

Pelvic Wall Metastasis From Malignant Melanoma Mimicing Subserous Myoma Uteri

Subseröz Miyoma Uteriyi Taklit Eden Malign Melanomun Pelvik Duvar Metastazı

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Abstract

A 67-year-old woman presented with a solid adnexial mass (as a subserous myomas) which was detected during her routine control. Her past medical history revealed that her left leg's fifth finger was amputated for nodular type malignant melanoma two years ago. During her following up, the solid mass size measured bigger. Because of suspecting leiomyosarcoma, we performed explorative laparotomy. The mass was seen on the left arterio-venous iliac region and resected successfully. Histopathological examination revealed neoplastic cell proliferation in iliac lymph node (metastasis of malign melanoma).

Anahtar Kelimeler: Pelvik duvar metastazı, Malign Melenom, Miyoma uteri

Özet

67 yaşında bir bayan hastada rutin kontroller sırasında subseröz myoma benzeyen solid adneksial bir kitle tespit edildi. Hikayesinde 2 yıl önce noduler tip malign melanoma nedeniyle sol ayak 5. parmağının ampute edilmişti. Hastanın takipleri sırasında solid kitlede büyüme tespit edildi. Leiomyosarkom şüphesi nedeniyle eksploratif laparotomi yaptık. Kitlenin sol arterio-venöz iliak bölgede olduğu görüldü ve başarıyla çıkarıldı. Histopatolojik incelemede iliak lenf bezlerinde malign hücre proliferasyonu tespit edildi. Bu malign melanomun metastazı olarak değerlendirildi.

Key Words: Pelvic wall metastasis, Malignant Melanoma, Myoma uteri

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INTRODUCTION

Leiomyomas are the most common pelvic tumors in women of the reproductive age; 20-25% of women have uterine myomas (1). Growth of myomas is known to be estrogen dependent (2). If there is evidence of rapid growing of a pre-described myoma in a post-menopausal women, and in ultrasound an increase of echoless area as a sign of necrosis, laparotomy should be performed because of a suspected malignant transformation (3).

The malignant melanoma is a tumor that may arise from any cell of the body capable of forming melanin; it is most common therefore on the skin and less in the eye, and it has been described in many organs as a primary tumor (4,5). As with superficial spreading melanoma, legs and trunk are the most frequent sites of occurrence.

Melanoma has been documented to metastasize to almost every organ (6,7). Metastatic disease usually follows a sequential order: first to the regional lymph nodes and then to distant sites, including subcutaneous tissue, lung, liver, brain, bone, and visceral organs (8,9).

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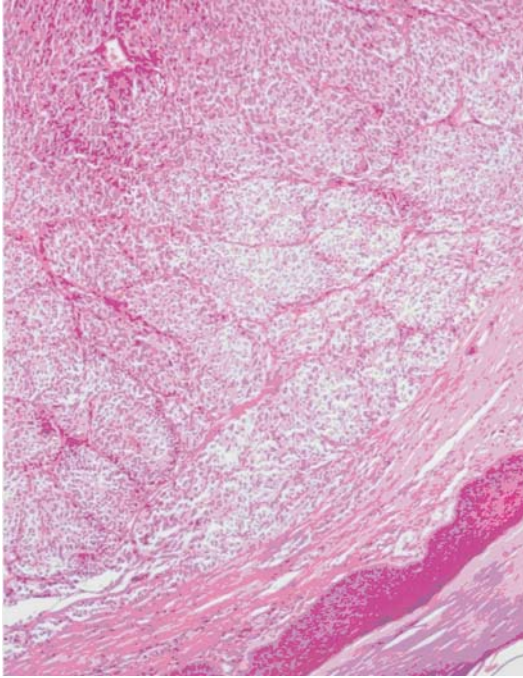


Figure 1. Shows nodular type malignant melanoma (Clark level 5).

