Misdiagnosed acral melanoma

Caterina Foti
Domenico Bonamonte
Michelangelo Vestita
Angela Filoni
Paolo Romita

Department of Biomedical Sciences and Human Oncology, Dermatologic Clinic, University of Bari, Bari, Italy

Address for correspondence:
Caterina Foti
Dermatologic Clinic, University of Bari
Piazza Giulio Cesare 11
70124 Bari, Italy
E-mail: caterina.foti@uniba.it

Summary

Acral melanoma is oftentimes misdiagnosed because of its location and peculiar clinical presentation. Literature reports a misdiagnosis rate of about 25-36%. Differential diagnosis is often against fungal disorders, non-healing ulcers, and hyperkeratotic lesions such as plantar warts. A possible association between diabetic elderly women and acral melanoma has long been described.

KEY WORDS: acral melanoma; amelanotic; diabetic ulcer; foot ulcer.

Case report

A 93-year-old female patient, suffering from type II diabetes and arterial hypertension, came to our attention complaining of punctory pain and intermittent bleeding from an ulcerative lesion of the left foot. Such symptoms had been going on for 15 days circa. At physical inspection a 3 cm nodular partially ulcerated area of diameter was present under the left fifth metatarsal head (Figure 1). Pigmented macules and papulo-nodules also extensively involved the plantar, dorsal and lateral surfaces of the left foot. Several of these lesions showed tendency to coalesce. Completing general examination, we noted bilateral aspecific lymphadenopathy, good pedal pulses and no peripheral neuropathy. We questioned the patient about how long the lesion had been present and were surprised to learn it had first appeared several years before as a limited ulcerative area, interpreted as a diabetic ulcer and treated with regular debridement, systematic antibiotics, and topical silver sulfadiazine. Patient reported that given the partial but considerable therapeutic response, her general practitioner had underestimated lesion evolution which had continued to grow over a time span of almost 5 years. She further stated that the surrounding pigmented lesions had appeared at a very late stage, as much so as only 2 months before our first visit. Considering the above we formulated the clinical diagnosis of locally advanced melanoma. Histopathological examination confirmed such diagnosis.
Management

We decided to refrain from any further diagnostic and therapeutic actions but those intended to alleviate pain and other subjective symptoms hampering life-quality. Such decision was made in agreement with the consultant medical oncologist and the relatives, given the tumour visible and presumed wide-spreading as well as patient age and physiological life-expectancy. She was therefore referred to a pain management specialist.

Comment

Acral melanoma is oftentimes misdiagnosed because of its location and peculiar clinical presentation (amelanotic and ulcerated) (1-5). Literature reports a misdiagnosis rate of about 25-36% (6, 7). A possible association between diabetic elderly women and acral melanoma has long been described and is further supported by our case (8). Differential diagnosis is often against fungal disorders, non-healing ulcers, and hyperkeratotic lesions such as plantar warts. Delayed diagnosis is most frequently a consequence of patients being seen by non-dermatologists. What is more, at present there is no consensus on when to biopsy a diabetic foot ulcer. Regardless, when signs of persistent infection, presence of a foreign body, diabetic neuropathy, peripheral arterial disease, or history of trauma are not present, a cutaneous malignant condition should be suspected and proactively investigated.

The case we observed is particularly deceiving, since the original ulcerative lesion responded reasonably well to therapy with partial but substantial reepithelialization. This misled the family physician into believing he had formulated the right diagnosis, although complete healing never occurred. To our knowledge this deceptive partial-healing behavior is exceptional among cases of amelanotic acral melanoma presenting as skin ulcers.

Our experience thus emphasizes the importance of biopsying chronic, atypical foot ulcerative lesions, even when apparently healing, and further underlines how dermatologic regular examination remains the ace up our sleeve in melanoma primary and secondary prevention. Regrettably, as of today a systematic screening protocol lacks in application and should more energetically promoted by the appropriate dermatological scientific associations.

References