



## Simultaneous Presentation of Metastatic Melanoma to the Stomach and Siewert Type II Adenocarcinoma

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### Abstract

Melanoma is commonly known to metastasize and can spread to any organ, however, gastric metastases from melanoma are rare. We present an unexpected case of a 66-year-old woman, with previous history of dorsal melanoma excision, presenting 5 years later with 2 subcutaneous melanoma metastases on the dorsum and 1 on the gastric body. During endoscopic evaluation, esophagogastric junction adenocarcinoma was also diagnosed and the patient underwent total gastrectomy with distal esophagectomy. There are few reported cases of metastatic melanoma of the stomach and, to our knowledge, none with concomitant adenocarcinoma of the esophagogastric junction.

### Introduction

The incidence of melanoma has been rising in the last decades and the peak age is at 65 years. Melanoma is able to spread to everybody part and the most common sites for distant metastases are skin, lung, brain, liver, bone and intestine. Although metastases in the gastrointestinal tract are relatively usual, they rarely occur in the stomach. Metastatic melanoma to the stomach predicts a poor prognosis and if left untreated, is associated with a very short mean survival time. Esophagogastroduodenoscopy (EGD) remains the most reliable exam to diagnose gastric metastases. Surgical option should be offered whenever possible, even in a palliative setting, not only because it treats symptomatic patients but also prolongs survival time.

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### Case Presentation

We present a case of a 66-year-old woman with a history of hypertension, type 2 diabetes mellitus, dyslipidemia, lithotripsy due to nephrolithiasis and melanoma of the dorsum submitted to local excision and re-excision to widen margins and Sentinel Lymph Node (SNL) biopsy, which came out negative. Five years later, on a follow-up Computerized Tomography (CT) scan complemented with Positron Emission Tomography (PET) scan, a hypermetabolic lesion in the distal esophagus compatible with malignancy and a subcutaneous dorsal node also with malignancy suspicion were detected (Figure 1). The patient had no associated symptoms. Percutaneous biopsy results of the dorsal region nodules came out as compatible with melanoma metastases and so, local excision of right and left dorsal lesions was made. The final pathology report confirmed the diagnosis and molecular studies detected the presence of BRAF V600 mutations. An EGD was also performed and two different lesions were observed: A polypoid lesion in the hiatal hernia and a sessile polyp on the greater curvature of the gastric body. The first lesion turned out to be a Siewert type II adenocarcinoma and the latter corresponded to metastatic melanoma (Figure 2, 3). Being an oligometastatic disease in a patient with a good functional status, surgical resection was offered and total gastrectomy with distal esophagectomy, splenectomy and Roux-en-Y esophagojejunostomy was performed. The post-operative period was complicated with an Acute Respiratory Distress Syndrome (ARDS) secondary to Transfusion-Related Acute Lung Injury (TRALI) and a grade A Postoperative Pancreatic Fistula (POPF). The patient was discharged home 17 days after surgery and the pathology report described an exophytic tumor on the esophagogastric junction, corresponding to a moderately differentiated (G2) tubulopapillary adenocarcinoma (Figure 4), stage pT1bN0; 5 smaller polypoid lesions were identified which corresponded to melanoma metastases (Figure 5, 6). During hospitalization, a CT scan was performed revealing new metastatic sites, one in the abdominal wall, two in the back and one in the right upper lobe of the lung. In view of these findings, therapy with iBRAF/iMEK was proposed; however, in a little less than 2 months following surgery,

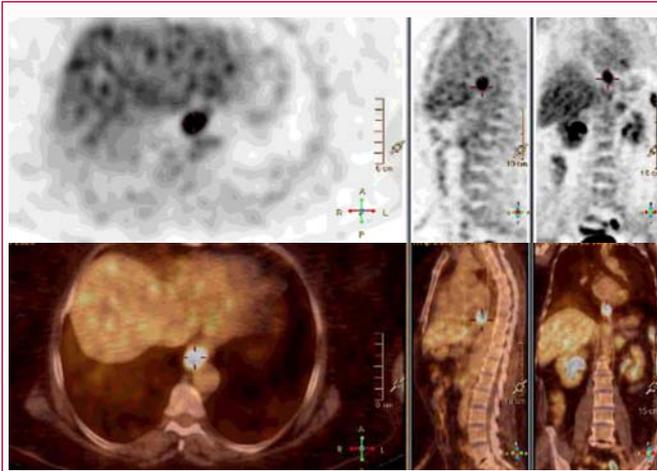


Figure 1: PET scan showing a hypermetabolic lesion in the distal esophagus.

