Primary malignant melanoma of the common bile duct: a case report and literature review

N. Bejarano González, N. García Moforte, A. Darnell Martín, M.C. Dinarès Fernández, E. Laporte Roselló and S. Navarro Soto

*Department of General Surgery, Hospital de Sabadell. Corporació Parc Taulí, Sabadell, Barcelona, Spain.
†Department of Radiology, Hospital de Sabadell. Corporació Parc Taulí, Sabadell, Barcelona, Spain.
‡Pathology Department, Hospital de Sabadell. Corporació Parc Taulí, Sabadell, Barcelona, Spain.

ABSTRACT

Primary malignant melanoma of the common bile duct is rare. Only seven cases have been described in the literature. Diagnosis is based on failure to find another primary site, histological examination with electron microscopy, and immunohistochemical tests. We describe a new case of primary malignant melanoma of the biliary tract and present a review of previous reports.

INTRODUCTION

Primary gastrointestinal melanoma is rare. Most gastrointestinal melanomas are metastatic from primary cutaneous lesions. Only eight cases of primary malignant melanoma of the common bile duct (CBD) have been described in the literature. The diagnosis is based on failure to find another primary site, histological examination with electron microscopy, and immunohistochemical tests.

CASE REPORT

A 47-year-old-man presented in July 2000 with progressive jaundice for 3-4 weeks, weakness, and anorexia leading to weight loss, as well as occasional right upper quadrant abdominal pain. He had been under treatment for a depressive syndrome for the previous 5 months and his medication had been changed due to a rise in serum aminotransferases. Liver function tests at admission showed pronounced cholestasis (total bilirubin 13.9 mg/dl, conjugated bilirubin 9.1 mg/dl, alkaline phosphatase 703 U/L, gamma glutamyl transferase 72 U/L) and mild hepatic cell necrosis (alanine aminotransferase 99 U/L (normal < 41 U/L) aspartate aminotransferase 44 U/L (normal < 37 U/L) without liver failure. Ultrasound showed intra- and extrahepatic bile duct dilatation with multiple hyperechogenic polypoid mural masses in bile tree and gallbladder.

Pathological findings were positive for malignant melanoma cells (figs. 3a-b). Histologically, neoplastic cells were large, hyperchromatic and had irregular nuclei, as well as a moderate eosin cytoplasm, with a significant presence of melanic pigment. They showed a poorly cohesive pattern. Because of the spread of the disease, surgery was rejected. Percutaneous drainage and biopsy of the gallbladder and biliary duct lesions were performed, and an endoprosthesis was placed. Pathological findings were positive for malignant melanoma cells (figs. 3a-h). Histologically, neoplastic cells were large, hyperchromatic and had irregular nuclei, as well as a moderate eosin cytoplasm, with a significant presence of melanic pigment. They showed a poorly cohesive pattern.
pattern and were sometimes found in isolation. Nucleoli were prominent
with occasional nuclei pseudoinclusions. Neoplastic cells were reactive
to antibodies to S-100 protein, HMB-45 and vimentin and were negative
to keratin antibodies (Q116).

A thorough physical examination including particular attention to the
skin, eyes, and digestive tract failed to reveal another primary source.
We concluded that the primary site of the malignant melanoma was the
biliary tract itself.

Due to disease progression, chemotherapy was indicated. Beginning in
March 2001, three cycles of 850 mg/m$^2$ dacarbazine every 21 days and
interferon 2b 3 million/3 times a week were administered, but the disea-
se spread to the stomach, spleen and lymph nodes. In October 2001, a
new palliative line of chemotherapy was initiated with three cycles of
carboplatin AUC 5, but the disease spread to subcutaneous, peritoneal,
kidney and gastrohepatic areas. The patient had good quality of life and
pain was controlled with metamizol, despite disease progression for 5
more months. He was included in a clinical trial of a new chemotherapy
protocol but was withdrawn from the program because of poor clinical
course. He died in June 2002.

