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Gynecology

BEAUTY SPOTS CAN BE DANGEROUS: A RARE CASE OF MALIGNANT MELANOMA IN PREGNANCY

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ABSTRACT Malignant melanoma is one of the most rapidly increasing cancers and, when it occurs during pregnancy it can frequently metastasize to the placenta and the fetus. We present a case of 29 years old patient with 31.3 weeks of gestation with complaint of mass over the labia and biopsy report suggestive of malignant melanoma. All cases should be managed according to the gestation and the treatment of melanoma should not be delayed.

KEYWORDS : Malignant melanoma, vulva.

INTRODUCTION:
Melanoma accounts for only about 1% of skin cancers but causes a large majority of skin cancer deaths. An important feature of melanoma is that the incidence rate is highest in lighter skinned patients and is much rarer in darker skinned individuals. The average age of people when it is diagnosed is 63. But melanoma is not uncommon even among those younger than 30. In fact, it's one of the most common cancers in young adults (especially young women).The incidence in pregnancy has been estimated to range from 0.14 to 2.8 per 1,000 live births and melanoma accounts for about 8 % of all malignant tumors arising during pregnancy.[1]

CASE REPORT:
29 years old patient, G3P2L2, with previous 2 lscs with 31.3weeks of gestation, was referred to our hospital with complaint of mass over the labia with biopsy report suggestive of malignant melanoma. The patient had noticed a small lesion over the labia 5 months back, which she initially ignored and later when it started to increase in size, she went to a local doctor, it was then that she was diagnosed to be 4 months pregnant. At 7 months of gestation as the lesion increased in size, she underwent wedge biopsy of the lesion, which was diagnosed to be malignant melanoma and the patient was referred to us.

Patient came with complaints of difficulty in walking, difficulty in passing urine and foul smelling discharge. No history of any major diseases or cancers in the family. On examination, there was a midline vertical scar on the abdomen, uterine height corresponding to 28 weeks with single live intrauterine fetus in cephalic lie, with regular fetal heart rate.

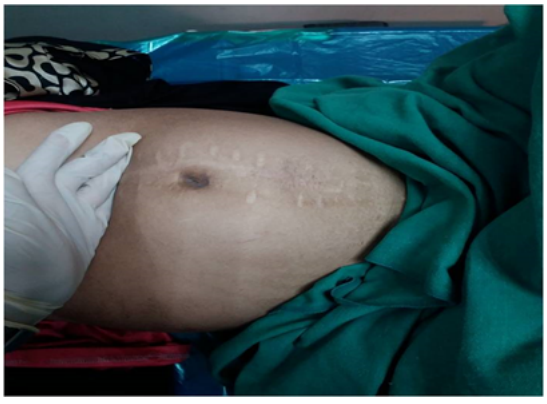

Figure 1:Per abdomen examination showing midline vertical scar with uterine height of 28 weeks.

A large fungating mass seen arising from the left vulva measuring 15 x 15 cm, with satellite lesions and foul smelling discharge. Bilateral firm to hard inguinal lymph nodes were palpable. On local examination, the mass was extending into the lower vagina.

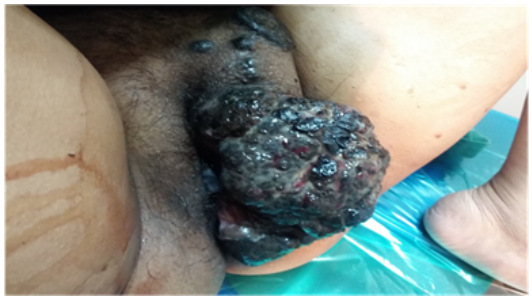

Figure 2: A large fungating mass seen arising from the left vulva with satellite lesions.

Patient was investigated. Haemoglobin was found to be 6.9 g %.Other routine blood investigations were found to be normal. Ultrasound was done which was suggestive of single live intrauterine gestation of 30.6 weeks, amniotic fluid index < 2 cm, placenta – posteriofundal, effective fetal weight of 1658 gm. MRI of abdomen and pelvis was suggestive of - hyperintense lobulated mass – exophytic, involving vulvar region, multiple enlarged necrotic lymph nodes in bilateral inguinal region suggestive of metastasis. Metastasis seen in the liver and the kidneys.

Two units of blood were given in view of Hb – 6.9 g% .Rescue dose of steroid was given for fetal lung maturity. Patient underwent caesarean section in view of severe oligohydraminos, female child of 1.6 kg delivered. Baby cried immediately with APGAR 8,9,9. Intraoperative and postoperative recovery was uneventful.

The baby expired on day 2 of life due to pulmonary hypoplasia.On external examination of the baby, there were no lesions, and the relatives refused for post-mortem. Histopathology report of the placenta was not suggestive of any malignant change or metastasis.

Patient was discharged home on day 9 of surgery, with referral to higher centre for oncology opinion. Suture removal was done on day 12, wound was healthy. Patient was started on chemotherapy and after one and a half month of the delivery, the patient expired due to sudden cardio respiratory arrest.

DISSCUSSION:
Malignant melanoma in pregnancy carries a high morbidity and

mortality specially if diagnosed at advanced stages. Melanoma is staged according to the AJCC- Melanoma staging system 8th edition 2017.[2] our case was stage IV – TNM – T4, N3c, M1c.

Median survival after the onset of distant metastases is only 6–9 months, and the 5-year survival rate is less than 10%.[3] Earlier reports suggested a rapid progress of the disease during pregnancy with a poor prognosis; however, recent controlled studies found that stage for stage, the prognosis of melanoma during pregnancy is similar to that in a non-pregnant state.[4] Early diagnosis and prompt treatment can avoid a tragic outcome. Metastasis to the products of conception portends a poor prognosis for the mother.[5] Common sites of metastasis of malignant melanoma include the lymph nodes, lungs, liver, spleen and the brain.

The management of melanoma during pregnancy requires several difficult decisions as the disease involves both the mother and the fetus. Decision making should be based on: 1) The impact of pregnancy on the outcome of the metastatic melanoma; 2) the gestational age and the risk of metastasis to the placenta and fetus; 3) the safety of radio diagnostic tests and chemotherapy during pregnancy, and 4) the treatment options for metastatic melanoma during pregnancy.[1]

Although surgery is the definitive therapy for early stage disease, rapidly progressive metastatic disease during pregnancy is difficult to treat. Chemotherapeutic regimens for metastatic disease administered during pregnancy have not demonstrated significant efficacy.

The different Management options_available for our case included counselling of the couple, chemotherapy, radiotherapy, and immunotherapy.

Chemotherapeutic drugs shown to be effective in the treatment of melanoma are dacarbazine temozolomide, paclitaxel, cisplatin, carboplatin, and vinblastine. Immunotherapy options available are ipilimumab (MDX-010), a human monoclonal antibody, interferon-based approaches, and Cytokines including IL-2 , IL-15 and IL-21.[6]

The rapid progression of the disease as mentioned may have been due to the natural history of the disease, although it is impossible to know whether hormonal changes during pregnancy had an impact. Whereas most of the data regarding malignant melanoma comes from white-skinned races, its natural history and progression during pregnancy in colored races, although light-skinned as in our case, may be different.

CONCLUSION:

All ANC patients on their visit should be screened for any suspicious lesions, and should be made aware about these. All cases should be managed according to the gestation and the treatment of melanoma should not be delayed.This woman might have been saved if she had been diagnosed earlier or had been more vigilant. Termination of pregnancy and aggressive therapy might have made a difference.

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