ISSN: 2755-0176

Journal of Cancer Research Reviews & Reports

SCIENTIFIC Research and Community

Case Report

Open Access

A Case of Late Delayed Metastasis of Malignant Melanoma After 27 Years After First Excision

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ABSTRACT

We report a case of an ultra-late delayed metastasis of malignant melanoma 27 years after the excision of the first tumor. The patient is a 67 years old Italian woman. She underwent a primary excision of a skin lesion of 1cm in diameter on the lower third of the left leg in 1984 when she was 39. According to the histological examination the lesion was a lentigo malign melanoma with an epithelial histological pattern with intra- and subepidermal diffusion. The lesion was 2.2 mm in thickness (Breslow) and was a Clark level IV melanoma; mitotic rate was 6 mitosis/mm2. No melanocytic lesions were found on excision edges and no lymph nodes were removed and examined. In March 2011, when the woman was 67 years old, an inguinal lymph node and an intraabdominal lesion were considered suspect for neoplastic process during a clinical exam of the GP.

A histological examination and an eco-imaging procedure described the lesions as metastasis of malignant melanoma probably related to the first skin tumor. Within a few days she was treated with the excision of the abdominal lesion, the total greater omentectomy and the lymphadenectomy of the left inguinal region. Histological examination confirmed the suspect of metastasis of the first melanoma with a predominant epithelioid growing pattern. This case underlines the need of a long-term follow-up period for patients with melanoma.

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Received: October 23, 2020; **Accepted:** October 27, 2020; **Published:** November 10, 2020

Introduction

Delayed recurrences of malignant melanoma are uncommon, especially those that occurred more than 10 years (late) or 15 years (ultra-late) after the excision of the primary tumor. Nevertheless, these recurrences represent a well-known clinical problem. Studies revealed that recurrences have an incidence of less than 7% for late recurrences and less than 2% for ultra-late ones [1]. We report a case of ultra-late recurrence after 27 years from the first surgery.

Case Report

The patient is a 67 years old Italian woman. She had a personal history of multiple (three) basal cell carcinomas on the back. In 1984, at the age of 39 she had a pigmented skin lesion of the tibial middle third area. She underwent a surgery excision of the lesion that was a lentigo malign melanoma type, 2.2 mm in thickness and with IV Clark level. The melanoma had a mitotic rate of 6 mitosis per mm2 and did not show signs of regression. Free margins had a width of at least 3 cm. No lymph nodes were removed. In March 2011, at the age of 67, during a medical examination performed by the GP, an inguinal lymph node enlargement and a pathological intraabdominal mass were found to be suspect for a metastatic process. The patient first did an echography of the left lower limb and left inguinal region discovering a neoplastic node partially involving the long adductor muscle.

The patient then did a total body CT scan (with Iomeron 350, 120 ml) and an eco-guided biopsy of the pathological inguinal lymph node (Figure 1).

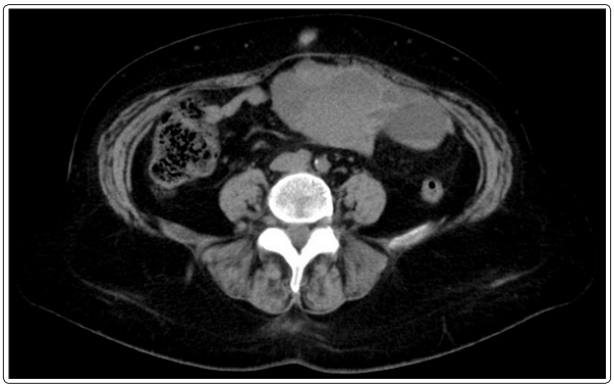

Figure 1: Abdominal CT scan of the patient showing a melanoma metastasis involving the greater omentum and some small bowel bends

CT revealed a multicystic intraperitoneal lesion of about 10x16 cm (3.39x6.29 in) involving the greater omentum firmly attached to some small bowel bends. Some cysts appeared to have a hematic-fluid inner content and some solid tissue elements. A moderate ascites was reported as well. No other suspect lesions were found neither in the liver nor in the spleen, nor in the brain; two suspect nodes were found in lungs. Histological examination of the inguinal enlarged lymph node revealed a neoplastic cells proliferation with epithelioid pattern compatible to a melanoma metastasis (Figure 2).

