

Scalp Melanoma- What Lies Beneath Is More Important: A Case Report

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Abstract: Melanomas are a aggressive group of malignancy with the prognostic aspect dependent heavily on the type and site of occurrence. The treatment should be holistic based and not simply surgical resection. This case report focuses on the multiple lines of melanoma management and the significance of early radical intervention

Keywords: scalp melanoma, subtypes, radiation, radical surgery, monoclonal antibodies.

I. Introduction

Scalp melanoma is defined as melanomas which usually occurs in the hair bearing area of the head, although it's commonly included within the group of Head/Neck Melanomas.¹ Scalp Melanoma has been often called as a invisible killer because of its poorer prognosis compared with melanomas of other body sites.^{2,3} Among the various types of melanomas, superficial spreading melanoma and nodular melanoma are predominantly found in the scalp.⁴ Patients with scalp melanomas have shown poor overall survival.⁵ Postoperative radiation therapy has shown promise in loco-regional tumor control but has yet to show any benefit for overall survival.^{6,7}

II. Types of Melanoma

Characteristics and Incidence of various subtypes of Melanoma-

Subtype	Incidence	Special Features
Superficial spreading	75%	Flat during early phase, typically from pre-existing nevus.
Nodular	15%	Early vertical growth
Desmoplastic	Low	Associated with perineural invasion
Lentigo maligna	10%	Prolonged radial growth
Acral lentiginous	2-8%	Palms, soles, nail beds
Mucosal	2%	Poorer prognosis

III. Case Report

A 27 year old male presented to the Dept of Head and Neck Oncology, Dr B.BOROOAH REGIONAL CANCER INSTITUTE, Guwahati complaining of a growth on his scalp at the vertex region. The patient gave a history of surgery being done in a Government hospital 2 months back, but as the cut-margins were positive the patient was referred to our Hospital.

On examination, the lesion appeared ellipsoid in shape, approximately 5cm × 1.25 cm with irregular margins and was dark grey in color. The scab tissue which was seen covering the residual lesion prevented an accurate judgement of the lesion and hence the treatment plan was to evaluate the initial post-operative HPE report, to clinically examine the patient, conduct a USG and CT imaging study of bilateral parotid and neck, followed by surgery and reconstruction. The margins will be decided after the removal of the scab on the operative table. The Histopathology report suggested features consistent with malignant melanoma and Clark level 5 lesion. The tumor infiltrates two of the lateral tissue margins. Clinically, no pigmented lesions elsewhere or lymph nodes were seen and the Ultrasound imaging and CT was negative for any significant lymph nodes or metastasis. The surgical plan involved wide resection of the lesion with a 1.5cm margin along with closure of the defect with bilateral rotation advancement flap and skin grafts. The surgery was uneventful and the post-operative report showed negative margins.



Figure 1- Lesion At Presentation



Figure 2- Lesion After Removal Of Scab.



Figure 3- Post Resection Margins



Figure 4- Primary Closure With Skin Graft



Figure 5- B/L Rotation Advancement Flap



Figure 6- Resected Tissue Specimen

IV. Discussion

The above is a classical example of the aggressive nature of scalp melanoma of which the standard line of treatment would have been a wide excision with bilateral neck dissection and superficial parotidectomy. After the initial surgery was done at an outside hospital, the patient was reluctant to undergo any further surgeries when the treatment plan of wide excision with bilateral superficial parotidectomy and elective neck dissection was told to the patient, though the grave nature of the disease was explained to the patient. Finally, after the USG reports the patient was convinced to undergo wide excision of the disease with revised margins and a short term follow-up of every 3 weeks.

The treatment and prognosis of scalp melanoma is greatly dependent on the lesion thickness. Excisional biopsy is indicated and it should be of full thickness with inclusion of subcutaneous fat and with a peripheral margin of 2-3mm. The biopsy should be performed at the highest or thickest point of the lesion. When the primary lesion involves the parietal, temporal or frontal scalp, lateral forehead, ear or cheek, superficial parotidectomy is indicated as it may harbour primary echelon nodes.⁸ The need for neck dissection is still a controversy as it has not shown to increase the survival benefits.⁹ Recent studies have shown that interferon (IFN) alfa 2b can be given as adjuvant treatment for high risk melanomas and survival rates have improved.¹⁰ Monoclonal antibodies are also considered as second line treatment in non-resectable metastatic melanoma¹¹.

Malignant Melanoma of Scalp is a aggressive disease and the treatment approach also should be on the same lines. Adequate workup and surgical experience is essential when managing the disease and a popular notion among surgeons is to assume the disease based on its external appearance which usually leads to under treatment. Once the patient is under treated, convincing the patient for a revision surgery is almost difficult more due to loss of faith in the Surgical process.

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