Annals of Medicine and Surgery 62 (2021) 182–185

Contents lists available at ScienceDirect

Annals of Medicine and Surgery

journal homepage: www.elsevier.com/locate/amsu

Case Series

Melanoma of the oral cavity: A silent killer

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ARTICLE INFO

Keywords:
Oral cancer
Mucosal melanoma
Diagnosis
Prognosis

ABSTRACT

Melanoma of the mouth is a rare entity of cancer. It has a bad prognosis. We report two cases of mouth melanoma. In the first case, 68 years old man developed a mandibular gingival tumor. Head and neck MRI scans showed an aggressive tumor process in the mouth with bone extension and in the deep spaces. The patient was free of cervical lymph nodes. The second case is a 75-years-old male with heavy tobacco smoke. The man felt a burgeoning mass on the right palate. The neck palpation found a firm mobile non-tender mass at the left upper jugular region. The anatomopathological study of the biopsies assigned both cases to malignant melanoma. Because of the rarity and delays in diagnosis, case reports are an invaluable source of information.

1. Introduction

The " Mosaic " representation of principal asymptomatic lesions, the rarity of these conditions, the poor prognosis, and the necessity of multidisciplinary management are predictive factors that require serious consideration by the health care professional in charge. Tobacco and alcohol use are two of the most important risk factors for oral cavity and oropharyngeal cancers.

The most common clinical cases of malignant melanoma of the mouth occur in the mucous membrane of the jaw, with the majority on the keratinised mucous membrane of the hard palate and gums. Further sites are the mandibular gingiva, the oral mucosa and the floor of the mouth [1].

Clinically, they are very easy to diagnose because of their pigmentation and irregular shapes and contours. They are mostly asymptomatic and are only detected when there is ulceration or hemorrhage of the overlying epithelium. Delayed detection may be the cause of the worst prognosis for a five-year survival rate of 15–38% [2].

2. Case report

2.1. The first case

A 68-year-old man, examined for mandibular gingival tumor observed for four months. The clinical examination found a healthy patient with the budding lesion, pigmented, bluish, and bleeding on contact, in the right mandibular gum extending from the 1st premolar to the glossopharyngeal pillar Fig. 1.

The areas of the lymph ganglions were free.

The biopsy confirmed at a nodular and ulcerated melanoma.

MRI show a tumor process of the mouth with bone, infratemporal fossa and retromolar trigone extension Fig. 2.

PET-CT revealed evidence of hyperfixation of the left side of the mandible without other hyperfixation sites. The case was debated in the Multidisciplinary Consultation Meeting (RCP) and the patient was proposed for palliative external radiotherapy.

2.2. The second case

A 75-year-old man with heavy tobacco smoke until recently. No history of alcohol abuse was reported. On regular visits for a prescription of medication due to his chronic health issues, he reported his claims (painless haemorrhagic mass) and his GP referred him for a maxillofacial assessment.

Clinical investigation of the oral cavity showed an oversized soft, pigmented mass extending from the left half of his hard palate.

Palpation of the neck revealed a firm, mobile, non-sensitive mass of 02 × 03 cm in the upper left jugular region. A buccal mass biopsy was done Fig. 3.

Computer tomography (CT) with contrast revealed pathologically important cervical lymph nodes in the left neck. Histological analysis of the material showed extensive infiltration of nodular melanoma.

The distant metastases were negative.

Following the multidisciplinary consultation meeting (MCP), our

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https://doi.org/10.1016/j.amsu.2021.01.026
Received 3 December 2020; Received in revised form 12 January 2021; Accepted 12 January 2021
Available online 18 January 2021

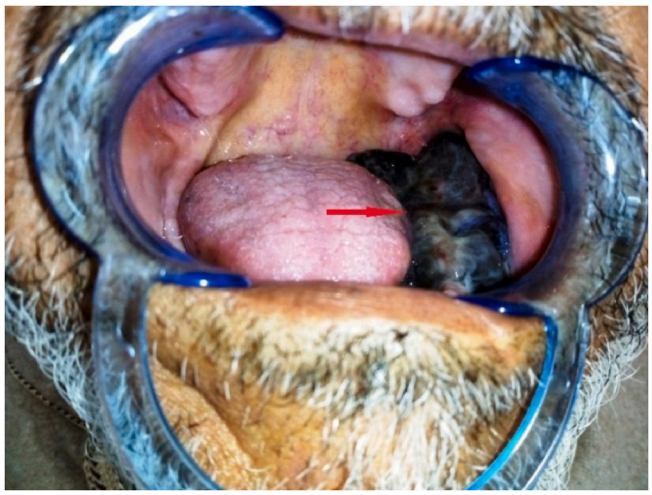

Fig. 1. Male 68-year-old patient with mandibular gingival melanoma measuring 6 cm × 3 cm, pigmented, bluish and bleeding on contact.

patient was excluded from any invasive treatment options.

He was treated in palliative care with hypofractionated radiotherapy.