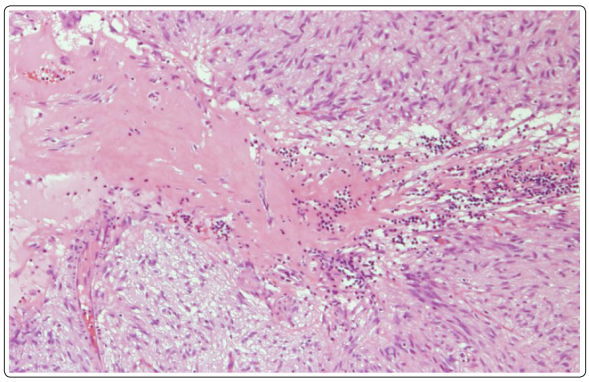

Figure 2: Picture of the histological exam of the abdominal metastasis; HE staining showing melanocytes

The patient then underwent a surgical procedure of total omentectomy and excision of 7 inguinal lymph nodes of which only one appeared to be involved in the metastasis. The larger omentum was later analyzed along with the multicystic abdominal lesion and the ascites liquid. No lesion compatible with a recurrence of melanoma was found in the omentum. Immune reactions with S100 and Mart-1 were both negative while the abdominal lesion was confirmed to be a secondary localization of the first melanoma. Later on the patient followed a therapy based on Fotemustine 100 mg/m2 in three administrations (one for week) suspended during the second week for an episode of thrombocytopenia (<9000 PLT/mm3) and then concluded successfully.

Discussion

This case illustrates the variability of the natural history of malignant melanoma. It also emphasizes the main need of a long-term follow-up for this disease. The probability of a recurrence, most of all for a very late one, should always be evaluated for the resulting effect it has on the survival rate of secondary tumoral lesions. Late and very late recurrences of malignant melanoma are uncommon but still represent a consistent clinical problem. In previous studies, the incidence of late recurrences of malignant melanoma were rated between 0.84 and 6.83% [2].

Most recurrences and deaths due to malignant cutaneous melanoma occur within 10 years from the first diagnosis. Some researchers maintain that none of the prognosis-related factors such as tumor thickness, ulceration, anatomical site or surgical treatment is useful to determine which patient is more likely to have a melanoma recurrence. Otherwise Gutman et al. showed that these melanoma histological features were important only for short term (<5 years) recurrence. Khanna et al. identified the connection between mitotic rate and free disease time-lapse observing that a higher mitotic rate was linked to early recurrences and there was no distinction between the patients with late recurrences and the patients with no recurrences [1-5].

Researchers have since noticed that there are no predictive factors that can give a solid forecast of later on recurrences, the development of melanoma developing and the survival rate. Gutman et al. asserted that an extended disease-free interval in malignant melanomas will not assure a better prognosis once metastases occurred [4]. They also observed that most of their patients with visceral metastasis died within 2 years.

A possible explanation for the existence of such late recurrences can be explained by the possibility that some tumor cells, potentially metastatic, can actually remain ineffective for years before becoming biologically active. Mastrangelo et al, suggested that there is a link between late recurrences and the immune system of the host [6]. Due to this, a loss of the normal immunological pattern of the host could result in the spread of the recurrence. On the other hand, according to the possibility that the second lesion could actually be a second primary metacronic tumor, Reintegan et al. believe that similar immunological factors could be responsible. Tahery et al, reported that the survival rate after a recurrence of melanoma was greater in the patients who have only a local skin involvement [7]. If there is evidence of a soft tissue metastatic process this rate was not influenced.

Shaw et al, describe that 47% of the cases of late recurrences appeared to be in areas distant from the first lesion region; in our clinical experience we contend that the second lesion is actually a recurrence of the first malignant melanoma rather than a second primary tumor, due to the involvement of a lymph node on the lymphatic drainage from the first lesion area [2]. This case highlights the main importance of a follow-up period of more than 10 years as the best way to discover, identify and successfully treat recurrences.

Disclosure

There are no conflicts of interest to declare.

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