Isolated melanoma metastasis to stomach with possible regressed primary lesion: the importance of pursuing solitary melanoma metastases

James D McKay, Alf Deacon

Abstract

This is a case of a 60-year-old man who presented with anaemia and was subsequently diagnosed with a solitary 5cm malignant melanoma metastasis of the gastric fundus. No primary lesion was identified. After surgical resection he is alive at 5 years follow-up, adding weight to the notion that solitary melanoma metastases should be aggressively pursued, as long-term survival is possible.

Case report

Mr C is a 60-year-old man who presented with anaemia. Gastroscopy revealed a smooth vascular tumour arising from the anterior aspect of the body of the stomach. It was noted to be ‘unusual’ in appearance and was thought to be a stromal tumour rather than an adenocarcinoma. A subsequent CT scan revealed thickening of the posterior aspect of the gastric fundus, normal serosal surface and two prominent locoregional lymph nodes, and histology from biopsies at gastroscopy was inconclusive, with no confirmed answer even after tertiary centre review.

The possibilities were a high grade stromal tumour with the differential being melanoma. Mr C subsequently underwent a laparotomy which revealed a 5cm tumour in the gastric fundus, two nodes adjacent to the gastrophrenic ligament and a total gastrectomy with roux-en-Y reconstruction was performed.

Histology on the resected tumour confirmed malignant melanoma with no lymph node involvement in 22 nodes. Further clinical review by a dermatologist, otolaryngologist and optometrist failed to find a primary melanoma. He was followed up 6-monthly with liver ultrasound and annual CT scans, and is alive and well at 5 years after diagnosis.

Discussion

Melanoma accounts for 1–3% of malignant tumours and is one of the most common malignancies to metastasise to the gastrointestinal (GI) tract; third only to adenocarcinoma of the kidneys and squamous cell carcinoma of the cervix. The issue of whether a melanoma in the GI tract (in this case the stomach) is primary or secondary has been raised when there is lack of a skin lesion, as with Mr C. The vast majority of GI melanomas are metstatic from a cutaneous primary; although it seems primary melanomas can also arise from the mucosal epithelial lining of the GI tract.

Jelinic et al presented a case of a 54-year-old man who was diagnosed with a gastric melanoma which subsequently widely metastasised causing his death. No primary
A cutaneous lesion was found. This was described as a primary gastric melanoma, a possible rare site of tumour.

Lagoudianakis et al.\(^1\) presented a case of a man with an ulcerated submucosal mass in the gastric antrum, histologically proven to be melanoma, with no clinical primary lesion found elsewhere. At the time their publication their case was only the fourth primary gastric melanoma ever published.

In contrast, High et al.\(^6\) describes the concept of a completely regressed primary cutaneous malignant melanoma with visceral metastases, reporting five such cases. They described this as a consideration in cases like Mr C when no skin lesion is found, rather than describing them as primary GI tumours.

Whether Mr C is a case of a primary gastric melanoma or a GI metastasis of a regressed cutaneous primary is unknown, but both are extremely uncommon.

Mr C is the first known published New Zealand case of a gastric melanoma (metastatic or primary) still alive after 5 years post surgical resection. This adds weight to the notion that solitary metastases from melanoma should be aggressively pursued, as long-term survival is possible.

**Author information:** James McKay, Senior House Officer; Alf Deacon, General and Upper GI Surgeon; Department of General Surgery, Nelson Hospital, Nelson

**Correspondence:** James McKay, c/- RMO Unit, Christchurch Hospital, PO Box 4345, Christchurch, New Zealand. Email: james.mckay21@gmail.com

**References:**