MALIGNANT MELANOMA

SPONTANEOUS REGRESSION AFTER PREGNANCY

BY

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Several reports have appeared recently dealing with two aspects of malignant melanoma—their relation to pregnancy and their spontaneous disappearance. Both these occurrences are said to be rare, and it may therefore be of interest to record the following case, which showed both these unusual features.

Case Report

A married white woman of 38 was first seen by me in May, 1943. For several years she had had on the extensor surface of the right forearm an area about the size of her thumbnail which, though normal in colour, was a little elevated above the normal skin surface. About the middle of 1942, possibly following a scratch with a pin, part of the area became black in colour. This area was excised by her doctor in July, 1942, and the pathologist, Dr. J. O. Mercer, reported on the specimen: "A circumscribed tumour composed of small naevoid cells with regular nuclei associated with a large quantity of melanotic pigment and surrounded by a zone of hyaline fibrous tissue. It is not invasive. This is a simple melanoma. There is no evidence of malignancy."

Two months later a black area appeared in the scar, and in May, 1943, when a black lump the size of a marble had developed, wide re-excision down to the deep fascia was undertaken. The pathologist now reported: "A cellular tumour composed of actively mitotic oval cells and large collections of pigment, mainly extracellular. The tumour has invaded the hyaline fibrous tissue and local fat. The appearances are quite unlike those previously reported on. It is a malignant melanoma."

At this stage she was referred to me for radiotherapy, mainly because the surgeon was reluctant to undertake re-excision for a tumour of unknown extent. She presented to me as a fit-looking woman with no evidence of residual disease. She had three children, then aged 10, 8½, and 4 years. She received an estimated tumour dose of 4,700 r in 17 days to the forearm through two opposing 15 by 10 cm. fields. She was seen again on November 8, when there was no sign of recurrence and when she was ten weeks pregnant. By mid-March, 1944, 10½ months after her second excision, and when she was seven months pregnant, she presented with multiple subcutaneous bluish nodules, up to the size of marbles. Such nodules were found on the left waistline, the right flank and the right upper arm. They were regarded clinically as blood-borne metastases, and the prognosis was thought to be hopeless, but to confirm the diagnosis the lesion in the right upper arm was excised on March 10, 1944. The assistant pathologist now reported that the specimen consisted of a lymph node, the structure of which was almost entirely replaced by tumour, consisting of solid masses of darkly staining polyhedral cells. There was little pigment present. The tumour was considered to have become more cellular and less well differentiated.

By May 8, 14 days after the birth of a normal child, the patient had developed further deposits in the right scapular and inguinal areas. Localized tumour masses were also noted in the left breast, but it was not certain that these were of the same nature, because there was a history of breast abscess on this side.

On July 10 she was seen again, and, to our surprise, all the nodules noted at her previous attendance had disappeared, except for a small node in the right groin. She was feeling very well and putting on weight. Small cres-

centic areas of pigmentation were seen on the temporal sides of both disks, but did not appear to be neoplastic in nature.

She has been seen on various occasions since, and at the time of writing (June, 1955) she is entirely well. This is twelve years after excision of the primary lesion, and eleven years after the appearance of widely scattered secondary deposits.

There can be no doubt that this tumour was malignant. The clinical course was entirely consistent until, of course, the point at which regression took place. The sections were twice reviewed by Dr. Mercer. On the first review, late in 1944, he expressed his agreement with his assistant's opinion that the tumour in the lymph node was an undifferentiated deposit from a malignant melanoma. In a second review within recent months he says: "The original report that the tumour was a pigmented naevus should certainly be qualified by a statement that, in the light of modern views on the histology of melanoma, it was clearly a malignant tumour when it was first removed."

