

## Letters to the Editor

### Intestinal perforation due to cutaneous malignant melanoma metastatic implants

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*Key words: Small intestine. Intestinal perforation. Cutaneous malignant melanoma. Intestinal metastasis.*

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Dear Editor,

Cutaneous malignant melanoma is the extra-abdominal neoplasia most frequently metastasized to the gastrointestinal tract. Although it can be located in any segment, it is most frequently established in the small intestine (51-71%), stomach (27%), large intestine (22%) and the oesophagus (5%). These metastases can occur synchronically with the primary tumour or appear decades later, as the first sign of a relapse of the disease in the form of: abdominal pain, dysphagia, intestinal obstruction, haematemesis, melaenas, etc. which require urgent surgery, justified by the improvement in the quality of life it provides with low morbidity and mortality (1).

The differential diagnosis between primary and metastatic intestinal malignant melanoma may be complicated with routine examinations such as a barium study and CT scan, as their sensitivity is limited. The Positron emission tomography, however, can improve the detection of melanoma metastasis to the gastrointestinal tract. Despite the different therapeutic strategies, surgical removal is considered to be the treatment of choice in patients with resectable metastatic intestinal malignant melanoma (2).

Prognosis is bad with an average survival rate of from 4 to 6 months (3), and is even worse in the case of primary intestinal malignant melanoma than when dealing with intestinal metastasis from extra-abdominal malignant melanoma (2).

We present the clinical case of a young man who has undergone surgery for multiple intestinal perforations secondary to cutaneous malignant melanoma metastatic implants.

#### Case report

Patient aged 23, with a history of resection of cutaneous melanoma and left axillary lymphadenectomy as a consequence of metastatic adenopathies of one year evolution, and "interferon" as adjuvant treatment. He was admitted to Oncology due to a severe vasogenic oedema and displacement of the midline secondary to unique cerebral metastasis in the left parietal lobe. During admission he presents a clinical picture of abdominal distension associated with pain and guarding of hypogastrium-RIF, the abdominal X-ray showing: distended loops of the small intestine and descending colon, an abdominal CT scan revealing pneumoperitoneum with free peritoneal liquid (Fig. 1). In the face of these findings he was submitted to urgent surgery, which revealed a generalized peritonitis secondary to perforation of the small intestine in 3 segments located in the proximal and distal jejunum, on the level of the distal ileum, related to cutaneous melanoma metastatic implants. Resection of the affected intestine was carried out. The postoperative evolution was satisfactory and the patient was discharged on the 10<sup>th</sup> day. The anatomopathological study confirmed the diagnosis of intestinal metastasis from cutaneous malignant melanoma (Fig. 2) The patient died at home, 5 months later, due to the progression of the disease.

#### Discussion

At present, metastatic melanoma is considered to be a practically incurable disease. The survival rate for patients with distant metastasis is 5-10% at 5 years and 2% at 15 years (4).

Gastrointestinal metastases from melanoma reflect an advanced stage of the disease, clinically undetectable in the initial phases. The diagnosis is normally carried out because of complications, which means that the principal aim of the treatment should be to palliate the latter (5).