DISCUSSION

Although malignant melanoma usually originates on the
skin, it can also develop from squamous mucous mem-
branes, uvea, retina, and leptomeninges. Primary gas-

trointestinal melanoma is rare and most gastrointestinal
melanomas are metastatic from primary cutaneous les-
ions, which are the most common tumors to metastasize
to the gallbladder. New diagnostic imaging techniques
allow a presumptive diagnosis to be made, as in our case$^1$.
It is important to establish a diagnosis of primary tumor,
and the steps to do so are well documented. Firstly, the
clinical absence of a primary cutaneous or visceral mela-
noma must be verified. To distinguish primary from me-
tastatic melanoma, a junctional component, formed by
clustered melanocytes at the mucosa-submucosa junction
adjacent to the tumoral mass, must be identified and defi-
ned by immunoreactivity (S100). This is the most conclu-
sive histologic evidence for primary melanomas in unu-
sual locations$^2$. Primary malignant melanoma of the CBD was first des-
cribed by Zaide$^3$ in 1963. Since then, seven other cases
have been reported. The first case reported was a 47-year-
old man with a 3-month history of obstructive jaundice.
He was treated by cholecystectomy and resection of the

Figs. 2a-b. Magnetic resonance cholangiopancreatography showed an
obstructive intraluminal mass in the distal common bile duct (CBD) and
multiple polypoid mural gallbladder masses.

Figs. 3a. Wide cytoplasm cells with abundant melanic pigment, irregu-
lar nuclei with cytoplasmic inclusions, and mitotic figures (hematoxylin-
eosin stain ×400). b) Abundant melanic pigment is shown in black (Font-
tana stain ×400).
CBD. There was no evidence of metastatic lesions and he was alive 6 months after surgery.

The second case, published by Carstens et al in 1986 and Wright et al in 1988, describes biliary tract obstruction in a 30-year-old man due to a primary malignant melanoma. A Whipple resection was performed and the primary origin of the tumor was confirmed by immunohistochemistry and electron microscopy. The patient had lymph node metastases and developed multiple liver metastases 1 month after surgery. He died 6 months later.

In 1991, two more cases were published. Deugnier et al described an obstruction of the extrahepatic bile duct due to malignant melanoma in a 34-year-old woman. Treatment consisted of a left hepatectomy with partial right hepatic bile duct and CBD resection. Clinical course was poor, with progressive involvement of lymph nodes and subcutaneous nodules. The patient died 18 months after diagnosis.

In the same year, Zhang et al reported a 58-year-old man presenting with obstructive jaundice caused by a CBD mass and another mass involving the gallbladder. After histologic diagnosis, a Whipple operation was performed. Two years after resection, the patient was alive and apparently disease-free.

Gates et al reported two cases in 1996. The first concerned a 45-year-old man with a 1-month history of obstructive jaundice. A Whipple technique was carried out, and 6 years later he was well and without signs of disease. The second case was a 43-year-old man who had experienced symptoms similar to those of the previous cases for 2 months. He underwent a right hepatectomy, cholecystectomy, and excision of the extrahepatic biliary tree for a lesion at the junction of the CBD. He remained alive and well 11 months after resection.

The last case before ours was published in 2000 by Wagner et al. A 48-year-old man presented with symptoms of acute cholecystitis. An open cholecystectomy was performed on an acalculous and necrotized gallbladder. He had an uneventful postoperative course and 6 weeks later he presented obstructive jaundice caused by a primary malignant melanoma. Initially, a T-tube was inserted into the proximal bile duct and 4 weeks later a Whipple operation was performed. Three months later he presented brain metastases and died 9 months after the initial diagnosis.

Metastatic melanoma rarely involves the CBD. Necropsies show only 6% of cases with CBD metastases in patients with primary melanoma at another site. Primary melanoma of the CBD is usually an intraluminal polypoid tumor with a single pedicle. In contrast, metastatic melanoma has usually been described as multiple, small, flat and pigmented nodules. The criteria used to make the diagnosis of primary melanoma include size and shape of the tumor, the presence of junctional activity (S-100 protein) and, most importantly, the lack of other primary sites. Nevertheless, Higgins et al have questioned the existence of primary melanoma in the gallbladder and bile duct because they found a metastatic melanoma at these sites with the features of a primary tumor. Further studies and follow-up are required to understand this entity but, given its rarity, this will not be easily achieved.

REFERENCES


3. Verbanck JJ, Rutgeerts LJ, van Aelst FJ, Tyszat JH, Decoster IM, Noi


