



Cutaneous metastases (CMs) signal the spread of a primary tumor to the skin and dermis, particularly in patients with melanoma or with breast, lung, or gastrointestinal cancers. Although these lesions may present as superficial and painless, some CMs may lead to ulceration, drainage, and discomfort, causing distress to patients. Oncology nurses require knowledge about the clinical presentation of CMs, including incidence, pathophysiology, diagnostic evaluation, and complex symptomatology, as well as standard treatment and care for patients. In addition, nurses can provide psychosocial interventions to assist patients experiencing distress from CM lesions.

#### AT A GLANCE

- It is important for nurses to be aware of and educated on how to care for patients with CMs so that they can provide interventions to limit patient distress.
- Nursing assessments of CMs should include an evaluation of patients' psychosocial concerns to ensure that supportive care needs are met.
- Increasing nursing knowledge of wound care management for patients who develop CMs can improve outcomes.

#### KEYWORDS

cutaneous metastases; distress; symptom management; nursing interventions; cancer

#### DIGITAL OBJECT IDENTIFIER

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# Cutaneous Metastases

## A case study on clinical care for patients

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**C**utaneous metastases (CMs) are a sign that cancer has spread from a primary tumor to the skin and subcutaneous tissue. Skin metastases are a rare occurrence in cancer, with few treatment options and many psychosocial considerations. The most common diseases to metastasize to the skin are melanoma and breast, lung, and lower gastrointestinal tract cancers (Dittmer & Liu, 2018). Most incidences of CM occur in patients with breast cancer or melanoma (De Giorgi et al., 2010; Dittmer & Liu, 2018; Kalmykov & Walker, 2011).

### Incidence

The incidence of CMs among patients with cancer ranges from 0%–10% (Dittmer & Liu, 2018; El Khoury et al., 2014; Fernandez-Flores, 2010; Gan et al., 2015; Handa et al., 2017; Hu et al., 2009; Wong et al., 2013, 2014). Although a study by Hu et al. (2009) highlighted possible differences in incidence rates among various ethnicities, evidence on ethnic and racial differences in CM rates is limited. Between 2% and 28% of CM cases lack primary tumor identification, which poses significant challenges in ensuring that CMs are treated appropriately. Barriers to effective treatment decisions for CMs include the loss of patients to follow-up care, early patient deterioration, and patients with an unidentified primary tumor (El Khoury et al., 2014;

Gan et al., 2015; Handa et al., 2017; Sittart & Senise, 2013).

### Pathophysiology

Most CMs are classified as adenocarcinomas, which often have identifiable histologic patterns associated with the primary tumor site (El Khoury et al., 2014; Wong et al., 2014). The presence of CMs indicates that a tumor has spread to the skin, blood capillaries, or lymphatic system (Kalmykov & Walker, 2011). The exact method of how CMs move from the primary organs to the skin has not yet been identified; however, previous studies have suggested that the lymphatic system is a possible mode of transmission for tumor cells (Dittmer & Liu, 2018; El Khoury et al., 2014; Kong et al., 2011). Understanding the histologic features of cutaneous lesions is important in helping to determine whether the lesion is a primary skin lesion or metastasis.

The histologic pattern for classifying CMs includes nodular, infiltrative, diffuse, intravascular, top heavy (i.e., tumor is primarily located in the top layer of the skin), or bottom heavy (i.e., the tumor is primarily located in the bottom layer of the skin) (Fernandez-Flores, 2010). Fernandez-Flores (2010) identified morphologic features of CMs using the following criteria: necrosis, nodular, ulceration, vascular lymphatic invasion, and/or inflammation. To confirm a CM diagnosis, serum tumor marker results and antibodies (e.g., cluster of differentiation in B-cell lymphoma,