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Gastrointestinal bleeding as presentation of small bowel metastases of malignant melanoma: Is surgery a good choice?

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ABSTRACT

INTRODUCTION: Melanoma shows a particular predilection in involving small intestine both in a single site and in multiple localization and acute or chronic gastrointestinal bleedings are often the first sign of tumour.
PRESENTATION OF CASE: We report two cases of GI metastases of malignant melanoma, one presented with only a big mass that cause intestinal obstruction and the other with a tumour spread throughout the small intestine that produce enterorrhagia.
DISCUSSION: Diagnosis and follow-up are very difficult: CT scan, PET-CT scan and capsule endoscopy should be complementary for the assessment of patients with GI symptoms and melanoma history.
CONCLUSION: What is the role of surgery? Several studies suggest metastasectomy to achieve both R0 results and palliative resolutions of acute symptoms, such as obstruction, pain, and bleeding.

1. Introduction

Enterorrhagia is a common sign in patients who come to a surgical department; after the exclusion of benign diseases (such as haemorrhoids, anal fissures or IBD), we focus on gastro-intestinal malignant tumours. However, even if colic or colorectal carcinomas are very common, the incidence of tumours of the small intestine, both primary and secondary, is very low; this is even more true if we consider the intestinal localization of melanoma, both in case of metastatic and primary tumours.

What should we do in such clinical circumstances? We report two cases of malignant melanoma metastasis; one was presented with only a big mass and the other was with a tumour spreading throughout the small intestine. Diagnosis was not easy especially without a previous clinical history of melanoma, or when it is omitted at the hospitalization, as what happened in our second case. Nevertheless some old and new devices could help surgeons, like PET/CT scan and capsule endoscopy.[14,16] Controversial is their use in melanoma follow-up, considering their costs and the prolongation of waiting lists. Despite that gastrointestinal investigations (such as faecal occult blood or colonoscopy) should be promoted by clinicians for patients with melanoma in order to prevent bowel metastasis complications.

In both our cases, surgery was performed with the aim to assure the best local control of symptoms and guarantee better prognosis, even in cases of spread involvement, according to several studies that support surgical treatment not only to obtain a complete resection but also for palliative intent.[18,21,23]

2. Case 1

A 49-year-old man with abdominal pain, anaemia and tarry stools came to our attention in October 2009. He reported that the symptoms started ten days before. Sixteen months before he underwent a malignant melanoma excision from the right leg and two months later a wide removal of skin around the first excision with a bilateral inguinal lymphadenectomy because of sentinel node positivity. Furthermore a secondary localization on the left cheekbone was removed in September 2008 and the patient started traditional chemotherapy with Dacarbazine in January 2009.

In order to determine the source of disease we arranged a CT scan which showed an huge jejunal mass (8 cm of diameter) that reduced intestinal lumen and determined dilatation of its upper part. A bowel resection with L-L manual anastomosis was performed and the histological diagnosis was "bowel localization of melanocitic melanoma that involved 5 out of 7 mesenteric lymph nodes".

During the postoperative period the patient underwent PET/CT scan which showed multiple brain recurrences. No postoperative

