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Amelanocytic melanoma of the cervix-a Case report

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Background Malignant melanoma represents 1% of all cancers and has an incidence of 3–7% in the female genital tract, the majority of cases being reported in the vulva and vagina. Cervical malignant melanomas are very rare. There are <100 uterine

melanomas reported in the literature. Among them, amelanocytic melanomas are few (12 cases).

Case A 64-year-old postmenopausal female presented with postmenopausal bleeding. She is a known patient with hypothyroidism, diabetes, bronchial asthma and triple-vessel disease with mitral valve replacement and coronary artery bypass graft with good medical follow-up. She is on warfarin after the mitral valve replacement (2014). On examination, a friable cervical polyp <4 cm from the cervical canal was identified without the involvement of the upper vagina. A punch biopsy was taken. Initial histology report suggested a poorly differentiated tumour suggestive of a high-grade non-Hodgkin's lymphoma. Further assessment with immunohistochemistry confirmed amelanocytic melanoma of the cervix. She was screened for any primary or secondary lesions in view of initial histology report. Exclusion of the primary tumour in other sites was made and after FIGO staging (IB1) the patient underwent a radical hysterectomy with bilateral salpingo-oophorectomy after a multidisciplinary team discussion. Her medical conditions were optimised before surgery. During surgery, a large polypoidal growth in the cervical canal was noted and cervix and the upper vagina were bluish in colour. Histology revealed an invasive melanoma involving the cervix and left paracervix. Upper vagina involved with superficially spreading intraepidermal component. Vaginal resection margin is 2 mm free from tumour. No tumour spread to uterine body or tubes parametrium. Most of the tumour showed amelanocytes.
Outcome She had stormy recovery in the postoperative period due to her complicated medical problems. No radiotherapy or chemotherapy was arranged. She is on regular oncology follow-up.
Conclusion There is no definitive hypothesis for melanocyte formation in the cervix. Benign melanosis of the cervix might occur in cervical skin as hyperpigmented lesions in cases of uterine prolapse, chronic irritation and cryotherapy for dysplasia. Special staining techniques needed to reach the final diagnosis as there are possibilities for misdiagnosis as in our case. In our case, the initial impression was non-Hodgkin's lymphoma. Immunohistochemistry confirmed the final diagnosis. The definitive treatment for the melanoma of the cervix is radical surgery. Complimentary therapies have minimal role. The prognosis is always on the lower side.