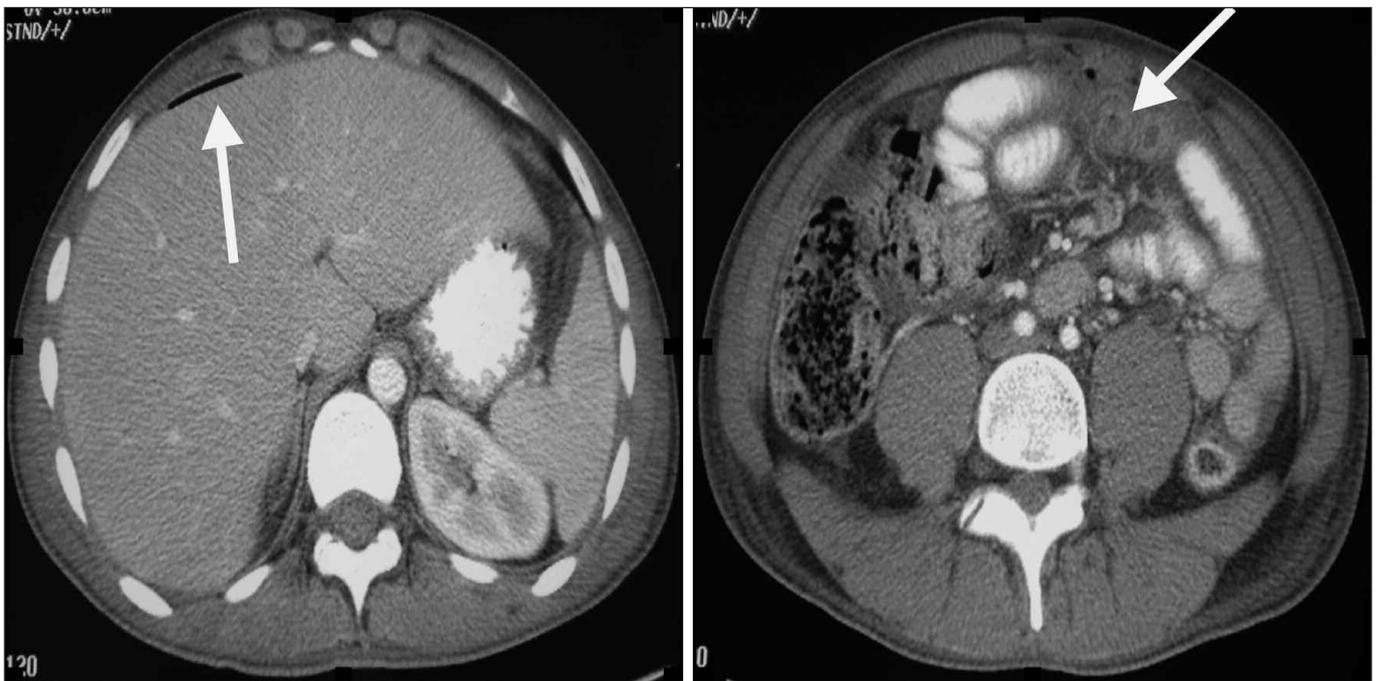


Fig. 1. Abdominal CT scan: pneumoperitoneum with free peritoneal liquid and thickening of jejunal loops.

Some series have shown increased survival in the group with complete resection of these lesions. Berger et al published a study of 50 patients with melanoma metastatic to the gastrointestinal tract, 37 of whom were submitted to surgical resection, those submitted to complete resection with a median survival of 23.5 months, compared with 8.9 months in patients submitted to partial resection (5,6).

Until only a few decades ago, the surgical treatment of metastatic melanoma was contemplated as a medical intervention which only makes any sense in the case of symptomatic metastases caus-

ing obstruction or haemorrhage. It is now known that the palliative surgical removal of unique metastases implies a significant lengthening of disease free time, with the consequent increase in quality of life (4).

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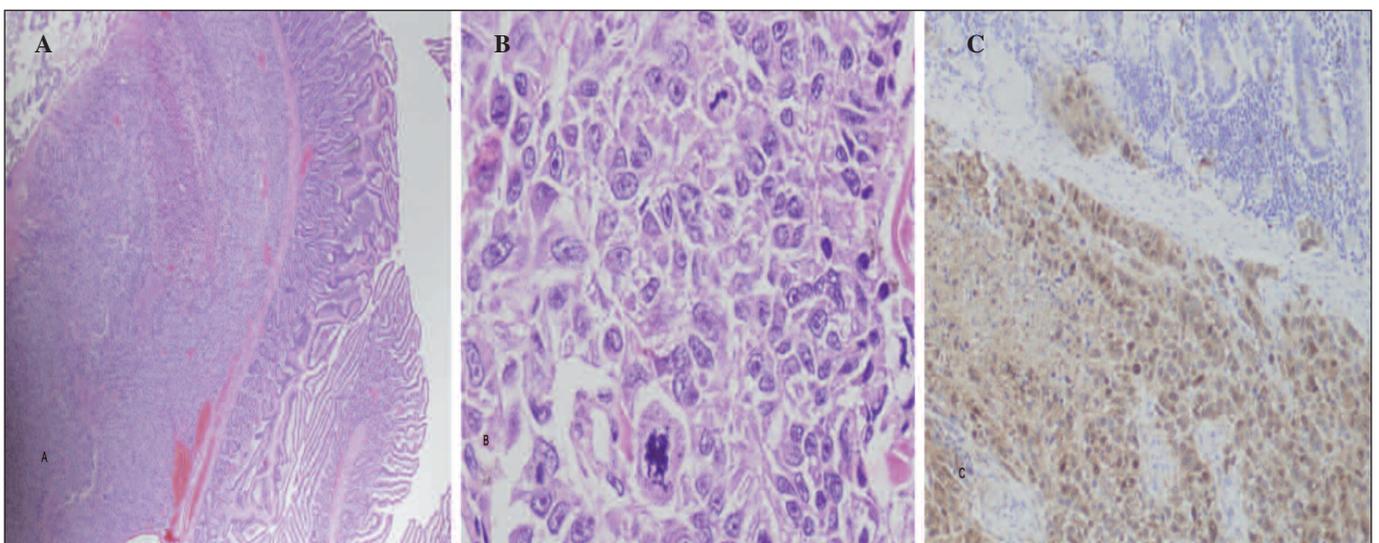


Fig. 2. A. Metastatic melanoma infiltrating the wall of the small intestine. B. The tumour is made up of severely atypical melanocytes, some containing intracytoplasmic melanin pigment. C. Nuclear and cytoplasmic immunostaining for S-100 protein in tumour cells.

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