



## SHORT REPORTS AND CORRESPONDENCE

### Marjolin's ulcer at a Nigerian hospital (1993-2003)

Marjolin's ulcers represent up to 30% of primary skin cancers we see in Nigeria.<sup>1</sup> Unlike elsewhere<sup>2,3</sup> the predisposing lesion has not been flame burns.<sup>1</sup>

Between January 1993 and December 2003 25 records of 29 patients, excluding albinos, with scar cancers were retrospectively examined. The senior author interpreted the histology slides.

### Results (Tables 1 and 2)

The male/female ratio was 1.23:1; much closer than elsewhere.<sup>2,3</sup> The age range was 16-65 years (mean: 42 years), similar to elsewhere in Africa.<sup>4</sup> Previous mean ages ranged from 50 to 59 years.<sup>2,5,6</sup>

Our peak was the 46-50 years bracket.

The transition time was 6 months to 40 years (mean 12 years). This is lower than elsewhere<sup>2,3,5,7</sup> and previous reports from here.<sup>1</sup> Five of six who had native/chemist medication had a transition time of 3 years or less, probably due to irritants used on their wounds, and three had disease progression after treatment. Many came with florid, incurable lesions.

As elsewhere<sup>2,5,8</sup> the lower limb was the commonest site. None was on the trunk.

In burn wounds ulcers developed at the fringe of depigmented scars, by the region of maximum tension. Two carcinomas developed in previously grafted wounds.

The histology showed squamous cell carcinoma in all. Three had clearly gone beyond the skin to involve muscle or lymph node.

### Treatment

Early recognition is best, when wide local excision alone may be curative.<sup>5</sup> Wound excision and closure was favoured. A month's interval was common between biopsy and definitive treatment.

Two refused treatment. Amputation was done in five cases, with added groin dissection in one. Split

skin grafting was done in four cases. It was combined with a flap in one. Radiotherapy and adjuvant chemotherapy in one case each was planned. One with bone involvement had recurrence following limited bone excision and flap cover. We are yet to start sentinel lymph node biopsy to detect occult nodal involvement.

### Recurrence/disease progression

This was noted in 11 patients: five within 3 months, two in 6 months and the rest within a year; giving a metastasis rate of 44% (worse than a Korean study<sup>2</sup>). This is associated with late presentation. Primary treatment in three had been amputation, and wide excision in eight. Three were in the upper limb, one in the face, and seven in the lower limb.

At the time of presentation all those involving the upper limbs had clinical evidence of bony

**Table 1** Previous lesion (recorded in 17 patients)

Previous lesion	Number
Burns	6
Traumatic ulcer	6
Osteomyelitis	2
Cancrum oris	1
Venous ulcer	1
Discoid lup eryth	1
Total	17

**Table 2** Associated features noted in 22 patients

Associated features on first presentation	Number
Bleeding	12
Foul odour and discharge	11
Pain	9
Weight loss	3
Enlarged regional nodes	11
Pallor	8
Pathologic fractures	3

involvement. For the lower limbs, five had clinical evidence of bony involvement.

All 10 in the limbs had associated symptoms or other clinical features on initial presentation: offensive odour (six patients), bleeding (two patients), and pain (three patients). Sometimes they are due to infection but in the absence of inflammation, increasing pain and bleeding probably indicate the tumour has escaped the confines of the scar. One had lymphadenopathy only. Pallor was noted in four, enlarged nodes in four, and weight loss in three.

The initial lesion was up to 9 cm outside the face. That in the face ( $4 \times 4 \text{ cm}^2$ ) showed muscle erosion on histology. Further, excision or amputation or cytotoxic therapy or radiotherapy was employed to manage recurrence.

When bony involvement was not treated by amputation the patient succumbed within a year. Malignant transformation in previously grafted ulcers<sup>1-3</sup> calls to question its adequacy in isolation for treatment of contractures, particularly when prone to repeated stresses.

### Follow up

Follow up was poor: only one survivor was followed up for 6 years. Most defaulted after 3-6 months following diagnosis.

Education is needed to encourage prevention and improve outcomes.

### References

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