Melanoma with cutaneous melanoma secondaries

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Case history

Mr HG presented in 2002 with a large black lesion on his left loin. It had been present for many years but had recently changed (*Figure 1*). Nearby, two similar lesions were apparently separated by normal skin. Histology confirmed these were malignant melanoma. The 'normal' skin between lesions also demonstrated melanoma beneath the surface. At its thickest, this melanoma was a (Breslow) 2.56 mm, Clark 4 lesion. The tumour was excised with a minimum 20 mm margin of normal skin. Given the depth of the tumour, Mr HG was co-managed with the Victoria Melanoma Unit. There are no radiotherapy or chemotherapy programs that have been demonstrated to improve survival in patients with an advanced primary melanoma such as this. Following discussion, Mr HG chose not have a sentinel lymph node biopsy (SLNB).

Mr HG had the opportunity to enroll in a randomised controlled trial (RCT) trial of emerging treatments. After discussion of his condition, prognosis and options, he and his wife declined to do so, instead choosing to buy a caravan and travel Australia.

Mr HG remained well until he presented with a subcutaneous mass 10 cm from the primary site in 2004. On dissection, a black mass was excised (*Figure 2*). Histology confirmed this was metastatic melanoma (*Figure 3*). While scans in 2002 were clear, computerised tomography (CT) scans now showed pulmonary metastases. Despite the poor prognosis, the family continued to elect not to enter any emerging drug trial. The concern regarding 'numerous trips to Melbourne' was clear. The patient's wishes were respected.

In time, metastases developed elsewhere including numerous cutaneous and subcutaneous nodules (*Figure 4*). Most of the cutaneous nodules demonstrated the dermoscopic appearance of metastatic melanoma (*Figure 5*). Mr HG remained well through 2005. In this year he and his wife toured the USA and Europe. In early 2006 he became tired and nauseous. Anaemia was treated with transfusion. By this stage, subcutaneous and cutaneous masses were abundant. Cerebellar and cerebral secondaries affected gait and motor function. The inevitable decline continued. Mr HR succumbed to his melanoma in May 2006.

Summary of important points

- While the majority of patients with melanoma present early and do well, the case study reminds us that melanoma is a potentially fatal condition.
- Melanoma management is not about fancy treatments in tertiary institutions. Effective management of melanoma is simply about early detection and wide excision. Nothing else improves long term outcome.[1,2]
- Subcutaneous metastases from any tumour are ominous with a 7.5 month average survival.[3] Lung cancer is the commonest cause of cutaneous secondaries (29%), melanoma is second (18%).
- Tests such as SLNB are not reasons to delay the treatment that matters – wide local excision. Even if the patient decides to undertake SLNB, this can be performed after the wide excision with no demonstrated difference in the accuracy of the test.[4]
- Patients with advanced melanoma should be offered the opportunity to enroll in trials of emerging treatments. We will not find that important breakthrough in future melanoma care without present day melanoma patients' participation in RCTs.
- Most commonly, metastatic deposits of melanoma have friable black contents, the histology merely confirms the clinically obvious.

Figure 1. Mr HG's primary malignancy with 'satellite' lesions

Conflict of interest: none.

Figure 2. Dissection of black subcutaneous mass 10 cm from original melanoma

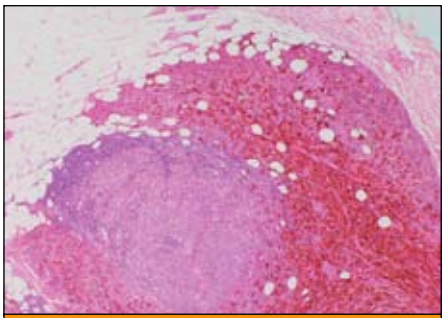

Figure 3. Histology of subcutaneous mass. Within subcutaneous fat is a deposit of metastatic melanoma. There are atypical epitheloid cells with adjacent macrophages containing melanin pigment

Photo courtesy Melbourne Skin Pathology

Figure 4. Mr HG's chest wall shows numerous cutaneous and subcutaneous deposits of metastatic melanoma

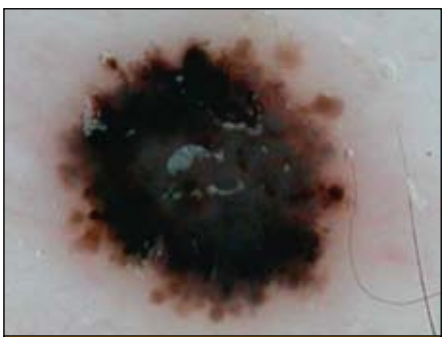

Figure 5. Dermoscopy of cutaneous metastaic melanoma. It has the appearance of malignant melanoma being 'sprayed' on to the site

Sentinel lymph node biopsy

Sentinel lymph node biopsy (SLNB) has been popular in recent years, especially with patients suffering a melanoma beyond 1 mm thickness. The idea is to detect early evidence of melanoma in the lymph node that drains the skin at the site of the primary tumour. When nodes were found to contain melanoma, the patient usually progressed to having the entire nodal basin excised.[5]

However, there was always concern that such an intervention may not benefit the patient. We have known for some time through multiple RCTs that elective lymph node dissection on melanoma patients offers no survival benefit.[6]

10% of patients who undergo SLNB develop side effects and up to one-third of patients who go on to block dissection experience complications.[7] Complications include infection, seroma and lymphoedaema. More serious complications include facial nerve[8] and brachial plexus damage.[9]

Recently the first and only RCT of SLNB has demonstrated no survival benefit. Australia contributed many patients to this multi-national study known as MSLT-I. Concern has been expressed that the much presented trial has not yet been published.[10]

Further, many investigators have demonstrated that a sentinel node with only small amounts of melanoma in it may not subject the patient to added risk and the patient may not benefit from then proceeding to block dissection.[11–14]

As such, SLNB does not improve patient survival and does not guide further management. It does however, provide some added information to the patient regarding survival prospects as SLNB negative patients survive longer than positive patients.[15–17]

In 2006, SLNB is not a standard of care in melanoma management. It is an option for patients who wish to have further information about their prospects and are aware of the risks and complications of such an invasive procedure. Counselling before SLNB should include advice that the test does not guide future management.

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