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# A very large Marjolin's ulcer on back without lymph node metastasis

Sir,

Malignant transformation occurring in an area of previously traumatised, chronically inflammed[1] or scarred skin[2] is called Marjolin's ulcer.

A 40-year-old male patient presented with a large, painful, nonhealing ulcer on the back. He had a history of burns at one year of age. The patient first noticed a small ulcer five years before, which kept increasing in size [Figure 1]. The ulcer extended from the right posterior axillary line to the left posterior axillary line and from the nape of the neck to the lower back. It measured 43 × 23-28 cm in size (approximately 1120 $cm^2$). The axillary and groin lymph nodes on both

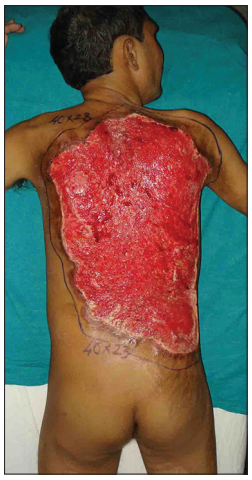

**Figure 1:** Marjolin's ulcer on the back

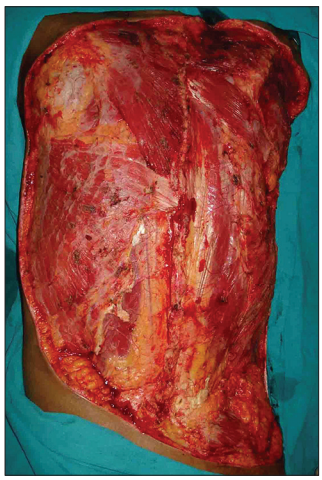

**Figure 2:** Extensive raw area after excision

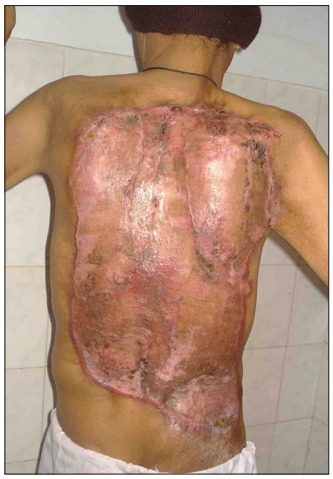

**Figure 3:** Postoperative view

sides were not palpable and were not detectable on ultrasonography. Biopsies from multiple places were suggestive of a well-differentiated squamous cell carcinoma [Figures 2 and 3].

The whole ulcer was excised with two centimetres of safe margin. Exposed skin grafting was done in one shot. One year of follow-up showed no recurrence.

Childhood burn is a condition which haunts the patient throughout life. It usually starts as suffering due to the burn leading to itching, contractures, keloids and bad cosmesis in adulthood and ultimately conversion to malignancy later in life.

The commonly adopted treatment regimen for Marjolin's ulcer is wide excision with 2-2.5 cm safe margin including muscle fascia. Dissection of lymph nodes is reserved for metastatic lymphadenopathies.[3] Chemotherapy and radiotherapies usually are less effective.

Traditionally Marjolin's ulcers do not metastasise unless the normal skin is breached. Here, the malignant changes were confined to scarred areas; so, no metastasis in other areas was noted even though the ulcer had grown considerably in size. This emphasises the importance of early recognition and prompt management of this malignancy when it is still confined to the scarred area.

Marjolin's ulcer can be prevented by managing full-thickness burns with early excision and grafting of skin. Patients and relatives should be warned about chances of malignant changes later in life. Educating patients, parents and doctors in urban as well as rural areas is important so that repeated breakdown of scars or ulcers are not unnecessarily being treated as benign nonhealing ulcers. 'Do a biopsy, when in doubt' principle should be emphasised to clinicians. The largest Marjolin's ulcer reported was of 19 × 11 cm in size in a lower limb.[4] We believe that ours is the largest Marjolin's ulcer reported in the literature developing in postburn scar without any lymphadenopathy.

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