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Case report / Olgu sunumu.

A CASE OF MALIGNANT MELANOMA OF THE PAROTID

Parotiste bir malign melanoma olgusu.

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ABSTRACT

Malignant melanoma rarely affects the parotid, and usually this diagnosis will herald a search for a primary skin neoplasm. Occasionally, no primary tumor is ever found, raising questions regarding prognosis and the issue of primary melanoma of the Parotid. The present Article is a brief recollection of one such case encountered with a malignant melanoma of the Parotid with the unique nature of the melanoma as regards the prognosis in the face of a stage IV disease.

Keywords: Malignant melanoma, parotis, metastasis.

ÖZET

Daha çok ciltte yerleşen bir tümor olan malign melanomların parotis tutulumu oldukça nadir bir durumdur. Bunula beraber parotisi tutan malign melanomların primeri sıklıkla bulunamaz. Burada, evre 4 aşamasında tanı konulabilen böyle bir vaka sunulmuştur.

Anahtar kelimeler: Malign melanoma, parotis, metastaz.

INTRODUCTION

Malignant Melanoma (MM) constitutes 15% of all malignant neoplasms, and 20% of MM occurs in the head and neck region (1). Malignant melanoma will rarely affect the parotid gland, presenting as progressively enlarging, asymptomatic, firm, fixed parotid tumors. Malignant melanoma of the parotid is presumed to be of metastatic origin, but occasionally the primary tumor site may never be identified thus raising the issue of regressed dermal primary tumors or primary parotid melanoma (2,3).

Case

A 43 year old Farmer presented with a difficulty in vision and accompanying headache to the Ophthalmology OPD. Further consultations in the Surgical Disciplines were made for many Lumps and bumps spread across the whole body amongst which the most remarkable was a parotid swelling present for about 8 years which slowly increased in size. The rest of the subcutaneous (predominantly cystic) swellings were present since last 9 months. The Headache was incessant and was present since the daybreak and was the main reason for medical consultation.

The General survey revealed numerous maculopapular hyperpigmented spots and patches present mostly in the trunk and extremities. There was clinically significant generalized lymphadenopathy in all the regions of the body. The left parotid gland was enlarged, firm in consistency and presented with a lobulated surface. The deeper structures (VII Nv.)was free from any compression. There was enlargement of the deep lobe also (Figure 1).

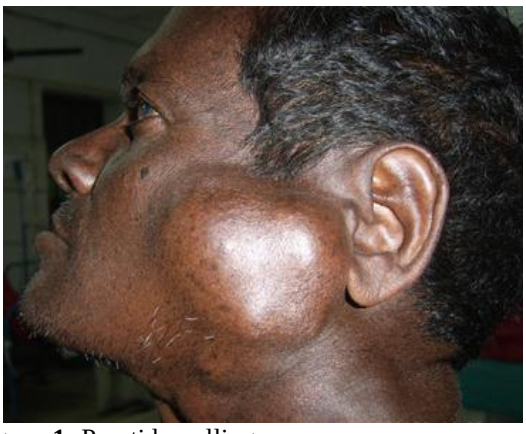

Figure 1: Parotid swelling.

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Except for a proptosis present in the right eye since last 3 months the patient did not any neurological signs indicating intracranial metastasis. There was no organomegaly or signs of lung metastasis clinically.

With the provisional diagnosis of metastatic melanoma the histologic confirmation of the Melanoma from the skin and parotid (a core cut Biopsy) was obtained which provided a report of melanoma deposits. Cross sectional imaging studies provided the evidence of diffuse metastasis present in Brain, lungs, bilateral adrenal glands with deposits in the right retro orbital region.

An active search for the primary sites included whole body skin surface, oral, nasal and anal mucosa, colonic mucosa and gastric mucosa and ocular sites which all were inconclusive. The immunohistochemistry for both S100 and HMB 45 was positive suggesting a Melanoma; Vimentin assessment could not be done due to cost considerations.

The patient refused any intervention in form of cytotoxic chemotherapy and biologic therapy and was lost for follow up.

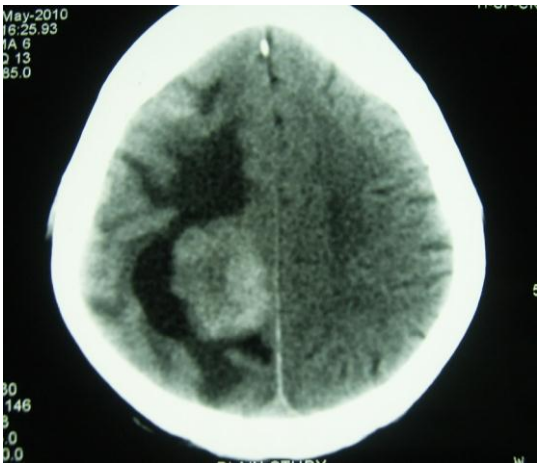

Figure 2: CT shows brain metastasis.

