CASE REPORT / OLGU SUNUMU

A case of malignant melonoma presenting with upper gastrointestinal bleeding.

Üst Gastrointestinal Kanama ile Prezente olan bir Malign Melanom Olgusu

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ABSTRACT

Malignant melanoma can metastasize to the gastrointestinal tract as it can metastasize to many parts of the body. Small bowel is the most common involvement in gastrointestinal tract, while gastric involvement is rare. A 82-year-old male patient who presented to the emergency department with complaints of hematemesis and melena had a large number of black polypoid masses in the gastric corpus and antrum in his gastroscopic examination. And the result of the biopsy taken from that part, was malignant melanoma. In this way, it is very rare that a patient who is not known to have malignant melanoma, presents with upper gastrointestinal bleeding.

Key words: Malignant melanoma; gastric metastasis; gastrointestinal bleeding.

ÖZET

Malign melanoma, vücudun birçok yerine metastaz yapabildiği gibi gastrointestinal sisteme de metastaz yapabilmektedir. Gastrointestinal sistemde en sık ince barsak tutulumu varken mide tutulumu nadirdir. Hematemez ve melena şikayetleri ile acil servise başvuran 82 yaşında bir erkek hastanın, gastroskopisinde mide korpus ve antrumda çok sayıda siyah renkli polipoid kitle saptanmış olup alınan biyopsi sonucunda ise malign melonoma tanısı almıştır. Bu şekilde henüz malign melonom olduğu bilinmeyen bir hastanın üst kanama ile prezente olması oldukça nadir bir durumdur.

Anahtar kelimeler: Malign melanom; gastrik metastaz; gastrointestinal kanama

INTRODUCTION

Malignant melanoma (MM) is a malignant tumor originating from neural cleft melanocytes and nevus cells thought to occur as a result of differentiation of melanocytes. [1] Although MM constitutes only 2-3% of all cancers, it is the most common cause of mortality among skin cancers. The most important localisation of the MM is skin. Rarely, it can also originate from mucosaes, meninges of brain, eye and internal organs. MM can metastasize to all organs in the human body[2] Gastrointestinal system metastases can also be observed, which is the most common in intestinal tract. Gastric metastasis is more rare. In the following, we present a case of MM presenting with gastrointestinal bleeding.

CASE

The 82-year-old male patient had a history of 5 mg/day warfarin usage due to chronic atrial fibrillation. He was admitted to the emergency department with sudden onset of hematemesis and melena. Physical examination; the arterial blood pressure was 90/55 mmHg and the pulse was 128 beats/min. A mass of 8 cm x 6 cm in the left inguinal region was detected. And also melena was seen in his rectal examination. In laboratory tests; Hb: 11.6 g/dL Hct: 33.7% Mcv: 69fL Plt: 308.000, INR: 6.45 Urea: 188 mg / dL, creatinine: 2 mg / dl. The patient was admitted to the department with the diagnosis of upper gastrointestinal bleeding; Inotropic agents, volume expanders and intravenous infusion of 0.9% NaCL were started. In his gastroscopic examination; "The appearance of a large number of polypoid masses in the corpus and antrum with a diameter of max. 3.5-4 cm, some of which are joined with each other, most of which are black, some are pink. In second part of duodenum, there is black-colored polypoid mass which is similar to those in the stomach, the largest one is 1 cm in diameter, the others are 6-7 mm in diameter" (Figure 1-2). Endoscopic biopsy was reported as MM (Figure 3). A biopsy was planned from a suspected skin lesion that was thought to be the

origin of MM. However, without the opportunity to excise the suspicious skin lesion of the patient, he died due to multiorgan failure in intensive care unit.

DISCUSSION

Primary non-cutaneous MM can rarely be seen in the small intestine, colon, stomach, esophagus, rectum and anal canal. Malignant melanoma originates mostly from the skin (>90%). MM is one of the most common malignancies that metastasize to the gastrointestinal tract.[3] The incidence of metastasis to the gastrointestinal tract is 43.5%; esophagus 4%, stomach 22.7%, small intestine 35.6%, colon 28.2%, rectum 5%, anal canal 1%.[4] In our case, the lesion causing gastrointestinal bleeding was thought to be metastasis; beacuse the lesions in the stomach of the patient showed itself later than the lesions on the skin, there was a suspicious inguinal lymph node involvement on the side of the skin lesion, and primary MM often occurs on the skin. Gastrointestinal bleeding due to gastric metastasis is rare; however, it is much rarer for a case who has not yet been diagnosed with MM to present with gastrointestinal bleeding. In the literature; a 73-year-old female patient with nodular melanoma was reported to have melena. And gastroscopy revealed that there were multiple lesions in the fundus and corpus.[5] Similarly, 2 male patients with a diagnosis of malignant melanoma at the age of 49 and 61 years; were reported to have upper gastrointestinal bleeding and then to have a diagnosis of gastrointestinal melanoma metastasis.[6] Unlike the above cases, our case had not yet been diagnosed as malignant melanoma. In the literature, a case similar to our case was reported by Kotteas et al.; a 81-year-old woman who had no history of any disease had multiple metastatic MM lesions in her gastric corpus, which were deteceted after her admission to hospital with complaints of melena and hematemesis.[7]

