

Case Report

From Corn to Cancer: A Case Report of Acral Melanoma with Unusual Longevity

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ABSTRACT

Melanoma is one of the most aggressive and lethal skin cancers worldwide. Although melanoma is more common over sun exposed areas, few variants arise from sun protected sites. One of such variants is acral melanoma (AM). We present a case of 68-year-old male with 12 years history of development of multiple, brown-to-black coloured outgrowths on the heel of the right foot along with reddish swelling in the right groin area since a few months. Patient's histopathological examination was consistent with the diagnosis of malignant melanoma. AM, one of the aggressive varieties, is often misdiagnosed and has poor prognosis. Here, we report a case of AM with disease duration of 12 years which led to dilemma in the diagnosis.

Keywords: Acral melanoma, Pigmented lesion, Skin of colour

INTRODUCTION

Acral melanoma (AM) is a rare form of melanoma in Caucasians but is the most common subtype found in individuals with darker skin, particularly those of Asian or African descent. The term 'acral' refers to the melanoma's location on the extremities, specifically the skin of hands and feet, including the nail unit.^[1-3] AM commonly appears in individuals aged 60 and above as a pigmented spot or raised lesion on the palms or soles. It typically features irregular borders and uneven coloration. As the disease progresses, the lesions can enlarge and develop into raised nodules with areas of blue-black pigmentation.^[4] Patients with AM tend to have a poorer prognosis, with 5-year survival rate being 64%, aligning with results reported in other Asian populations.^[5,6] This is largely attributed to delayed diagnosis or presentation at a more advanced stage compared to other melanoma subtypes.^[2,3] The exact causes of acral lentiginous melanoma are not well understood; however, factors such as trauma, pre-existing nevi, and chronic inflammation are frequently suggested as potential contributors. Unlike other variants, ultraviolet radiation does not play a role in aetiology of AM.^[7] We, hereby, present a case of AM arising on plantar skin where the time of onset of lesion to diagnosis was 12 years.

CASE REPORT

A 70-year-old male, farmer by occupation, presented with multiple, black, exophytic growths on the right heel for 12 years and a swelling in the right groin area since last few months. Patient first noticed a papule over plantar aspect of the right foot 12 years back without any apparent injury, which gradually progressed in size, number and with increased pigmentation of the

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nodular outgrowths. Patient underwent complete excision of the lesion 7 years back which then recurred after 6 months as multiple black-coloured nodules over the previously excised area and progressed rapidly to involve whole heel extending to the dorsum of the right foot.

Cutaneous examination revealed multiple, non-tender, well defined, black coloured nodules and plaques of varying sizes (smallest being 1 × 2 cm and largest 4 × 2 cm) on sole of the right foot extending up to the medial malleolus with intermittent areas of scarring extending to the dorsa of foot [Figure 1]. A few papules to nodules of similar morphology were present over the right shin [Figure 2]. Lymph node examination revealed presence of multiple enlarged masses matted together with irregular surface, firm to hard in consistency, non-tender, measuring about 5 × 4 cm, not adherent to the overlying skin in the right inguinal/femoral region with erythema of the overlying skin.

Based on clinical history and examination, differential diagnosis of chromoblastomycosis, lupus vulgaris and malignant melanoma were kept and skin biopsy was sent for histopathological examination and tissue cultures.



Figure 1: Clinical picture of the right foot showing multiple, well to ill-defined, hyperpigmented nodules of varying sizes with intermittent areas of scarring over (a) Sole of the right foot and (b) Nodules extending to the medial malleolus.



Figure 2: (a) Clinical picture of the right leg of the same patient showing two, well-defined, black coloured satellite nodules on the shin (red arrow). (b) Inguinofemoral mass with erythema of overlying skin (black arrow).

Histopathology revealed pleomorphic malignant tumour cells with coarse nuclear chromatin, prominent nucleoli and moderate amount of cytoplasm arranged as diffuse sheets and nests at dermo-epidermal junction and dermis, showing atypical mitosis, extracellular and intracellular melanin with 6 mm Breslow's thickness and no pagetoid spread. Immunohistochemistry showed positivity of malignant cells with Masson-Fontana stain [Figure 3]. These findings confirmed the diagnosis of acral lentiginous melanoma. Fine-needle aspiration cytology from the right inguinal lymph nodes revealed metastatic infiltration by melanoma cells. Investigations to look for solid organ metastasis were within normal limits (T4aN3M1a). Patient was managed with wide local excision of the lesion along with inguinal lymph node dissection followed by adjuvant radiotherapy but unfortunately, succumbed to his condition after 1 year of diagnosis.

