secondary to lymphatic or hematogenous spread, local extension of the tumor, and surgical implantation during resection of the primary lesion.

Cutaneous metastases have been associated with a poor prognosis, with overall survival approximately 12-18 months. Aravind et al. in their article have divided cutaneous metastasis cases into two groups:

- **Group 1:** One who primarily present with cutaneous manifestations with primary not identified
- **Group 2:** This group is the one which has been treated with resection of the primary tumor and is being followed up by medical oncology.

The investigators pointed out that the former group is usually associated with more poor outcomes and other visceral involvement.

No clear guidelines exist for treatment of cutaneous metastasis with primary go to treatment being wide excision of the lesion. Systemic chemotherapies and local radiation have also been used but no topical treatment options have been ever reported. Radiation is mostly used in palliation for painful or bleeding lesions but with modest results. Table 1 summarizes all case reports published on PubMed with English abstracts since 2013 and treatment options utilized. Overall, the goal of treatment is symptomatic relief. No topical chemotherapy has been previously reported. Our patient was prescribed topical 5-FU (5%) once daily and initially her lesion responded as shown above in the picture, but eventually her overall disease progressed though being on systemic chemotherapy and eventually passed away after a total treatment time of 18 months.

We searched the medical literature with diligence and finally found two more cases who received topical 5-FU for skin metastases in patients with breast cancer. Among a case series, two patients used topical 5-FU. When used alone, 5-FU reduced bleeding and drainage of lesions and when combined with cryotherapy and systemic therapy, rapidly decreased tumor burden. The authors concluded that combined treatment with cryotherapy and topical 5-FU is superior to cryotherapy alone, suggesting that 5-FU induces an antitumor activity independent of cryotherapy. Similar to imiquimod, the authors also suggested that the dramatic response in both patients is in part owing to a favorable immune milieu induced by 5-FU that synergizes with systemic therapies.

Our case showed that topical 5-FU can result in partial regression or local control when used as monotherapy or in combination with other treatment modalities like in our patient along with radiation therapy. Side effects include irritation to the applied area and burning sensation. This treatment modality is feasible with a favorable side effect profile; however, the role of topical 5-FU needs to be further investigated, including tests to characterize the antitumor responses elicited by 5-FU.

**Conclusions**

Cutaneous metastasis is of rare occurrence. In literature they occur either as primary presentation or develop while patient has been treated and is being followed up appropriately. No specific guidelines exist for treatment options of cutaneous metastasis with wide surgical excision being the most reported treatment. Topical 5-FU can be used as a potential treatment but clinical trials need to be conducted.

**Disclosures**

- **Informed consent:** Written informed consent was obtained from the patient for the publication of the case report and the accompanying images.
- **Peer-review:** Externally peer-reviewed.
- **Conflict of Interest:** None declared.

**References**

2. A Amal, K Krishnaprasad, GP Praveen, V Shankar, N Keerthi N:
Table 1. Summary of previously published Case Reports with cutaneous metastases associated with CRC

<table>
<thead>
<tr>
<th>Author et. al</th>
<th>Age</th>
<th>Gender</th>
<th>Site of cancer treatment</th>
<th>Phase of Mets</th>
<th>Site of skin Mets</th>
<th>Presence of systemic Mets</th>
<th>Treatment</th>
<th>Outcome (survival after cut Mets diagnosed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ha JY et. al; 2016[^6]</td>
<td>78</td>
<td>Male</td>
<td>Ascending Colon</td>
<td>Follow up</td>
<td>Right Parietal Scalp</td>
<td>Lung</td>
<td>Systemic Capecitabine</td>
<td>Poor</td>
</tr>
<tr>
<td>Góes HF et. al; 2016[^11]</td>
<td>76</td>
<td>Female</td>
<td>Descending Colon</td>
<td>Initial</td>
<td>Right Parietal Scalp</td>
<td>None</td>
<td>Surgical Excision and FOLFOX</td>
<td>Good</td>
</tr>
<tr>
<td>Udkoff J et. al; 2016[^2]</td>
<td>56</td>
<td>Male</td>
<td>Colon</td>
<td>Follow up</td>
<td>Scrotum</td>
<td>None</td>
<td>FOLFIRI</td>
<td>Fair</td>
</tr>
<tr>
<td>Dehal A et. al; 2016[^13]</td>
<td>47</td>
<td>Male</td>
<td>Rectal</td>
<td>Follow up</td>
<td>Genital area and perineum</td>
<td>None</td>
<td>Local Radiation</td>
<td>Good</td>
</tr>
<tr>
<td>Reusser NM et. al; 2015[^14]</td>
<td>58</td>
<td>Male</td>
<td>Rectal</td>
<td>Follow up</td>
<td>Right Flank</td>
<td>NA</td>
<td>Palliative</td>
<td>Poor</td>
</tr>
<tr>
<td>Abt NB et. al; 2015[^15]</td>
<td>67</td>
<td>Male</td>
<td>Sigmoid Colon</td>
<td>Initial</td>
<td>Pelvis and Scrotum</td>
<td>Local Lymph nodes and skin</td>
<td>Patient declined treatment</td>
<td>Poor</td>
</tr>
<tr>
<td>Sheets N et. al; 2014[^16]</td>
<td>78</td>
<td>Male</td>
<td>Ileocecal Valve</td>
<td>Initial</td>
<td>Left Scapula</td>
<td>None</td>
<td>Surgical Excision</td>
<td>Good</td>
</tr>
<tr>
<td>de Miguel Valencia</td>
<td>55</td>
<td>Male</td>
<td>Rectal</td>
<td>Follow up</td>
<td>Multiple subcutaneous lesions on face, axilla, chest, flank and lower extremities</td>
<td>Lung and Liver</td>
<td>Surgical resection</td>
<td>Poor</td>
</tr>
<tr>
<td>Nesseris I et. al; 2013[^17]</td>
<td>80</td>
<td>Male</td>
<td>Ascending Colon</td>
<td>Follow up</td>
<td>Abdominal Surgical Scar</td>
<td>None</td>
<td>Surgical Excision</td>
<td>Good</td>
</tr>
<tr>
<td>Hashimi Y et. al; 2013[^8]</td>
<td>70</td>
<td>Male</td>
<td>Rectal</td>
<td>Follow up</td>
<td>Right Cheek</td>
<td>Lung</td>
<td>Surgical Excision</td>
<td>Fair</td>
</tr>
<tr>
<td>Aravind B et. al; 2013[^9]</td>
<td>61</td>
<td>Female</td>
<td>Rectal</td>
<td>Follow up</td>
<td>Scalp (recurrent)</td>
<td>Lung</td>
<td>Surgical resection</td>
<td>Good</td>
</tr>
<tr>
<td>Balta AZ et. al; 2013[^18]</td>
<td>84</td>
<td>Female</td>
<td>Rectal</td>
<td>Initial</td>
<td>Left Occiput</td>
<td>None</td>
<td>Chemotherapy and Radiation</td>
<td>Poor</td>
</tr>
<tr>
<td>Relles D et. al; 2012[^19]</td>
<td>55</td>
<td>Male</td>
<td>Sigmoid</td>
<td>Follow up</td>
<td>Right upper lip</td>
<td>Liver</td>
<td>Excision</td>
<td>Poor</td>
</tr>
<tr>
<td>Balta I et. al; 2012[^20]</td>
<td>46</td>
<td>Male</td>
<td>Rectal</td>
<td>Follow up</td>
<td>Anogenital region</td>
<td>Local</td>
<td>Patient declined chemo</td>
<td>Unknown</td>
</tr>
<tr>
<td>Nguyen VX et. al; 2012[^21]</td>
<td>65</td>
<td>Male</td>
<td>Caecum</td>
<td>Initial</td>
<td>Right Flank</td>
<td>None</td>
<td>Systemic Capecitabine and cyclophosphamide, progressed then on FOLFOX</td>
<td>Poor</td>
</tr>
</tbody>
</table>


