Late melanoma metastases in stomach and small bowel: a case report

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ABSTRACT

Background: Primary cutaneous malignant melanoma with gastric metastases is a rare phenomenon, which usually occurs within one year from the time of the primary tumor diagnosis. In this case, the diagnosis of primary melanoma was 8 years prior to gastric metastases diagnosis.

Case Presentation: A 75-year-old male with a history of malignant melanoma presented with ferropenic anemia was found to have metastases to the stomach, detected on endoscopy. A Palliative Subtotal Gastrectomy was performed because of recurrent gastrointestinal bleeding. After surgery, the patient was referred to our oncology clinic for chemotherapy.

Conclusion: Surgical intervention offered symptomatic relief while attempting to prolong the patient's survival. Most publications on this topic are limited to single case-reports given the low frequency of gastric lesions in patients with primary cutaneous melanoma. This case report contributes to the understanding of this rare phenomenon while reaffirms that Metastatic Melanoma in the stomach should be suspected in any patient with a previous history of Melanoma.

Keywords: Case report, gastric metastases, melanoma, palliative surgery, polypoid lesions, subtotal gastrectomy.

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Background

The melanocytic melanoma has a high metastasis potential. Metastatic melanoma to the stomach, however, is a rare phenomenon with a median survival of 4 to 6 months [1]. The most common gastrointestinal (GI) metastatic sites from cutaneous melanoma are the jejunum and ileum, followed by the colon, rectum, and then the stomach [2]. Studies show that 60% of patients who die of melanoma are found to have metastases to the GI tract on autopsy, with gastric involvement in approximately 20% of these cases [3] and only 1.5%-4% of the gastrointestinal metastases are diagnosed before patient's death [4].

Case presentation

We present the case of a 75-year- old Caucasian male, gardener, ex-smoker (20 pack/year) with a previous medical history of type 2 diabetes, Vitiligo and Lipoma Excision. He also had a personal history of cutaneous dorsal Melanoma on the left scapula with surgical excision in another institution 8 years before (2010). Five years later, in 2015, he developed bones and lung metastases. Lung lesions responded to chemo and radiotherapy (last course of chemo on September 2018). The patient was referred by his family physician to our clinic with complaints of 20 days of asthenia, fatigue, and melena. The upper endoscopy evidenced 3 polypoid lesions in gastric antrum and body (polilobulated, larger than 5 cm) and erosions (PA: Malignant Indifferenciated Tumor) (Figure 1). The colonoscopy was normal.

On physical exam, the patient was pale, apyretic, and hemodynamically stable. During routine blood analysis, a ferropenic anemia was revealed, for which red blood cell transfusion was needed. Laboratory test: Hematocrit 28 g/dl; Hemoglobin 9.3 g/dl; White blood cells 4700 mm^{-3}; Total Protein 5.1 g/dl; Albumin 2.7 g/dl. Standard