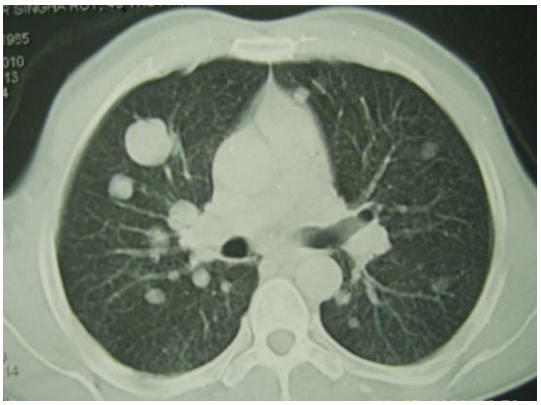

Figure 3: Lung metastasis.

DISCUSSION

There are 3 logical possibilities in a patient with parotid MM. Most commonly MM are only second amongst deposits in the parotid gland after Squamous cell cancer but our failure to pin point the primary site despite a detailed search possibly ruled out a secondary deposit from a "known site".

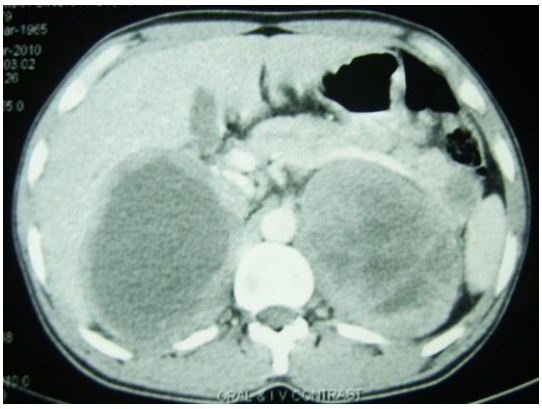

Figure 4: B/L Adrenal metastasis.

Secondly is there a possibility for a primary parotid melanoma. MM is known to arise from basal melanocytes which are derivatives from neuroectodermal tissue. The demonstration of Takeda, however, recently documented the existence of benign melanocytes in the basal and suprabasal layers of a parotid interlobular duct suggesting the possible origin (4). Previous hypothesis of Greene and Bernier reasoned that melanoblasts may be present within the parotid, as this gland develops from invaginating buccal epithelium, which is known to have the potential of containing melanoblasts (5).

Woodward et al proposed the following criteria for the diagnosis of a primary parotid MM: (1) the tumor epicenter is within the parotid; (2) there is no identifiable lymph node tissue present in the mass; (3) there is no evidence of MM elsewhere after diligent search of eyes, skin, nose, pharynx, mouth, esophagus, anogenital region, and meninges; and (4) there is no evidence of previous excisions of an MM or progression of a pigmented (6).

The presence of the gross metastatic disease and the late presentation probably complicates the scenario in our case to comment on the diagnosis of primary MM parotid.

Lastly is metastasis from unusual, noncutaneous sites (e.g., paranasal sinuses or sclera) or "unknown primary". The definite proof of melanoma (IHC) refutes other possible diagnosis of metastatic poorly differentiated Squamous cell carcinoma, adenocarcinoma, and anaplastic carcinoma. Probably our case as discussed is one such example.

The interesting dogma surrounding the survival differences amongst the stage IV MM patients in which there has been a documented increase in survival amongst Metastatic MM with unknown primary has been proved from series from Memorial Sloan Kettering Cancer Center (1,3). Their data shows that only 1 of 13 patients with known primary MM was disease free at follow-up; 9 patients died after a mean of 2.6 years, and 3 had evidence of metastatic disease at a mean of 4.3 years. By comparison, only 1

of 6 patients without known primary MM died of disease, and the remaining 5 patients were disease free after a mean of 4.2 years. Probably this dogma explains the prolonged survival of the patient in the face of such a massive metastatic disease involving almost all parts of the body.

We need to have more databases to refute our observations on metastatic melanomas. Our data support the idea that patients with metastatic MM from unknown primary tumor sites may follow a more improved course than those with metastases from known primary tumor sites.

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