# Vaka Takdimleri

## Primary Scrotal Malignant Melanoma (A Case Report of Two Cases and Literature Review)

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Malignant tumors ot the scrotum are rare. The World Health Organization reported an incident of approximately 0.2 to 0.3 case per 100.000 men over age 35 years in the late 1960 (1). The incidence in the United Kingdom is more than any other country in the world.

A primary lesion on the scrotum is the rarest manifestation of genitourinary melanoma. The general belief is that this neoplasm arise from malignant degeneration of a preexisting junctional or compound nevus (2-3).

Clinical experience with this tumor is not only too small but also too poorly documented. But the basic principles of staging and treatment are similar to other cutaneus melanoma elsewhere. We report two cases of primary melanoma of the scrotum. A review of the literature revealed only five other cases between 1949-1992 (4-8).

### CASE REPORT 1

A 69-year-old male presented to our Urology clinic in March 1991 with a nine month history of painful increasing mass on the left inguinal region.

Physical examinational findings were vitiligo limited to the glans penis, multiple blue-black pigmented lesions on the left hemiscrotum and enlarged multiple lymph nodes in the left inguinal region (see Figure 1-a,b).

An excisional biopsy of the largest lesion which was 2x1.5 cm, revealed nodular malignant melanoma with a depth of 0.5 cm. Tumor was present in another nodular mass with a diameter 0.3 cm which showed continuity at the margins of the specimen (Figure 2-a,b).

Metastatic evaluation with computerized tomography (CT) of the abdomen and pelvis, bone scan revealed no iliac, retroperitoneal lymph adenopathies, no hepatic or osseos lesions. Multiple bilateral pulmonary metastatic lesions were present on chest X-ray.

The patient's age, extensive depth of penetration, evident regional involvement and pulmonary meta-

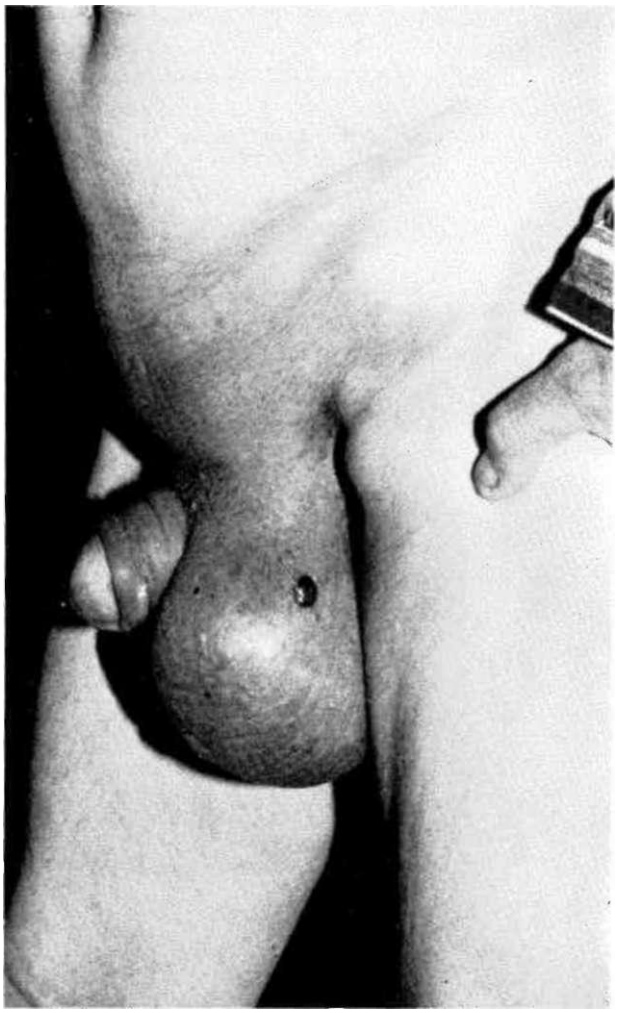

Figure 1 a. Malignant melanoma of the scrotum (Case 1).

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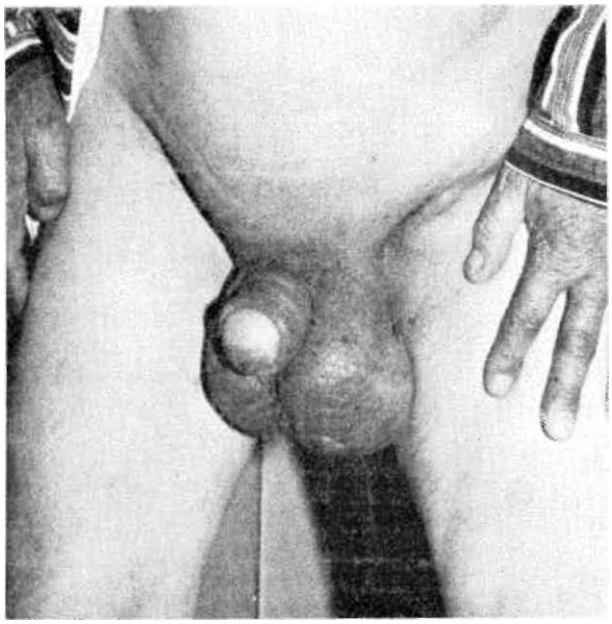


Figure 1b. Malignant melanoma of the scrotum. Note the enlarged lymph nodes in the left inguinal region (Case 1).

stases ruade us to treat patient with a limited left hemiscrotectomy plus chemotherapy. After 3 cycles of BVP (Bleomycin, Vinblastine, Cisplatin), physical condition continued to decline and the patient died of disease six months after the initial diagnosis of melanoma.

