Unusual localization of melanoma.

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Abstract

Penile's melanoma is a rare situation associated with late diagnosis and high morbi-mortality. We report the case of a 70-year-old. Represented skin lesions of the penile gland. A surgical biopsy established the diagnosis of Penile's melanoma in the metastatic stage. Malignant melanoma of the penis represents an exceptional situation

Introduction :

Melanoma is a malignant tumor developed from melanocytes. Melanoma represents 1% to 3% of all cancers and is the most common and severe skin tumor. It's the leading cause of death from skin cancer. Generally, malignant melanoma is observed in areas of the skin exposed intermittently and intensely to sunlight and UV radiation [1].

Primary melanomas of the male genital tract are very rare and represent less than 1% of all malignant melanomas; they are associated with high mortality and often late diagnosis [2].

We report the observation of a patient followed for metastatic melanoma of the penis. And through this observation, we will illustrate the epidemiological, clinical, and therapeutic characteristics of malignant melanoma of the penis.

Case presentation:

A 70-years-old man without any specific medical history presented to our institution with skin lesions of the penis gland that have appeared for three months. His physical examination revealed hyperchromic, greyish, nodular, and ulcerated lesions. The largest of which was 1 cm in diameter on the penile gland and around the urethral meatus, Associated with a fixe right inguinal lymphadenopathy of 3cm in diameter [figures A].

A surgical biopsy on the skin lesion with histopathological and immunohistochemical studies confirms the diagnosis of melanoma. The Breslow index was estimated to be at least 4 mm with a Clarck and Mihlim level IV and the mitotic index at tree mitoses per 10 high power fields.

A Thoraco-abdominopelvic CT scan was performed and demonstrated the presence of multiple secondary hepatic lesions, the largest of which are visible in segments VI and VII measuring 20 mm and 16mm, respectively, with a right inguinal and iliac lymphadenopathy [figures B].

The patient received treatment with immunotherapy (pembrolizumab 200 mg / 21 days). After two years of follow-up of immunotherapy, the patient is still stable with good clinical and biological tolerance [figures C].

Discussion:

Penis melanoma was first described by Murchinson in 1985 [3]. And since then, several cases and series of cases have been reported. Malignant melanoma of the penis remains extremely rare. It represents less

than 1.4% of all malignant tumors of the penis and less than 1% of extraocular melanoma [4]. Malignant melanoma of the penis develops mainly in the penile gland (55%), followed by the foreskin (28%), while it is rarely in the penis shaft (9%) and the urethral meatus (8 %) [5]. the diagnosis of malignant melanoma of the penis is often late and usually at an advanced stage. This delay in diagnosis can be explained mainly by the frequency of differential diagnoses. But also by the private site of the lesion, which bothers the patient to consult early [6]. Clinically, penis melanoma should be suspected in the presence of any skin lesions (ulcerative or Maculo-nodular) accompanied by a change in the color of the skin (blackish or brownish appearance). There are four clinical forms of malignant melanoma: Lentigo malignant melanoma, superficial melanoma, lumpy melanoma, and acral lentiginous melanoma [7]. The diagnosis is based on a histological and immunohistochemical study of the biopsy. In light of the American Joint Committee on Cancer (AJCC) recommendations, the histology report should include information on at least: the type of melanoma, anatomical site, maximum vertical thickness, mitotic rate, presence of ulceration, and clearance of the surgical margins [8]. For a patient with unresectable or metastatic disease, screening for BRAF, NRAS, and c-Kit mutations seems mandatory.

For the localized stages, the treatment of melanoma of the glans penis is essentially surgical, with a large excision of the primary tumors with safety margins of 0.5 cm for the melanoma in situ, 1 cm for the tumors of a thickness up to 2 mm [8]. Currently, the aggressive surgical approach based on total amputation of the penis associated with bilateral dissection of the ilioinguinal ganglion has become increasingly rare [9]. Lymph node dissection should not be indicated systematically. Sentinel lymph node biopsy is preferred in melanoma with a tumor thickness of > 1 mm. And for a patient with positive sentinel nodes, complete lymphadenectomy should be discussed in a multidisciplinary meeting as it may have benefits in terms of relapse-free survival without benefit in terms of overall survival [8].

For metastatic patients with BRAF mutation, the recommended first-line treatments are anti-PD1 or combined BRAF / MEK inhibitors, whereas, in the case of wild-type BRAF, anti-PD1 is preferable in the first line.

Two and five-years overall survival in a patient with penis melanoma is 63% and 31%, respectively. And this is related to the diagnosis, often in the advanced stage of the disease [10, 11]. Hence the interest of raising awareness both: the patients to seek the doctor's advice in the face of any skin lesion of the penis and the doctors not to hesitate to do a complete clinical examination of patients whenever possible.

Conclusion:

Penile's melanoma represents a very rare localization that is often confused with other lesions, in particular infectious. Only an early consultation, a biopsy of the lesion with histological study, and confirmation of the diagnosis at an early stage will improve the prognosis of this tragic disease.

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The authors declare that they have no competing interest.

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Data availability statement:

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