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RECURRENCE OF A CUTANEOUS MELANOMA AS COLON MASS THREE YEARS AFTER THERAPY

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ABSTRACT

Melanoma is one of the common skin malignancies that spread to the gastrointestinal tract. All types of melanoma can metastasize to the gastrointestinal tract, especially to the liver. But isolated metastasis to the colon is rare. Metastatic melanoma to the colon can present as colonic submucosal mass, polyp or as a large exophytic mass that mimics colon cancer. Localized colonic melanoma can be surgically resected. In this report, we present a patient treated for cutaneous melanoma and later developed recurrence of the melanoma as colon mass three years after treatment.

Key words: *Metastatic melanoma, colonic recurrence, cutaneous melanoma*

INTRODUCTION

It is estimated that 14% of new cases of melanoma die from metastatic disease (1). Melanoma metastasizing to the gastrointestinal tract occurs in 60% of patients (2). However, only 4.4% of patients with gastrointestinal metastases will be diagnosed pre-mortem (3). The liver and small bowel are most commonly affected, with stomach and esophagus equally involved (4,5). Melanoma of the colon is unusual (4

). Symptomatic patients with metastatic colonic melanoma are very rare (6). In patients with localized malignant melanoma, 75% will have recurrence, of which 65%-85% becomes evident within three years after definitive treatment (7). Only very few cases of recurrence of melanoma as colon mass have been reported in the literature to date. We hereby report a case that received definitive treatment for cutaneous melanoma, and presented three years later with colonic recurrence.

CASE SUMMARY

A 38-year-old male presented to Tikur Anbessa Specialized Hospital (TASH) with a three-month history of tarry stool, fatigue, anorexia, vomiting and significant weight loss. He also had low-grade intermittent fever and night sweats. The patient had a history of cutaneous nodular amelanotic melanoma involving the right upper extremity diagnosed three years ago and was treated with local excision and chemotherapy at the same hospital.

On physical examination, he was sick looking with conjunctival pallor. On investigation, he had iron deficiency anemia and abdominal computerized tomography (CT) scan showed bowel wall thickening at the right colon. Colonoscopy revealed a big ulcerated mass in the ascending colon (Figure 1).

Histopathology examination of the endoscopic biopsy showed nests of pleomorphic and hyperchromatic cells with negative alcian blue stain and non-dysplastic colonic mucosa (Figure 2). These all were suggestive of secondary melanoma infiltrates.

The patient was sent to the surgical and oncology side for possible resection of the colon mass and follow up. He was referred abroad by the oncology team for better management. There, colonoscopy and biopsy were repeated and findings showed a picture of malignant melanoma with immunohistochemical staining positive for S100 and HMB-45.

Following this result, colonic resection and primary anastomosis was performed. The patient returned home and he was relatively well for about 18 months, when he presented with extensive liver solitary nodules, which were considered metastatic lesions and the patient passed away shortly after.

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Figure 1: Ulcerated exophytic mass in the ascending colon

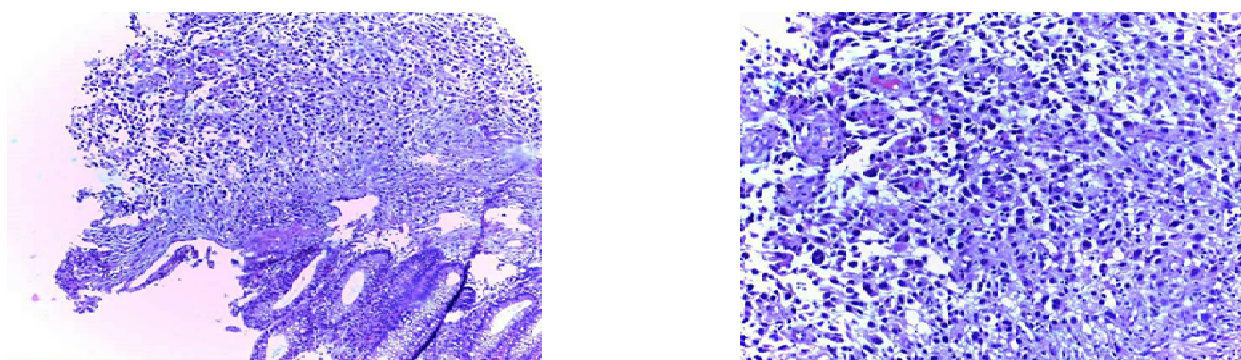


Figure 2: Nests of pleomorphic and hyperchromatic melanoma cells

DISCUSSION

It is well established that malignant melanoma is one of the most common malignancies to metastasize to the gastrointestinal (GI) tract (8). However, the large intestine is the least common site of metastasis, and does not appear to be a site of primary tumor (9).

As it is the most common subtype of melanoma, superficial spreading melanoma is the most common subtype to spread to the GI tract (8). Metastases could be present at the time of primary diagnosis or years later as the first sign of recurrence. The symptoms usually mimic those of other GI malignancies, including abdominal pain, fatigue, tenesmus, constipation, hematemesis, melena and anemia. Our patient presented with melena and symptoms of anemia.

Diagnosis of metastatic melanoma of the GI is generally made by radiographic imaging studies and endoscopic evaluation [8]. Endoscopically, the lesions could be pigmented or amelanotic and might present as submucosal nodules, polypoid masses or, like our patient, as a large exophytic mass that mimics colon cancer (10).

Biopsy of masses either endoscopically or during laparotomy often secures the diagnosis (8,10). Doing special immuno-histochemical stains are useful in confirming the diagnosis (8). In this patient, both histopathology and immunohistochemistry were in line with the diagnosis of malignant melanoma.

Curative surgical resection of the metastatic disease improves survival. One study reported a median survival of 46.7 months for those patients who underwent curative surgical resection, compared with 5.8 months for patients treated with non-surgical procedures (11). Our patient was relatively well for 18 months after surgical resection.

In conclusion, a high index of suspicion for metastasis should be maintained in patients with a history of melanoma. Cutaneous melanoma has a predisposition to metastasize to the GI tract, so metastatic disease must be considered in patients who present with abdominal pain or gastrointestinal bleeding. Treatment includes surgical resection and chemo-immunotherapy.

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