A Giant Metastatic Inguinal Lymph Node from Melanoma

N. Bertheuil · J. L. Heusse · L. Khamphommala ·
E. Watier

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Abstract A 49-year-old woman was admitted to our institution with a giant necrotizing and ulcerative inguinal mass that measured 17×11 centimeters. She had a history of dorsal ulcerated nodular melanoma with a Breslow thickness to 10 mm, Clark's level was 4 and an mitotic activity of 1 mitosis per 40 high-power fields. She was operated in emergency for an ilioinguinal dissection, then 15 days later, a secondary coverage by Taylor's flap. The pathological examination found a melanoma metastasis. She is alive at fourteen months after the operation.

Keywords Metastatic lymph node · Melanoma · Cancer · Reconstructive surgery

A 49-year-old woman was admitted to our institution for sepsis with a left necrotizing and ulcerative inguinal lymphadenopathy abscessed. She had a history of dorsal ulcerated nodular melanoma with a Breslow thickness to 10 mm, Clark's level of 4, and a mitotic activity of 1 mitosis per 40 high-power fields, which was requiring surgical resection

Fig. 1 Preoperative view of the left inguinal mass (17×11 cm size) ulcerated and necrotic in the center

N. Bertheuil (✉) · J. L. Heusse · E. Watier
Department of Plastic, Reconstructive and Aesthetic Surgery,
University Hospital Sud,
16 Boulevard de Bulgarie,
35200 Rennes, France
e-mail: nbertheuil@gmail.com

L. Khamphommala
Department of Surgery, Hospital Bretagne Atlantique,
Vannes, France

to 2 cm in combination with chemotherapy by interferon. However, the patient refused care and she was lost for 2 years. On admission, clinical examination revealed a left black inguinal mass (Fig. 1) that measured 17×11 cm. The scan showed a mass of 17×11×10 cm (Fig. 2) in contact with the external iliac vessels and common femoral vessels. Besides, thoraco-abdomino pelvic computed tomography (CT) showed a pancreatic metastasis. She was operated in

Fig. 2 Pelvic computed tomography in axial views with injection of contrast (17×11×10 cm size) and in contact with the common femoral vessels

emergency for an ilio-inguinal dissection, then 15 days later, a secondary coverage by Taylor's flap [1]. As the patient was reluctant for the operation, we chose the simplest and most reliable reconstruction. It provides a sufficiently large skin paddle and a direct closure of donor site. Healing by secondary intention and skin grafting was not possible because we had to cover the femoral vessels by providing a tissue filler; the risk of bleeding by vascular erosion was too important. The pedicled ipsilateral anterolateral thigh flap [2] was possible, but a skin graft for donor site was necessary which was not desired by the patient. However, all free flaps were possible but a lower security vascular and greater technical difficulty. The pathological examination found a melanoma metastasis with destruction of the lymph node architecture and the presence of lymphatic tumor emboli. Thereafter, the patient was referred to an oncologist to complete the

management. She was treated by chemotherapy (carboplatin/dacarbazine). She is alive at 20 months after the operation.

Conflict of Interest none

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