colour and indistinct margins which shows rapid growth. Routine light microscopy detects primitive small malignant cells growing in diffuse, organoid or ribbon-like fashion. Immunohistochemically, neuron-specific enolase and cytokeratin are important diagnostic markers [2]. Most of the tumours occur in the head and neck region and subsequently in the extremities and trunk. The reported incidence of local recurrence varies between 30 and 45%. The risk of regional lymph node involvement is >50% and for distant metastases 20–40%, respectively. Approximately 30% of the patients die of metastatic disease [3–7].

Treatment of the primary lesions should be wide excision, which especially in the head and neck region, is difficult to achieve. After less extensive surgery, tumours >2 cm should be irradiated with generous margins up to 50–60 Gy. This dose has also been recommended by other authors [7, 8]. There is no consensus about adjuvant treatment of regional lymph nodes, nor for prophylactic dissection or radiotherapy. Short-term follow-up is mandatory due to the rapid growth of recurrence and metastases. Metastatic disease can be treated either with radio- or chemotherapy regimens which are normally used for small cell lung cancer. Merkel cell carcinoma is known to be highly radiosensitive, confirmed in Case 2 with a complete regression of gross disease after 60 Gy. Complete clinical remissions have also been reported with various cytotoxic drugs, i.e. doxorubicin, etoposide, cyclophosphamide and vincristine [8–10].

Dissemination usually appears within 2 years after diagnosis of the primary. Most commonly involved are soft tissues, liver, lymph nodes, bone, lung, spine and bone marrow whereas the brain, kidney, pancreas, parathyroid gland and pleura are less frequently affected [5]. Metastases of Merkel cell carcinoma in the breast, to our knowledge, have not been reported before. We therefore recommend careful review of the pathological specimen if a rapidly growing tumour in the breast of an elderly patient has been excised and primary histopathological diagnosis indicates metastases of small cell lung cancer or lymphoma. Immunohistopathological staining with neuron-specific enolase and cytokeratin should be performed to exclude or confirm Merkel cell carcinoma. In this case, axillary clearing might be unnecessary, but postoperative radiotherapy of the breast with at least 50 Gy should be initiated without delay.

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Myocardial Infarction Associated with Vinorelbine (Navelbine^{R})

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VINORELBINE (NAVELBINE^{R}) is a unique semisynthetic vinca alkaloid. The drug is effective as a single agent in inoperable/advanced non-small cell lung cancer (NSCLC), producing objective response rates of approximately 15–30% [1]. Myelosuppression is the most frequent side-effect, while neurotoxicity, nausea, emesis, alopecia and mucositis occur less often.

In this letter, we report on the case of a 87-year-old Caucasian man who developed acute myocardial infarction that was probably related to the administration of vinorelbine. He had a history of coronary heart disease with a posterior Q-wave infarction 35 years ago. However, over the last 30 years, the patient had not experienced any cardiac problems. He was in excellent physical condition, when locally advanced NSCLC was diagnosed. At that time, levels of electrolytes, haemoglobin and thrombocytes, and liver and kidney function and coagulation tests were all in the normal range. An electrocardiogram (ECG) and two-dimensional echocardiography confirmed the old myocadial scar. Vinorelbine monotherapy was initiated (30 mg/m^2) and 10 h later the patient developed long-term angina pectoris. Repeated ECG controls revealed an acute anteroseptal infarction that was stuttering in nature, with only slightly elevated levels of creatinine kinase (100 U/ml) and troponin-T. Treatment with aspirin, low-dose heparin and mononitrate was initiated. Repeated echocardiography confirmed the diagnosis of an anteroseptal myocardial infarction and showed a marked depression in left ventricular function.

To the best of our knowledge, this is the third report of a vinorelbine-related myocardial infarction [2, 3]. We conclude

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that this drug should be used with caution in patients with a history of coronary heart disease.

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