Clinical picture

Primary melanoma of the oral cavity

A 75-year-old white man presented with a 4-month history of a slowly growing, pigmented soft mass of the oral cavity. Physical examination revealed an asymptomatic vegetant nodule, white-red to blue-black in colour, arising from the right edentulous maxilla (Figure 1). The lesion had well-defined borders, and appeared to not involve the contiguous alveolar ridge and the hard palate.

Neck palpation was performed, with no abnormal findings. A complete blood count, biochemical profile and urinanalysis were also unremarkable, as well as the chest X-ray examination.

The lesion was surgically excised with limited margins. Histopathologically, the biopsy demonstrated a nodular proliferation of atypical spindle-shaped cells in the submucosa, partially arranged in nests and fascicles (Figure 2), with pigmented melanoma cells invading the deep layer (maximum depth: 0.5 mm). Tumour cells strongly expressed S100 protein, gp100 (HMB-45) and Melan-A.

Histopathological and immunohistochemical features were consistent with the diagnosis of malignant melanoma. The surgical margins were microscopically free from disease. Work-up for distant metastases, including computed tomography (CT) scan of chest, brain and abdomen and positron emission tomography (PET) was negative. Current patient management includes clinical examination and CT scans every 6 months. At 12-months follow-up, no evidence of the disease has been detected.

Primary malignant melanoma of the oral cavity (PMO) is rare, accounting for <1% of all melanomas.1 It represents 0.5% of all oral neoplasia and mainly occurs in the sixth decade of life, two decades later than cutaneous melanoma, with a male:female ratio of 2.5–3:1.2

PMO may present a variety of clinical features that are, anyway, similar with its cutaneous counterpart. The most common picture of PMO is that of a rapidly growing, asymptomatic brown, dark blue to black macule or nodule, with red or withish areas of erythema and/or ulceration. It is usually located on the mucosa that covers the bone tissue, such as that of the hard palate and maxillary gingival.3 In anamnesis, pre-existent melanocytic nevi are reported in only a minority of cases.2

Because of the unusual anatomic location, so the advanced stage of the disease at presentation, and the lack of specific guidelines for its management,
PMO has a poor prognosis, with a 10–20% 5-year survival rate.\textsuperscript{2,4} Histologically, POM is not classified into the classical cutaneous melanoma categories (nodular, superficial spreading, lentigo maligna and acral lentiginous melanoma), being considered simply \textit{in situ} and invasive variants. Moreover, the Breslow and Clark grading systems have not been validated as prognostic predictors.\textsuperscript{2,3}

The treatment of choice is wide surgical excision, but presents some difficulties in obtaining adequate surgical margins, because of anatomical and functional concerns.\textsuperscript{4}

Differential diagnosis may be intriguing, and includes amalgam tattoo, vascular neoplasms (as Kaposi’s sarcoma), Peutz-Jeghers syndrome, Addison’s disease, physiological, post-inflammatory or drug-induced pigmentation.\textsuperscript{2}

Photograph and text from: C. Guarneri and M. Vaccaro, Department of Social Territorial Medicine, Section of Dermatology, University of Messina, Messina, Italy. email: cguarneri@unime.it

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\section*{References}