

A Huge Melanoma

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Malignant melanoma is one of the most aggressive cancers and often disseminates from a relatively small primary tumor and metastasizes to multiple sites, including the lung, liver, brain, bone and lymph nodes [1].

Although patients with distant metastasis to organs such as the lung, liver, or brain have a 5 year survival rate of less than 10%, primary melanoma can be cured via surgical resection [2]. Unfortunately, melanoma cells from primary observable and superficial nidi have the capacity to penetrate the dermis, enter the lymphatics or vasculature, attach to the vessel walls in distant organs, and extravasate into the parenchyma and generate metastatic lesions initially too small to be identified via current techniques. These metastases then progressively grow and develop over time, leading to the patient's death. Once the melanoma cells leave the primary tumors and enter the vasculature or the lymphatics, they are equipped with all the features needed to complete the metastatic process. For example, melanoma cells share many antigens with vascular endothelial cells [3]. Among these are adhesion molecules. Once metastases are established in distant organs, the 5 year overall survival rate of patients with melanoma drops drastically to less than 10%.

Large tumor masses are difficult to eradicate with systemic therapy alone. Surgery in combination with novel immunotherapies and targeted treatment can potentially improve clinical outcomes and/or patients' quality of life. However, not all metastatic sites respond to therapy and surgery may be required to remove resistant lesions. In several cases, analysis of the excised tissue has revealed the presence of a diffuse immune infiltration which correlated with the outcome in these patients [5]. Thus, to lower the recurrence rate of the disease, reduction of the tumor mass which can be obtained with surgery should be combined with immunotherapy [4].

We describe a 54 year old male patient, a nursing home resident, who suffers from

uncontrolled diabetes type 2 with target organ damage including amputated toes. His medical history is relevant for ischemic stroke, hyperlipidemia, and personality disorder. The patient presented to our department with bleeding from a melanoma tumor in his distal right leg [Figure 1A]. Even though the tumor was huge it did not metastasize.

During his admission his hemoglobin was stable around 9.5 g/dl, but due to complaints of profound weakness he was given two blood transfusions with consequent improvement. Magnetic resonance imaging of the leg showed that there was no invasion of the bone and deep tissues [Figure 2A and B]. As a result of these findings the patient underwent a local

Figure 1. [A] Huge melanoma tumor in distal right leg, fungating and bleeding. **[B]** After wide local excision of the huge melanoma tumor in distal right leg. The wound is attached to a VAC (vacuum-assisted closure) machine to improve the healing

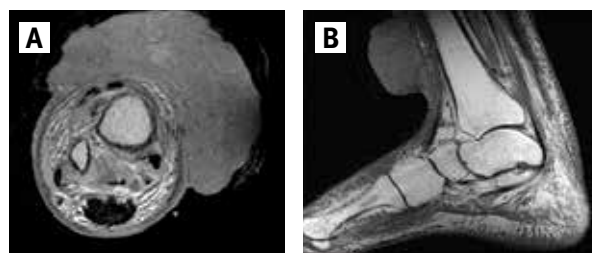
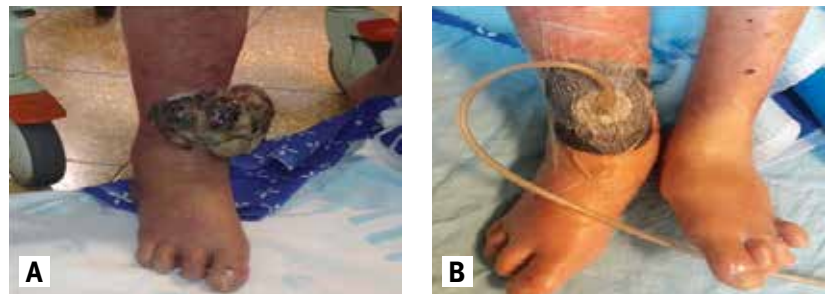
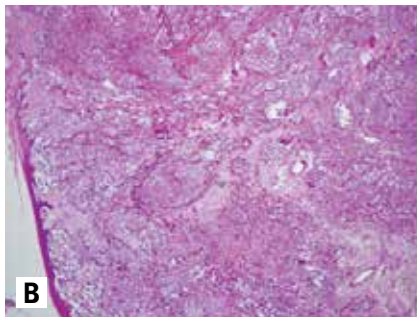
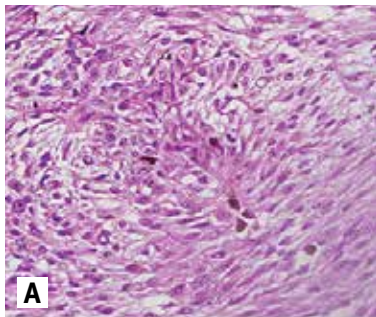


Figure 2. [A] Axial section of lower leg showing the huge melanoma without invasion. **[B]** Sagittal section of lower leg showing the huge melanoma without invasion

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Figure 3. [A] Microscopic view x400 showing the melanin pigment. We can see epithelioid cells with elongated nuclei. **[B]** Microscopic view x40 showing general view of the hypercellular tumor; on the left side a narrow and ulcerated epidermis is seen



wide excision of the mass without complications and a VAC (vacuum-assisted closure) machine was placed to facilitate healing [Figure 1B]. The excised mass was pathologically analyzed and confirmed the

diagnosis of melanoma [Figure 3A and B]. During his hospitalization the patient felt well and was discharged in stable condition; his wound is in a healing process. He refused further suggested therapy.

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