Coexistent Primary Choroidal and Cutaneous Melanoma

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Sir,

The development of primary choroidal and cutaneous malignant melanoma in the same patient is rare, with only 8 cases described in the literature (1–3). In contrast, the occurrence of primary cutaneous and choroidal melanoma in association with the atypical mole syndrome has been documented by a number of authors (2). We describe here the case of a 71-year-old man who presented initially with deterioration in the vision of his left eye secondary to a retinal detatchment (Fig. 1). Ultrasound examination showed a solid appearance, and on ultrasound and clinical grounds he was suspected of having a choroidal melanoma. He was treated with surgery followed by proton beam therapy. Unfortunately, subsequent B scan ultrasonography showed there to have been little change in the lesion, therefore the patient underwent enucleation of his left eye. Four months later he presented with a pigmented lesion on the left side of his abdomen, which had increased in size. Histopathological examination confirmed a primary cutaneous superficial spreading malignant melanoma, Clark level IV and Breslow depth of 2.15 mm.

Physical examination, CT scan on the chest and abdomen and liver function tests were normal. The patient displayed no features of atypical mole syndrome and there was no family history of this phenotype. As melanocytes of the skin and eye both originate from the neural crest during embryological development, it would seem possible that cutaneous and choroidal malignant melanoma could develop in the same patient. Swerdlow et al. (4), studied 12,000 cutaneous and 2,000 occular melanomas and found a small increase in primary cutaneous melanomas in those with primary choroidal melanomas.

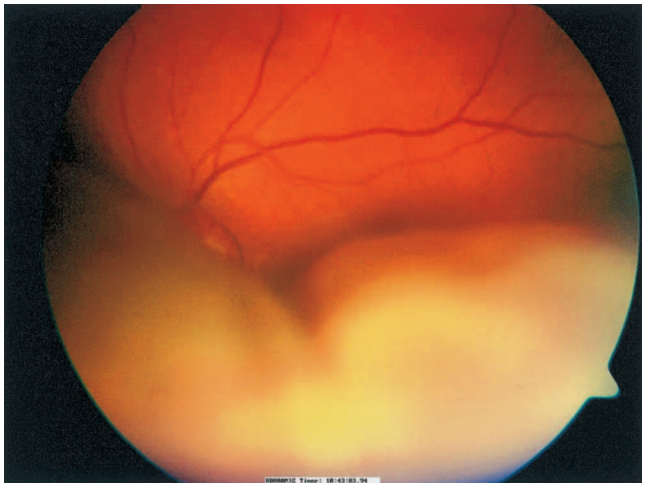

Fig. 1. Left retinal detachment secondary to choroidal melanoma.

Batallie et al. (2) examined 207 consecutive patients with ocular melanoma and found that 5 patients had primary melanoma of both the eye and the skin. This figure was statistically significant compared to the expected UK incidence for both tumours of 0.4.

The coexistence of primary choroidal and cutaneous melanoma in the same patient is rare, although a number of authors have found an increased risk of ocular melanoma in families with the atypical mole syndrome and cutaneous malignant melanoma (5). Three of the 5 patients studied by Batallie et al. had the atypical mole syndrome, suggesting predisposition to both types of malignant melanoma in those with this phenotype. Most of the reported cases of primary choroidal and cutaneous melanoma, which are not associated with the atypical mole syndrome, have occurred within the past decade. This increased rate of reporting may represent an increased awareness that these tumours can reside in the same host or a real increased incidence.

Whether choroidal and cutaneous malignant melanoma share common hereditary and environmental factors remains to be determined, certainly the choroid is one of the few sites of the body where a history of sun exposure is unlikely to have played a part in the development of a melanoma. Perhaps further study of patients with such coexistent melanomas may identify other risk factors be they genetic or environmental.

We have commented on the apparent increase of reported cases of such coexistent melanomas. In this case the cutaneous melanoma was diagnosed 4 months after the patient had presented with his choroidal tumour. Should we make it common practise to examine the skin of all patients presenting with a positive diagnosis of a choroidal melanoma? Certainly in our patient this practise would have resulted in his cutaneous primary being diagnosed 4 months earlier.

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