An asymptomatic palatal tumor

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1. Description

A 62-year-old male consults for an asymptomatic palatal swelling progressing for about 2 months. He is a retired informatician and has no medical history. Clinical examination reveals a large, flesh-coloured, slightly ulcerated and painless palatal mucosal nodular mass measuring 3.8 centimetres in diameter (Fig. 1). There are no adenopathies in the cervical lymph node areas and the other aspects of the examination along with nasofibroscopy do not reveal any abnormalities.

An injected head and neck computed tomography does not show any associated osteolysis

The anatomopathological examination of the biopsy reveals a squamous mucosa whose chorion is massively infiltrated by epithelioid or elongated tumor cells, with eosinophilic cytoplasm sometimes pigmented (Fig. 2). The nuclei are oval with a prominent nucleolus. The stroma is thin and fibrous. The surface coating is focally ulcerated. Tumor cells are marked with anti-PS100, anti-MelanA, anti-HMB45 and anti-SOX10 antibodies. They are not marked with anti-CKAE1/AE3 antibody.

What is your diagnosis?

2. Response

It is a mucosal melanoma.

These aggressive malignant tumours derived from melanocytes are rare (0.8 to 3.7% of melanomas) [1] and frequently discovered at a late stage due to their hidden locations. In more than 50% of cases they concern the cervico-facial area (66% in sinuso-nasal and 25% in the oral cavity)[1].

The median age of discovery of 70 years hides a very wide distribution. Their incidence is stable, without ethnic predominance, identified risk factors or a clinical specific presentations. If melanic lesions are evoking the diagnosis, in 40% of cases the lesion is amelanotic, flesh-coloured or greyish[2]. Symptomatology may include obstructive nasal mass or epistaxis events[3]. Oral locations are more frequently palatal or gingival with lymphatic lymph node metastases frequent at diagnosis (33% of cases)[1].

The anatomopathological analysis of the diagnostic biopsy does not systematically find tumour pigmentation. Immunohistochemistry allows diagnosis to be made using a series of markers, some of which are very sensitive (S100 protein) and others specific (MelanA and HMB45)[1].

Therapeutic management requires a surgical excision with safety margins of 2 centimetres. Cervical neck dissection is recommended in patients with oral cavity disorders, but the lesser lymph node invasion of nasosinus melanomas does not justify lymph node dissection in the absence of clinical or radiological cervical adenopathy[1].

Systematic adjuvant irradiation appears to improve local control[1, 3]. The 5-year survival rates range from 0 to 31% for sinusonasal locations and from 15 to 45% for the oral cavity[1]. No adjuvant systemic therapy has been shown to be effective. In the metastatic stage, it is the advent of targeted therapies that could improve prognosis in the coming years[1]. The classical histological characteristics of prognostic relevance in cutaneous melanomas are not sufficient to classify mucosal melanomas[1, 3]. Their molecular alterations and therapeutic targets are distinct[4].

Mucosal melanomas will not fully benefit from the therapeutic advances acquired with cutaneous melanomas. Clinical trials specific to this subgroup of patients are essential.

3. Conflict of Interest

The authors declare that they have no interest links.

4. References

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Figure 1

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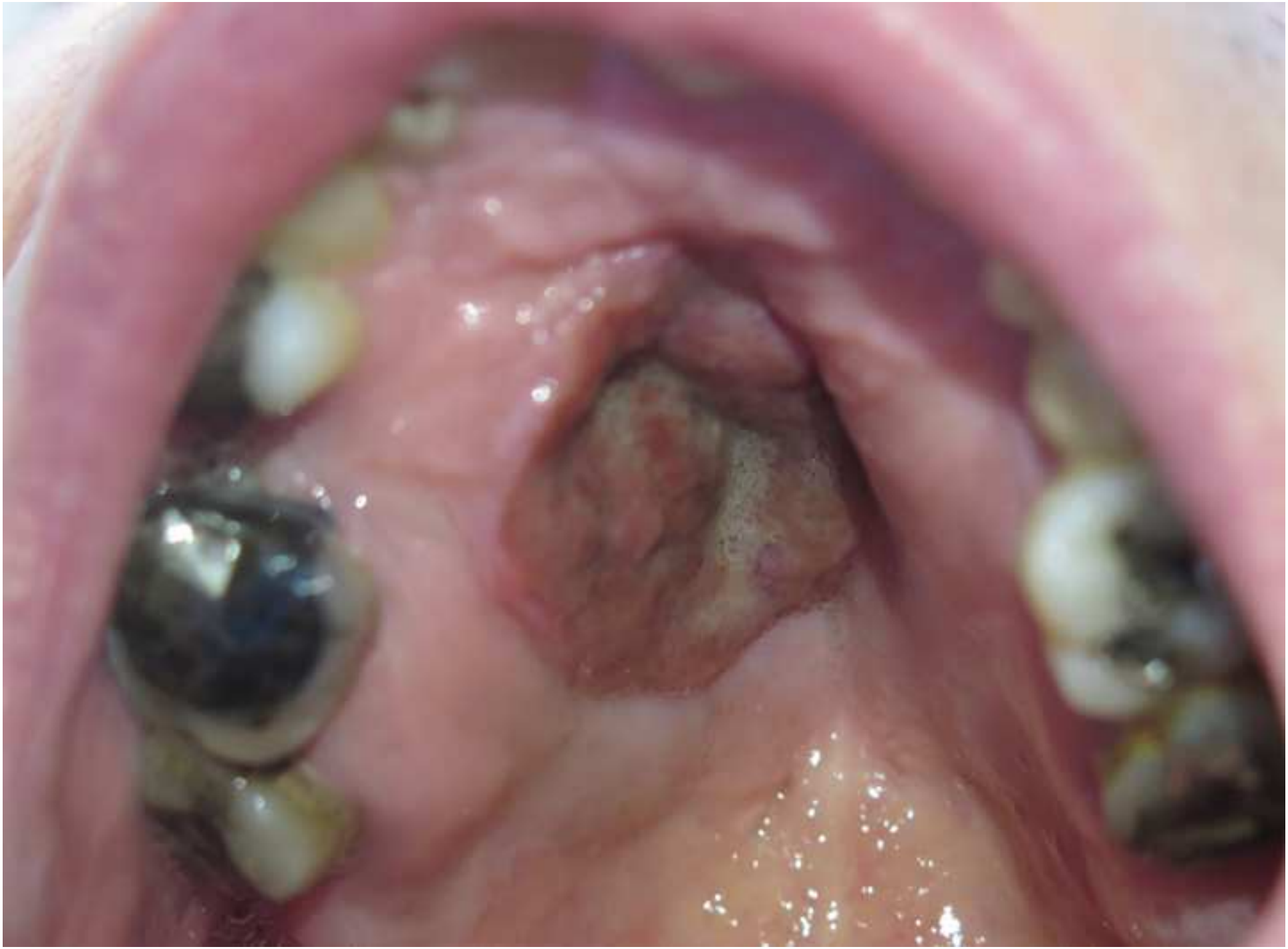

Figure 2

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