Scrotal Melanoma with Brain and Lung Metastasis

Rodrigo Beserra Sousa*, Marcos Francisco Dall’Oglio, Gabriel Barbosa Franco, Mikael Vieira da Silva, Hermano Covre Argolo, Cassius Martins e Silva and Luiz Jorge Budib

Department of Urology, Santa Marcelina Hospital, Brazil

Abstract

We describe a case of a patient diagnosed with melanoma complications due to cerebral metastatic lesion and at a later investigation diagnosed primary lesion in the scrotum.

Keywords: Scrotal melanoma; Metastatic melanoma; Orchiectomy; Scrotum; Scrotectomy

Introduction

Primary melanoma of the genitourinary system occurs in less than 1% of all cases, with the scrotal location having only 17 cases described in the literature. Cases diagnosed in the initial phase of the disease presented a more favourable prognosis [1].

In a review study upon penile and urethral melanoma, 57 cases of penile melanoma and 26 of urethral location were revised [2]. In another case series, the files of 16 men with a diagnosis of melanoma were revised, with 9 cases in the penile location, one in the urethra and 6 in the scrotum; half of these last were diagnosed incidentally after a local trauma and one was related to a pigmented scrotal lesion which had been perceptible for the previous 5 months [3].

Taking into account the rarity of the primary scrotal melanoma, the object of this case study is to show the aggressive and rapid evolution of a melanoma in the scrotum, diagnosed at advanced stage.

Case Presentation

Male, 76 years old, with history of systemic arterial hypertension, chronic angina and alcohol consumption, complaining of left hemiplegia and sudden loss of consciousness. A secondary, haemorrhagic, cephalic, vascular accident was diagnosed, together with a parietal tumour on right side (Figure 1). The patient was submitted to drainage of the haematoma with biopsy of the lesion, which was suggestive of malignant melanoma after immunohistochemical analysis.

There was a lesion in the right scrotal sack which had begun 2 years previously, with no medical attendance during this period (Figure 2). Upon physical examination, an ulcerated lesion of around 6 cm was found in the right scrotum with apparent infiltration of the testicle as well as two palpable nodes in the right, ipsilateral, inguinal region.

He was submitted to a right orchiectomy with partial resection of the scrotum (Figure 3). The result of this under anathomo pathological analysis, with immunohistochemical profile of markers.
Melan-A, HMB-45 and diffuse S-100 protein positives, together with KI-67 in 80% of the cells, was compatible with scrotal melanoma.

Staging tests with computerized tomography of the thorax, abdomen and pelvis showed multiple nodular pulmonary lesions, without apparent metastases into abdominal regions, but inguinal lymph node enlargement (Figures 4 and 5).

Palliative radiotherapy was indicated for the cerebral tumour nodule, effected with 2000 Gy, but total intended dose was not completed due to deterioration of general clinical condition. In this same month, there was a new episode of intracranial haemorrhage due to growth of the tumour, with re-admittance, evolving to intracranial hypertension and obit.

Discussion

Genitourinary melanoma is rare and scrotal melanoma is the rarest reported. Penile lesions of old, well defined aspect and single colour are less suspect for melanoma, but should be examined with frequency and any suspicious alteration must be correctly biopsied and monitored [4].

Currently available information reveals that, although the genitourinary melanoma is an aggressive disease, it is potentially curable if the pathological characteristics and clinical presentation are favourable [5]. Within a series of 11 cases of scrotal melanoma, it was observed that patients submitted to ascrotum resection alone presented an effective local control, but were at higher risk for locoregional recurrence [3].

The handling and treatment of the inguinal region in cases of genitourinary melanoma without palpable lymph nodes is debatable [6]. In these cases, the indication for inguinal, surgical staging is based on the site of the tumour and pathological, prognostic factors such as the thickness of Breslow, Clark level and presence of tumour ulceration [7]. When lymph nodes are clinically absent, the recommendation for prophylactic, inguinal lymphadenectomy would be for melanomas with an invasive depth of 1 mm or over, Clark IV or V and presence of ulceration [8]. Another possibility would be the biopsy of dynamic, sentinel lymph node [9]. In cases of clinically palpable inguinal lymph nodes or when they are shown in imagery exams (stage III AJCC), the lymphadenectomy is indicated bilaterally for melanomas of the penis, urethra and scrotum [6,7,10].

The use of adjuvant therapy, either systemic chemotherapy or radiotherapy, lacks evidence and protocols for use. Even in the studies with the highest rates of scrotal melanoma, patients submitted to one modality or another followed distinct schemes with unfavourable outcomes [1,3].

More important than the management of scrotal melanoma, this report demonstrates the importance of the evaluation of genitourinary lesions, taking into account the anatomopathological result that, as described, may show rare lesions and with a different management than usual.

References


