CASE REPORT

SECONDARY MALIGNANT STOMACH MELANOMA

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ABSTRACT

Melanoma is a malignant tumor of melanocytes. In the gastrointestinal tract, most commonly occurs as a metastatic deposit, which is usually diagnosed at autopsy. We have described a 74-year-old woman with secondary deposits in the stomach. Manifested with nonspecific symptoms such as the palpatory painful tenderness of the epigastrium, anemia, high sedimentation and low serum iron. Fecal occult blood test was positive. Esophagogastroduodenal endoscopy was done and she was seen polypoid resizing of 60 x 30 mm with uneven edges. A pathological finding of biopsy shows existence malignant melanoma in the mucosa of the stomach.

Keywords: *Malignant melanoma, stomach, secondary deposit.*

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INTRODUCTION

Malignant melanoma usually arises from typical sites where there are melanocytes: namely, the skin, eyes, meninges, and anal region, but the vast majority of gastrointestinal tract melanomas are metastases from a cutaneous primary tumor (1). The incidence of malignant melanoma has increased in recent years, is one of the most aggressive and fastest increasing cancers with a high mortality and a poor prognosis. In some cases, patients may live many months or even years with metastatic melanoma. Malignant melanoma is one of the most common malignancies which metastasize to the gastrointestinal tract. Symptoms may include abdominal pain, dysphagia, small bowel obstruction, hematemesis and melena (2).

CASE REPORT

A 74-year-old patient was admitted to the Internal Clinic's Gastroenterohepatology department of Clinical center Kragujevac because of abdominal pain, sickness, nausea, vomiting, anemia and occasionally black stools. She was operated for malignant melanoma in the left lower leg 4 years ago. The physical examination findings showed palpatory painful tenderness of the epigastrium. In the biohumoral status, in addition to anemia, the findings showed high sedimentation and low serum iron. Fecal occult blood test was positive. Abdominal ultrasound is normal.

After the adequate preparation, the esophagogastroduodenal examination was done and tumor polypoid change was seen. It was approximately 60 x 30 mm in size, with uneven, cobbled edges, in livid color, fragile, bleeding by contact (Figure 1). A pathological finding of biopsy suggests existence malignant melanoma in the mucosa of the stomach.

Passages of the small intestine indicates normal findings. Colonoscopy revealed diverticulosis of the colon and peduncular polyps, 2 cm in size, located on the 17th and 20th centimeter of the colon, which were electrically resected, while pathological findings showed tubulovillous adenomas. Through the computed tomography of the abdomen, light gastric dilatation with exophytic endoluminal tumor change in the fornix region and proximal part of corpus. This change protrudes into lumen, were found, with lobular outer contours, clear with inhomogeneous postcontrast staining. Infiltrations of adipose tissue were not observed and there was no abdominal lymphadenopathy. Finding in the liver, spleen and pancreas were normal. Chest radiography without pathologiocal process. After the diagnosis had been confirmed, the surgical treatment was suggested, which the patient refused and decided to go home on her own for home treatment.

Figure 1. Polypoid change size 60 x 30 mm, with uneven, cobbled edges, in livid color, fragile, bleeding by contact



DISCUSSION

The most frequent symptoms of the secondary mailgnant gastric melanoma are: nausea, vomiting, abdominal pains and gastrointestinal bleeding (3).

Endoscopy is a sovereign method of diagnosis and local treatment of gastric metastases. Indoing so, they can be verified in the form of multiple small submucosal nodules, polypoid mass, ulceration and very rarely as large tumor mass (4).

Metastatic melanoma of the gastrointestinal tract of the skin in mainly diagnostic during autopsy, and only 5% are diagnostic before death (5). In the stomach and duodenum occur in 5-50% (6).

Initial endscopic procedures determined the location, morfology and size of the observed change, and the computerized tomography confirmed the tumor proliferation in the stomach region. Definitive diagnosis was made by immunohistochemical confirmation of the biopsized material received by esophagogastroduodenoscopy.

According to research of Wysocki at al., the average time interval from diagnosis of the primary location of the malignant melanoma, to diagnosing metastases in the gastrointestinal tract is 43.8 ± 11.3 months (range from 21.6-54) (7), which corresponds to the verification time of the stomach metastatic malignant melanoma in our patient.

Diagnosed metastatic tumor in the stomach was 60 x 30 mm in size, and the only secondary deposit after the primary disease of 4 years ago, which is why this paper is particularly significant, because it is a large and only secondary deposit of the malignant skin melanoma, which is a rarity for secondary forms. Malignant melanoma in the mucosa are usually in the form of submucosal lesions, so that there is no possibility of endoscopic mucosal dissection, which is why radical surgical resection is the method of choice. Faster diagnosis of melanoma in gastrointestinum and radical surgical intervention enables prolonged survival (8).

We have shown a case of secondary malignant melanoma and rare localization of nonspecific symptoms. Special significance of this discussion is that it is large and only a secondary deposit, as a consequence of malignant melanoma, which underwent surgery before 4 years.

CONFLICT OF INTEREST

None declared.

REFERENCES

1. Song SE, Lee CH, Kim KA, Lee HJ, Park CM. Malignant glomus tumor of the stomach with multiorgan metastases: report of a case. Surg Today 2010;40:662–7; DOI:10.1007/s00595-011-0077-5
2. Bhatia S, Tykodi SS, Thompson JA. Treatment of metastatic melanoma: an overview. Oncology (Williston Park) 2009;23:488–506.
3. Sundersingh S, Majhi U, Chandrasekar SK, Seshadri RA, Dakshinamurthy SK, Narayanaswamy K. Metastatic malignant melanoma of the small bowel-report of two cases. J Gastrointest Cancer 2012;43(2):332-5; DOI:10.1007/s12029-010-9180-x
4. Vedat Goral, Feyzullah Ucmak, Serdar Yildirim, Sezgin Barutcu, Serdar Ileri, Ilknur Aslan and Huseyin Buyukbayram. Malignant melanoma of the stomach presenting in a woman: a case report. J Med Case Reports 2011;5:94; DOI:10.1186/1752-1947-5-94
5. Shenoy S, Cassim R. Metastatic melanoma to the gastrointestinal tract: role of surgery as palliative treatment. W V Med J 2013;109(1):30-3.
6. Kenney B, Dotto J, Homer R, Shafi N, Davydova L. Primary malignant melanoma of the transverse colon: report of a case and review of the literature. Int J Surg Pathol 2007;15:401-407; DOI:10.1177/1066896907302370
7. Wisocki WM, Komrowski AL, Darasz Z. Gastrointestinal metastases from malignant melanoma: report of a case. Surg Today 2004;34(6):542-546; DOI:10.1007/s00595- 004-2741-5
8. Alazmi WM, Nehme OS, Regalado JJ, Rogers AI. Primary gastric melanoma presenting as a nonhealing ulcer. Gastrointest Endosc 2003;57:431-433; DOI:10.1067/mge.2003.120