It is therefore believed that both the clinical and the pathological evidence is quite conclusive that a malignant melanoma recurred in widely disseminated form during pregnancy and disappeared spontaneously after delivery. We find it very hard to believe that these two unusual happenings were not in some manner directly related one to the other. The sequence of events strongly suggests that the metastases developed as a direct response to the stimulus of pregnancy, and that they were in fact so dependent upon this stimulus that upon its withdrawal they themselves disappeared. The speed of their disappearance is in itself remarkable, regression being clinically complete within eleven weeks of delivery. One other feature is that there was no local recurrence after the re-excision. This raises the possibility that the "metastases" may have been multicentric foci of disease arising *de novo* in tissue particularly sensitive to the physiological stimulus, or, alternatively, that the stimulus led to the activation in these areas of malignant cells which up to that time had been lying dormant.

I have to thank Dr. J. O. Mercer for permission to make use of his reports and letters.

Medical Memoranda

Uterine Fibroids in a Young Woman

The following case is worth reporting on account of the large size of the tumours in a young woman, and because the only symptom complained of was swelling of the feet. There had been no menstrual abnormality at any time if one excepts a slight suggestion of water retention for the latter half of the menstrual cycle. There was no interference with normal daily bowel action.

CASE REPORT

An unmarried virgin aged 29 was referred to hospital complaining of having had swelling of the feet for the past year. Her doctor had referred her to a general surgeon for this condition and for a palpable mass in her abdomen. For the past 12 months she had noticed her feet swelling about the middle of the menstrual period and then becoming normal after the period had begun; the swelling had become more pronounced during the year.

On questioning she said that just before the period she had had a headache, which disappeared when the menstrual discharge started, and that there might have been some swelling of the upper abdomen. Her menstrual periods had always been regular every 28 days and lasted for four days, with pain for some hours before the flow but not bad enough to interfere with her work as a clerk. The loss had always been heavy, and small clots had often been noticed, but there was no pain when they were passed. The menarche had

occurred at the age of 13. The last menstrual period was normal on September 28, 1954, the date of examination being October 6.

There was no intermenstrual vaginal discharge, but on one occasion about 12 months previously there had been a slight sanguineous discharge per vaginam for about an hour.

Her weight was 8 st. 9½ lb. (55.1 kg.), which corresponded to her normal limits of 8½ to 9 st. (54 to 57.2 kg.).

On abdominal palpation a somewhat irregular mass was felt arising from the pelvis, corresponding in size to a pregnant uterus of 26 weeks' gestation. The mass gave the impression of solid tumour with cystic areas. The patient was virgo intacta, the hymen just admitting one finger. A markedly effaced small vaginal cervix was felt to be expanded. Bimanually it was not possible to differentiate the mass from the uterus; the adnexa could not be satisfactorily identified. On rectal examination small subserous fibroids could be felt in the posterior wall of the mass. These findings were confirmed by examination under anaesthesia immediately before operation.

Despite the feeling that at her age and in view of the cystic spots in the mass this should be a case of ovarian tumour, a diagnosis of uterine enlargement due to fibroids with cystic degeneration was made.

Laparotomy.—A right subumbilical paramedian incision was made. The uterus was grossly enlarged by a large fibroid, extending from the parametrium behind to the posterior fundus; there were other smaller fibroids lying subserously and scattered over the surface of the uterus. The organ was rotated to the right through 45 degrees and was firmly incarcerated into the true pelvis by the mass of the largest tumour. Both ovaries were enlarged, cystic, and sclerotic, and did not show any evidence of recent ovulation. The uterus was elevated out of the abdominal cavity with difficulty and myomectomy of the large tumour achieved through a fundal incision, the smaller tumours being removed separately. The cavity, which was about 4 in. (10 cm.) deep by 2 in. (5 cm.) wide after retraction, was closed by a long continuous "cobbling" stitch which ensured that no dead spaces were left behind. Gilliam suspension of the still very enlarged uterus and appendicectomy were performed, and the abdomen was closed with catgut and "nobecutane" dressing applied.

Convalescence was normal, the patient being out of bed for increasing periods from the evening of operation.

