Lesson of the Week

Missed malignant melanomas

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Early diagnosis of malignant melanoma of the skin may be life saving, for though disseminated metastatic disease carries a poor prognosis, early superficial spreading primary lesions with limited penetration into the dermis carry an excellent prospect of cure. Indeed, the depth of the invasion of the primary cutaneous lesion is a major determinant of prognosis.[1]

In the past 18 months we have seen several cases of primary cutaneous malignant melanoma arising on the face in which the diagnosis had been repeatedly overlooked—sometimes for several years—by doctors who had seen the patient for other disorders. We have termed such cases "missed malignant melanoma" as in each case not only was the diagnosis missed but also the opportunity to treat the patient at an early stage in the disease, when there would have been an excellent prospect of cure and less radical surgery would have been necessary.

Lesions of malignant melanoma are often overlooked for several years. Early diagnosis results in an excellent prospect of cure and entails less radical surgery than that required after the lesion has penetrated deep into the dermis

Case reports

Case 1—A 37 year old woman had had a flat, brown pigmented lesion on the cheek for 10 years. During pregnancy a deeply pigmented tumour developed, arising from the flat lesion (fig 1); she saw five different doctors at the local maternity hospital on 14 occasions, but none commented on the facial tumour. Nodular malignant melanoma was finally diagnosed by a general practitioner three months postpartum. The lesion was widely excised, and she required extensive plastic reconstruction of the cheek. The depth of the tumour was 2·2 mm. She was completely unaware of the importance of the lesion until the diagnosis was made. Her prognosis was uncertain, whereas if the diagnosis had been made earlier complete cure would have been likely.

Case 2—A fit 81 year old man presented with a haemorrhagic nodule in the centre of the forehead, which had been present for two months. The nodule had arisen from an extensive flat pigmented lesion, which had gradually developed over 18 years; during this time he had consulted numerous doctors for a variety of incidental, minor complaints and none had commented on the facial lesion. Acute haemorrhage and formation of a tumour finally led to his referral. The nodule was excised and confirmed to be a nodular malignant melanoma penetrating deeply into the dermis and arising from a lentigo maligna. The whole area was subsequently excised and grafted. The prognosis was probably reasonably good as Hutchinson's lentigo malignant melanoma is the least aggressive form of malignant melanoma, but delay in the diagnosis led to unnecessary extensive surgery.

Case 3—A 72 year old retired ward sister was referred because of a small rodent ulcer on the face. This lesion had been noted by a consultant physician whom she had been attending over the preceding year. An incidental finding on examination of the skin was an extensive lentigo maligna, which had been gradually enlarging over the past 15 years. In view of the site and extent of the lesions surgical excision would have required skin grafting, and she refused this. Diagnosis at an earlier stage would have permitted simple excision without grafting. Careful follow up was required to pre-empt vertical invasion, which would make surgical excision of the nodule mandatory (fig 2).

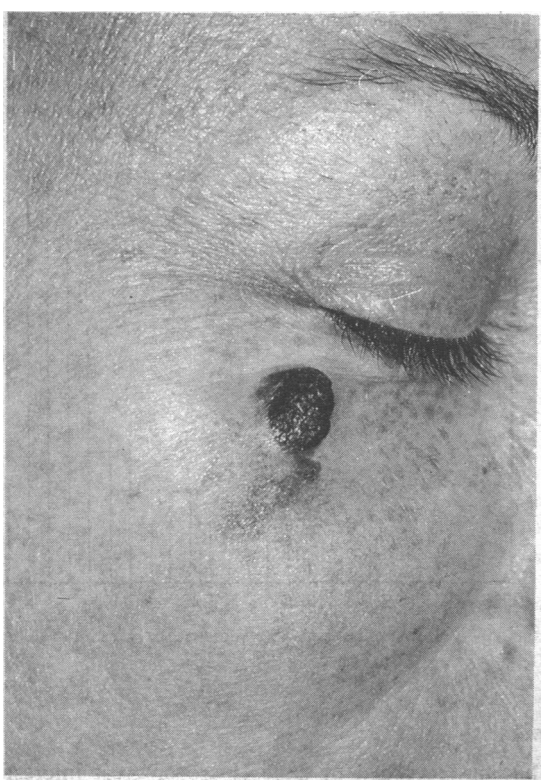

FIG 1—Malignant melanoma on the cheek.

Case 4—An 82 year old man was referred for treatment of a seborrhoeic wart on the face. An incidental finding, on which neither the patient nor the referring doctor had remarked, was a malignant melanoma on the right temple. This was successfully treated by excision and grafting.

Case 5—A 74 year old man was eventually referred by his general practitioner for treatment of a nodular malignant melanoma of the face (fig 3). The lesion had been present for four years. In that time he had been regularly followed up by two consultant physicians and one surgeon at a teaching hospital for unrelated conditions; the malignant melanoma had not been remarked on. The lesion was excised and found to have a Breslow thickness of 3·3 mm. He remained well three years later.

