Malignant Melanoma
Malıgn Melanomanın Olgu Sunumu

ABSTRACT Malignant melanoma in oral cavity is a rare tumor with aggressive prognosis. Diagnosis may be delayed because it is asymptomatic. In this article, we reported a case of oral malignant melanoma and clinical findings in a 82-year-old male patient. There was a reddish-blue, ulcerous, bleeding and painless mass on the hard palate. This mass was formed in 3 weeks.

Keywords: Melanoma; neoplasms; maxilla


Anahtar Kelimeler: Melanom; tümörler; maksilla

Melanoma is a malignant neoplasm of melanocytic origin, that develops from a benign melanocytic lesion or de novo from melanocytes in normal skin, mucosa and other sites.1,2 It was first described by Weber in Germany in 1856-1869.3 Melanoma is the third most common skin cancer. However, it constitutes only 5% of all cancers.1,2 Mucosal melanomas constitute less than 10% of melanomas, in the head and neck region. The majority of these occur in the nasal cavities followed by oral cavity and paranasal sinuses.4 The affected areas in the oral cavity are hard palate (42.2%), maxillary alveolus (32%), followed by soft palate, tongue, floor of the mouth, sinuses, pharynx, larynx and esophagus.3,4

Melanomas localized in the oral cavity are presented with painless bleeding mass, ulceration, discoloration and they can develop with ill-fitting dentures.5 Oral malignant melanomas are rarely seen and poor prognosed.6 Mucosal melanomas are less than 25% of the five-year survival rate and behave aggressive.3 They are often seen in males.1,3,7 The average age of a mucosal melanoma is 50-55 years while it can be seen at 30-80 years.1,3 Melanomas are asymptomatic in clinical appearance and progress quietly.3,8,9 About 60% of patients are detected incidentally during routine dental examination.8 This may cause late diagnose and radical treatment may be needed.3,9 In early
stages, pigmented and irregularly bounded, superficial lesions are seen in the skin and mucosa. First, the lesions begins as small macular, non-swollen, then it expands. These lesions are usually larger than 1 cm with an irregular shape. It can expand whole palate. Progressive lesions appear thicker with more swollen surface and ulceration.

CASE REPORT

A 82-year-old male patient with no systemic diseases applied the State Hospital with a rapidly growing mass on his palate in a short period (3 weeks) and he was referred to Cumhuriyet University Faculty of Dentistry, Oral and Maxillofacial Radiology Department. On clinical examination, a lesion was determined with a bleeding surface in the left half of the hard palate with irregularly bounded, raised, ulcerous, approximately size of 6x5 cm (Figure 1). There was no suspicious cervical lymphadenopathies noticed.

Whether the lesion had bone involvement or not, it was not clearly seen on panoramic radiographic evaluation of the patient (Figure 2).

Informed consent was obtained from the patient and he was consulted to the Department of Plastic and Reconstructive Surgery at Cumhuriyet University Medical Faculty Hospital for biopsy and definitive diagnosis. Histopathological examination of the patient who underwent incisional biopsy revealed a tumor in which the solid areas are formed by the atypical epithelioid cells where untracked surface epithelium. There was no pigment in the tumor. Clinical appearance of mass was reddish-blue due to vascularization. Immunohistochemically applied S-100 diffuse positive, Melan-A focal positive, HMB45 diffuse positive and Ki index were found to be 60%. Malignant melanoma was diagnosed (Figure 3).

PET images could not be reached. But according to reports obtained from the patient’s son, PET (positron emission tomography) scanning with 2-fluorodeoxyglucose (FDG) for metastasis was detected in the bilateral cervical lymph nodes and distant metastasis was not observed in June 2017. With these symptoms, the patient was accepted to be T₃N₁M₀. The patient continued the treatment at Istanbul University Medical Faculty Hospital, where a tumor resection was performed and he underwent bilateral neck dissection in November 2017. Following the excision, a temporary prosthetic obturator was made (Figure 4), but oral feeding could not be provided and naso-gastric tube was inserted to him for feeding. Then, the patient was directed to Radiation Oncology Department and radiotherapy was given to him for 2 months. One year after the operation, PET scanning revealed distant metastases to the kidney, liver, lung, skeletal system, corpus of L4 vertebra. A malignant melanoma metastasis was diagnosed by tru-cut biopsy from the kidney. The patient has lost 40 kg and chemotherapy could not be applied because his age and weight lost. Instead, he received 6 cycles of immunotherapy for 3 months, 15-day intervals. The patient is being followed up regularly and his general health condition is not good due to distant metastases and inadequate nutrition.
DISCUSSION

Oral melanomas are extremely rare, aggressive and they are silent progressive neoplasms.\textsuperscript{3,9,11} 80% of the cases are localized on maxillary gingiva, hard palate and alveolar crest, while about 20% are localized on mandibular.\textsuperscript{11} They may occur on buccal mucosa, lips, tongue and floor of the mouth in the mandible which is rare.\textsuperscript{2} However, it is frequently on hard palate region.\textsuperscript{9-11} In this case the lesion was
on hard palate and because the development of lesion was asymptomatic, the patient applied late to clinic.

When the intraoral findings of oral melanomas are to be irregularly bounded, bleeding, asymmetric, non-melanotic, it is reported to be dark brown, black, blue, red colored and as flat or high leveled lesions. This case supports the above-defined symptoms.

Lesions are seen in 5 types:
- Pigmented nodular
- Non-pigmented nodular (amelanotic), (seem less than 10%)
- Pigmented macular
- Pigmented mixed
- Non pigmented mixed.

The pigmentation in the tumor does not affect the prognosis. In our case, it was defined that the lesion is an amelanotic nodular type, due to the absence of pigmentation.

Metastases can be seen on the lymph nodes, liver, lung, bone, and brain as the disease progresses. After diagnosis, CT, MR, PET/CT images are used to detect lymph node involvement or distant metastasis. The involvement of regional lymph node is 25% on the oral cavity. Therefore some investigators suggest elective lymph node dissection at the malignant melanomas in oral cavity. Sentinel lymph node biopsy is not generally recommended. Despite of aggressive surgery, recurrence develops in 29-79% of patients. Radiotherapy can be used for locoregional control. Despite of that, no significant effect has been specified on survival. Some centers recommend post-operative radiotherapy in cases with palpable lymph nodes or extracapsular spread following wide local excision and neck dissection cases. Adjuvant immunotherapy (high-dose interferon alpha or ipilimumab) has limited data on melanomas in the oral region. The ethiopathogenesis of melanoma in the oral cavity is not clear. It behaves like acral lentigenous melanoma.

Mucosal melanomas should be investigate for V600 BRAF mutation, and for those patients without this mutation, KIT mutation should be analyzed. BRAF mutation is detected in 10% of mucosal melanomas while KIT mutation is detected 25% and targeted treatment (imatinib) is applied.
provides or produces medical instruments and materials which may negatively affect the evaluation process of this study.

**Conflict of Interest**

No conflicts of interest between the authors and / or family members of the scientific and medical committee members or members of the potential conflicts of interest, counseling, expertize, working conditions, share holding and similar situations in any firm.

**Authorship Contributions**

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