Metastatic Malignant Melanoma to the Gastrointestinal Tract

Madhavan Mukunda, Mathew Shibi, Varma Mahesh, John Joseph, Mohan Ramesh, Devadas Krishnadas, Vinayakumar Kattoor Ramakrishnan Nair

Department of Medical Gastroenterology Medical College, Trivandrum, India

A 65-year-old male presented with upper abdominal pain, decreased appetite and weight loss for 3 months but no history of gastrointestinal (GI) bleed or fever. Patient underwent disarticulation of 2nd, 3rd and 4th toes of right foot with marginal clearance for malignant melanoma 2 years back. Examination showed pallor and clubbing. Hemogram, serum biochemistry, and X-ray chest were normal. Abdomen ultrasonography was normal except for small left renal calculus and prostatomegaly. Upper GI endoscopy showed blackish nodular and flat lesions in the esophagus, stomach and duodenum (Figures 1, 2 and 3). Colonoscopy was normal. Histopathology showed pleomorphic spindle cell with melanin deposits suggestive of malignant melanoma. A diagnosis of metastatic malignant melanoma was made in view of the past history of surgery for malignant melanoma.

The GI tract involvement by malignant melanoma may be either primary or metastatic. GI mucosal sites, affected by primary melanoma include the oral cavity, esophagus, small bowel, colon, rectum, and anus, in the absence of prior cutaneous melanoma. Clinically, a primary GI mucosal melanoma is suggested if the patient has no obvious primary cutaneous melanoma or has an isolated GI lesion without other extra intestinal metastases.

Malignant melanoma is one of the most common malignancies to metastasize to the GI tract. Metastases to the GI tract can present at the time of primary diagnosis or decades later as the first sign of recurrence. Symptoms may include abdominal pain, dysphagia, small bowel obstruction and GI bleeding. A large review of autopsies from Memorial Sloan Kettering Cancer Center previously found the incidence of GI metastases to be a follows: liver, 68%; small bowel, 58%; colon, 22%; stomach, 20%; duodenum, 12%; rectum, 5%; esophagus, 4%; and anus, 1%. The metastatic deposits as seen at imaging or endoscopy may present as intraluminal masses, ulcerating lesions, diffusely infiltrating lesions, or mesenteric implants. Endoscopic or surgical biopsy of masses in conjunction with special immunohistochemical stains with HMB-45 and S100 are useful in confirming the diagnosis of metastatic melanoma. The prognosis of patients with metastatic malignant melanoma is poor. Treatment of metastatic melanoma to the GI tract may include surgical resection, chemotherapy, immunotherapy, biochemotherapy, observation, or participation in clinical trials.

References


Source of support: Nil; Conflict of interest: none declared

Reprints requests and correspondence:
Dr. M Mukunda
Room No. 300 Department of Medical Gastroenterology, Medical College, Trivandrum
e-mail-drmmukunda2001@gmail.com; Phone-09447903958