

## Cutaneous Squamous Cell Carcinoma Presenting as Cellulitis

El Boukili Hafsa\*, Soughi Meryem , Douhi Zakia , Elloudi Sara, Baybay Hanane and Mernissi Fatima Zahra

Department of Dermatology, University Hospital Hassan II , Morocco

\*Corresponding author: El Boukili Hafsa, Department of Dermatology, University Hospital Hassan II , Fez, Morocco

Received: January 08, 2024

Published: May 21, 2024

### Abstract

In general, skin squamous cell carcinoma (SCC) presents as papules or plaques with erythematous or pigmented appearance that may ulcerate the skin. Cellulitis caused by metastatic deposit from a known primary skin SCC has been reported twice [1-2]. We add a new case of a patient who presented with cellulitis on the face that did not respond well to full course of antibiotics treatment, and turned out to be a newly diagnosed SCC after biopsy.

**Keywords:** Squamous cell carcinoma; Face; Cellulitis

### Introduction

SCC is non-melanoma skin cancer. Typically, SCC is diagnosed early before it infiltrates local subcutaneous tissue or metastasizes. However, unusual presentations are possible and can lead to delayed treatment and possibly worse outcomes. We report a case of a historical squamous cell carcinoma inducing destructive cellulitis in a 58-year-old-man.

### Observation

A 58-year-old smoker and alcoholic man, with a history of excessive sun exposure, presented to the emergency department with a chief complaint of painful swelling of the left facial region. His facial swelling had started on the 06th day prior to admission, accompanied by an erythema around the cheek,

which was painful. The erythema eventually spread to the entire left side of his face and involved the mucous membranes in the oral cavity, accompanied by a high fever of 40°C with a worsening of his general condition, and visual acuity of the right eye was diminished. Furthermore, he reports the occurrence of a painless plaque in his right nasal wing fold 02 years ago; with a history of handling and squeezing.

On local examination, the right side of face was diffusely swollen, erythematous, and indurated. There was a giant ulcerative growth arising from left lateral nasal wall of size approximately 10cm\*6cm\*5cm, encroaching whole, left upper lip, left cheek and left lower eyelid. Its surface was irregular and contained patches of necrotic tissue at places (**Figure 1-2**). Foul smelling seropurulent discharge was also present.



Figure 1 and 2: Destructive ulcerative growth arising from left lateral nasal wall, encroaching whole, left upper lip, left cheek and left lower eyelid with necrotic surface.

The patient was hospitalized for cellulitis and treated with intravenous antibiotics according to sensitivities (amoxicillin-clavulanic acid + fluoroquinolones + metronidazole), which produced only partial improvement after 3 weeks. A cranio-orbital Computerized tomography scan was performed that showed diffuse inflammation and a tumoral process involving the soft tissues of the face extending into the facial sinuses and eyelids on both sides. Signs of bone destruction particularly involving the lower wall of the left orbit and extension into the left extraconal fat, were observed. Therefore, an underlying tumoral skin disease was suspected and punch biopsy was taken after a surgical drainage and sent for histopathological examination, that conclude the diagnosis of well differentiated SCC, the extension assessment carried out did not reveal any notable anomaly. The therapeutic decision taken by the ENT (Ear, Nose and Throat) oncology committee consisted in opting for radiotherapy.

### Discussion

Squamous Cell Carcinoma (SCC) is the second most common cutaneous malignancy worldwide behind basal cell carcinoma [3]. It has been shown to develop more frequently in chronically precursor lesions, including long-standing ulcers, sinus tracts, burns or osteomyelitis [4]. The incidence of SCC has increased considerably over the past 20 years, because of the growing life expectancy, and increased sun exposure [5].

In general, SCC presents as papules or plaques with erythematous or pigmented appearance that may ulcerate the skin. The area of interest often shows poor signs of healing and bleeds easily.

By far, SCC detected late in the course may already have metastasized involving the regional lymph nodes in the head region. By diagnosing SCC in the early stage, advanced metastasis of the disease can be prevented and good prognosis with a modest mean survival rate can be achieved. Unfortunately,

because SCC can present in many different ways, it is difficult to detect at such an early stage.

Our case is one of the very few to report SCC presenting with cellulitis. Based on clinical-histological considerations, we believe that our patient had facial cellulitis, of which the SCC on the right nasal wing was the underlying disease.

### Conclusion

We therefore recommend that other differential diagnoses such as malignancy, be suspected and biopsy be taken if patients do not show an optimal and desired improvement after receiving a full-course of antibiotic therapy for cellulitis. This observation highlights the importance of careful monitoring and investigation in cases of extensive facial cellulitis, in order to screen for possible underlying malignancies such as squamous cell carcinoma SCC.

### References

1. Zhao M, Sasikumar K, Kinoshita M, Abdullah M, Alhusaini H, Alaie D, et al. Skin Squamous Cell Carcinoma Pre-senting as Cellulitis. *Clinical Medicine Insights: Case Reports*, 2015; 8: CCRRep.S18915. doi:10.4137/ccrep.s18915.
2. Bramhall S, Varma S. Metastatic squamous cell carcinoma presenting as cellulitis. *British Journal of Plastic Surgery*, 1991; 44(8): 622–623. doi:10.1016/0007-1226(91)90104-r.
3. Williams JD, Bermudez Y, Park SL, Stratton SP, Uchida K, Husrt CA, et al. Malondialdehyde derived epitopes in human skin result from acute exposure to solar UV and occur in nonmelanoma skin cancer tissue. *Journal of Photochemistry and Photobiology B: Biology*, 2014; 132: 56.
4. Cassarino DS, Derienzo DP, Barr RJ. Cutaneous squamous cell carcinoma: a comprehensive clinicopathologic classification part two. *J Cutan Pathol*, 2006; 33(4): 261.
5. Guidelines for the diagnosis and treatment of cutaneous squamous cell carcinoma and precursor lesions. *Guidelines. Annales de Dermatologie et de Vénérologie*, 2009; 136: S166-S17.