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Authors

Wu, Jashin J.
Huang, D B
Woodruff, C
[et al.](#)

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Morphology

An unusual presentation of two simultaneous primary melanomas

Jashin J. Wu, MD, David B. Huang, MD, PhD, MPH, Christy Woodruff, MD, and Stephen K. Tyring, MD, PhD, MBA

From the Department of Dermatology, University of California, Irvine, Irvine, CA, USA, Division of Infectious Diseases, Department of Medicine, Baylor College of Medicine, Houston, Texas, USA, University of Texas at Houston School of Public Health, University of Texas Health Science Center at Houston, Texas, USA, Division of Infectious Diseases, Department of Medicine, University of Texas Health Science Center at Houston, Texas, USA, Department of Dermatology, Baylor College of Medicine, Houston, Texas, USA, Department of Dermatology, University of Texas Health Science Center at Houston, Houston, Texas, USA, and Center for Clinical Studies, Houston, Texas, USA

Correspondence

Jashin J. Wu, MD
C340, Medical Sciences 1
University of California
Irvine, CA, 92697-2400
E-mail: jjwu@uci.edu

Case Report

A 55-year-old man with no significant past medical history presented with a 4 month history of a rapidly growing, irregular mass on the chest. The patient, who had a 9th grade education and lived alone, had missed his first appointment 2 months prior since he was asymptomatic. The necrotic, pedunculated, fungating mass was 8 × 6 cm in size (Figs 1 & 2). This mass initially began as a black mole similar to the lesion on his left flank (Fig. 3). The left flank lesion was an asymmetrical, irregular pigmented brown macule with notched borders. Prior to presentation, the patient reported that the chest wall lesion grew and “split open” over a period of 7 weeks. Because of the foul odor and yellowish discharge from the lesion, the patient reported “cleaning” the mass with a bleach solution. The only other symptom the patient reported included a 14-pound weight loss 1 month prior to presentation to the dermatology clinic. The patient had no history of skin cancer, extensive exposure to sun, or dysplastic nevi.

In addition to the skin abnormalities, the patient had four 2 × 2 cm hard lymph nodes palpated in the left axilla on

physical exam. Computed tomography (CT) of the thorax and abdomen showed numerous metastases in the lower lungs bilaterally, liver, and spleen. CT of the head was normal. Biopsies of the chest wall mass and of the left flank were obtained. The chest wall lesion showed nodular malignant melanoma, Clark's level IV, 2.15 mm thickness with ulceration, tumor-infiltrating lymphocytes, and approximately two mitoses/mm without evidence of regression. The left flank showed superficial spreading malignant melanoma *in situ* associated with a compound melanocytic nevus with architectural disorder and cytologic atypia of melanocytes. This lesion was reviewed for the presence of epidermotropism, which was not found, hence the diagnosis of a simultaneous primary melanoma.

The clinical findings and histopathologic findings were consistent with two primary melanomas with metastatic involvement. The patient was subsequently placed on temozolomide, an oral angiogenesis inhibitor, 1 week after the initial visit. He was to receive temozolomide 150 mg/m²/day for 5 days, then 200 mg/m²/day for 5 days every 4 weeks for 5 months for a total of six courses.



Figure 1 A 8 × 6 cm necrotic, pedunculated, fungating mass on the chest wall (anterior view)



Figure 2 A 8 × 6 cm necrotic, pedunculated, fungating mass on the chest wall (lateral view)

Four months into treatment, he did not have any improvement with temozolomide. The patient's health rapidly declined 9 weeks after his initial presentation. The patient became too weak to make his appointments and requested hospice care. The patient expired 12 weeks after his initial presentation.



Figure 3 A 5 × 8 mm black lesion on the left flank

Discussion

The frequency of multiple primary melanomas in an individual patient has been reported to be between 1.7%¹ and 4%.² Of these multiple primary melanomas, 30%²–39%³ are diagnosed concurrently within 1 month. This represents a frequency of about 0.5%–1% of all melanoma patients having multiple simultaneous primary melanomas. New lesions that may initially appear to be primary melanomas may actually be epidermotropic metastases from the original melanoma.⁴

Unfortunately in this case, the patient presented late, probably several months to years after the occurrence of the melanomas. This case is unusual in the way the patient handled the melanoma on his chest wall. It is unknown if the bleach may have worsened the appearance of the mass-like lesion on his chest wall. The patient did not have any known psychiatric reasons for ignoring or denying the existence of the growing lesion on this chest. Nevertheless, with evidence of metastatic lesions likely from his primary melanomas, he had advanced-stage melanoma. Late-stage melanomas are notoriously difficult to treat, despite new advances in management.⁵ This unusual presentation without significant risk factors for

melanoma highlighted that undiagnosed psychiatric disease, low level of education, and lack of a social network may have prevented the early detection and diagnosis of melanoma.

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