

# Surgical Approach to Complicated Abdominal Metastasis of Cutaneous Melanoma

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## Abstract

Melanoma is the most common malignancy of the skin. It is characterized by a high mortality rate due to his ability to metastasize to all organs. Gastrointestinal tract is an unusual metastatic localization among the non-cutaneous melanoma localizations and is also linked to poor prognosis. Many studies have demonstrated that surgical approach to intestinal metastases improves the quality of life and leads to an increase in survival. In this case, we report the clinical presentation of an intestinal perforation due to melanoma metastatization in an elder patient who already had bone metastases.

## Case Presentation

### Chief complaints

A 74-year-old female patient presented to the ER with diffuse abdominal pain for 3 days, refractory to painkillers.

### History of Present Illness

Patient denied fever, vomiting, and any other intestinal changes.

### History of Past Illness

Patient denied alcoholism, smoking and drug use. She was receiving chemotherapy for melanoma with bone metastases. She underwent appendectomy in the past and she had laparotomy for ectopic pregnancy.

### Physical Examination

At the physical examination, she presented a regular general condition, anicteric, and afebrile. The abdomen was tense and painful on the left flank surface palpation, peristalsis decreased. The initial diagnostic suspicion was of intestinal occlusion.

## Laboratory Examinations

Laboratory examinations included general blood tests, liver function tests and tumours markers (CEA and CA 19-9). All the results were within normal values, except for 10,17 10e3/uL WBC and 149,40 mg/L CRP.

## Imaging Examinations

Radiograph of the abdomen: No pneumoperitoneum signs, no air-fluid levels. Computed tomography scan showed some extra visceral air nucleoli with the contextual presence of fluid collection (41 x 27mm) to the left of the descending tract of the colon, in the context of the adipose tissue at the height of the middle third of the kidney. The fluid collection expanded between jejunal loops, that appeared relaxed by reflex reactivity, and reached the pelvis towards sigma and left colon.

## Final Diagnosis

Based on the images, the final diagnosis was jejunal perforation.

## Treatment

Patient underwent laparotomy where jejunal perforation and general peritonitis were found. We proceeded with a jejunal resection with 10cm of free margins and performed a L-L jejuno-jejunal anastomosis and surgical toilette for massive peritonitis.

**Anatomopathological:** High-grade malignancy with submucosal, infiltrating development and aspects of angioinvasiveness.

Immunohistochemistry gave evidence of jejunal localisation of malignant alveolar melanoma. (HMB45 + diffuse; S100 + diffuse; VIM + diffuse; Ki67 + diffuse; NSE and Cromogranine negatives; CK7 and CK20 negatives)

### Outcome and Follow-Up

Patient was discharged on the ninth postoperative day with indication to adjuvant chemotherapy. She was readmitted at the

eleventh postoperative day for pneumonia treated with antibiotic therapy and dismissed after 11 days.

## Discussion

Small bowel melanoma's metastases are common because of the tendency for cutaneous melanoma to metastasise to the gastrointestinal tract [1], and often the diagnosis is delayed [2]. Most of the times diagnosis of metastatic lesions occurs only after presentation of their complications and they are mostly treated by surgery.

Melanoma can spread to distant sites hematogenously as well as through lymphatic channels [2]. Any site of the body may be involved.

Metastatic intestinal melanoma is very common, and among affected patients, the proportion with involvement of the small intestine ranges from 35% to 70% [4], dependent on tumor stage and evidence of intestinal blood loss. Most patients with metastatic intestinal melanoma are clinically non-diagnosed during their lifetime (1.5-4.4%) [4].

Patients with small-intestinal metastases have a significantly worse prognosis, but operative intervention is recommended for palliative reasons and can be performed with low morbidity and mortality, with an excellent improvement in quality of life [5].

The most common sites of primary tumour metastasizing to small bowel are uterus, cervix, colon, lung, breast and melanoma [6]. Clinical presentation is usually the same as melanomas secondary lesions, with occlusion, bleeding, anaemia, intussusception [7] and, as shown in this report, frank perforation and peritonitis. By multivariate analysis, the 2 most important prognostic factors for long-term survival were complete resection of the metastasis and the GI tract as the initial site of distant metastases [8].

Studies revealed that surgical approach is the most safe and effective treatment for late small bowels metastasis, and can even be lifesaver in case of intestinal perforation and peritonitis [9].

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