

Title:

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ACCEPTED MANUSCRIPT

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Metastatic melanoma of the gallbladder: an uncommon finding

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CASE REPORT

A 48-year-old male was operated on due to nodular melanoma located at the left infrascapular region. The characteristics of the tumor were as follows: T4bN1aM1, Breslow 1.8 mm, Clark level IV, superficial ulceration, vascular invasion, BRAF gene mutation, axillary lymph node micrometastases and lung metastases. Lung metastases were treated with nivolumab (300 mg every 15 days). After 36 cycles, the computed tomography (Fig. 1A) revealed an image with a higher density in the gallbladder. On sonography (Fig. 1B), two vegetative images with doppler flow of 16 and 27 mm were identified on the gallbladder wall.

A laparoscopic cholecystectomy was performed (Fig. 2) due to a suspicion of melanoma metastases, without incidents. The histopathological analysis revealed melanoma metastases in the gallbladder (Fig. 3). The metastatic lung disease prior to cholecystectomy remains stable after seven months of follow-up and 66 cycles of nivolumab.

DISCUSSION

Melanoma metastasizes to the gastrointestinal tract in 2-4% of cases (1,2). In addition, this type of tumor most frequently metastasizes to the gallbladder (50-67% of metastases at this level) (1,3). Even so, these metastases are infrequent (2). The indication of cholecystectomy is determined by the patient performance status, extension and prognosis of disease (2). Although open surgery is the preferred option to treat melanoma metastases at this level (2,3), laparoscopic surgery could be a safe technique that allows a fast recovery of the patient. In conclusion, laparoscopic cholecystectomy allows a good local control of metastatic melanoma in the gallbladder.

COMMENTARY

Metastases of cutaneous melanoma to the gallbladder and biliary tree are very rare. It is uncommon for metastatic gallbladder melanoma present with symptoms during the patient's life time. The role of surgical treatment in this scenario remains unclear due to a lack of experience. Despite the advances made in chemotherapy and immunotherapy for metastatic melanoma, the results regarding survival are still poor and disappointing. The key point should focus on the following question: is it worth undergoing a cholecystectomy while the patient is asymptomatic?

José Lariño

Associated Editor of *The Spanish Journal of Gastroenterology*

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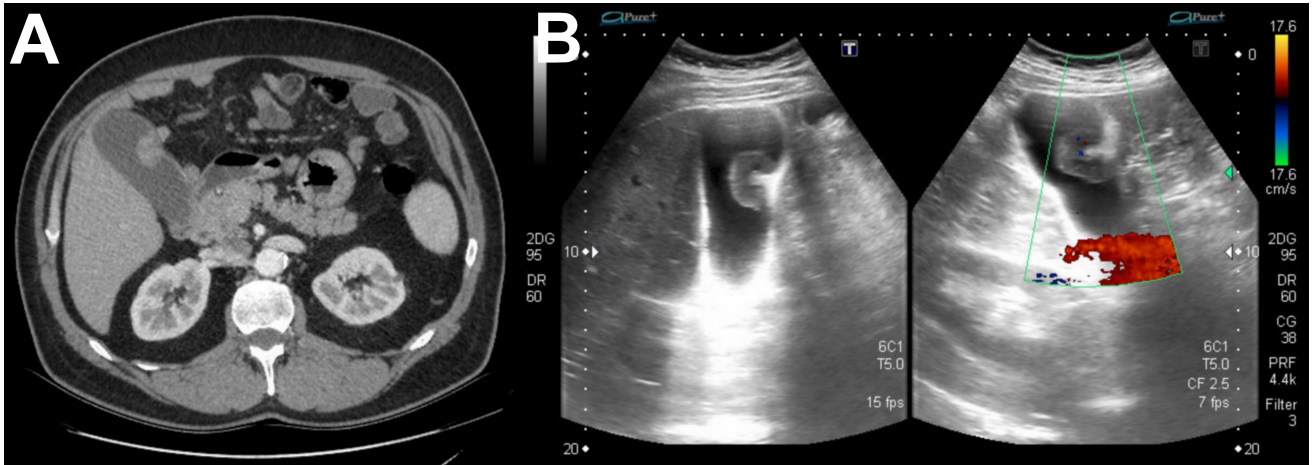


