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Case Report

A RARE CASE OF SQUAMOUS CELL CARCINOMA (SCC) OVER THE SACRO-COCCYGEAL REGION

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ABSTRACT
A 60 year old man presented to us with a large cauliflower like growth over the sacro-coccygeal region with bleeding ulcer over the growth. He had no history of long-standing pilo-nidal sinus. He was thoroughly investigated and was diagnosed to have squamous cell carcinoma. He was operated and wide local excision with bilateral V-Y plasty was done considering the unequal growth. Post-operatively he healed well.

Keywords: *Squamous Cell Carcinoma, Sacro-Coccygeal Region, V-Y Plasty*

INTRODUCTION
Primary squamous cell carcinoma in the buttock region is extremely rare and there is always a history of long-standing pilo-nidal sinus. However, such rare tumors have been reported (Luiz Fernando Nunes, MC Faschin). Squamous cell carcinomas arise from the keratinising cells of the epidermis, are locally invasive and have the potential to metastatize (BAD 2009). We report a case of primary squamous cell carcinoma over the sacro-coccygeal region in a 65 year old man which was treated by wide local excision with bilateral V-Y Plasty.

CASE
A 60 year old farmer came to us with the complaints of inability to sit properly because of a swelling on the sacral region and staining of dhoti with blood since 3-4 months. He had no history of discharging sinus or wound from that area previously. He did not give history of injury or similar swelling in the past. No significant co-morbidities were present. On examination, he was medium built, in good health but distressed due to staining of blood and inability to sit. On local examination, a large cauliflower like growth, about 20cm by 15 cm over the sacro-coccygeal region that had a central large ulcer with slough, foul smelling discharge and everted edges. It bled on touch. Biopsy was sent, X-ray sacral region was negative for bony involvement and rest of the routine examination was within normal limits, except for borderline anaemia. The biopsy came as Squamous cell carcinoma (moderately differentiated). He was assessed pre-operatively, anemia was corrected with blood transfusion and posted for surgery. Considering the size and unequal growth extending on both buttocks, a wide local excision with bilateral V-Y plasty was planned and done. Excised growth was sent for histo-pathology. Post-operative recovery was good except a small central wound gape which was later secondarily re-sutured. Patient was discharged in good condition.

DISCUSSION
Primary cutaneous squamous cell carcinoma (SCC) is a malignant tumour that arises from the keratinising cells of the epidermis or its appendages. It is locally invasive and has the potential to metastasise to other organs of the body (BAD 2009).
Chronic UVR exposure is the most important risk factor. Some of the known causes are chemical carcinogens: arsenic and chromium, soot (scrotal cancers in chimney sweeps), tar and pitch oils, Human papilloma virus infection, Ionising radiation exposure, Immunodeficiency, Chronic inflammation near chronic ulcers (Gur *et al.*, 1997), around chronic sinuses (eg .osteomyelitis), lupusvulgaris (chronic form of cutaneous tuberculosis) and certain genetic conditions - eg, xeroderma pigmentosum and albinism and pre-malignant conditions - eg, Bowen's disease.

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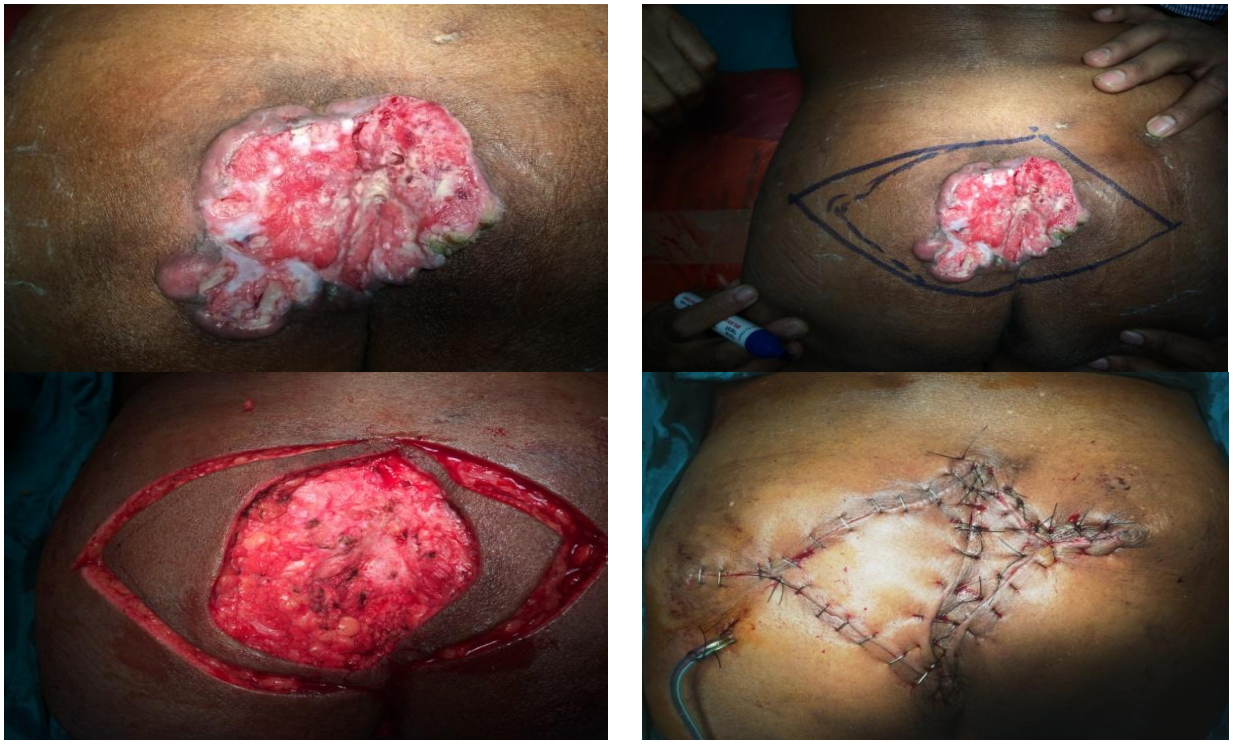

Figures 1- Ulcerated Growth; 2- Planning Excision; 3- Post Excision; 4- Postoperative

Typically, SCC presents as a non-healing ulcer or growth in one of the higher-risk sun-exposed areas. Most SCCs appear on the skin of the head and neck. The clinical appearance is very variable. A small nodule enlarges and the centre becomes necrotic and sloughs, developing into an ulcer. The tumour therefore usually presents as an ulcerated lesion with hard, raised edges, slow-growing ulcer or reddish skin plaque. Bleeding may occur from the tumour. SCC may give rise to local metastases or spread to local lymph nodes.

SCC in pilonidal sinuses are rare but have been reported (Luiz Fernando, MC Faschin). The management of sacral SCC ulcers is essentially surgical wide excision with perforator based myo-cutaneous flaps. (Stephen Kroll, 1998, MC Fashin). In our case the ulcerated growth had unequal dimensions on either side of the buttocks and hence a bilateral V-Y Plasty based on perforating branches of superior gluteal arteries was planned and executed with good results.

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