Merkel cell carcinoma (MCC) is a rare and lethal skin cancer with few known treatment options. Management of this disease is challenging, and oncology nurses must understand the medical, physical, and psychosocial burden that MCC places on the patient and family caregivers. Patients must navigate a complex medical and insurance network that often fails to support patients with rare cancers. Nurses must advocate for these patients to ensure quality comprehensive cancer care.

Merkel cell carcinoma (MCC) is a rare and aggressive nonmelanoma skin cancer, derived from cutaneous tactile nerve cells, that behaves similarly to small cell lung cancer (SCLC) (Becker, 2010). MCCs are neuroendocrine tumors with an increased growth rate and may rapidly recur locally and distantly. Mortality rates are significant and exceed that of melanoma (Allen et al., 2005). Risk factors for MCC include a prior history of sun exposure (i.e., work, recreation, or fair skin) and being Caucasian, male, and older than age 65 years (Agelli & Clegg, 2003). The disease tends to originate in sun-exposed areas and frequently will spread via the lymphatic system to either dermal metastasis or visceral organ involvement. Prior reports have also suggested that immunocompromised patients may be at higher risk for developing MCC (Becker, 2010). Two similar and challenging patients with MCC presented to the authors’ cancer center.

Case Study 1

B.Y. was a 61-year-old Caucasian woman with a past medical history of epilepsy, fibromyalgia, and diverticulosis who developed a left groin mass that was biopsied. The pathology confirmed MCC. Positron-emission tomography (PET) demonstrated multiple inguinal, internal, and external iliac lymph nodes and a left breast lesion, but no superficial cutaneous lesions. B.Y. was started on chemotherapy with cisplatin (Platinol®) and etoposide (VePesid®) for two cycles but had complications related to neutropenia. Repeat imaging showed progressive disease in the left breast and inguinal regions. The patient was enrolled in a clinical trial for an anti-PDL1 antibody; however, prior to treatment, she developed hydronephrosis of the renal pelvis related to retroperitoneal lymph node enlargement. After receiving two doses of the anti-PDL1 antibody, she quickly began to decline clinically. B.Y. was placed on hospice care and died about nine months after her initial diagnosis.

Case Study 2

P.C. was a 46-year-old Caucasian man with a past medical history of squamous cell carcinoma of the lip who presented with a nodule along the fifth digit of the left hand. The excisional biopsy pathology was positive for MCC. A PET scan, performed for staging purposes, found distant disease in the left axilla. An amputation of the digit was performed, as well as a left axillary lymph node dissection. Merkel cells were found within the resected lymph nodes, and P.C. was counseled about the need for postoperative radiation therapy to the axilla. A review of the patient’s complete blood count (CBC) showed the presence of a sudden