CASE REPORT

A 67-year-old woman presented with a solid pelvic adnexial mass which was detected during her routine control. Her past medical history revealed that her left leg's fifth finger was amputated for nodular type malignant melanoma (Clark level 5) two years ago (Figure 1). She was under intravenous interferone therapy since then in another hospital. In transvaginal ultrasonographic examination, a solid hypoechoic adnexial mass (as a subserous myoma uteri) in 5 cm was seen on the left side in the pelvis. During following up for one month, we determined that it was bigger 1 more cm. Transvers CT scan obtained at the level of upper bladder showed a solid adnexial mass in 6 cm on the left side in the pelvis (Figure 2). A solid tumor with a mean diameter of 5 cm was observed on the left iliac arterio-venous region in the explorative laparotomy. Its macroscopic appearance was consistent with a subserous myoma.

We did total abdominal hysterectomy and bilateral salphingo-oophorectomy. The cut surface of the tumor had brownish appearance. Histopathological examination revealed neoplastic cell proliferation with large eosinophilic cytoplasm and nuclei with prominent nucleoli in iliac lymph node (Figure 3). There were melanin pigmentation in the cytoplasm of some tumor cells. Tumor cells were reacted for S-100 and HMB-45.



Figure 2. Transvers CT scan obtained at the level of upper bladder shows the left adnexial solid mass in 6 cm size.

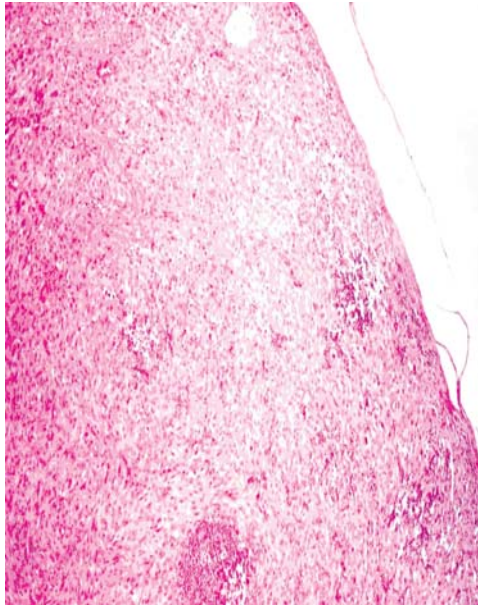


Figure 3. Shows neoplastic cell proliferation with large eosinophilic cytoplasm and nuclei with prominent nucleoli in iliac lymph node. There were melanin pigmentation in the cytoplasm of some tumor cells. Tumor cells were reacted for S-100 and HMB-45.

DISCUSSION

Uterine fibroids of 0.5 cm can be detected by transvaginal ultrasonography (TVS) and their relationship to the endometrial cavity precisely defined (e.g. submucous, intramural, subserous). Growth of myomas is known to be estrogen dependent. One can use ultrasonography as a means of monitoring the size and the ability of growth the leiomyomas around and after the menopause. If there is evidence of rapid growth of a pre-described myoma in a postmenopausal women, and in ultrasound an increase of echoless areas as a sign of necrosis, laparotomy should be performed because of a suspected malignant transformation.

The management of myoma around the menopause is highly conservative, since after the menopause they suppose to regress in the lack of the hormonal support. Our patient was in postmenopausal period, and the myomas size was measured bigger in one month. Therefore, we decided to perform explorative laparotomy.

Nodular melanoma may occur anywhere on the body and is characterized by a shorter history and nodular morphologic features from its inception. It has a more uniform blue-black to gray color, and its border is more sharply demarcated from the surrounding skin (7,8). Any patient with a diagnosis of melanoma requires long-term follow-up.

Patients are at risk of developing another primary tumor, which will have an independent prognostic risk rate depending on its thickness measurement. Recurrences of metastasis most often present within 2 years and then may be after 30 years from the initial presentation (9).

Since melanoma appears to have symbiotic relationship with the immune system, surgical removal of lesions is indicated when feasible. Many patients have demonstrated improved survival over the long term with tumor removal. In general, patients with solitary metastases do better than those with metastasis to other, non-visceral sites. Metastasis in patients may remain stable for months or even years without treatment, but progression is almost a rule (10,11).

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