Malignant Melanoma Of The Vagina: A Case Report

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Abstract

This paper presents diagnostics and treatment of malignant melanoma of the vagina in an 80-year old patient who reported for a regular gynecological checkup and was symptom free at the moment when diagnostics was made. After the biopsy of the tumor which histopathologically verified the malignant melanoma of the vagina a wide excision and complete tumor extirpation was performed. Several months later a foudroyant development of the disease occurred with lethal result. Malignant melanomas of the vagina are very rare yet aggressive tumors, unfortunately usually resistant to oncological therapies, thus making their early diagnostics and quick and radical surgical treatment crucial for prognosis.

INTRODUCTION

Malignant melanoma of the vagina is a rare yet very aggressive malignant tumor with very poor prognosis. It usually affects postmenopausal patients. Vulvar and vaginal melanomas tended to occur among older women, as opposed to cutaneous melanomas, which were more common among younger women. According to Kalampokas data from year 2017, average age of occurrence is approximately 57 (1), while data presented by Daix M in 2018 show that the average age is approximately 60 (2), i.e. between 50 and 65 according to Tanwar RK (3). The first case of such tumor was described in the medical literature in 1887. Since then about 500 cases were reported globally. Vaginal melanomas are rare tumors, accounting for less than 1% of all melanomas and about 1-5% of all vaginal malignant tumors. The prognosis of vaginal melanoma is extremely poor, as it is often resistant to chemotherapy and radiotherapy, and metastases may develop in the early stage of the disease.

This paper presents diagnostics, treatment and foudroyant development of malignant melanoma of the vagina diagnosed during a regular checkup in an asymptomatic 80-year-old patient.

CASE REPORT

An 80-year-old patient reported for a regular gynecological checkup during which a verrucous lesion on the posterior vaginal wall directly above the introitus of the vagina was detected. Contact bleeding occurred during the exam. Prior to that patient felt no discomforts or had any vaginal bleeding. Colposcopic findings of the cervix were normal, exocervical epithelium was atrophic, corresponding to patient's age. Cytological examination of the exocervical smear was also normal (papa 2). Due to a suspected verrucous lesion on the posterior vaginal wall biopsy was indicated in order to perform histopathological verification of the described lesion. Biopsy was scheduled and performed two weeks after the first examination during which it was detected. At the time of the biopsy, the lesion was more than double in size than previously described and it looked like a hematic cyst on the posterior vaginal wall 3-4 cm in diameter, connected to the posterior vaginal wall by its wide basis. Histopathological examination set the diagnosis of a malignant melanoma of the vagina. Immunohistochemical analysis was done: vimentin+, S-100 focally+, melanin A+, HMB45+, CK PAN+. Detailed examinations according to oncological protocol were performed including abdominal and pelvic CT scans, lung radiography and endocranial CT scan. No pathological changes were found. Surgical removal of the lesion was indicated. The patient was prepped for surgical treatment three weeks later. A wide excision was made and the entire tumefactive lesion was removed and subsequently sent to histopathological examination. The diagnosis of vaginal malignant melanoma was confirmed. After the surgery patient felt well, the wound healed, sutures were taken out. Followup after three months resulted in normal findings. At surgical treatment site only the surgical scar was present. A

month after the first followup, patient noticed scarce bleeding and reported for a checkup. The existance of a verrucous lesion of 1 cm in size was determined on the posterior vaginal wall at the site of the operative scar. The lesion was excised completely, and relapse of malignant melanoma of the vagina was confirmed. Two months later another relapse occurred. The patient reported for a checkup when the tumor was 5cm in size and it bled more massively than before. Another wide excision and tumor extripation were performed. The relapse of the vaginal malignant melanoma was again confirmed by histopathological examination. The scar healed with difficulty, bleeding from the posterior vaginal wall continued. Bleeding was stopped by vaginal tamponade. Disease progression still continued even after repeated surgical intervention, causing the tumor to grow to approximately 8cm in size after a month. It was fixed to the posterior vaginal wall, growing inwards toward the vagina and rectal exam confirmed it was growing and infiltrating the perineum too. The tumor was determined inoperable at that stadium. The foudroyant course of the disease continued. The patient died one month later. Only 6 months have passed between the moment the asymptomatic lesion was discovered and the moment of patient's death.

DISCUSSION AND CONCLUSION

Primary melanomas originating from the gynecological tract are rare and agressive cancers. The clinical outcome of patients with female genital tract melanoma is very poor, with a 5-year overall survival of 37% for vulvar, 13% for vaginal and approximately 10% for cervical melanoma (4). Considering the age in which these tumors most frequently occur, vaginoscopy and vulvoscopy in this period must be as important as colposcopy. This is especially important due to age-related changes in immunity and skin barrier function of vulvovaginal tissues. Vaginal atrophy is commonly complicated by dryness and inflammation. The differential of vaginitis includes inflammatory, infectious and malignant diseases, plus drug hypersensitivity. Even though melanomas of vagina and vulva are rare, the possibility of their occurrence at this particular age must always be taken into account, especially when therapy is administered to reduce vaginal disorders. Basic method for treatment of malignant melanoma is surgical intervention which must be as radical as possible. Tumor lesion must be completely removed and the excision of the lesion should be as wide and extensive as possible. This, however, is not always possible, considering the number of different anatomic localizations of the tumor and the vascularization of the tumor and surrounding tissue. Another problem are the regional lymph node metastases which occur frequently and as such significantly affect the prognosis. Postoperative chemotherapy and biologic therapy described in references have not given satisfactory effects causing radical surgical treatment to still remain crucial for the treatment of malignant melanoma. Unfortunately the prognosis is still very poor as confirmed by this study describing a patient with a melanoma detected accidentally, during a regular checkup. Even though surgical excision was performed in a very short time period after histopathological diagnostics, the foudroyant course of the disease occurred immediately after the intervention reducing the survival of the patient to only 6 months.

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