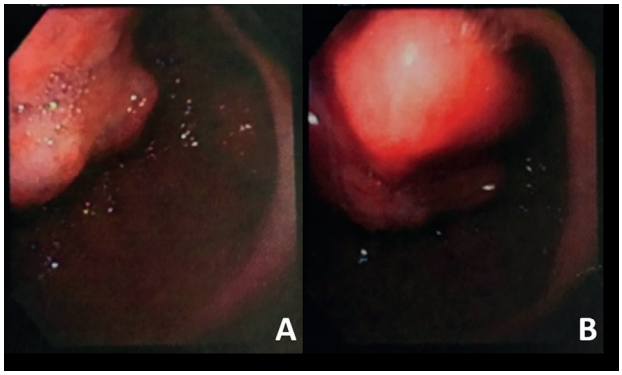

Figure 1. *Endoscopic polypoid lesions.*

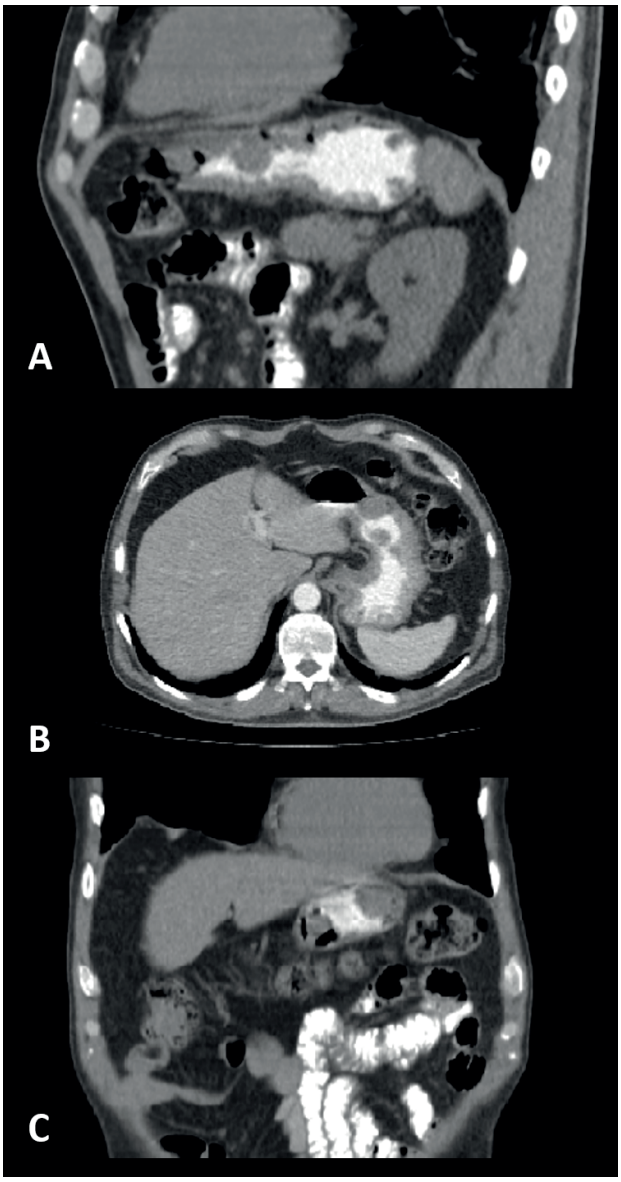

Figure 2. *Standard abdominal computed tomography, with solid polypoid gastric lesions. (A) Sagittal cut. (B) Axial cut. (C) Coronal cut.*

abdominal computed tomography (CT) scan showed solid gastric lesions (Figure 2)

The Multidisciplinary Tumor Board decided a Palliative Subtotal Gastrectomy because of Recurrent Gastrointestinal Bleeding during the last 3 months.

The Subtotal Gastrectomy with lymph node dissection was performed with general anesthesia. The surgery was performed by the General Surgeon and two junior residents. The patient was placed in a supine position and a supra-infra umbilical medial incision was performed. Gastric and jejunal polypoid lesions were evidenced and resected. Mechanical sutures were used for the stomach section and subsequent manual anastomosis (Figure 3). Enterotomy was performed 30 cm away from the stomach anastomosis to resect jejunal lesions. Enterorrhaphy was done with Vicryl continuous sutures. Histopathological examination was compatible with metastatic melanoma

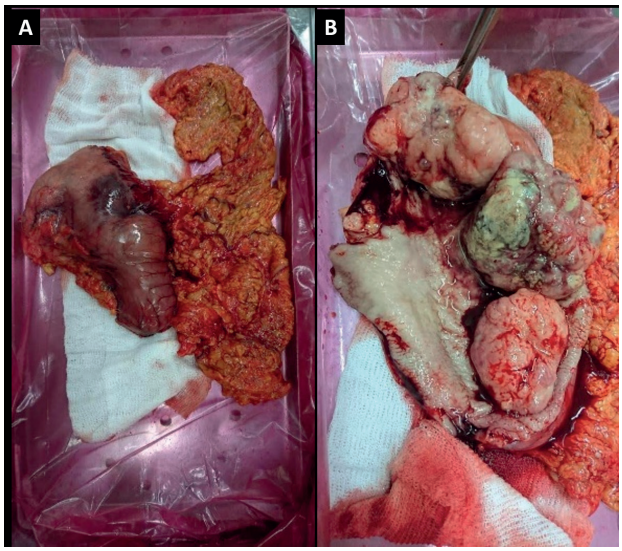

Figure 3. *Intraoperative findings (A) Resected tissues. (B) Body polypoid lesions.*