3. Discussion

The melanoma of the mouth is a malignant neoplasm of melanocytes. It is a rare entity accounting for only 0.5% of melanomas. There is a male predominance, and the median age at diagnosis is 55–66 years.

The most common mouth sites of melanoma are the palate and maxillary gingiva. Mucosal melanomas, which are biologically distinct from their cutaneous aspects, are caused by unknown factors. They often appear from pre-existing benign pigmented lesions [1,3].

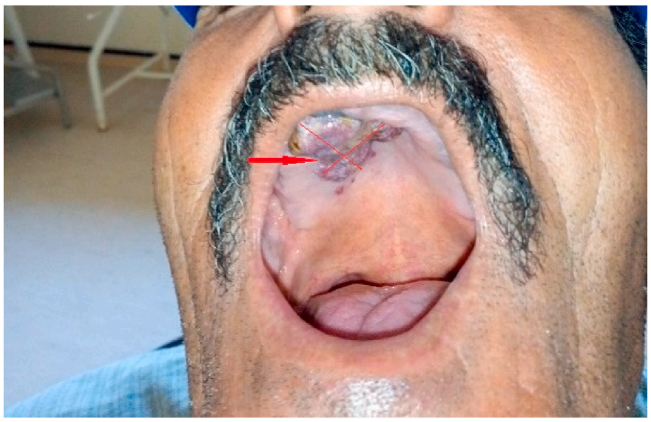

Fig. 3. Clinical setting of a 31-year-old patient with oral melanoma in hard palate with a 2-year disease length.

The real mechanism of malignant alteration is still unrevealed. Cutaneous premalignant melanocytic lesions have been well described [3,4]. But, clinical and histological marks of "oral premalignant melanocytic lesions" are lacking.

As most of the melanomas are unpainful in their early stages, the diagnosis is often delayed until symptoms resulting from ulceration, growth, or bleeding are noted. The pain may be the latest manifestation in melanoma as in our case that again could cause a delay in asking for treatment [7].

Contrary to cutaneous melanomas, the pathogenesis and etiology of mucosal melanoma are still unrevealed and suggest tobacco smoking,

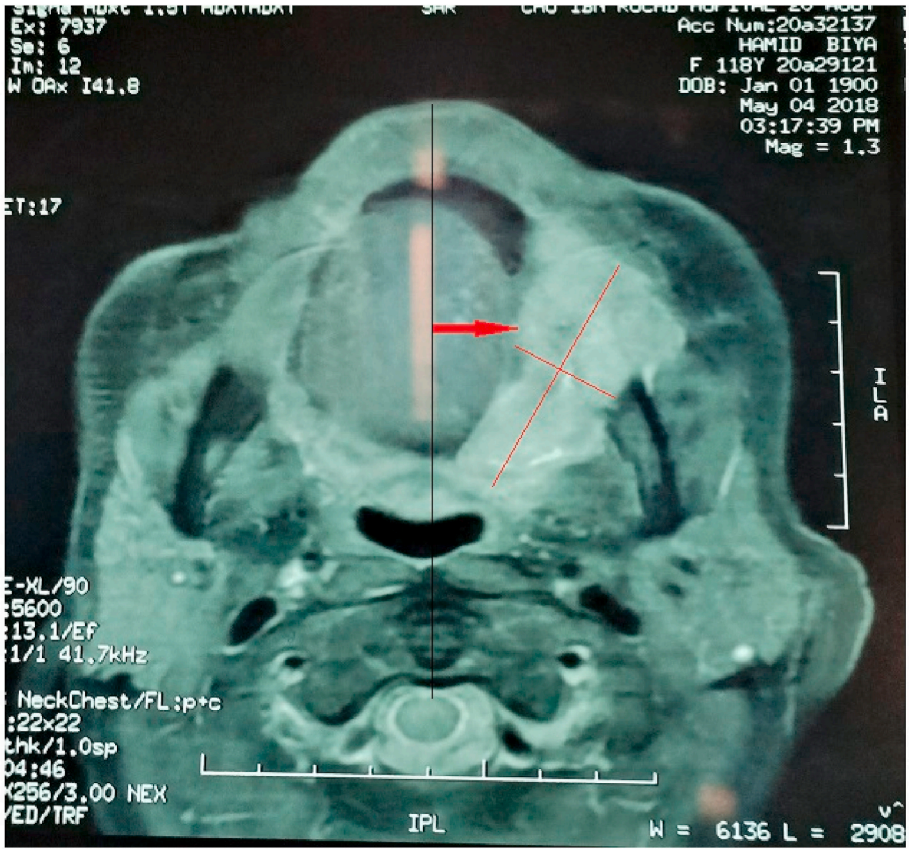

Fig. 2. MRI contrast tomography detected a large mass of the mandible, which appears infiltrated into the deep spaces of the face.

alcohol daily use, and HPV contamination as possible risk factors [2]. Unusual of the melanoma's malignancy could also be responsible for the lack of information in different countries [1,12].

