

throughout their life.² The chronic and most debilitating sequelae of lymphatic filariasis often develop years after initial infection.³ Chylous ascites is characterized by chyle in the peritoneal cavities produced by obstruction and disruption of the retroperitoneal lymphatic channel.⁴ The diagnosis of microfilaria is conventionally made by demonstration of microfilaria in the peripheral blood smear. Pathogenesis of nonchylous filarial ascites remains enigmatic. Lymphangitis because of partial obstruction is a postulated cause for such nonchylous low SAAG (exudative) ascites.⁵

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Cutaneous metastasis from intrahepatic cholangiocarcinoma

Cutaneous metastasis from internal malignancy is rare. Furthermore, cutaneous metastasis from cholangiocarcinoma is extremely rare and none have been reported from India, to best of our knowledge.

Case Report

A 63 year old male, presented to us with history of weight loss, anorexia for last 2 months. Patient also had history of gradually progressive cholestatic jaundice since 10 days. On physical examination, patient was icteric, had multiple matted, firm, mildly tender, erythematous, subcutaneous nodule on the left axilla (**Figure 1**). Per abdomen palpation revealed hard, non-tender liver extending upto 5 cm below subcostal margin. Contrast enhanced CT scan (**Figure 2b**) revealed ill-defined heterogeneous mild enhancing mass seen predominantly involving medial segment of left lobe of liver causing narrowing and obstruction of left hepatic ducts with resultant mild dilatation of left intrahepatic biliary ducts s/o cholangiocarcinoma. CT scan image of upper thorax (**Figure 2a**) showed enhancing soft tissue lesion in skin and subcutaneous tissue of left axillary region suggestive of metastasis. Multiple enlarged portal, porto-caval, peripancreatic and mesenteric lymph nodes



Figure 1: Axillary multiple subcutaneous nodules.

were present. Subsequent whole body PET CECT scan showed increased FDG uptake in left axillary region soft tissue lesion further confirmed the diagnosis of metastatic cholangiocarcinoma (**Figure 2c,2d**).

Laboratory analysis showed the following results: total bilirubin 24 mg/dL, with direct component 18.8 mg/dl, serum aspartate transaminase (AST) 102 IU/L, alanine aminotransferase (ALT) 80 IU/L, alkaline phosphatase 523 IU/L, carbohydrate antigen 19-9 (CA 19-9) 1.2 ng/mL, carcinoembryonic antigen (CEA) 3.42 ng/mL, and alpha-fetoprotein (AFP) was 4.05 IU/mL.

Endoscopic ultrasound guided biopsy taken from portal lymph node revealed metastatic adenocarcinoma. Since skin metastasis is extremely rare in cholangiocarcinoma fine needle aspiration (FNAC) of skin lesion was taken which also revealed similar cytology (**Figure 3**).

Based on these findings; diagnosis of metastatic cholangiocarcinoma was made. The patient is being treated with systemic chemotherapy; to which he had partial response after three cycles of gemcitabine and oxaliplatin.

Discussion

Cutaneous metastases of cholangiocarcinoma are rare and have been reported to occur in only 0.4-5.3%, mainly at percutaneous biliary drainage site.^{1,2} There are few case reports about distant cutaneous metastasis from cholangiocarcinoma.³⁻⁵ Previous reports showed that the most common presentation of cutaneous metastases of cholangiocarcinoma is the nodular phenotype; other skin lesions described include ulcers, abscesses, and erythematous plaques.³ Most nodular lesions are non-ulcerative, covered by a normal appearing epithelium, firm and painless; which results in some lesions being misdiagnosed as benign. Clinicians should therefore consider the possibility of cutaneous metastases in patients with history of malignancy when examining skin nodules.

The most common site of cutaneous metastasis in cholangiocarcinoma is abdomen (at percutaneous drainage site) than chest.^{1,6} There are reports of scalp metastasis as

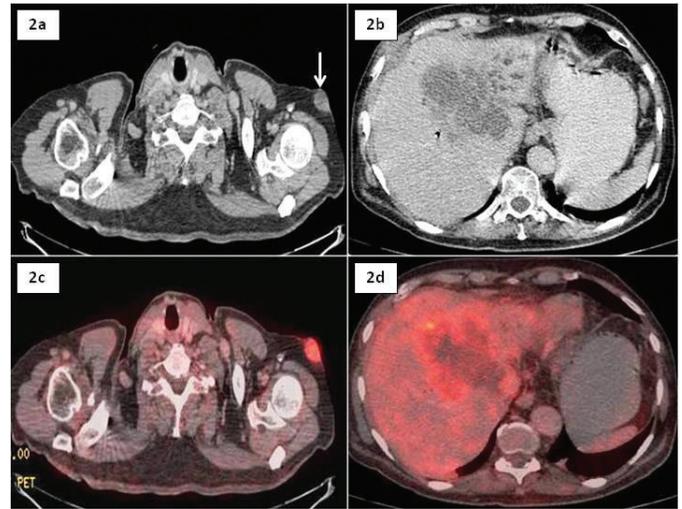


Figure 2: Axial image of contrast enhance CT scan of the upper thorax (2a) revealed an enhancing soft tissue lesion in skin and subcutaneous tissue of left shoulder region (white arrow) and axial image of the upper abdomen (2b) showed a large heterogeneous mild enhancing mass lesion predominantly in medial segment of left lobe of liver causing mild dilatation of left intrahepatic biliary ducts. Corresponding axial images of 18-FDG enhanced PETCT scan showed FDG uptake in skin, subcutaneous axillary soft tissue lesion (2c) and liver mass lesion (2d).

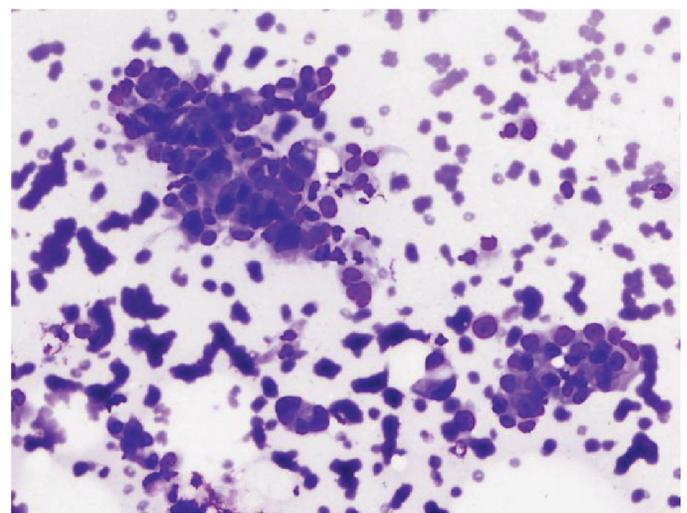


Figure 3: Smears are cellular and comprise of clusters, groups and occasional acini lined by atypical epithelial cells. These cells show enlarged, pleomorphic nuclei with high NC ratio, irregular nuclear membrane.

well.⁵ However to best of our knowledge subcutaneous axillary metastasis is being reported for the first time.

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