A 55-year-old man presented to the ENT outpatients’ department with a mass at the tip of his nose, which bled occasionally. On examination, his pulse was 80/minute; respiration was normal and blood pressure was 130/90 mm of Hg. The nasal mass was nodular, greyish black, covered with skin, measured 3 x 3 cm, and bled on touch (Figure 1). Despite being advised surgical excision of the lesion, he ignored it. Two weeks later, he returned with profuse bleeding from the mass, following which he became unconscious and was hospitalised.

On admission, he was unconscious, blood pressure was 170/100 mm Hg. A CT scan of the head revealed right-sided basal ganglia bleed, with intraventricular extension. A vascular lesion was noted at the tip of the right nostril. The paranasal sinuses were normal. His haemoglobin was 11.5 gm%. All other routine haematological and biochemical investigations were within normal limits. A Burr hole surgery was done to drain the haematoma, but his condition remained unchanged and he eventually succumbed 3 days later.

The findings on complete autopsy corroborated the CT findings in the brain of right-sided basal ganglia bleed. The nasal mass was friable, with an extremely hemorrhagic cut surface (Figure 1, inset).

The kidney weighed 140 gm, and the cut surface showed a 4 x 4 x 3 cm, irregular, nodular grey white mass in the mid-cortex with areas of haemorrhage and necrosis. Histologically, the sections from the nasal mass showed intradermal islands of tumour cells separated by fibrovascular septae, with areas of haemorrhage and necrosis (Figure 2). The individual cells had abundant clear to pale eosinophilic cytoplasm, with a central round nucleus (Figure 2, inset). Sections from the renal mass also showed tumour with similar morphology as above (Figure 3). This was thus a case of renal cell carcinoma, presenting with a bleeding cutaneous metastatic mass. At autopsy, the liver and lung also harboured metastatic disease. The brain only showed hypertensive ganglionic haemorrhage, without any metastasis.

**Discussion**

Cutaneous metastasis, a rare primary manifestation of cancers, is often a harbinger of advanced disease with a poor prognosis. Common primary tumours that cause cutaneous metastasis are those in the lung (28.6%), malignant melanomas (18.2%) and gastrointestinal tract (14.2%). Cancers of the genitourinary tract account for only about 10% of cutaneous metastases.
Cases of renal cell carcinomas in particular, presenting as cutaneous metastatic deposit are quite infrequent; rarer still is a cutaneous metastatic lesion being the presenting manifestation of an undetected asymptomatic renal cell carcinoma. Haematuria remains the most important symptom of renal cell carcinoma and should be elicited during preliminary clinical enquiry in an appropriate clinical setting.

The histological differential diagnosis, especially relevant while studying surgical biopsies is eccrine acrospiroma, which is multinodular and non-haemorrhagic. It is the striking stromal vascularity, which should alert the pathologist to the possibility of metastatic renal cell carcinoma. Further, the sweat gland tumour would show tubular lumina lined by cuboidal ductal cells.

The time interval between the initial diagnosis of renal cell carcinoma and the detection of cutaneous metastasis is relatively long and has poor prognosis. The scalp and face are common sites of metastasis followed by the chest and the abdomen. In an Indian study of 306 cases of renal cell carcinoma, the incidence of cutaneous metastasis was only 3.3%, half of whom had cutaneous disease at initial presentation. However, only one of the patients had cutaneous deposits as the sole presenting feature.

In short, it is imperative that a thorough search for cutaneous metastatic disease be carried out as part of initial tumour evaluation, especially in patients of renal cell carcinoma, as it has important connotations as far as treatment is concerned. In patients with a single cutaneous deposit and no evidence of systemic spread, nephrectomy and excision of the metastatic lesion is mandatory. Cases with multiple nodules or systemic involvement, warrants chemotherapy, though the results may be dismal. Further, patients of renal cell carcinoma need to be followed up for longer periods of time to pick up metastatic disease at the earliest. The mean survival after detection of cutaneous metastasis was only 7 months.

References