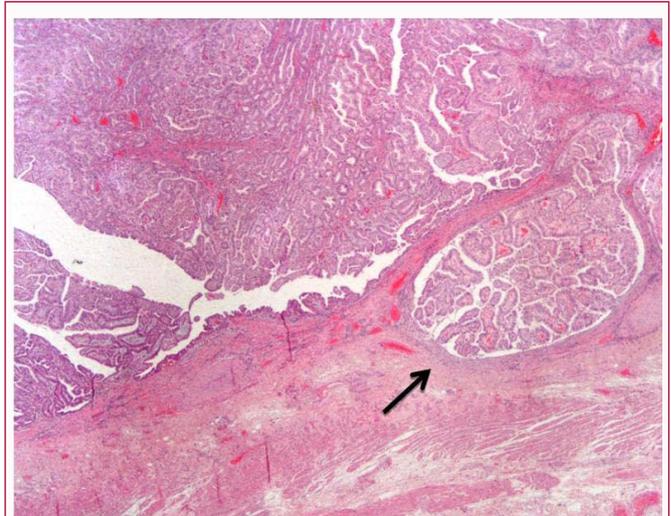


Figure 4: [HE 20x] – Moderately differentiated tubulopapillary adenocarcinoma of the esophagogastric junction invading the submucosa (arrow).

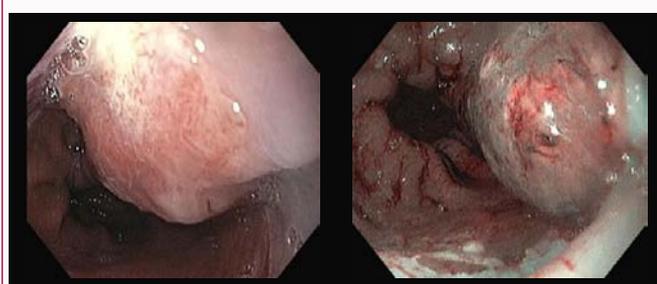


Figure 2: EGD viewing a sessile polyp in the hiatal hernia Siewert type II.

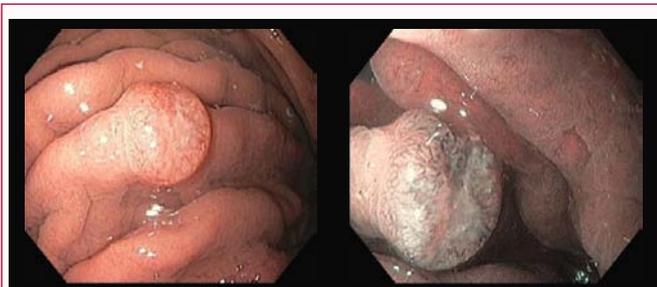


Figure 3: EGD viewing a sessile polyp in the greater curvature of the gastric body.



Figure 5: [formalin fixed gastrectomy specimen] – Esophagogastric junction exophytic tumor (circled) and 5 polypoid lesions with central ulceration (arrows).

the patient presented an acute pyelonephritis and was hospitalized in another institution where she eventually died from sepsis progression.

**Discussion**

Gastric metastases of melanoma are rare but under diagnosed as they are seen more frequently on autopsy examinations [1-3]. They usually occur within the first year after primary tumor detection. In our case, this diagnosis was made five years later. Clinical manifestations include abdominal pain, anemia or bleeding, weight loss and abdominal mass. Many patients, as in this case, are asymptomatic and may continue to be so for a long period of time. Endoscopy is the main diagnostic tool and lesions are usually solitary and located in the body or fundus of the stomach [4-7]. The appearance of these lesions may vary, including subtle mucosal changes, melanotic nodules (the most frequently seen), submucosal tumor masses ("bull's eye" lesions) and mass lesions, ulcerations, subepithelial growths or polypoid tumor masses. Even if the patient is

asymptomatic, with an acceptable functional status, surgical resection should be offered, as it is associated not only with symptom relief, thus improving the quality of life, but also results in prolonged survival time. The early diagnosis of the adenocarcinoma was only possible due to the strict follow-up of melanoma, detecting a lesion on CT and PET scan and thus requiring EGD to confirm this simultaneous presentation [8-11]. In our department, we prefer to perform an Ivor Lewis esophagectomy in Siewert type II adenocarcinoma, but in this patient, given the fact that the prognosis was deeply associated with the metastatic disease of the melanoma, we accepted a compromise of total gastrectomy with distal esophagectomy. The most important prognostic factors are surgical resection with curative intent and the gastrointestinal tract as the initial site of distant metastasis. Following curative surgery, metastasis location, number of metastases and time interval between initial diagnosis and metastasis development are the main predictive factors.

**Conclusion**

Gastric metastases of melanoma are rare and portend a bad

prognosis. Surgical resection should always be taken into consideration as it contributes to symptom relief and improvement in mean survival time. We report a case of a simultaneous presentation of metastatic melanoma to the stomach and an esophagogastric junction Siewert type II adenocarcinoma in a 66-year-old woman who underwent total gastrectomy and distal esophagectomy. This rare site of melanoma metastasis associated with an esophagogastric junction tumor marks this case as unique and very interesting to report.

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