Fig. 1. Radiological proofs. A. Abdominal computed tomography in which an image of higher density is shown in the gallbladder. B. Abdominal sonography in which a 27 mm vegetative image is shown that is part of the wall of the gallbladder, with doppler flow inside.

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Fig. 2. Open gallbladder after performing laparoscopic cholecystectomy, in which two vegetative pigmented masses can be seen.

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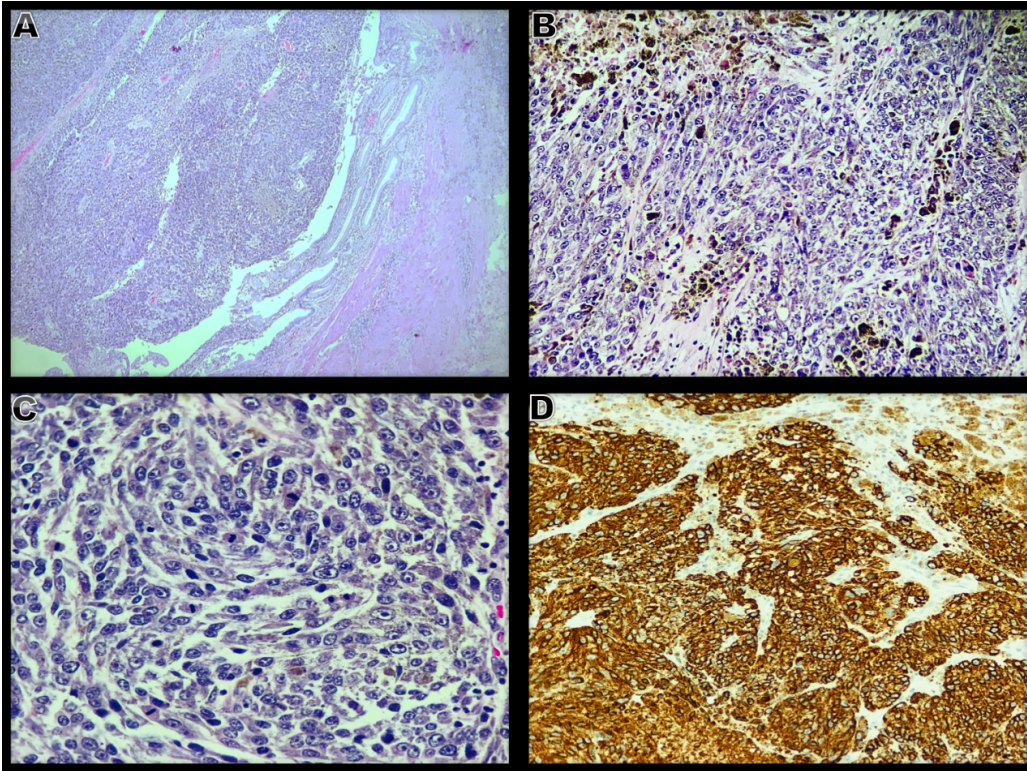


Fig. 3. Histopathology. A. Malignant neoplastic infiltration by a solid mass, with foci of necrosis (left) and non-atypical preserved mucosae (right) (hematoxylin-eosin staining, 100x). B. Large nests of polygonal and fusiform cells with atypical nuclei. Many cells present fine granules of melanin pigment in the cytoplasm (hematoxylin-eosin staining, 200x). C. Cells with prominent nucleoli and frequent mitosis (hematoxylin-eosin staining, 400x). D. Positive immunohistochemistry staining of HMB-45 (200x).