Pathology (Dr. H. C. Moore).—"The large tumour weighed 1½ lb. (680 g.), and had been apparently 'well encapsulated.' It was very soft. Section disclosed a uniform grey appearance, with very little degenerative change; there were only a few small foci of hyaline change. Several sections showed a uniform appearance. The tumour is a leiomyoma and is extremely cellular—much more so than is usually seen. Nevertheless the nuclei are regular, do not show pleomorphism, and there are no mitoses. In my opinion the tumour is benign."

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Munchausen Syndrome

The following case of Munchausen syndrome (Asher, 1951) is described in the hope that the patient will be recognized and correctly diagnosed at an early stage during any subsequent admissions to hospital.

CASE REPORT

A man giving his age as 22 was brought into the casualty department on September 6, 1954, as a case of suspected skull fracture. He had been found lying in the street near by bleeding from his ears and nose and in a dazed condition.

A long history was obtained, starting with meningitis and convulsions at the age of 8 years. Bleeding from the ears and nose began at 10 and had continued intermittently ever since. In 1951 he had a swelling in the left hypochondrium accompanied by the usual bleeding from the ears

and nose and also skin haemorrhages. He was admitted to hospital in Dublin and splenectomy was performed; during convalescence from this operation he began to have haematuria, and cystoscopy was said to have shown bleeding from the right kidney; purpura was then diagnosed and he was given special tablets which he thought were cortisone; these improved his general condition and controlled the bleeding. He stated that he had come to England for the first time two weeks before admission and that bleeding had again begun on the previous day.

Clinical examination revealed a patient of somewhat prognathous appearance with small but normal general physique. The respiratory, cardiovascular, and central nervous systems showed no abnormality. The abdomen was soft, with splenectomy and appendicectomy scars. There was subjective tenderness over the whole of the right side of the abdomen, maximal in the right renal area. There was dried blood around the ears and nose, but no obvious bleeding points could be found. Hess's test was faintly positive on one occasion and negative on numerous others. Lumbar puncture and full haematological examinations, including bone-marrow biopsy, revealed no abnormality. The urine, however, showed macroscopic haematuria with small blood clots.

In view of the positive Hess's test a tentative diagnosis of Henoch-Schönlein purpura was made, and a course of corticotrophin was started, which caused no improvement in his bleeding. On the day after admission he became somewhat uncooperative and refused to stay in bed despite sedation. During the next few days he became increasingly unruly, leaving the ward on numerous occasions at all hours of the day and night, and wandering around the hospital, usually with his face and clothes liberally smeared with dried blood. Remonstrance and very heavy sedation proved equally unavailing, and on September 12 it was found necessary to have him transferred to an observation ward at St. John's Hospital, Battersea. A report from this hospital stated that the man was kept under close observation, which precluded self-injury, and that he failed to produce any physical signs. He was discharged after 72 hours at his own request, the diagnosis being "psychopathic malingering."

Subsequent inquiries revealed that this patient is well known at many hospitals and his case has in fact been briefly described (Short, 1951). As long ago as 1951 he was known to have been in 29 hospitals in various parts of the British Isles. His appendicectomy was carried out in Paris, but where and when his splenectomy was performed has not been revealed. He has been an in-patient in various London hospitals in recent months, each admission following a similar pattern to that described above. Since his discharge from St. John's he is known to have been in another hospital in this area. He rarely visits the same hospital twice.

COMMENT

The diagnostic difficulty in this case is the haematuria; it seemed feasible that the patient could simulate bleeding from the ears and nose by scratching the aural and nasal orifices and smearing the blood from the resultant excoriations over his face. It was noted at another hospital, however, that the haematuria and "clots" were produced by soaking small pieces of blood-stained cotton-wool in the urine. This patient will undoubtedly remain a constant nuisance, and any doctor having to treat him in future should consider the desirability of certification. The cost to the Health Service of his innumerable admissions to hospital and exhaustive investigations on each occasion must be fabulous.

We wish to thank Dr. Philip Ellman for permission to publish this case. Acknowledgments are also due to Dr. H. S. Hamilton for his report on this patient's admission to St. John's Hospital, Battersea.

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