

A Case of Malignant Melanoma of the Uterine Cervix

Mosse Wilfried BA*, Oswald Houessou, Kietga Gael G, Hanan El-Kacemi, Tayeb Kebdani, Sanaa El-Majjaoui and Nouredine Benjaafar

Department of Radiation Oncology, Mohamed V University, Rabat, Morocco

*Corresponding author: Mosse Wilfried BA, Department of Radiation Oncology, Mohamed V University, Rabat, Morocco, Tel: 698912749; E-mail: mossleboss2@gmail.com

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Abstract

Malignant melanoma of the cervix uteri is a rare cancer. It constitutes less than 2% of cases of malignant melanoma of the genital tract.

We reported a 52 years old woman with a 4-month history of peri-menopausal bleeding and leucorrhea. She had no medical history. The pathology of cervical punch biopsy showed malignant melanoma; the nuclei are frankly enlarged, rounded or oval, rarely irregular and always hyperchromatic with prominent nucleoli. There are some atypical mitoses and important melanic deposits. The final diagnosis was stage IIA1 primary cervical melanoma with involvement of the vaginal wall according to the International Federation of Gynecology and Obstetrics staging system (FIGO). She underwent a total colpophysterectomy expanded to the left lateral wall and the posterior wall of the vagina without pelvic lymph node dissection. The patient further underwent adjuvant fractionated radiotherapy to the pelvis with a dose of 50Gy; 2Gy/fraction, 5 sessions per week in 5 weeks.

In general, the prognosis of primary cervical melanoma is poor, because it is diagnosed at an advanced stage.

Keywords: Uterine cervix; Malignant melanoma; Leucorrhea; Nucleoli

Introduction

Malignant melanoma of the cervix uteri is a rare cancer. It constitutes less than 2% of cases of malignant melanoma of the genital tract [1]. The vast majority of these cases occur in vulva and vagina; the cervix is a rare site for melanoma [2].

The diagnosis is confirmed by histological examination using special staining and by immune histochemical study [3]. The treatment is based on experience from cutaneous melanoma. There is no consensus for the treatment due to scarcity [4]. Radical hysterectomy with regional lymphadenectomy is generally advocated. Malignant melanoma of the cervix uteri has a poor outcome as a consequence of delayed diagnosis and lack of standardized treatment. There is a lack of evidence on the efficacy of postoperative radiation or chemotherapy.

We report a case of a 52-year-old patient with malignant melanoma of the uterine cervix with a brief review.

Case Report

A 52 years old woman was admitted to the Department of Radiation Oncology of National Institute of Oncology/Rabat (Morocco) with a 4-month history of peri-menopausal bleeding and leucorrhea. She had no medical history. Her gynecological examination showed a 3 cm budding lesion of the left vaginal wall and uterine cervix with exophytic formations at noon. A colposcopy-guided cervical biopsy was performed and that tissue was sent to the pathology laboratory for examination. The pathology of cervical

punch biopsy showed malignant melanoma; the nuclei are frankly enlarged, rounded or oval, rarely irregular and always hyperchromatic with prominent nucleoli. There are some atypical mitoses and important melanic deposits. The pelvic Magnetic Resonance Imaging (MRI) revealed intravaginal process, fairly well posterior lateralized to the left of the upper 2/3 of the vagina, hypo signal T1, intermediate signal T2, hyper signal diffusion, raised in a heterogeneous way by the contrast medium and measuring 18 mm × 19 mm × 30 mm (Figure 1).

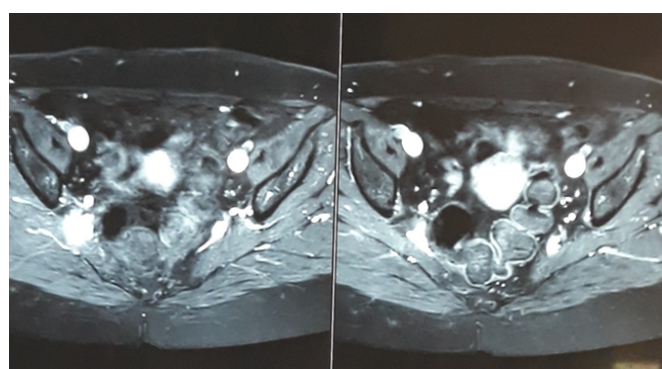


Figure 1: MRI aspect showing the left lateral cervicovaginal process heightened in a heterogeneous way by the contrast product.

Whole-body Positron Emission Tomography-Computed Tomography (PET-CT) showed a pathological hyper-metabolic mass of uterine cervix with no associated involvement, with SUV max=12. An extensive search for a melanotic lesion including skin and eye was

performed to verify the primary site of melanoma, but we could not find any primary site of the melanoma (Figure 2).

