

MALIGNANT MELANOMA — WHAT IS THE REAL RISK?

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INTRODUCTION

Malignant melanoma is a common tumour of the white races. These tumours in the head and neck region constitute only about 1% of all the melanomas encountered. Its incidence is extremely low in the coloured population where it almost exclusively involves the sole and palm regions of the body. However, we have seen six patients with advanced malignant melanoma of the head and neck in the past six months (February to July 1995). Histories of the patients follow. In view of the universally bad prognosis of the disease, a brief review of literature is presented along with the current recommended management.

Case No. 1

A 45 year old man from Afghanistan presented with two black lesions on the left cheek. They had appeared recently and grew quite fast over a period of three to four months. The lesions were deeply infiltrating and one of them had ulcerated. No regional lymph nodes were palpably enlarged. Wide excision with a minimum margin of 10 mm was carried out and the defect covered with a split skin graft. The immediate postoperative course was uneventful and the graft took well. Histological report confirmed the diagnosis of malignant melanoma with Breslow's thickness of more than 4 mm. The patient has not turned up for follow up yet. (Fig. 1 and 2).

Case No. 2

A fifty year old Afghan refugee who had long standing paraplegia, turned up in our out patient department with a fungating black lesion, involving the whole left cheek. This growth had evolved to this size over a period of 6 months from a small mole present since birth. It was biopsied in a Refugee Hospital before being sent to us. It was reported as malignant melanoma. He had cervical lymph nodes enlarged on the ipsilateral side. The prognosis was explained to the relatives of the patient who decided to take him home without any operation. (Fig. 3).

Case No. 3

A sixty year old man from Dir, had a small ulcer on right preauricular area. A clinical diagnosis of Squamous cell carcinoma was made and excision biopsy was taken for histological examination. The wound could be closed directly. This gentleman went to perform Hajj. He came in the last week of May 1995 with the histological report of malignant melanoma. Clark's or Breslow's classification was not mentioned. The patient had a fungating recurrence without any black pigmentation. He also had ipsilateral lymph nodes enlarged. The attendants of the patient refused surgery when the prognosis was discussed with them. However, they were persuaded to take the patient to IRNUM



Fig. 1 Case No. 1, Two big moles are being excised.



Fig. 2 Case No. 1, Skin grafting after excision.

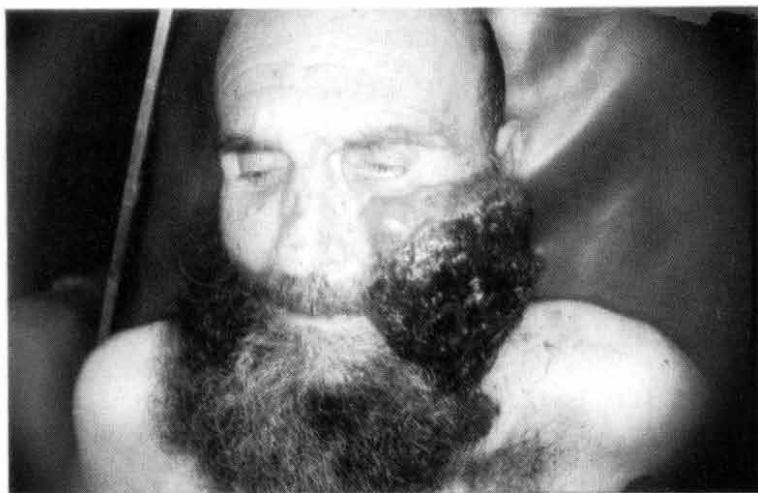


Fig. 3 Case No. 2, Patient with a big tumour on his left cheek. He refused surgery.

(Institute of Radiotherapy and Nuclear Medicine), Peshawar. (Fig. 4)

Case No. 4

A sixty five year old Afghan refugee was seen in one of the Afghan Hospital with a black pigmented ulcer on the left cheek. Left cervical jugulodigastric node was palpable and enlarged. A provisional diagnosis of malignant melanoma was made and excision biopsy with block dissection of the neck was planned. The excision was carried out and the defect was covered with split skin graft. Before the block dissection was commenced, the patient went into cardiac arrest. Though he recovered from the arrest, the neck dissection was abandoned on the anaesthetist's request. The patient had otherwise uneventful recovery and the graft took well. We are strictly following him up. (Fig. 5)

Case No. 5

A young doctor, 32 years of age came to us who had a small itchy mole excised from his right temple. The unexpected histological report came as malignant melanoma without specifying Clark's or Breslow's classification. So the slide was taken to another histopathologist for reading with a view to classify it. It was more than 4 mm thick and of Clark's grade V. So wider excision was performed with a minimum margin of 3 cm around the scar. The patient is being regularly monitored for any neck nodal metastases or recurrence.