DISCUSSION

The palms and soles are regularly exposed to repeated trauma and mechanical stress. In support of this, two case series AM investigated history of trauma: One found that 13% of 119 patients reported incidents such as puncture wounds, stone bruises, friction blisters or contact dermatitis, while another reported similar incident in 25% of 35 patients.^[1,8] Frequently misinterpreted as corn, plantar wart, chronic wounds post trauma or diabetic foot leads to misdiagnosis in approximately 60% cases of melanoma of foot. Around one-third cases of AM have been first evaluated as chronic infective condition.^[9] AM is often diagnosed after a significant delay, with reported time frames ranging from 1

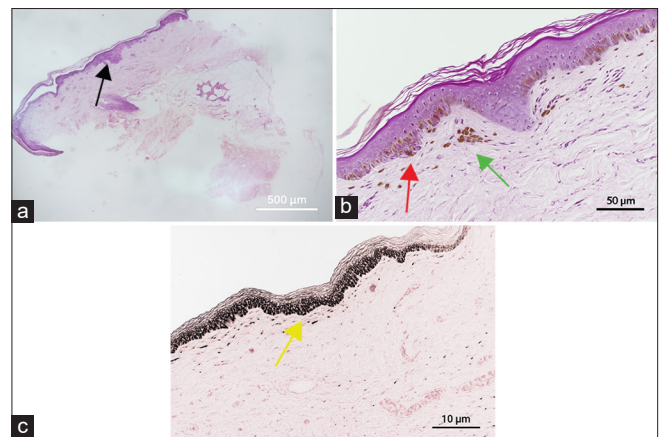


Figure 3: (a) Histopathology at 4x (scanner view) showing diffuse sheets of tumour cells at dermo-epidermal junction (black arrow). (b) Histopathology at 10x showing pleomorphic malignant tumour cells with coarse nuclear chromatin, prominent nucleoli, atypical mitotic figures, moderate amount of cytoplasm arranged as diffuse sheets and nests at dermo-epidermal junction (red arrow). Tumour cells show extracellular and intracellular melanin with no pagetoid spread (green arrow). (c) Immunohistochemistry at 10x showing positivity of malignant cells with Masson-Fontana stain (yellow arrow).

to 3.7 years between the onset of symptoms and diagnosis.^[10] Exceptionally long duration of 12 years in our patient in such a rapidly fatal disease condition as malignant melanoma lead us in dilemma of an infective or malignant aetiology at the time of presentation.

In our case, the patient had an exceptionally prolonged disease course of 12 years, which is highly unusual for a malignancy as aggressive as melanoma. Initially, the lesion presented as a painless, brown-to-black macule on the sole, which was clinically diagnosed as a corn or wart. After multiple extractions, the lesion recurred at the same site and progressively evolved into a nodular growth. Despite repeated removals, it continued to recur and expand across the sole.

This clinical course was highly suggestive of acral nodular melanoma. However, histopathology revealed lentiginous spread, typically associated with prolonged radial growth and less aggressive behaviour, which could explain the patient's unusually long survival. The 12-year symptomatic period implies a predominantly radial growth phase, rather than early vertical invasion seen in typical acral nodular melanomas. The natural history in this patient appears more consistent with acral lentiginous melanoma, despite the nodular clinical morphology.

CONCLUSION

Melanoma is an aggressive carcinoma with a lethal disease course, high mortality rate especially in older age group and acral sites being poor prognostic factors. Our case report emphasises a critical point regarding melanoma, particularly in regions like the Indian subcontinent where it is not as prevalent. The atypical longevity and asymptomatic nature of the disease in our case underscore the challenges in timely diagnosis and management. Melanoma's varied presentation indeed complicates its recognition, especially when physicians may not consider it as a primary differential diagnosis due to its lower prevalence. This often results in underdiagnosis and delayed intervention, contributing to its poor prognosis. Enhancing awareness among healthcare providers and the general public about the diverse presentations of melanoma and the significance of early detection is essential for improving clinical outcomes.

Ethical approval: Institutional Review Board approval is not required.

Declaration of patient consent: The authors certify that they have obtained all appropriate patient consent forms. In the form, the

patients have given their consent for their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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