PRIMARY MALIGNANT MELANOMA UTERINE CERVIX


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Abstract:
A 40 years old premenopausal female presented with foul smelling per vaginal discharge for three months. Diagnostic work revealed a locally advanced primary malignant melanoma of uterine cervix. Patient declined pelvic surgery and was treated with Da carbazine. Malignant melanoma is rare tumour of skin and has been ranked in top five cancers of Australia and Sweden. It is a tumour of melanocytes which forms melanin pigment in the skin. In men the most common site is trunk while in females common site is limbs. However, melanoma can arise from mucosal surfaces where the melanocytes are present. Most common mucosal sites are head and neck followed by female genital tract.

Keywords: Malignant Melanoma, cervix, Dacarbazine

Introduction:
Malignant melanoma is rare tumour of skin and has been ranked in top five cancers of Australia and Sweden.1 Highest incidence has been reported from Queensland Australia.2 There is slight preponderance of males as compared to female as reported in one study of Pakistan.3 Females most commonly develop these lesions on extremities while male usually on trunk and head and neck regions. No definite aetiology can be identified however, it is found to be more in individuals exposed to sunlight. Interestingly, it does not have a direct relationship with the amount of sun exposure as is with other skin tumours because it is more common in white-collar workers than in those who work outdoors. Diagnosis is usually clinical but histopathological confirmation is usually required. Special immunohistochemical (IHC) stains i.e., S-100, HMB-45 and Melan-A further helps in its diagnosis. Best treatment of melanoma is wide margin excision as it is radio and chemotherapy resistant. This middle age lady presented with unusual per vaginal foul smelling discharge which on further workup was confirmed a case of primary malignant melanoma of cervix.

Case Report:
Forty years old premenopausal female presented with three months history of foul smelling per vaginal discharge. She was house wife with no co-morbidities. Her exposure to sun was not extra ordinary. She had seven children, all by spontaneous vaginal delivery. Her youngest child was seven years old.

Patient was initially seen by local general physicians and was started antifungal treatment with no improvement in symptoms. She was finally seen by a gynaecologist and advised ultrasonography. Ultrasound revealed a 7.5x5.5 cm mass in lower uterine segment involving anterior wall of the cervix. Differential diagnosis was calcified fibroid or a malignant growth. Per speculum examination revealed a growth in uterine cervix involving upper 2/3rd of vagina. Biopsy of the mass revealed primary malignant melanoma of the cervix. Immunohistochemistry was positive for S-100, HMB-45 and Melan-A while negative for cytokeratin AE1/AE3, cytokeratin 5/6, p-63, Desmin, CD-99, LCA, synaptophysin and vimentin. MRI pelvis and

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MRI pelvis showed 5.8x8.0x6.5 cm (APxTSxCC) mass involving proximal 2/3rd of vagina and distal part of cervix. The mass was extending in to endocervix and endometrium causing its thickening. Anteriorly, it was causing indentation on posterior wall of urinary bladder with loss of intervening fat planes. Posterior, the mass was focally infiltrating in to the anterior rectal wall (Figure 1). CT scan chest/abdomen was negative for metastases. Disease was staged as FIGO stage IVA if staged on the lines of squamous cell carcinoma cervix.

The case was discussed in city tumour board of Karachi. Patient refused surgery due to risk of pelvic exenteration. Immunotherapy with Ipilimumab was not feasible due to high cost. Option of radiotherapy was not considered due to risk of rectovaginal fistula formation. Combination chemotherapy like CVD (Cisplatin, Vinblastine and Dacarbazine) was not considered due to higher risk of toxicity with no survival benefit over single agent. Patient was planned for 6 cycles of single agent Dacarbazine therapy (250 mg/m²) day 1-5 Q4 weeks). However, patient only received only 3 cycles and quit treatment.

Figure 1: MRI pelvis (sagittal view) showing the lesion of malignant melanoma in cervix (arrow).

Discussion:

Malignant melanoma is a rare malignancy of skin. It accounts only 2% of all skin malignancies. Predisposing factor are genetics, sun exposure and multiple nevi. Prognosis of these case is usually poor if involving nodes or metastasizing to distant site. Most common site of metastasis is lung. Most common mucosal sites of involvement are head and neck followed female genital tract regions. No definite treatment is available if mass is irresectable. Most of the dermal melanoma are resectable but this was a rare case where mass was at an unusual site and irresectable. It was irresectable due to its invasion in to surrounding structures. Mucosal melanoma usually behaves aggressively. Their spread to regional lymph node is quite early as compared to dermal melanoma and makes the condition of patient miserable if not resected well in time.

We reviewed the literature to check the total number case of cervical melanoma reported up till now. A total of 60 cases have been reported from different part of the world. Latest report found was from Portugal published in 2011.

References: