

Right Inguinal Bowel Fistula On The Course Of Melanoma Disease

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Citation

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Abstract

Melanoma is the most dangerous type of skin cancer. It is the leading cause of death from skin disease. It involves cells called melanocytes, which produce a skin pigment called melanin. Melanin is responsible for skin and hair colour. Melanoma can also involve the colour part of the eye. Although it is less common than other types of skin cancer, the rate of melanoma is steadily increasing. Melanoma may appear on normal skin, or it may begin at a mole or other area that has changed in appearance. The development of melanoma is related to sun exposure, particularly to sunburns during childhood, and is most common among people with fair skin, blue or green eyes, and red or blond hair. Unlike these previous facts, the authors have been treated during the last 3 year seven patients all of them from Zulu ethnic. Here the authors present a 61 years old female patient who was diagnosed of melanoma by SLN [Sentinel Lymph Node] biopsy on the Right groin on September 2008; the patient defaulted from Vryheid Hospital Out Patient Department until October 18 2008 when she came back to Casualty for presenting a fungous ulcer on the Rt. Foot and necrotic lymph nodes on the Rt. Groin area. A small bowel fistula was diagnosed as well. After being treated from her weakness / deteriorated health conditions, the patient was operated first on 23/10/08 [Rt. below Knee Amputation + debridement necrotic lymph node area + catheterization of the bowel fistula]; second 13/11/08 [debridement, resection & repair of fistula, prolene mesh repair of rt. groin]. The patient underwent chemotherapy with dacarbazine (DTIC), immunotherapy with interferon (IFN) as well as local perfusion. It is remarkable the increasing number of patients of Zululand community affected by Acral lentiginous melanoma, that is the least common form of melanoma.

INTRODUCTION

The French physician René Laennec was the first to describe melanoma as a disease entity. His report was initially presented during a lecture for the Faculté de Médecine de Paris in 1804 and then published as a bulletin in 1806[1] Generally, an individual's risk for developing melanoma depends on two groups of factors: intrinsic and environmental [2, 3] A family history of melanoma greatly increases a person's risk because mutations in CDKN2A, CDK4 and several other genes have been found in melanoma-prone families [4]

There are 4 major types of melanoma:

- Superficial spreading melanoma is the most common type of melanoma. It is usually flat and irregular in shape and color, with varying shades of black and brown. It may occur at any age or body site, and is most common in Caucasians.
- Nodular melanoma usually starts as a raised area that is dark blackish-blue or bluish-red, although

some are without color.

- Lentigo maligna melanoma usually occurs in the elderly. It is most common in sun-damaged skin on the face, neck, and arms. The abnormal skin areas are usually large, flat, and tan with intermixed areas of brown.
- Acral lentiginous melanoma is the least common form of melanoma. It usually occurs on the palms, soles, or under the nails and is more common in African

The Vryheid Hospital multidisciplinary team has already included into its protocols related to cancer the identification of some risk factors:

- Family history of melanoma
- Red or blond hair and fair skin
- Presence of multiple birthmarks

- Development of precancerous lesions
- Obvious freckling on the upper back
- Three or more blistering sunburns before age 20
- Three or more years spent at an outdoor summer job as a teenager
- High levels of exposure to strong sunlight

As we mentioned before, the authors' experiences in Melanoma diseases are in treating African Zulu patients. This local incidence into the Zulu populations could be explained due to particular environmental conditions, severe pandemic of AIDS diseases or/ and genetics predisposition. Vryheid Hospital Health team encourages on Out Patient Department, Casualty and peripheral clinics level the knowledge of A B C D system, it may help the doctors, sisters, health workers and patients to remember features that might be a symptom of melanoma:

Asymmetry: One half of the abnormal area is different from the other half.

Borders: The lesion or growth has irregular edges.

Color: Color changes from one area to another, with shades of tan, brown, or black (sometimes white, red, or blue). A mixture of colors may appear within one lesion.

Diameter: The trouble spot is usually (but not always) larger than 6 mm in diameter -- about the size of a pencil eraser.

The key to treating melanoma is recognizing symptoms early. The patient might not notice a small spot of concern if he or she doesn't look carefully, so the authors advice to perform thorough self-examinations monthly.

Preventive strategies include reducing sun exposure (eg, by wearing protective clothing and using sunscreen regularly), avoiding sunlamps and tanning equipment.

People with metastatic melanoma may not feel like eating especially if they are uncomfortable or tired. Foods may taste different than they did previously. Poor appetite, nausea, or vomiting are all side-effects of melanoma. Good nutrition however often helps people with cancer feel better and have more energy. The patients are permanently stimulated to quit or decrease the tobacco and alcohol consumption, also the health and social worker emphasizes in eliminating the habit of eat unprocessed animal viscera.

CASE REPORT

A 61 year old female patient who was diagnosed of melanoma by SLN [Sentinel Lymph Node] biopsy on the Right groin on August 2008; the patient defaulted from Vryheid Hospital follow up, until October 18 2008 when she came back to Casualty for presenting a fungous ulcer on the Rt. Foot, necrotic lymph nodes on the Rt. Groin area. A small bowel fistula was diagnosed as well .The patient had an abnormal Full Blood Count, Electrolytes, high urea and urine output < 300ml in 24 hours. The anaemia was corrected with blood transfusion [HBG = 7.1 gr/Dl], Bio plasma was prescribed in order to correct the low albumin levels, the sepsis was treated with broad spectrum antibiotics, and additional Vitamins B 12, C, E and K1 were indicated. The patient underwent Norm saline solution, Haemaccel and Darrow as IVI treatment. After being treated from her weakness / deteriorated health conditions, the patient was operated first on 23/10/08 [Rt. BKA + DEBRIDEMENT NECROTIC LYMPH NODE AREA + CATHETERIZATION OF THE BOWEL FISTULA

Figure 1

Legend 1: Intra-operative picture showing the Rt. Inguinal bowel fistula



Figure 2

Legend 2: Intra-operative picture showing the necrotic lymph nodes [melanoma] on the Rt. Groin



Second surgical intervention-13/11/08 [DEBRIDEMENT, RESECTION AND REPAIR OF FISTULA, PROLENE MESH REPAIR OF RT. GROIN]- Dressing with saline solution and aqueous hibitane solution were done twice a day on the operated areas. Patient needed strong analgesia, nerve blocks, chest physiotherapy -nebulisations and psychological support for stabilizing her health conditions.

PATHOLOGY REPORT FROM DURBAN LANCET INSTITUTE:# 470701vdh-10-2008:-amputation right foot showing a large ulcerated fungous malignant melanoma with invasion into the subcutaneous and muscle (clark's v/ depth greater than 3 cm) the margins of resection including the proximal bony margin appears to be free of involvement.

The patient underwent chemotherapy with dacarbazine (DTIC), immunotherapy with interferon (IFN)) as well as local perfusion. Patient was transferred stable in January 2009 to Pietermaritzburg Oncologic Unit.

DISCUSSION

On the management of patients affected by melanoma a complete surgical excision with adequate margins and assessment for the presence of detectable metastatic disease along with short- and long-term follow-up is standard. Often this is done by a "wide local excision" (WLE) with 1 to 2 cm margins. Melanoma-in-situ and lentigo malignas are treated with narrower surgical margins, usually 0.2 to 0.5 cm [5, 6, 7, 8]. In the abovementioned patient, she came in late stage with complicated secondary bowel inguinal fistula due to lymph node necrosis. On the authors experience this was the first opportunity in treating this kind of complications, and

the decision to treat the patient on the stages was due to her compromised health conditions. Some controversies were risen on the clinical discussions among the doctors related in how to apply properly in this patient the chemotherapy, the surgery or radiotherapy. Various chemotherapy agents were used, including dacarbazine (also termed DTIC), immunotherapy with interferon (IFN)) as well as local perfusion on the Rt inguinal area. The hope in performing this protocol was that the combined treatment can occasionally show dramatic success, but the overall success in metastatic melanoma is quite limited [9] IL-2 (Proleukin) is the first new therapy approved for the treatment of metastatic melanoma in 20 years. Studies have demonstrated that IL-2 offers the possibility of a complete and long-lasting remission in this disease, although only in a small percentage of patients. [10]

The working Protocol of Radiation therapy is often used after surgical resection in patients with locally or regionally advanced melanoma or for patients with complicated distant metastases. It may reduce the rate of local recurrence but does not prolong survival [11]

The authors systematically use in Cancer diseases management, [since October 2005], the concept of SENTINEL LYMPH NODE (SLN) mapping introduced by Dr Donald Morton and colleagues from the John Wayne Cancer Institute.[12, 13]

The incidence of melanoma is increasing faster than that of any other cancer [14]. The development of melanoma is related to sun exposure, particularly to sunburns during childhood, and is most common among people with fair skin, blue or green eyes, and red or blond hair. Unlike these previous facts, the authors have been treated during the last 3year seven patients from Zulu ethnic.

When melanomas metastasize, regional lymph nodes are usually the first-detected sites of spread. Furthermore, it is relatively rare for patients who develop distant metastatic melanoma to never manifest nodal metastasis at some point in time, although nodal metastasis is not always the first-detected site of metastatic disease. Of course, many patients with nodal metastasis will subsequently develop distant metastatic disease. Not long ago, patients with intermediate or thick melanomas and clinically negative (non-palpable) regional nodes were offered either elective lymph-node dissection or nodal observation.

The Department of Surgery in Vryheid Hospital encourages

the juniors and community services doctors to learn and develop skills in SLN biopsy, these procedures minimizes the number of patients that require full lymphadenectomy, and is associated with a complication rate of around 5% compared with 20% for full lymphadenectomy. [15]

CONCLUSIONS

It is remarkable the increasing number of patients of the Zululand community affected by Acral lentiginous melanoma, that is the least common form of melanoma. The health staff needs to be prepared scientifically in order to face properly this challenger.

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