case report

# Amelanotic melanoma with tonsillar and thyroidal metastases and no primaries detected

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## ABSTRACT

### Introduction

Amelanotic Melanoma is a rare entity (2-8% of melanomas), its diagnosis is difficult, due to its pleomorphism and to the impossibility to make use of dermoscopy. These features imply a delay in diagnosis so that often these lesions are detected already in a metastatic stage. This delay leads to worse prognosis.

### Clinical case

In our report we describe the case of a patient affected by a metastatic amelanotic melanoma without evidence of a primary lesion (Tx). The metastatic tumor was first diagnosed in 2003 after a parotidectomy and a concomitant lymphadenectomy. The patient underwent a bilateral neck dissection, hepatectomy, extended lymphadenectomy and thyroidectomy.

### Discussion

The prognostic factors in melanoma are: stage, presence of ulceration, type of surgical intervention, depth of invasion and the localization of the primary tumor. Our patient presented a bad prognosis for all these features. In addition, the metastatic lesions found in our patient were localized in uncommon sites such as palatine tonsil, thyroid and parotid. The other localizations were quite common( bowel, liver).

### Conclusion

Although the characteristics of the melanoma case in our patient indicated bad prognosis, the patient had a long survival (7 years).

Keywords: amelanotic melanoma, neoplasm metastasis, lymphatic metastasis, tonsillar neoplasms, neoplasms/unknown primary.

## INTRODUCTION

The term amelanotic melanoma is often misused to describe both a melanocytic lesion with minimal residual component or a true amelanotic lesion.[1] Incidence reported in the literature for amelanotic melanoma is 2-8% of all melanomas, but this statistic includes also partially pigmented lesions.[2] Superficial spreading amelanotic melanomas are very rare and difficult to diagnose, especially if it appears in plate form, very similar to a scurfy process. This implies that, at the moment of diagnosis, that the majority of these lesions are already in a metastatic form. Although dermatoscope can help in the diagnosis of pigmented lesions[3] there is no evidence for its effectiveness in the diagnosis of amelanotic melanoma, although it can detect areas of amended skin.[4] Diagnosis can be made if the lesion is positive for antigens of melanosome, such as protein S-100 and HMB45.[5]

As a consequence of difficulty in diagnosis, melanoma lesions may be wrongly treated. According to the work of Charles and De Giorgi, only the 72% of melanomas are reported correctly to surgeons.[6]

The treatment of melanoma depends on its thickness. It can be studied either with the Breslow or the Clark scale. Usually the treatment is based on surgery but laser and cryotherapy can be used for particular body regions.[7]

The rarity of our case is the presence of amelanotic melanoma in palatine tonsil. This localization has never been reported in literature for amelanotic melanomas and only four cases were found for pigmented melanomas.[8-11]

## CLINICAL CASE

The patient is a 65 years old Caucasian man, brought to our attention in March 2009 for an expansive neoformation of 20x15 cm in the right tonsillar region, detected with MRI (Magnetic Resonance Imaging). The patient's clinical history began on July 2003 when he underwent a right parotidectomy and removal of a chin lymph node. The histological report indicated the presence of a metastatic melanoma. One month later, the patient underwent a bilateral radical neck dissection but the histological analysis was negative for melanoma. The patient was clinically free of disease for three subsequent years. During that period the patient was subjected to periodic control with $T_C$ Pet imaging (every 6 months); the imaging results led to the diagnosis of various metastases that were subsequently removed.

On January 2007 the patient underwent multiple segmental bowel resections (the total length of the resected segments was recorded in cm and was 35 cm of small intestine). The histological analysis was compatible with the diagnosis of melanoma. On the June of the same year, the patient underwent an excision of the left parotid gland, which was free of metastatic infiltration. On July of 2007, new metastases in the right liver lobe were found and a liver metastasectomy followed.

On March 2008, a bilateral axillary lymphadenectomy revealed new metastases of the tumor. On July 2008, the patient was thyroidectomised with positivity in the presence of metastatic melanoma. On the September of the same year,

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