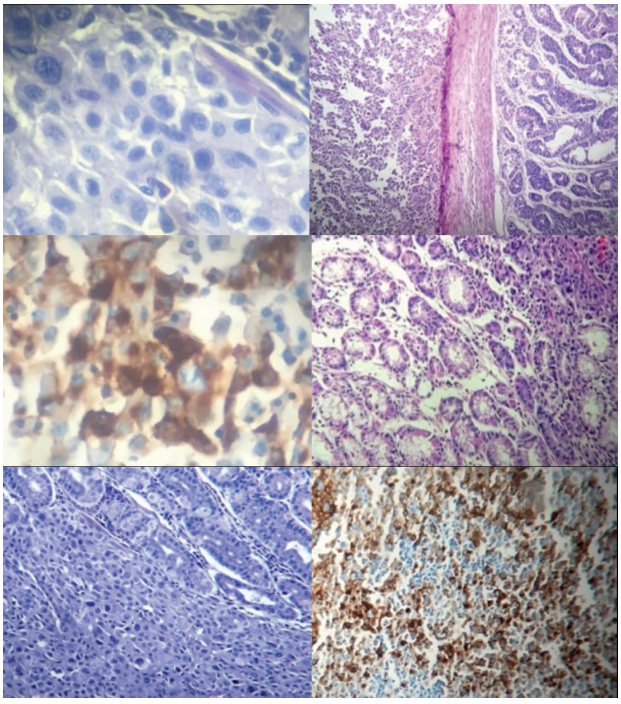

Figure 4. *Histopathological images of gastric metastasis of the malignant melanoma. Immunohistochemical staining was performed for HMB45 and MELAN A, both positive for morphologic and inmunohistochemical melanoma metastasis.*

(Figure 4). The length of the stay was 11 days, without complications.

Stomach pathological anatomy: Melanoma Metastasis, 3 polypoid lesions (9, 8, and 6.5 cm). Small bowel pathological anatomy: Melanoma Metastasis, 2 polypoid lesions. The patient was referred to our oncology clinic after the diagnosis for chemotherapy.

Discussion

Metastasis to the stomach is a relatively unusual entity, and even more, melanoma metastasis [1]. Endoscopy is

the most important tool during the diagnostic assessment, and it can take a direct biopsy of the lesion. More than half of Melanoma metastases occur in the initial year of diagnosis [5]. Treatment options include surgical resection, immunotherapy, targeted therapy, and radiation therapy to symptomatic sites. Some studies show that patients with total excision of intra-abdominal metastases had a median survival between 9.6-11 months, and a surgical resection is an option for symptomatic palliation [2]. For these reasons, we decided to perform a subtotal gastrectomy as a surgical palliative resection because of the ferropenic anemia and red blood cell transfusions necessity. Unfortunately, this patient also presented bone metastases and died four months after surgery.

Conclusion

Metastatic melanoma in the stomach represents a challenging problem in diagnosis, prognosis, and treatment. It should be suspected in any patient with a previous history of melanoma. Early detection of these metastatic lesions could help avoiding radical local excision. In this case report, a subtotal surgical intervention offered symptomatic relief while attempted to prolong the patient's survival.

What is new?

Primary cutaneous malignant melanoma with gastric metastases is a rare phenomenon and gastric metastases usually occur within one year from the time of the primary tumor diagnosis. In this case, the diagnosis of primary melanoma was 8 years prior to gastric metastases diagnosis.

Acknowledgments

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Conflict of interest

The authors declare that there is no conflict of interest regarding the publication of this article.

Funding

None.

Consent for publication

Informed written consent was obtained from the patient for publication of this case report and accompanying images.

Ethical approval

This study has been approved by the Hospital.

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Summary of the case

1	**Patient (gender, age)**	Male, 75
2	**Final diagnosis**	Melanoma metastases in stomach and small bowel
3	**Symptoms**	20 days of asthenia, fatigue, and melena
4	**Medications**	N/A
5	**Clinical procedure**	Endoscopy followed by surgery and oncology treatment
6	**Specialty**	General Surgery