Adenosquamous Carcinoma Evades Diagnosis

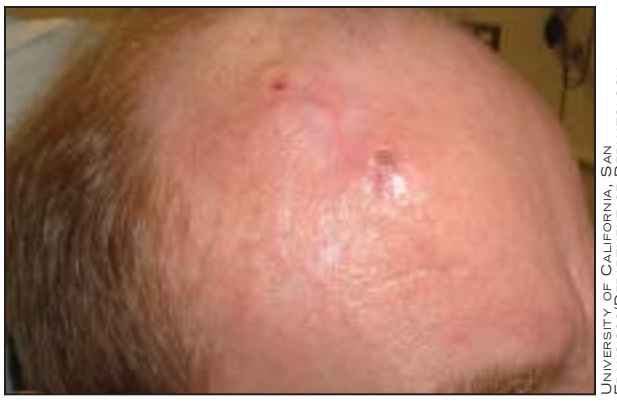
BY SUSAN LONDON
Contributing Writer

VANCOUVER, B.C. — Adenosquamous carcinoma often is a misdiagnosed, more aggressive type of skin cancer, which requires close follow-up for possible recurrences, according to a review that identified 27 patients with primary adenosquamous carcinoma.

As skin cancers go, adenosquamous carcinoma (ASC) is somewhat newly recognized and uncommon, observed Dr. Jennifer M. Fu, a dermatology resident at the University of California, San Francisco.

"We are starting to get the sense that it can be very clinically aggressive and, in fact, may be more aggressive than conventional cutaneous squamous cell carcinoma [SCC], with a high risk of local recurrence and, in some case series, distant metastases," Dr. Fu said at the annual meeting of the American College of Mohs Surgery.

A rise in the number of cases at her institution in recent years, with some of them proving to be very locally aggressive, prompted a closer look at this cancer. Dr. Fu and her colleagues searched their institution's records for the past 10 years to identify cases of ASC diagnosed there. The search identified 27 patients with primary ASC, 7 of whom experienced a recurrence. The patients had a mean age of 74 years (range 50-97 years), and 70% were men.



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Recurrent ASC nodules/plaques are visible at the edge of a scar from previous treatment.

Some 56% of the primary tumors were on the face, 15% were on the scalp, and 15% were on the arm or shoulder. "Clinically, this was a very difficult diagnosis for people to make, often presenting just as a firm papule or plaque and not infrequently ulcerated," Dr. Fu said.

"Most of the clinicians diagnosed this as something else—as basal cell carcinoma, scar, metastatic carcinoma, rosacea in one case, and a spider bite in another case," she said, adding that SCC was listed in the differential diagnosis in only four cases. "In no case was adenosquamous carcinoma correctly diagnosed," she said.

Clinical outcomes were assessed in the six patients who received most of their treatment at her hospital. Five were immunosuppressed. All underwent Mohs surgery at least once, and two received adjuvant therapy consisting of radiation therapy and cetuximab (Erbitux) for locally advanced disease. For all of these patients, "the Mohs defect postoperatively far exceeded what was evident clinically," she noted.

Two patients were alive with no evidence of disease, and another patient with brief follow-up (5 days) was alive with persistent disease. The remaining three patients had locoregional recurrences 3 months, 4 months, and 5.5 years after their primary tumor, but there were no cases of distant metastases. Two of these three patients with recurrences were alive with no evidence of disease after 4 and 4.5 years, while one was alive with unclear disease status after 3.5 years.

Dr. Fu reported that she had no conflicts of interest in association with the study. ■

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Most CA-MRSA Skin Infections Treatable Without Antibiotics

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

SAN FRANCISCO — While almost unheard of 10 years ago, community-associated methicillin-resistant *Staphylococcus aureus* has now become the single biggest cause of skin infections in the United States, Dr. Greg Moran said at the 12th International Conference on Emergency Medicine.

"We really don't know what's begun this sudden explosion of resistant staph in the community all over the United States, as well as in Canada and Europe," said Dr. Moran, an emergency physician at the Olive View–UCLA Medical Center, Sylmar, Calif. "One thing we do know is that this is not a phenomenon of the hospital strains moving into the community. These are genetically distinct strains."

In his 2006 study, virtually all the skin infections cultured from hospitals in 11 cities across the country were caused by community-associated strains; 78% of those were a single clone of USA300. "There is something about this strain that has given it a very, very strong survival advantage in the community," Dr. Moran explained. "Almost all of [the skin infections] (98%) carried the Panton-Valentine leukocidin toxin gene and the SCCmec type IV gene."

The SCCmec gene confers methicillin resistance, while the Panton-Valentine leukocidin toxin gene is associated with spontaneous skin and soft-tissue infections, as well as necrotizing pneumonia. Those mutations make the community-associated MRSA strains much more likely to cause infections than those MRSA strains found in hospitals, Dr. Moran said.

In addition to authoring a seminal paper on the topic (N. Engl. J. Med. 2006;355:666-74), Dr. Moran has kept track of the MRSA skin infections occurring in his own hospital since 1997. There were 25 cases documented that year. "That number rose to almost 450 per year in 2006 and 2007," he said. "In 2001, 29% of our skin infections were MRSA. That more than doubled by 2003-2004, to 64%. In a very short time, we went from something we virtually never saw in the community, to it being the single largest cause of skin infections."

Despite their prevalence, most of these infections are not serious and don't grow the "killer flesh-eating super bugs," Dr. Moran said. "More than 90% of the isolates in our study were susceptible to at least one [antibiotic] agent."

For most uncomplicated skin infections, he performs an incision and drainage, and he doesn't give antibiotics. "I do give antibiotics if there is a fever, significant associated cellulitis, immune or vascular compromise, if the lesion is in a high-risk area like the hands or face, or if the patient has already failed an incision and drainage," Dr. Moran explained. ■