

Obscure GI bleed from Metastatic Gastric Melanoma

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INTRODUCTION

Malignant melanoma is an epithelioid cancer arising from melanocytes. GI tract is the usual site of involvement in patients with metastasis. We encountered a patient who presented with GI bleed and was found to have metastatic gastric melanoma.

CASE REPORT

An 84 year old female with past medical history of atrial fibrillation; on Eliquis was recently diagnosed with melanoma in right upper extremity along with regional axillary lymphadenopathy. Patient had undergone wide local excision and was being treated with adjuvant Pembrolizumab. On her follow up with oncology service, patient reported having fatigue and recent onset of melena. Lab work up showed anemia with Hgb of 5.5 g/dl (baseline of 13 g/dl). She was hospitalized for further work up. On arrival, patient received blood transfusions which resulted in improvement of her Hgb to 8.6 g/dl. GI service was consulted. On evaluation, patient reported having mild epigastric pain. Rest of review of systems was unremarkable. Last colonoscopy was performed more than 10 years ago. She was scheduled for an EGD. EGD showed two 10 mm submucosal nodules in stomach with central ulceration (fig 1) along with duodenal erosions with normal examination of esophagus. There was no evidence of fresh or old bleeding. Gastric findings were suspicious for possible pancreatic rest versus GIST. Patient was scheduled for an upper endoscopic ultrasound (EUS) for further evaluation. A colonoscopy was also scheduled to determine cause of GI bleed.



Figure 1. EGD with submucosal gastric nodules

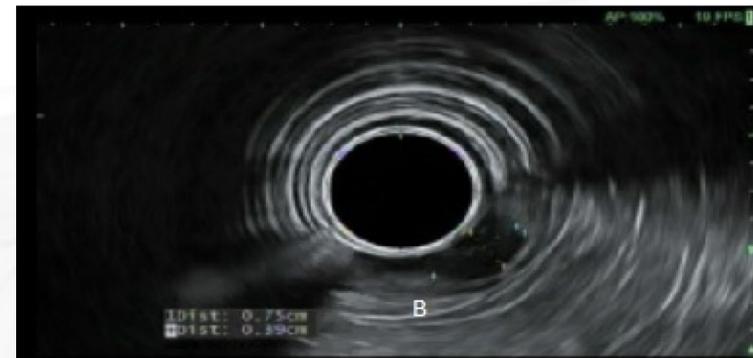


Figure 2. EUS with lesions in layer 2



Figure 3. Tumor cells with positive SOX10 and S100

CASE REPORT (Continued)

EUS was performed which showed evidence of two round and ulcerated intramural (subepithelial) lesions in the body of the stomach and at incisura of the stomach. These lesions were hypoechoic and heterogenous. These lesions appeared to originate from the deep mucosa (layer 2) measuring 5 mm in maximum thickness. The outer endosonographic borders were well defined. (fig 2). In addition, pancreatic cysts were found. Sonographic findings were considered to be consisted with aberrant pancreas versus metastasis. Fine needle biopsies were collected. Colonoscopy was unremarkable other than diverticulosis and non-bleeding internal hemorrhoids. Subsequent lab work showed stable blood counts without need for any further blood transfusions. Anticoagulation was resumed on discharge. Biopsy results confirmed presence of tumors cells diffusely positive for SOX10 and S100 and negative for MNF116. These were considered to be related to metastatic melanoma (fig 3). Follow up with oncology was established on discharge to discuss further management. Patient unfortunately passed away 6 weeks after her hospitalization.

DISCUSSION

Malignant melanoma is commonly associated with metastasis with involvement of GI tract. 23% of patients have gastric involvement. Patients usually present with abdominal pain and GI bleeds. Prognosis is usually poor with median survival reported up to 6-8 months. Treatment involves surgical resection, chemotherapy or immunotherapy. Use of BRAF targeted therapies and immune checkpoint inhibitors have increased survival rates.