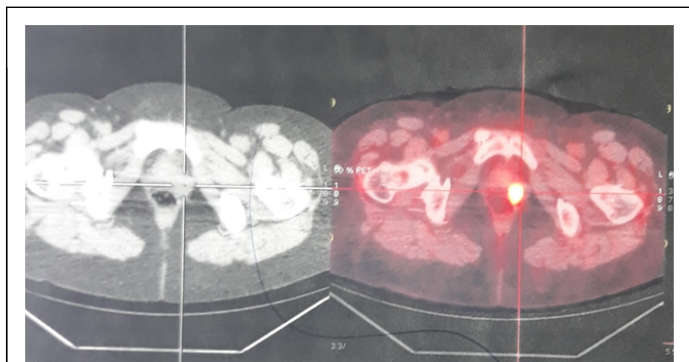


Figure 2: Pathological hypermetabolic tissue mass (SUV max=12) in uterine cervix.

Therefore, the final diagnosis was stage IIA1 primary cervical melanoma with involvement of the vaginal wall according to the International Federation of Gynecology and Obstetrics staging system (FIGO).

She underwent a total colpohysterectomy expanded to the left lateral wall and the posterior wall of the vagina without pelvic lymph node dissection. A histologic examination revealed a 3.5 cm × 2.5 cm-sized malignant melanoma infiltrating the left hemi-cervix and the posterior wall of the vagina, located 2 cm from the vaginal surgical limit. She further underwent adjuvant fractionated radiotherapy to the pelvis with a dose of 50Gy; 2Gy/fraction, 5 sessions per week in 5 weeks.

Discussion

Malignant melanomas of the cervix uteri are an extremely rare disease that origin from the cervical melanocytic cells, less than 100 cases where described in the world [5]. Diagnosis is determined by gynecological examination, histological results and immune histochemical staining. Before the diagnosis of cervical melanoma, it's important to ensure that there is no melanoma lesion elsewhere. Melanoma in the uterine cervix may be melanotic or amelanotic and half of the melanomas are amelanotic [6,7]. The diagnosis of amelanotic melanomas may be difficult due to the absence of pigment. In our case, the presence of pigment made the diagnosis easier. Norms and Taylor have suggested the following diagnostic criteria:

- The presence of melanin in the normal cervical epithelium
- The absence of melanoma elsewhere in the body
- The demonstration of the junctional change in the cervix
- The metastases according to the pattern of cervical carcinoma

The clinical presentation and spread pattern of malignant melanoma of the cervix uteri are similar to that of cervical carcinoma and the FIGO staging system has been accepted by most researchers [8,9]. The most frequent symptoms of malignant melanoma of the cervix uteri are vaginal bleeding, vaginal discharge, abdominal pain, dyspareunia and post-coital bleeding [10]. The symptom at the presentation of our patient was vaginal bleeding and leucorrhea.

There is no consensus on optimal management strategy malignant melanoma of the cervix uteri due to the rarity of the lesion. The most common mode of treatment in literature is surgery, including radical

hysterectomy, pelvic lymphadenectomy and partial vaginectomy [11]. There is a lack of evidence on the efficacy of postoperative radiation or chemotherapy. Malignant melanoma of the cervix uteri is considered as a radio-resistant tumor. RT applied as an adjuvant, preoperative and palliative treatment in some case reports [12]. Adjuvant pelvic radiotherapy might be applied to patients with unsatisfactory surgical resection, infiltrated parametria and involved lymph nodes [13]. Our patient underwent total colpohysterectomy expanded to the left lateral wall and the posterior wall of the vagina without pelvic lymph node dissection with adjuvant radiotherapy to the pelvic.

The overall prognosis for this kind of cancer is very poor because diagnosis is usually made at an advanced stage and the tumor is highly aggressive as both local recurrence and widespread metastases. The 5-year survival rate after radical hysterectomy is not exceeding 40% in stage 1 and reaching only 14% in stage 2. The reported survival time ranges from 6 months to 14 years, 90% of the reported patients with follow-up data have been died of their diseases, within 2 years-3 years of presentation [14]. The disease can take a fulminant course with the development of distant metastasis or may remain quiescent for a few years, manifesting elsewhere in the body later [15]. Six month after her treatment our patient have a good response and good local control.

Conclusion

Malignant melanoma of cervix uteri is a rare form of melanoma with a poor prognosis, because it is diagnosed at an advanced stage. Surgery is the main stay of treatment for localized disease while chemotherapy and radiotherapy are appropriate for women with advanced disease or recurrent melanoma of the cervix uteri.

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