Case No 6

A 24 year old lady came to the outpatient department with a mole on the left preauricular area since birth. It showed signs of ulceration and increase in size over a period of three months. One examination, there was nodular ulceration in one corner of the lesion which was 3x2.5 cm. There was also an area of hypopigmentation in about quarter of the area. This lady was

seven months pregnant. Excision biopsy under local anaesthesia was undertaken. The result confirmed the diagnosis of malignant melanoma of Clark's level V. A prophylactic ipsilateral block dissection of the neck and superficial parotidectomy was offered. However, she and her husband asked for an interval so that she could deliver before the anticipated surgery. (Fig. 6)

DISCUSSION

The incidence of malignant melanoma is increasing rapidly throughout the world at an alarming rate.¹ In USA, the incidence has increased by 80% between 1973 and 1982.² Similarly, an increasing incidence has been reported from New Zealand.³ As with other regions of the body, melanoma of the head and neck share the alarming increase in its incidence world-wide.⁴ Various reported, between 15 and 20% of them would originate in the head and neck region. Female patients outnumber males in the face region where the reverse is true in the scalp and auricular pinna.^{5,6} Malignant melanoma is predominantly a disease of the white race especially with blonde or red hair and those who tan poorly in the sun. It is rare among blacks and other non-white races. In the coloured races, melanoma commonly arises in the skin of the palms and soles and is of the acral lentiginous type.⁷ It is extremely rare in the head and neck regions where mucosal surfaces rather than the skin is involved in the coloured races.

In view of the very low incidence of malignant melanoma in our population and universal low incidence in the head and neck region it would imply that malignant melanoma of the head and neck in our population would be unlikely to see. However, seeing these six patients in a very short duration is scaring and it might be taken as an indication of rising incidence of once a rare malignancy.



Fig. 5 Case No. 4, Melanoma of the left cheek before excision. He had enlarge cervical lymph node.



Fig. 4 Case No. 3, Recurrent amelanotic melanoma of the right preauricular region with metastases to the regional nodes. He refused surgery but agreed to radiotherapy.

Fig. 6 Case No. 6, Melanoma of the right preauricular region in a 28 years old lady.

This is not a population based study and could not be related with even the hospital based statistics. The purpose of the this paper is to increase awareness of the medical profession that every mole is no longer as benign as previously thought. Therefore, any naevus with sign of any change over a short period of time should be considered for biopsy.

An ideal biopsy report should include the diagnosis, the histopathological type of melanoma, growth phase (vertical horizontal or both), Clark's level of invasion, Breslow's thickness of the tumour and host response in the form of lymphocytic infiltration.³ Anything less than this should be either returned to the pathologist for further evaluation or sent to another pathologist.

The above factors are extremely important in planning the treatment and predicting prognosis. Of the various types of melanoma, nodular variety has the poorest prognosis. Similarly the tumour thickness is an important prognostic factor. Tumours of less than 0.76 mm in maximum thickness carry good prognosis. These thin tumours almost never metastasise and local resection with a one cm margin is all that is required. On the other hand tumours that are thicker than 4 mm develop distant metastasis in over 70% of the cases and a clearance margin of 3 cm or more with elective regional node dissection with or without parotidectomys are warranted. A high lymphocytic infiltrate is a good sign on the part of the host response and indicates better prognosis.

The treatment of melanoma is predominantly surgical. However, tumours of the head and neck region pose particular problems in the surgical management as excision margins are limited by the anatomic, aesthetic and functional consideration.¹⁰ This limitation greatly decreases the survival rate of patients with melanoma of the head and neck. Of this region scalp melanoma carries the worst prognosis.¹¹ Early diagnosis and treatment is the only

hope of these patients if longer survival is the goal.

REFERENCES

1. Evans GRD, Manson PN. A variation in the appearance of melanoma-in-situ (Clark's level I malignant melanoma). *Plast Reconstr Surg.* 1994; 94(3): 513.
2. Medina JE. Malignant melanoma of the head and neck. *Otolaryn Clin North Am* 1993; 26(1): 73.
3. Cooke K, McNoe B, Hursthous M, Taylor R. Primary malignant melanoma of the skin the dour regions of New Zealand. *N Z Med J.* 1992. 105(939): 303.
4. Hudson DA, Krige JEJ. Results of 3 cm excision margin for melanoma of the scalp. *J Royal Coll Surgeons* 1995; 40: 93.
5. Chen YT. Malignant melanoma incidence in Connecticut (United States): The trends and age-period-cohort modeling by anatomic site. *Cancer Causes Control* 1994; 5(4): 341.
6. Ringborg U, Afzelins LE, Lagerlof B, et al. Cutaneous malignant melanoma of the head and neck. Analysis of treatment results and prognostic factors in 581 patients: a report from the Swedish Melanoma Study Group. *Cancer* 1993; 71(3): 751.
7. Cassion PR, Robins P. Malignant tumours of the skin. In McCarthy: *Plastic Surgery* Vol. 5 Philadelphia, WB Saunders Company 1990; 3614.
8. Feun LG, Moffat F, Saveraj N, et al. Melanoma in Southeast Hsipanic Population. *Cancer Detect Preven* 1994; 18(2): 145.
9. Barr LC, Skene AI, Fish S, Thomas TM. Superficial parotidectomy in the treatment of cutaneous melanoma of the head and neck. *Br J Surg* 1994; 111(4): 64.
10. O. Brien CJ, Coates As, Peterson-Scaefter K, et al. Experience with 998 cutaneous melanomas of the head and neck over 30 years. *Am J Surg* 1991; 162(4): 310.
11. Shmate Cr. Carlson GW, Giacco GG, et al. The prognostic implications of location for scalp melanoma. *Am J Surg* 1991; 162(4): 315.