A Metastasising pigmented stain on the sole

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Introduction

The term acral lentiginous melanoma (ALM) was introduced by Reed in 1975. It has a predilection for acral areas of the body like palms, soles, and the subungual areas and has a distinct radial or "lentiginous" growth phase[1]. We present a case of ALM on sole of a 76 year old male with inguinal metastasis.

Case report

- A 76 year old male presented with blackish hyperpigmented lesion associated with pain and discharge on sole of left foot since last 6 months. There was no history of melanocytic nevus at the site. The lesion turned larger and darker after excision. Three months later patient developed left side inguinal lymphadenopathy. No history of anorexia, weight loss, cough, haemoptysis, seizures, bone pains, urinary or bowel complaints was present. His personal and family history were not contributory.
- On examination there was a single blackish hyperpigmented plaque of size 2.5 cm x 1.5 cm with regular margins present on middle part of left sole with serous discharge and crusting surrounded by an irregular macular hyperpigmented rim. [Fig. A]. Left inguinal region showed enlarged lymph nodes that were tender, hard and fixed to underlying tissues with a maximum size of 3 x 4 cm. Dermoscopy showed irregular diffuse hyperpigmentation surrounded by greyish border and a parallel ridge pattern characteristic of macular portion of ALM[Fig. B]. Biopsy from lesion showed epidermis and dermis infiltrated by malignant neoplastic cells with high N:C ratio, coarse chromatin and cytoplasm filled with abundant brownish to blackish pigment[Fig. C-F]. PET scan showed metabolically active swelling in left foot and active left internal, external iliac and inguinofemoral group of lymph nodes.

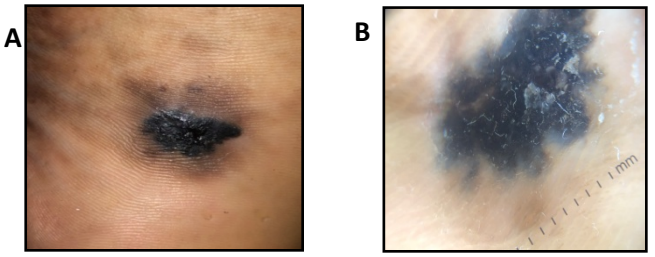
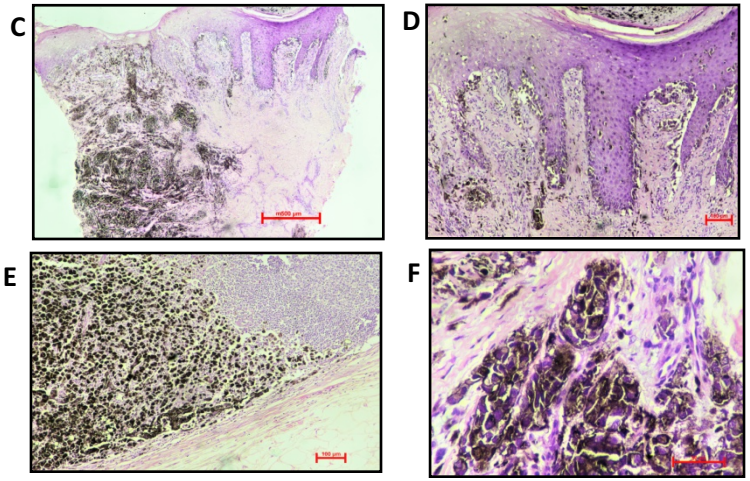


Figure [A] Single hyperpigmented plaque present on left sole. [B]: Dermoscopy:-Irregular diffuse hyperpigmentation surrounded by greyish border and a parallel ridge pattern present



Figure[C-F]: C: Collection of neoplastic cells infiltrating epidermis as well as dermis(100 X)

D: Magnified view of neoplastic cells infiltrating the epidermis (400X)

E: Neoplastic cells infiltrating up to the subcutis (100X)

F: Cells with high N:C ratio and cytoplasm filled with abundant brownish to blackish pigment (400X)

FNAC of lymph node was also suggestive of malignant melanoma. The patient was diagnosed with AJCC stage IV melanoma after wide local excision and dissection of reginal as well as pelvic nodes. The dissection site was covered with a split thickness skin graft taken from thigh and patient was started on chemotherapy.

Discussion

Acral lentiginous melanoma accounts for about 2% to 3% of all melanomas. Though melanomas are rare in Indian population, acral lentiginous melanoma is the most common subtype with most common presentation on soles[2]. Its relative rarity, atypical appearance and late presentation frequently serve as poor prognostic indicators. The out of site location of tumour prevents its detection during radial growth phase, thus associated with distant metastasis and unfavourable prognosis. Histopathology with immunohistochemistry is the gold standard method to confirm the diagnosis of melanoma. All patients with high index of suspicion for melanoma should be thoroughly investigated by biopsy, immunohistochemistry and dermoscopy so that early and appropriate treatment can be started for the same.

References

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