## CASE REPORT 2

A 38-year-old patient referred to our hospital in October 1992 with a diagnosis of primary scrotal malignant melanoma for further evaluation and treatment. Tissue specimen were reviewed in our pathology department and histopathologically reported as malignant melanoma (Figure 3).

Physical examination was unremarkable except for surgical wound on the inferior aspect of the left scrotum. There were no inguinal adenopathy. Metastatic evaluation consisting of CT of the abdomen, pelvis and chest was negative. Left hemiscrotectomy and because of invasion of the testis radical orchiectomy was performed after two weeks the initial biopsy. Although we offered to the patient ipsilatera! ilioinguinal lymph node dissection, he refused. He was followed monthly without evidence of disease for 25 months.

## DISCUSSION

Scrotal carcinoma involving the scrotum occur rare and the rarest of these lesions is primaiy malig-

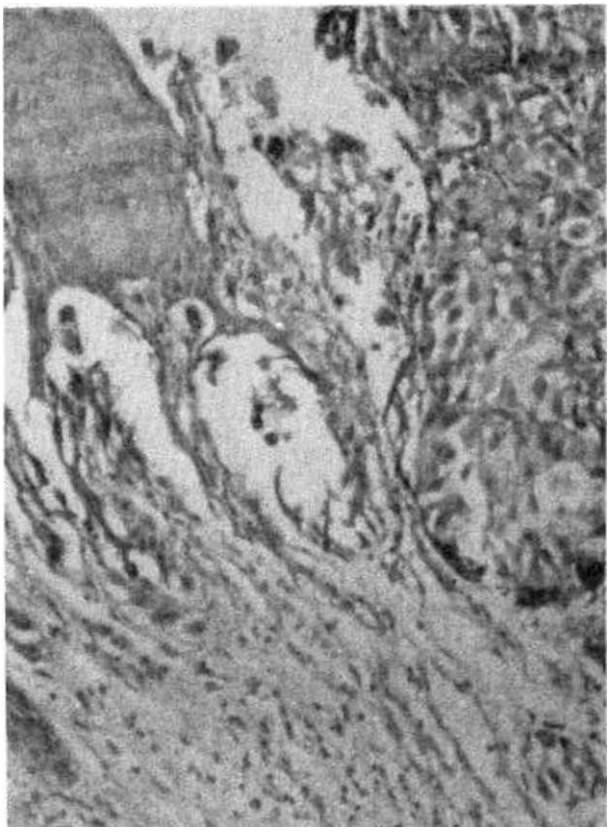


Figure 2a. Malignant melanoma (low power). Note the extension of tuwour into deep dermis. Original magnification X4 HE (Case 1).

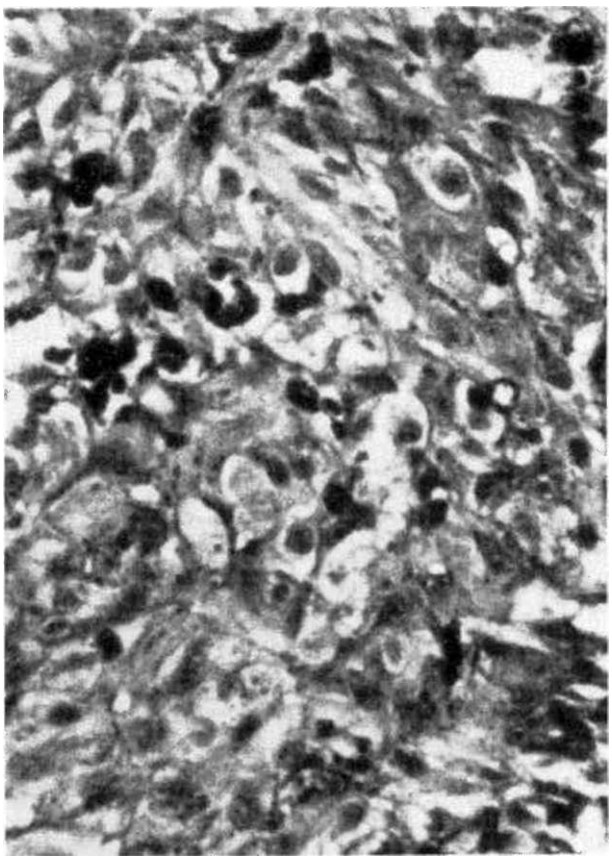


Figure 2b. Malignant melanoma (high power). Original magnification X10 HE (Case 1),

