CASE REPORT

Nodular Vulvar Melanoma: A Rare Tumor with Worse Prognosis

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Introduction

Vulvar melanomas are rare, with incidence rates in the range of 0.1–0.19 per 1000,000 women. In India, due to less reporting and late onset, only a few cases are reported. They account for 4–10 % of all cases and are the second most common form of vulvar malignancy after squamous cell carcinoma. Mean age of the occurrence is 69 years (most common in 60–70 years). Also, 5 years' survival is rare as it is associated with very poor prognosis.

Case Report

A 50-year-old woman married for 30 years, Para 2 presented to the out patient clinic at Zanana Hospital, Udaipur on July 16, 2004 with complaint of small mass over vulva for 10 months which suddenly increased in size and developed ulcer over it since 2 months. Woman was apparently asymptomatic and was menopausal since 2 years. General physical examination showed a lean and thin built, cachexic lady weighing 45 kg with mild anemia but no edema, cyanosis, clubbing. Vitals were: Pulse–78/min; BP–110/70 mm Hg; Heart,

Lungs–NAD. No other skin lesion was found on any part of body. Local examination revealed a dark-colored 1×0.75 cm nodular mass on labia minora (right) which was non-tender (on palpation). Above this, an ulcerated lesion 0.75×0.50 cm was present. On inspection, ulcer was irregular, single with everted edges, and pale granulation tissue. On palpation, ulcer was non-tender with marked induration. Along with this, an asymmetric growth was present in lower 1/3rd of vagina with irregular borders, brownish in color, and diameter about 2 cm, and the growth was elevated from base. According to the woman, growth was previously pink but in last 2 months it turned dark and became elevated. Inguinal lymph nodes were enlarged, four in number (1×0.75 cm) fixed, hard, non-tender on right side. Iliac and aortic nodes were not palpable. Patient was admitted with provisional diagnosis as melanoma. Routine investigations along with serum lactate dehydrogenase (LDH) were done. Excision biopsy was decided along with biopsy of lymphnodes. Biopsy was taken with full thickness including 2 cm adjacent normal looking skin and was sent for HPR. Routine investigations were normal including chest X-ray. Serum LDH was raised. Proctoscopy and Cystoscopy were done. CT and MRI were not available at our center. Histopathological analysis showed Clark's level IV (growth extension into reticular dermis). Breslow thickness 2.6 mm with ulceration and four inguinal lymphnodes involvement. Hence, this tumor was provisionally diagnosed as nodular melanoma stage IIIc according to AJCC TNM classification 2002 and considered inoperable. Previous studies showed no benefits for lymph node dissection in

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consultation with radiotherapist, and so the patient was advised chemotherapy. Prognosis was explained and patient continued further treatment at our hospital (Fig. 1).

VDP regimen was started.

Vinblastin 5 mg/m² IV on day 1, 2

Dacarbazine 150 mg/m² on day 1–5

Cisplatin 75 mg/m² IV on day 5

Cycles were repeated every 21 days, six cycles were given. On completion of third cycle, routine investigations, USG abdomen, and chest X-ray were repeated. The six cycles were completed in July 2005, and woman was discharged. On an outpatient follow-up no new lesion appeared and no changes in previous lesion noted. Woman was followed up every 3 months for 2 years. After this, woman was lost to follow-up for 18 months, she reported on January 16, 2009 with pain in abdomen. Routine investigations were done. Along with this CT scan, abdomen and pelvis were also done. On physical examination, no lymphnodes were palpable, but CT pelvis showed single lymph node of 12 mm which was consulted with radiotherapist who considered it nonsignificant for radiotherapy. Woman is now under strict follow-up (Fig. 2).

Discussion

A few cases of nodular vulvar melanoma at relatively younger age and five-year survival has been reported which compelled us to present this report. Studies reported incidence rate of 0.27 per 100,000 in 1960–1964 and 0.14 per 1,00,000 in 1980–1984, a 3 % decrease per year. The five-year survival of patients with vulvar melanoma was 35 % with an average age 67 year at presentation [1]. For vulvar melanoma, the most common patterns reported differed from cutaneous melanoma in most series, with mucosal lentiginous being the most common (27–57 %) followed by nodular (22–28 %), unclassified (12–16 %), and superficial spreading (4–56 %) [2]. Several reports confirmed lymph node status as the most powerful prognostic indicator for vulvar and cutaneous melanoma with ulceration and tumor thickness of primary lesion are the other most important prognostic factors [3]. In the present case, woman presented with melanoma and having five years' survival after chemotherapy treatment till now. In Swedish study, overall five-year survival was 35 % with 26.8 % for lymph node positive and 65.2 % for lymph node negative. Of the vulvar melanomas, 23 % had lymph node involvement at the time of diagnosis. Mean Breslow depth was 2.8 mm. The development of sentinel lymph node biopsy (SLNB) in 1990s represents minimally invasive technique to accurately shape the entire nodal basin in clinically node

Fig. 1 Black nodule and ulcer on right labia minora with nodular growth in vagina

Fig. 2 CT Scan showing enlarged lymph node (arrow) in follow-up missing three (3) more images as per the supplied hard copy

negative patients and thus provide information for counseling and management.

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