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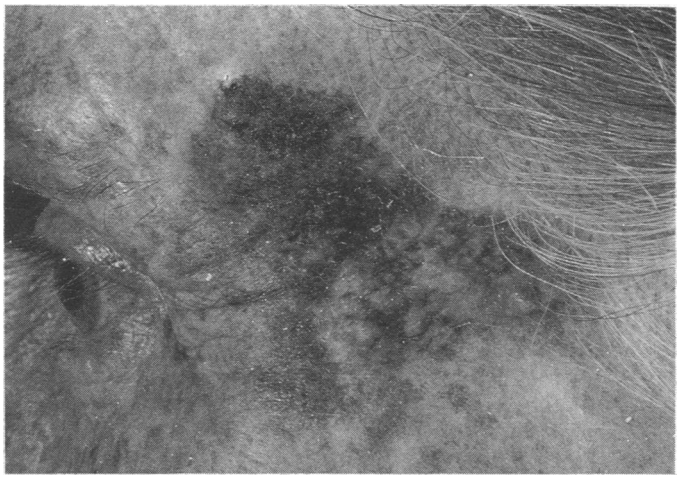

FIG 2—Lentigo maligna melanoma on the temple.

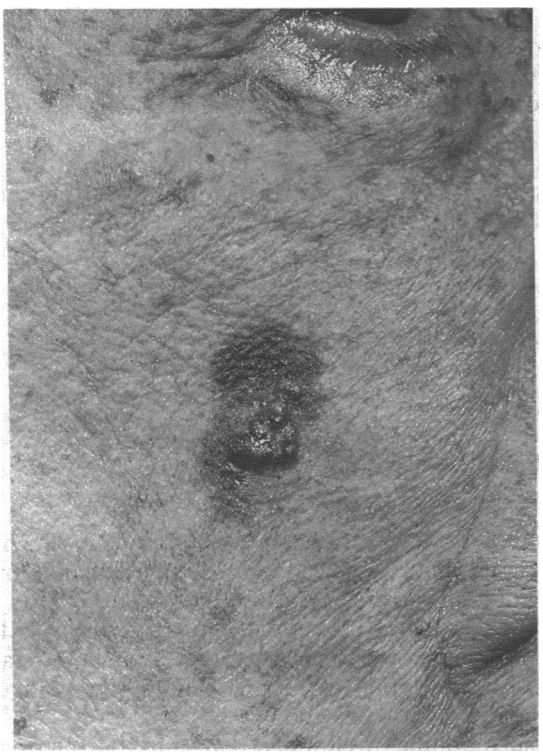

FIG 3—Nodular malignant melanoma.

Discussion

Primary cutaneous malignant melanoma should no longer be regarded as a rare form of cancer: in 1983 it accounted for 853 deaths in England and Wales,[2] and reports from many parts of the world including Britain have shown a rapid increase in both the incidence of and mortality from the disorder.[3] In the South East Thames Region the Thames Cancer Registry recorded an increase in incidence from 116 cases in 1968 to 172 in 1982.

The prognosis of the disorder is influenced to a major degree by the depth of penetration of the primary tumour into the dermis. Lesions penetrating less than 1·5 mm carry a five year survival of 89%, whereas those that penetrate by more than 3 mm carry a five year survival of only 55%.[1] Thus early diagnosis is essential if a good outcome is to be ensured, but clearly this also depends on early presentation of patients to their medical practitioners. In Queensland, Australia, where the incidence of cutaneous malignant melanoma is the highest in the world, an intensive programme of public education has been associated with an increase in the proportion of patients in whom the condition is diagnosed in the early horizontal growth phase.[4]

In Britain public awareness of skin cancer in general and malignant melanoma in particular is poor. Patients who delay seeking medical attention until late symptoms such as ulceration and haemorrhage have developed are, regrettably, all too common; furthermore, a recent study of patients with melanoma in Scotland indicated that the reason for delay in presentation is generally ignorance of the importance of the change in appearance of a pigmented lesion rather than any fear of the diagnosis.[5]

Notwithstanding the importance of public education in the early diagnosis of malignant melanoma it must be remembered that areas such as the back or the back of the calf—common sites for melanoma—are not readily accessible to inspection by patients. We previously drew attention to the phenomenon of the "incidental malignant melanoma," a lesion unnoticed by the patient but found in the course of an examination for some incidental complaint.[6] Such cases continue to present in our clinic and emphasise the importance of inspecting the skin in any general medical examination. The cases reported here differ in that the lesions were on the face and obvious to the patients but their importance was not appreciated. In each case the lesion had been overlooked, sometimes for months or years, by a succession of doctors attending the patient for some other complaint. Diagnosis at an earlier stage might have given the patient a far better prognosis or permitted successful treatment with more limited surgical intervention.

The ultimate aim of health education for malignant melanoma is to reduce the incidence of the disorder by alerting those at the greatest risk—that is, fair or freckled people whose skin burns rather than tans (or burns before it tans)—to the hazard of recreational exposure to ambient ultraviolet light. Until such an aim is achieved, reducing the mortality of malignant melanoma depends on recognition of the primary lesion at an early phase in its growth, and certainly before the well known sinister features of nodules, ulceration, and haemorrhage have occurred. As the skin is an organ uniquely readily accessible for inspection and as patients are all too often unaware of the importance of pigmented lesions all practitioners should be alert to the possibility of making a potentially life saving diagnosis of early malignant melanoma in their patients.

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