Introduction

The gastrointestinal tract is a frequent site of malignant melanoma metastases (35.6%; 1). Diagnosis is often delayed because of atypical clinical onset: chronic iron deficiency anaemia, rectal bleeding, intestinal obstruction (2, 3).

Case report

A 51-year old man was admitted to the General Surgery Department with acute abdominal pain since a week. In the last two days he was suffering from fever, persistent vomiting, abdominal pain and no stool passage. The ultrasound of the abdomen revealed “flatus and intestinal enlargement”; plain abdominal X-ray detected “central air fluid level in the small intestine”. Routine laboratory tests showed WC: 15.85x10^3 (neutrophils 79.3%); HB 10.2; Hct 32.5%, LDH 297.

A nasogastric tube was positioned, which drained 400 cc of alimentary content. The past medical history was unremarkable. Physical examination showed abdominal swelling air mainly in low hypogastrium and pain. Peristalsis was reduced. Enlarged fixed painful lymphatic nodes were present in the right axilla (Fig. 1).

Tumor markers CEA, CA 19.9, AFP were normal. During the hospital stay the clinical conditions worsened, with vomiting, drop off Hb, acid-base imbalance. The abdomen was painful, contracted without peristalsis. Blumberg was positive. Plain abdominal X-ray underlined the increase of air-fluid levels. Patient underwent emergency laparotomy. We found a bulky tumor involving ileum and causing the intussusception (Fig. 2). We performed a resection of 36 cm of the ileum including the large tumor and the mesentery with lymph nodes (Fig. 3).

During hospital stay CT showed several lymph nodes (the biggest one was about 60 mm) in the right axilla with small bilateral pleural and pelvic effusion. The right axilla ultrasound showed bulky dysomogeneous tumour of doubtful evaluation. In the left axilla there were multiples “reactive” lymph nodes.

Pathology showed the presence of a bulky neoplasm...
Small bowel intussusception due to metastatic melanoma of unknown primary site. Case report

Small bowel intussusception (5x4 cm) extended up to the ileal mucosa with focal areas of ulceration and stenosis of bowel lumen. One of eleven lymph nodes was positive for metastasis; the margins of resection were healthy. The immunophenotype of neoplastic population was: Vimentin, S100 and HMB45 intensely and diffusely positive; MART-1 focally positive; cytokeratin AE1/AE3, EMA, CD45, chromogranin, synaptophysin, CD34 and c-kit negative; NSE not conclusive; Ki67 12% (Fig. 4).

The diagnosis was metastasis of unknown primary malignant melanoma.

In order to check typical melanoma localization, the patient was subjected to ophthalmological, otorhinolaryngological and oncological videat with MRI and PET scan. PET scan revealed pathological hypermetabolic nodal masses in the right paramedian posterior cervical region (SUV max 6.3), right laterocervical, left retro-clavicular (SUV max 3.6), left back and scapula regions (SUV max 3.6), right axilla (SUV max 11.3), right parasternum region (SUV max 4.9), lower margin of the liver (SUV max 6.4), pre-sacral region (SUV max 4), left abdominal wall, left and right thigh (SUV max 6.9 and 5.8), bladder (SUV amx 5.6) with hypermetabolic focus on D7 paravertebral line (Fig. 5).

Vertebral MRI confirmed “foci” described on PET and revealed other multiple masses of unknown pattern on spine, medulla, aortic and para aortic lymph nodes.

Dermatologist found a suspicious naevus in epigastrium. The axillary lymphadenectomy (Fig. 1) was performed. Histology confirmed metastatic localization of melanoma. The naevus was benign. Oncologist diagnosed malignant melanoma IV stage (according to American Joint Committee on Cancer). The patient died 8 weeks after the beginning of chemotherapy, with CNS metastases.

Discussion

In 4-9% of all melanoma cases the primary site is unknown. In some patients it is possible to describe a pre-
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Intestinal obstruction due to melanoma metastasis is a rare surgical condition. In any case, it is important a very detailed familiar and case history, beside a “total body” physical exam of the patient. To achieve a correct diagnostic, we suggest performing an evaluation about any typical site of primary focus melanoma (eye, oral mucosa, skin). As first step of diagnosis, abdomen ultrasound is useful to diagnose intussusception, but it is necessary to complete the work-up with CT and PET imaging.

When the clinical presentation is intestinal obstruction, surgery is the only treatment and the only possibility to achieve a correct diagnosis.

It is useful to perform the histopathologic exam including the immunophenotype of neoplastic population.

References


Conclusions
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