Metastases may present as the first sign of relapse at the time of initial diagnosis or after years. MM can present with nonspecific symptoms such as abdominal pain, dysphagia, obstruction, hematemesis or melena.[8] MM can metastasize to the gastrointestinal tract and may also be primary. Primary MM can occur anywhere from the oral cavity to the anüs, without skin lesions or other organ involvement. They are rarely diagnosed in the early period and are very aggressive. It may be difficult to differentiate the metastatic MM from the primary. While metastatic MM usually produces ulcerative polypoid lesion in the gastrointestinal tract; the spontaneously regressed primary mass histologically makes

lymphocyte infiltration together with melanophages in the dermis. When the primary origin of MM is not detected in any organ; gastrointestinal MM can be evaluated as primary lesion. On the other hand; metastatic lesions can be distinguished from the primary by the presence of melanocytes or by detecting the precursor lesion.[9,10] It may be quite difficult to differentiate MM, especially in cases where the primary skin lesion is regressed.

In this case, we aimed to show that the etiology of a patient with gastrointestinal bleeding may be gastric metastasis of MM.

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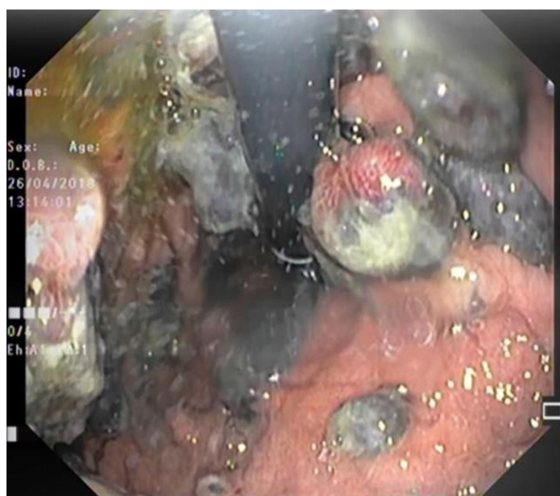

Figure 1 Black-colored polypoid mass in the stomach

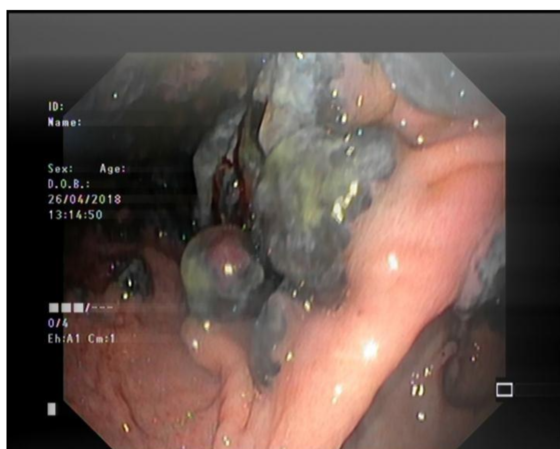

Figure 2 Black-colored polypoid mass in the stomach

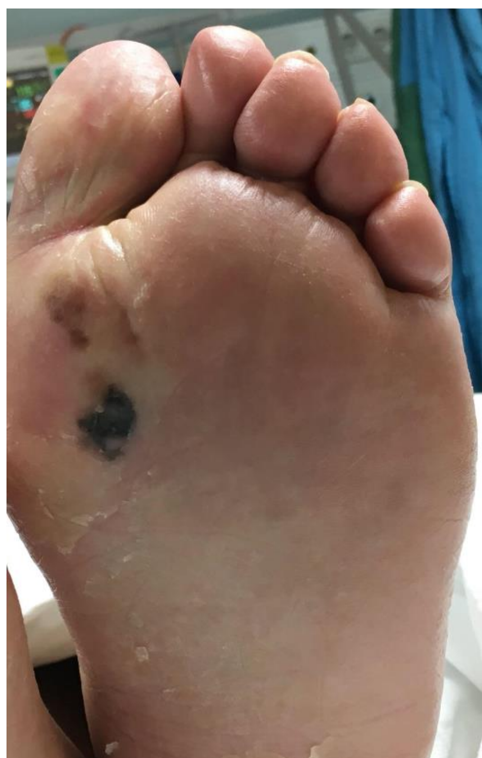

Figure 3 Malignant melanoma lesion on the foot base