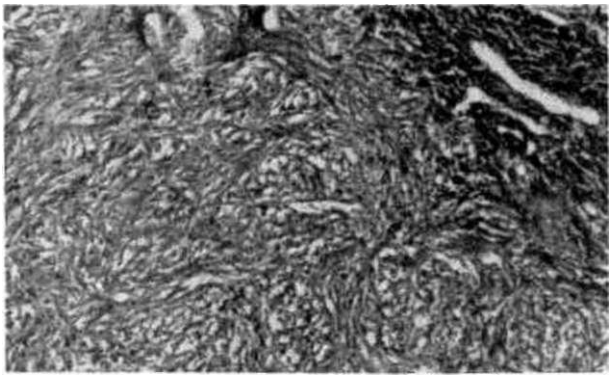


Figure 3. Malignant melanoma of the scrotum. Original magnification X4 HE (Case 2).

riant melanoma. Except our two cases there are only five cases reported in the literature. The first step of a darkly pigmented suspicious lesion on the scrotum is to make excisional biopsy. Once the pathologic diagnosis is malignant melanoma the disease must be clinically staged (Table 1). Surgery is the principal mode of thetapy for solitary lesions, local recurrences and regional metastases. Delayed wide excision of a previously biopsied melanoma site does not adversely affect outcome. For surgical staging or prophylactic inguinal node dissection remains controversial (6-10). Since it is generally accepted that surgery provides the best prospect for cure if nodal involvement are present bilateral ilioinguinal lymphadenectomy should be performed (6,10-13).

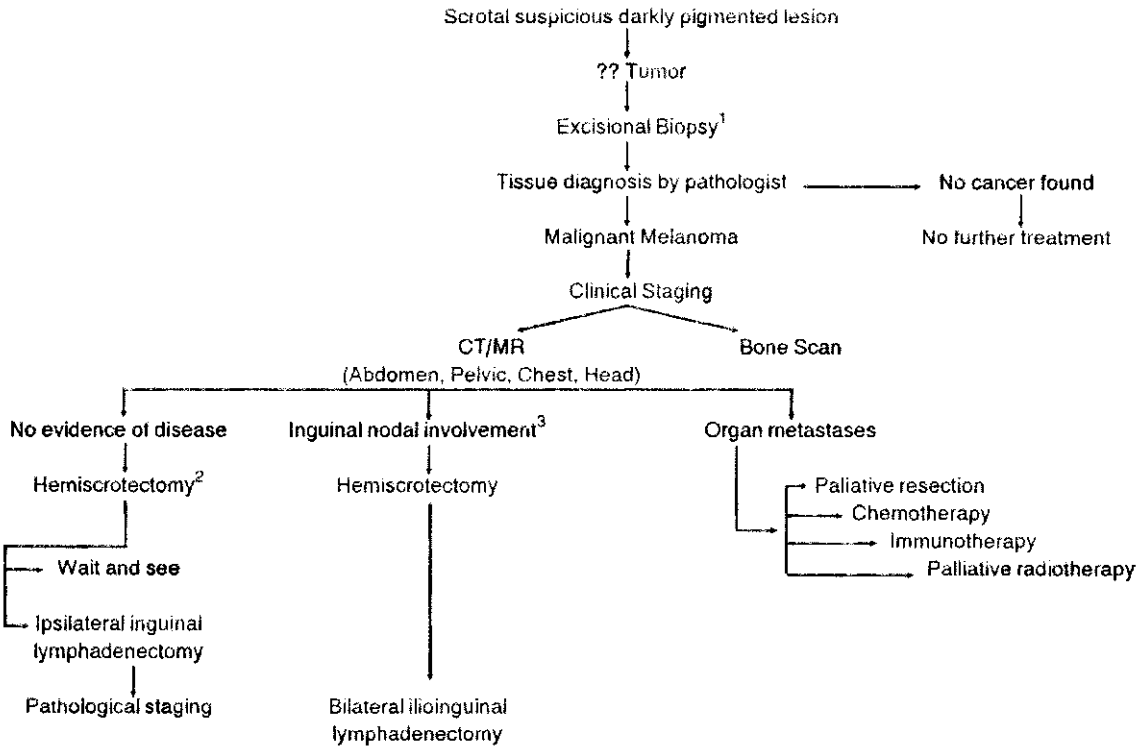
Surgery has a lesser role for metastatic malignant melanoma beyond the regional nodes (12). Radiotherapy have been used primarily to treat bone and CNS metastases.

The vinka alcoholoids and cisplatin based different chemotherapy protocols is generally accepted and used in metastatic melanoma (13).

Monoclonal antibodies, the recombinant interferons and specific immunotherapy based on tumor vaccines are also used for the treatment of melanoma (7).

It is obvious that metastatic malignant melanoma remains refractory to treatment and prognosis is poor. Surgical management remains the best curative modality. The most important prognostic determination is the depth of invasion.

Tablo 1. Staging process and management for scrotal malignant melanoma*




CT: Computerized tomography, MR. Magnetic resonance imaging
[1]Must inculide a margin of 1-3 cm of normal appering tissue, orchiectomy must be combined if the testis invaded.
[3]Proved with fine needle aspiration biopsy,
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