

2013

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James W. Walter, MD

Thomas Jefferson University Hospitals, James.Walter@jefferson.edu

Rebecca Matro, MD

Thomas Jefferson University Hospitals, Rebecca.Matro@jefferson.edu

Daniel M. Quirk, MD, MPH

*Thomas Jefferson University Hospitals, Daniel.M.Quirk@jefferson.edu*Follow this and additional works at: <https://jdc.jefferson.edu/tmf> Part of the [Medicine and Health Sciences Commons](#)[Let us know how access to this document benefits you](#)

Recommended Citation

Walter, MD, James W.; Matro, MD, Rebecca; and Quirk, MD, MPH, Daniel M. (2013) "Metastatic Uveal Malignant Melanoma: A Case Report," *The Medicine Forum*: Vol. 14 , Article 20.DOI: <https://doi.org/10.29046/TMF.014.1.020>Available at: <https://jdc.jefferson.edu/tmf/vol14/iss1/20>

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METASTATIC UVEAL MALIGNANT MELANOMA: A CASE REPORT

James Walter, MD, Rebecca Matro MD, and Daniel Quirk, MD, MPH

Case Report

A 77-year-old woman presented with a chief complaint of one day history of severe, acute abdominal pain. The patient described the pain as “intense,” non-radiating, and located primarily in the left upper abdominal quadrant. The pain was associated with nausea and multiple episodes of non-bilious, non-bloody emesis. She denied melena and hematochezia. On physical examination, her abdomen was soft and exquisitely tender in the left upper quadrant and epigastric regions. Aside from trace lower extremity edema, the remainder of her physical examination was unremarkable. Laboratory results at the time of admission were notable for: hemoglobin 10.8 g/dL, alkaline phosphatase 459 U/L, aspartate transaminase 56 U/L, and alanine transaminase 66 U/L.

The patient’s past medical history was significant for hypertension, gastroesophageal reflux disease, papillary thyroid carcinoma, and right eye uveal melanoma. The ocular melanoma was treated 16 years ago with radioactive plaque followed by transpupillary thermal therapy. The patient was diagnosed with metastatic disease to her liver approximately 6 years prior and she had received several rounds of hepatic radiation and chemotherapeutic embolizations. The patient’s oncologist closely monitored her for disease progression through regular abdominal imaging studies.

An esophagogastroduodenoscopy revealed a normal esophagus, numerous hyperpigmented flat to slightly raised lesions throughout the stomach, particularly in the proximal body and fundus (Figures 1, 2), and a 2 mm lesion in the duodenal bulb. Histopathology and immunohistochemical staining of these lesions confirmed metastatic malignant melanoma (Figure 3).

Discussion

The incidence of cutaneous malignant melanoma is rising at a rate faster than that of any other malignancy.¹ Melanoma is notorious for its aggressive ability to metastasize to nearly every part of the body, with the liver, lung, and bone being the most common sites.² With specific regards to uveal melanoma (UM), it is the second most common form of melanoma.³ Unlike the cutaneous form, UM’s incidence rate has remained stable over the years. UM can arise anywhere within the uveal tract (iris, ciliary body and choroid) and spreads hematogenously. Hematogenous spread is favored over lymphatic spread due to the lack of sufficient lymphatic drainage.^{4,5}

Melanoma’s particular affinity for metastasizing to the gastrointestinal (GI) tract has been well described in the literature. GI involvement has been found in up to 60% of primary cutaneous

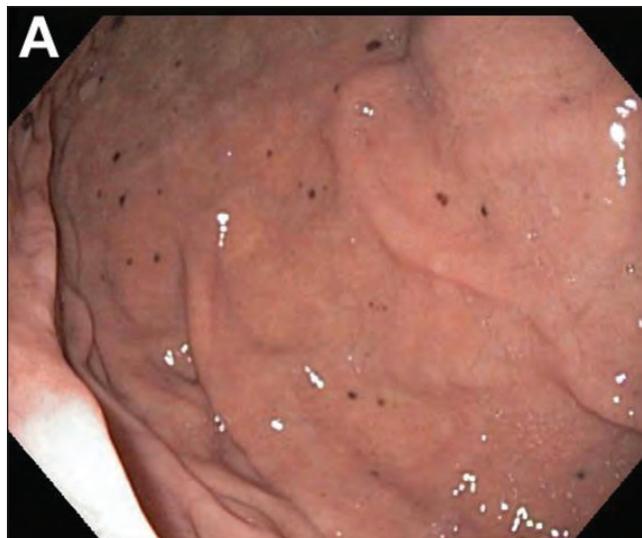


Figure 1. Metastatic malignant melanoma lesions within gastric body.



Figure 2. Closer endoscopic view of a lesion.

malignant melanoma patients at autopsy and is commonly associated with invasive visceral organ disease. Given the highly vascularized nature of the small bowel, it is the most common site of GI tract metastasis. Stomach involvement comprises approximately 20% of GI tract metastasis cases. Antemortum diagnoses of GI metastasis are made in only 1% - 4% of patients with malignant melanoma. Such a diagnosis can go clinically undetected until years after the initial diagnosis.⁶⁻⁸

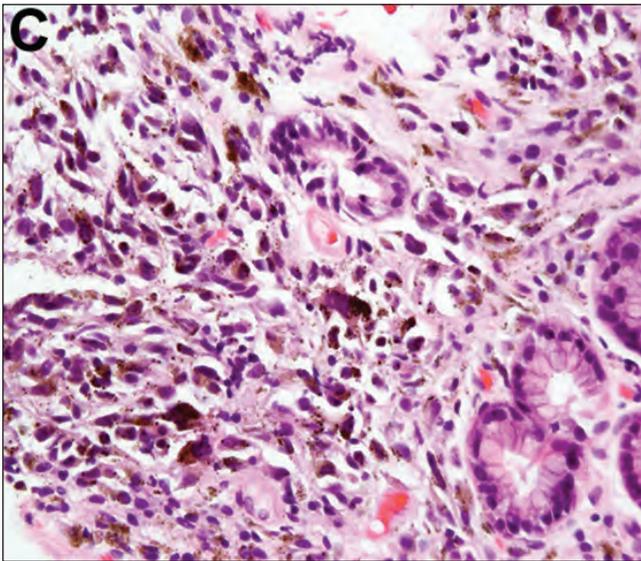


Figure 3. Biopsy histopathology showing invasion of malignant melanocytes into gastric mucosa.

Endoscopically, metastatic melanoma can be polypoid in nature, is frequently ulcerated, and is either pigmented or amelanotic.⁸ Large polypoidal lesions can be obstructive in nature and can act as lead points for intussusception. Submucosal nodules with similar characteristics have also been seen.

Symptoms of GI melanoma metastasis tend to be inconspicuous and nonspecific. Patients may report vague abdominal pain, weight loss, nausea/vomiting, and/or malaise. Anemia may also be seen as a result of slow, chronic blood loss from ulcerated lesion sites giving rise to melena. Such symptoms should raise suspicion in patients with a known history of melanoma. However, with a median survival time of less than six months after confirmed GI involvement, the prognosis is generally very poor.⁶

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