MALIGNANT MELANOMA- AN UNUSUAL PRESENTATION

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Introduction

Malignant melanoma is a malignant neoplasm arising from epidermal melanocytes. The earliest description is in the writings of Hippocrates in the 5th century BC. It is no longer considered a rare tumor and has an unpredictable behaviour ranging from spontaneous regression to rapid progression and death. It may rarely present as a metastatic deposit in a lymph node or visceral organ without any evidence of primary lesion. Here it is assumed that the primary lesion may have completely regressed [1]. We present a case of right inguinal suppurative lymphadenopathy mistaken for an abscess

Fig. 1 : Scanner view showing capsule of the lymph node and effacement of nodal architecture by malignant cells

which proved to be metastatic malignant melanoma on histopathology.

Case Report

A 60-years-old farmer was admitted with history of a 2 month swelling in the right inguinal region which was rapidly increasing, painful and with purulent yellowish discharge of 5 days from the same. Examination revealed a 10x4 cm ovoid tender right inguinal lymphadenopathy with overlying ulceration & yellowish seropurulent discharge. The patient was febrile. He was diagnosed to have suppurative inguinal lymphadenitis and antibiotics started.

After 3 days, the patient was taken up for excision of the lymph node mass. Intraoperatively, there was massive suppurative lymphadenopathy involving the superficial and deep group close to the femoral vessels. Careful and deliberate excision was done. Patient recovered well but the wound disrupted and started discharging.

Histopathology revealed metastatic deposits of malignant melanoma. The nodal architecture was effaced by malignant cells which had large vesicular nuclei and very prominent nucleoli (Figs. 1,2) The tumour was seen outside the lymph nodes as well. The covering fat of lymph nodes contained abundant granulation tissue and inflammatory cells.

Fig. 2 : High power view photomicrograph showing large spindled to oval cells with large vesicular nuclei and very prominent nucleoli. Melanin pigment is seen in the melanoma cells.

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Investigational work up revealed multiple metastasis in the liver as well. However inspite of a thorough search no evidence of a primary could be established.

Discussion

A small proportion of melanoma patients present with metastatic disease to the regional nodes or distant sites but no detectable primary site. Patients presenting with occult primary melanoma make up 1-12 % of patients being diagnosed with melanoma. About 2/3rd of these present with tumor in the lymph nodes and 1/3rd with distant metastasis [2]. Our patient had both lymphatic and visceral metastasis. About 10-20% of patients will describe previous nevi within the lymphatic drainage area of metastatic lymph node. However 2/3rd of patients give no history of suspicious pigmented lesions.

All patients with occult primary melanoma should be examined carefully for potentially sequestered primary lesion. In this group of patients, it is important to get a careful history of prior treatment. The survival rate of patients with unknown primary lesions is no different from that of patients with metastatic cutaneous melanoma when matched for prognostic factors

particularly stage of the disease [3]. When appropriate, surgical management should be considered first.

Lymphadenectomy for nodal disease can be associated with long term survival similar to results seen in patients without cutaneous metastasis to lymph nodes. Hence the physician managing melanoma must be vigilant in making a diagnosis and instituting prompt treatment because 25-50% of the patients can be cured by surgical excision alone. Moreover effective palliation can be provided to even those whose disease is not curable.

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