Dear Editor,

We report the case of a 71-year old male presenting with urethral bleeding for the previous 10 days and the appearance of a pigmented lesion seen through the urinary meatus. There were no other associated clinical manifestations. Physical examination, including the palpation of inguinal lymph node chains, complete blood count and the blood biochemistry findings proved strictly normal. Cystoscopy revealed the presence of a nodular, friable and gray-colored lesion measuring about 17 × 7 mm in size, located in the fossa navicularis, and which was subjected to biopsy. The pathology report described a proliferation of polygonal cells with spherical and hyperchromatic nuclei that stained positively for HMB45, melanin A, vimentin and S100, with negativity for keratin. These observations were consistent with primary urethral melanoma. A thoracoabdominal and pelvic CAT scan indicated no lymph node or visceral metastatic involvement. At this point partial amputation of the penis was carried out, with tumor-negative resection margins. The bilateral sentinel node technique proved negative, as a result of which lymphadenectomy was not carried out. The results of the urethral biopsy were confirmed in the surgical resection piece.

During the follow-up of this patient, PET-CAT was performed 6 months and one year after surgery, with normal findings. Six months later, the patient presented with pain and abdominal bloating for the past two weeks, with signs of ascites at exploration. Thoracoabdominal CT confirmed the presence of ascitic fluid, as well as thickening of the peritoneum and mesenterium, and the presence of a retroperitoneal adenopathic mass, bilobular liver metastases measuring up to 6 cm in size, multiple lung nodules and bilateral pleural effusion (fig. 1). The blood tests in turn showed an LDH concentration of 833 IU/L. Paracentesis was performed, with the obtained serohematic fluid. With a diagnosis of metastatic melanoma recurrence, palliative chemotherapy was started with intravenous dacarbazine at a dose of 250 mg/m² during 5 days. Three weeks later the patient developed hemorrhagic ascites and multiorgan failure, with pancytopenia secondary to palliative intravenous dacarbazine chemotherapy – leading to the death of the patient a few days later, despite the pharmacological and supportive treatment provided.

Urethral melanoma is a very infrequent variant of melanoma, particularly in the male, and has a very poor prognosis due to the aggressive nature of the disease and the fact that the diagnosis is generally established in advanced stages. Due to the difficulties in accessing these lesions, the secondary preventive measures adopted in application to this type of neoplasm are not useful. Approximately one-third of all patients have lymph node involvement at the time of diagnosis, with an overall survival after 5 years of less than 30%. The Breslow classification in application to these tumors is insufficient, due to the increased aggressivity of the disease with respect to skin melanomas. As a result, in clinical practice they are classified as follows: stage i-ii for localized disease; stage iii in the presence of regional (inguinal) lymph node involvement; and stage iv for metastatic disease. As regards treatment, only stage i-iii disease is potentially curable provided surgery is as aggressive as possible (total or partial penectomy with lymphadenectomy in the case

Figure 1 – Abdominal computed axial tomography views showing liver metastases, ascitic fluid and retroperitoneal nodules.
of lymph node involvement), and ensuring microscopically tumor-free surgical resection margins of at least 2 cm – since partial urethrectomy is associated with a 50-70% local recurrence rate in the first year. This objective is difficult to reach in male urethral melanomas, however, due to the traumatic nature of the amputation. Exenteration techniques are only used with palliative intent.

Adjuvant immunotherapy is indicated in cases with residual disease after surgery, or in those patients with lymphatic involvement (a situation not found in our patient) – the standard treatment being interferon-α 2b at a dose of 20 million IU/m² 5 days a week during four weeks, followed by maintenance therapy at a dose of 10 million IU/m² three days a week during 48 weeks. In stage iv patients palliative chemotherapy should be evaluated – the first line option being dacarbazine or temozolomide, while sorafenib plus paclitaxel and carboplatin can be regarded as second line treatment, though in most cases response and survival are very poor.

REFERENCES


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