

Case Report

Malignant melanoma of index finger

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Abstract Malignant melanoma is rarely encountered in pigmented skin. Acral melanoma is the usual type seen in coloured skin. It can present as palmar, solar or subungual melanotic macules. In subungual location, the diagnosis may be delayed. We describe an adult female with acral malignant melanoma in whom the diagnostic delay led to spread of disease to regional lymph nodes.

Key words

Malignant melanoma

Introduction

Malignant Melanoma is an uncommon cancer in Pakistan unlike in the western world where it is the commonest skin cancer. Melanomas of the extremities are rare.

Surgical management is a difficult and challenging problem. We report a case of malignant melanoma in a 50 years old female who presented with an ulcerated lesion of her index finger and a mass in axilla. Biopsy confirmed the diagnosis. Surgical removal of the primary lesion and axillary nodal clearance had a successful outcome.

Case

A 50-year-old lady, resident of Quetta, presented with a history of purulent discharge from her right index finger under the nail with a blackish ulcer. This was initially dealt with by drainage by her family

physician. The condition got worse and a swelling appeared in axilla. Excision biopsy of the nail bed revealed fragments of squamous epithelium with underlying tissue exhibiting a pigmented neoplastic lesion comprising of cells with abundant melanin pigment, prominent nucleoli and marked degree of pleomorphism, these cells invading into the overlying epithelium, suggestive of malignant melanoma.

On examination she was an average built, fair skinned woman who was vitally stable. A bleeding ulcer, discharging pus with pigmentation was noticeable at the right index finger under the nail bed. There was a palpable node in the right axilla. Systemic review was within normal limits. Routine preop tests were normal. Radiological metastatic workup including CT scan of chest and abdomen confirmed presence of large right axillary nodes measuring 4.1x 3.1 cms. No infiltrate, mass or consolidation was seen in either lung. Mediastinal and hilar lymphadenopathy was absent. Abdomen was normal with absence of any

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Figure 1 A bleeding ulcer with discharging pus and pigmentation affecting the right index finger.



Figure 2 Dissection of right axilla showing a large black nodal mass

lesion in liver, gallbladder, spleen, pancreas, adrenals, kidneys, urinary bladder and the uterus. No evidence of abdominal or pelvic lymphadenopathy was present.

Surgical treatment included disarticulation of right index finger at metacarpophalangeal joint and axillary dissection with removal of large black nodal mass (**Figure 2**). The patient had smooth post-op recovery. Biopsy later confirmed Stage III malignant melanoma.

Discussion

John Hunter (1728-1793) first described malignant melanoma in 1787.¹ Jonathan Hutchinson (1828-1913) described a flat-

pigmented brown to black melanocytic naevus with malignant potential that occurs on sun-damaged skin on the face, dorsum of the hands and forearm.² The malignant transformation occurs in the fifth to seventh decades. These tumours are the commonest skin cancer in the west in whites and relatively rare in blacks.¹⁻⁴ The largest study of skin cancer in Pakistan by Mansoor *et al.*⁵ reported an incidence of 1.2 % in their series. Another study from Karachi by Yasmeen *et al.*⁶ showed an incidence of only 5 cases of malignant melanoma out of 75 skin tumors, with 2 belonging to extremities. Khursheddi *et al.*⁷ had previously reported the first ever case of cutaneous melanoma of the sole of the foot in Pakistan in a 97-year-old woman. This case report adds to the list of this exotic tumor at a site hitherto not reported in local literature. We plan chemotherapy and immunological manipulation with interferon for the control of the disease. Wide local excision or amputation (e.g. for subungual lesion) and regional lymph node dissection for clinically positive nodes is the treatment of choice. Palliation may be achieved with radiotherapy, or by using cytotoxic agents systemically or regional perfusion with dacarbazine, cisplatin, and nitrosoureas with variable response.

Finally we would again emphasise the point that any lesion on the skin, which suddenly shows signs of enlarging, must be biopsied as early as possible.

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