According to recent research in Africa, 1.7% of all melanomas in morocco occurred in the oropharynx and 0.9% of the melanomas in Nigeria were found in the oral cavity.

Oral malignant melanoma is usually unpainful. One-third of the patients are asymptomatic at the time of diagnosis and episodes of hemorrhage seem to be the leading symptom [11].

In the reported case, the underestimation of the patient's condition, possibly due to their painless character, was the main reason for not seeking treatment in time [6].

Oral melanomas can present a diversity of morphological and macroscopic characters [5] which can make the clinical diagnosis so difficult. Differential diagnosis includes melanoma macule, post-inflammatory pigmentation, drug-induced melanosis, nevi, Addison's disease, Peutz-Jeghers syndrome, Kaposi's sarcoma, and many other conditions that have similar macroscopic characteristics [9].

The "ABCD" scoring system is used to differentiate malignant melanoma from benign pigmented lesions. These characteristics are as follows: A, Asymmetry; B, Irregularity of the border often including an irregular notch or indentation; C, Color variations such as red, white and blue; and D, Diameter greater than 0.6 mm [10].

Oral melanomas are usually silent with minimal symptoms up to the advanced stage (TNM assessment begins in T3) Table 1.

Generally, wide surgical removal with sufficient negative margins with or without neck dissection is the treatment of choice for malignant melanoma, with radiotherapy and chemotherapy as an adjunctive therapy [8a,b].

In the case of oral melanoma, if the disease is localized, radiotherapy can control it, as opposed to skin melanoma. Chemotherapy and immunotherapy can play a role in the prevention of distant metastases [6,12].

Most oral melanomas are large at presentation and have a poor prognosis in comparison to skin melanomas. The five-year survival rate for oral melanoma ranges from 4.5% to 29%, with a median survival rate of 18.5 months after initial diagnosis [13].

Preventive measures for oral malignant melanoma are educating patients on regular oral self-examination and help them to identify early suspicious lesion.

Melanoma cares require a multidisciplinary approach. The head and neck melanomas, especially in the mouth, have a bad prognosis and often have advanced disease. Dissertation with Maxillofacial surgeon, dentist, medical oncology, pathology, and other experts, depending on complications and distant metastases are warranted. Due to the threat of recurrence, patients with a mouth melanoma history need lifelong follow-up.

Our recommendations regarding oral melanomas are:

- To encourage and initiate other studies on a larger sample to improve the overview of this pathology.
- To improve diagnostic conditions by training specialists in maxillofacial and stomatological surgery and Anatomical Pathology.
- To strengthen the technical platform of hospital structures.
- To create specialized services of health structures at the regional level and bring skills closer to the population.
- To seek means of financing for the support of the populations.
- To encourage the training and information of therapists in the care of patients.

Table 1
Mucosal Melanoma of the Head and Neck Staging update 05 June 2018. (American joint committee on cancer: cancer stage).

Tumor, T
There is no T1 or T2 in mucosal melanoma.
• T3: Tumors limited to the mucosa and immediately underlying soft tissue, regardless of thickness or greatest dimension; for example, polypoid nasal disease, pigmented or non-pigmented lesions of the oral cavity, pharynx, or larynx
• T4: Moderately advanced or very advanced
• T4a: Moderately advanced disease. Tumor involving deep soft tissue, cartilage, bone, or overlying skin
• T4b: Very advanced disease. Tumor involving the brain, dura, skull base, lower cranial nerves (IX, X, XI, XII), masticator space, carotid artery, prevertebral space, or mediastinal structures
Lymph Nodes, N
• NX: Regional lymph nodes cannot be assessed
• N0: No regional lymph node metastases
• N1: Regional lymph node metastases present
Distant Metastases, M
• M0: No distance metastasis
• M1: Distant metastasis

4. Conclusion

Oral melanomas are different from cutaneous melanomas, therefore Close clinical follow-up of elementary malignant lesions is emphasized up to a better understanding of the cancerization phenomenon, also establishing new criteria for diagnosing and treating this malignancy.

Maxillofacial surgeons and physicians who treat oral lesions must be conscious of the need for early diagnosis of melanoma.

Sources of funding

The authors declared that this study has received no financial support.

Ethical approval

Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal on request.

Consent

Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal on request.

Author contribution

Amine kaouani: Corresponding author writing the paper.
Rachid Aloua: writing the paper.
Ouassime kerdoud: writing the paper.
Salissou IRO writing the paper.
Faiçal Slimani: Correction of the paper.

Registration of Research Studies

1. Name of the registry:
2. Unique Identifying number or registration ID: 6313
3. Hyperlink to your specific registration (must be publicly accessible and will be checked):

Guarantor

Amine kaouani.

Declaration of competing interest

Authors of this article have no conflict or competing interests. All of the authors approved the final version of the manuscript.

Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.amsu.2021.01.026.

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