# Pancreatic resection for isolated metastasis from melanoma of unknown primary

S. Ben Slama[1,3], D. Bacha[1,3], R. Bayar[2,3], L. Gharbi[2,3], A. Lahmar[1,3].

(1) Department of Pathology, Mongi Slim Hospital, Tunis, Tunisia ; (2) Department of Surgery, Mongi Slim Hospital, Tunis, Tunisia ; (3) University of Tunis El Manar, Faculty of Medicine of Tunis..

**To the Editor,**

A 55-year-old female patient presented with a three-week history of upper abdominal pain and itching. She had no past medical history. Examination revealed fever and jaundice. Laboratory tests showed cholestasis. Tumor markers including CEA and CA 19.9 were normal. Computed tomography (CT) and magnetic resonance imaging (MRI) showed a 6x5 cm mass located in the head of the pancreas with peripheral enhancement, leading to intra and extrahepatic biliary tract dilatation (Fig. 1). The patient underwent surgery and a pancreaticoduodenectomy was performed. She had an uneventful postoperative course and was discharged 10 days later. The macroscopic examination of the pancreatectomy found a pigmented mass measuring 5,5×4 cm in the head of the pancreas (Figure 1). Histological examination confirmed melanoma with epithelioid and polygonal cells (Fig. 2). All resection margins were free and there was no lymph node involvement. Immunohistochemistry showed strongly positive expression of anti-HMB45, anti-S100 protein and anti-melan A. The primary site of melanoma was unknown. There were no obvious cutaneous, ocular, anal or nasal lesions. After a nine-month follow-up, a CT-scan showed a pelvic metastasis of 2x3 cm. She refused all therapies and she only lived 15 months after surgery.

Pancreatic metastases are rare and account for approximately 2% of all pancreatic malignant tumors (1). Renal-cell carcinoma is the most common primary site followed by colorectal cancer, gallbladder carcinoma, lung cancer, breast cancer, melanoma and sarcomas (2). Most primary sites described of melanoma are the skin, ocular, nasal or genital areas (1). Complete surgical resection is the best treatment of metastatic melanoma and impacts positively on patients' survival (3). The five-year survival of patients undergoing complete resection of pancreatic melanoma metastases was 37% with a median disease free interval of 24 months (versus 0% and 8 months respectively for incomplete resection) (3). Pancreatic melanoma metastases prognosis is poor compared to other primary tumor sites such as renal cell carcinoma (4,5). Metastatic melanoma of unknown primary is estimated for 2-6% of all melanoma cases

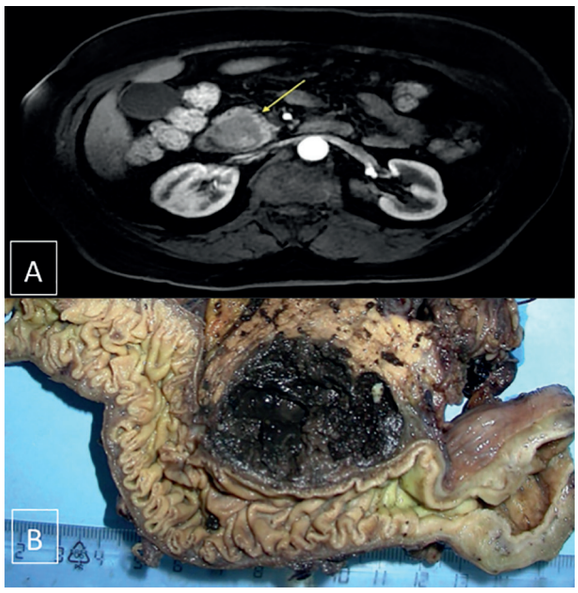


Fig. 1. — A : Preoperative MRI showing a mass of the head of the pancreas with peripheral enhancement (arrow). B : Surgical specimen : nonencapsulated but well limited dark brown nodule in the head of the pancreas which was pushing but not invading the ampulla of Vater.

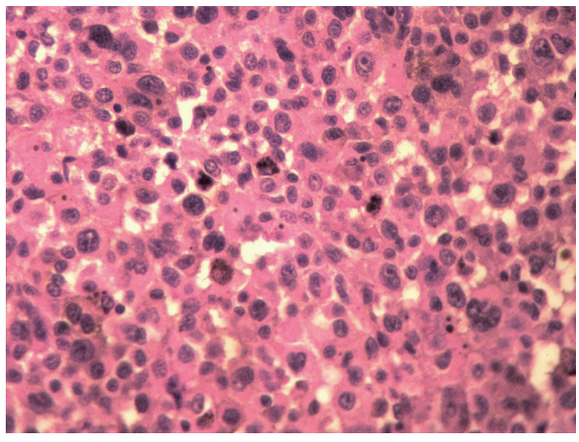

Fig. 2. — Histological aspect : The cells had abundant clear to eosinophilic cytoplasm and atypical hyperchromatic nuclei with enlarged prominent nucleoli. Melanin pigment is present (HEx25).

Correspondence to : Sana Ben Slama, Department of Pathology, Mongi Slim Hospital, 2046 Sidi Daoued, Tunis. Tunisia.
E-mail: mallouli.sana@gmail.com

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and seem to have similar prognosis than patients with melanoma of known primary (4). PET/CT has to be considered as a useful tool in identification of primary melanoma (6). The place of chemotherapy agents is controversial (1). The use of cytokines such as interferon-α or interleukin-2 as immunotherapy showed response up 15% (1,4). Complete surgical resection of an isolated pancreatic of unknown primary melanoma can provide short survival and benefit. However, surgery should be considered as a part of management for the future, including chemotherapy and immunotherapy.

**Key words :** metastatic melanoma, pancreas, pancreatectomy, pancreatic

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