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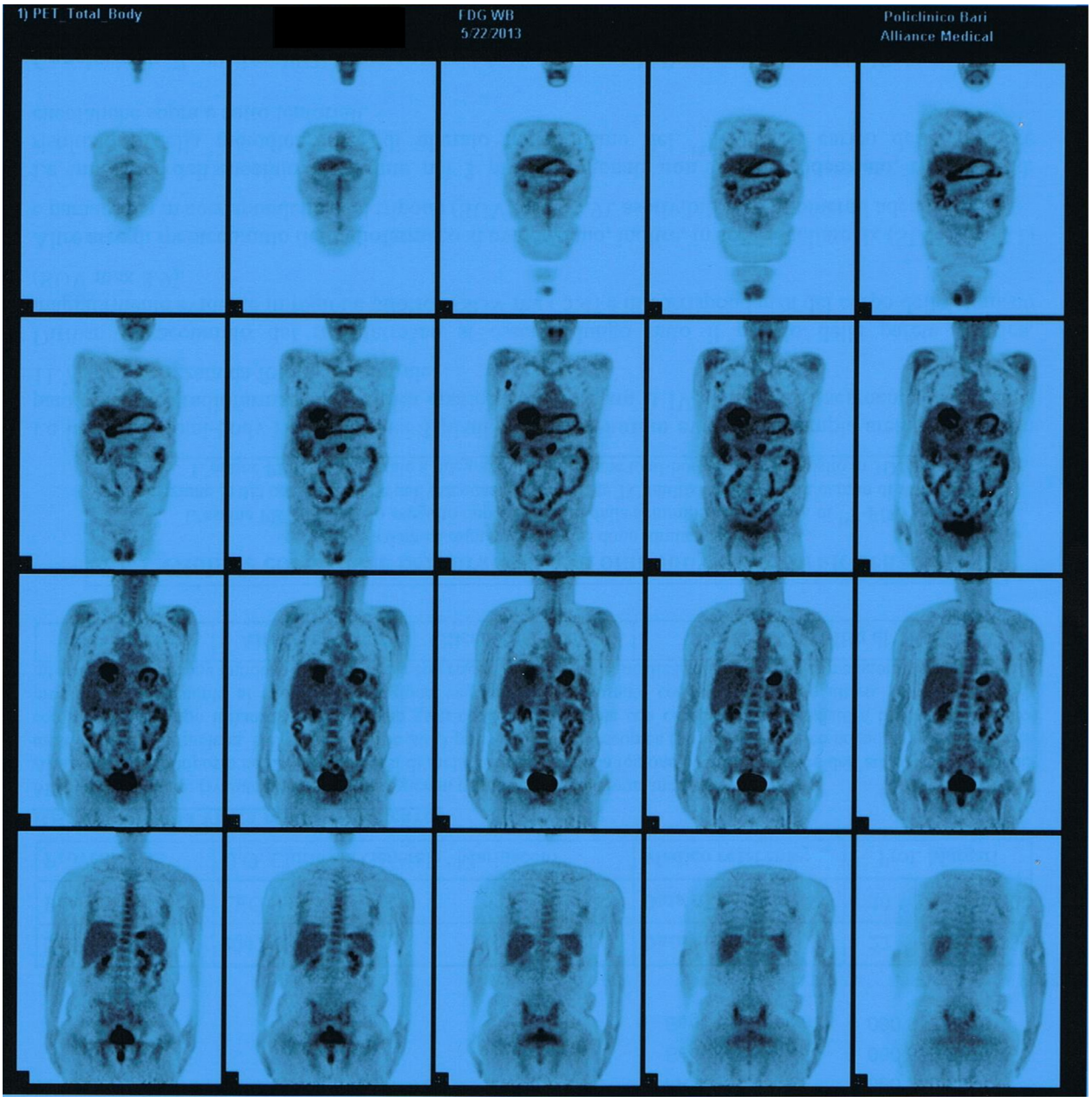

Fig. 1. 18-FDG PET-CT scan reveals the extension of the disease.

chemotherapy was carried out and he died because of intracranial bleeding three months after abdominal surgery.

3. Case 2

A 61-year-old man was admitted to our Department on May 2013 as emergency case because of gastrointestinal bleeding and anaemia. The patient's medical history was significant for hypertension, noninsulin-dependent diabetes mellitus and iron-deficiency anaemia.

Anamnesis is also characterized by a diagnosis of skin melanoma in the abdominal region on April 2011; however, the patient gave us such information only at the end of our surgical treatment. At that time a diagnostic excisional biopsy of the lesion was performed and the histological report confirmed: "III Clark level, Breslow thickness 0.55 mm malignant melanoma with the prevalence of superficial diffusion and without regression or vascular infiltration". Consequently a wide skin removal was performed, because a melanoma was found on the skin near to the previous excision. However the patient did not have sentinel lymph node biopsy procedure or any follow-up control because he did not accept them.

At the beginning of 2013 the patient had several episodes of melena and, with the aim to discover the source of bleeding, we performed a colonoscopy with biopsy (the histological diagnosis was hyperplasic adenomatosus polyp) and a gastroscopy which solely showed an antral gastritis and an inflammatory stomach polyp. Moreover the patient underwent abdominal US and MRI and a total body CT scan that showed right axillary lymphadenopaty, a nodular lesion in the medial lobe of the right lung and a big mass (7 cm of diameter) in the IV–VIII segment of the liver of which an US-guided biopsy was carried out. In addition we founded an increase in the tumour markers (TPA, NSE, S100B). For a more accurate diagnosis,