regional lymph node metastasis and no distant metastasis reported so far,[9] in contrast the various metastatic visceral malignancies, which morphologically and sometimes immunophenotypically mimic SCACP, carry a dismal prognosis. This stresses the importance of always excluding a secondary metastatic visceral adenocarcinoma before making the diagnosis of a primary cutaneous adnexal carcinoma. The distinction can be accomplished, by a thorough clinicoradiologic evaluation, histopathologic examination, and usage of an appropriate immunohistochemical panel. As SCACP can show a varied range of histomorphologic features such as micropapillary, squamous, and spindled areas, the differential diagnoses are quite broad, including metastatic carcinoma of the breast, gastrointestinal tract, thyroid, lung, ovary and endometrium, micropapillary variant of the urothelial carcinoma, and primary squamous cell carcinoma. Various immunohistochemical markers may aid in differentiation of these entities. Thyroid transcription factor-1 negativity argues against a thyroid or lung primary, and negative immunostaining for GCDFP-15, PAX 8, and GATA3 respectively make the diagnosis of metastatic breast carcinoma, high-grade serous carcinoma of the gynecologic tract, and micropapillary urothelial carcinoma highly unlikely.

In conclusion, invasive SCACP is a neoplasm with low propensity for regional lymph node metastasis and a complete excision and follow-up is the treatment of choice.

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