

Letters

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Contralateral Groin Node Metastasis from Lower Limb Melanoma

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PATIENTS PREVIOUSLY treated for lower limb primary melanomas occasionally develop metastases in the contralateral groin, but have no clinical evidence of metastatic disease elsewhere. 15 such patients treated at the Sydney Melanoma Unit since 1967 were identified from its 12 400 patient database. Each of them had previously undergone a radical lymph node dissection of the ipsilateral groin, either electively at the time of initial treatment (9 patients) or as a therapeutic procedure when metastatic disease in that groin became clinically apparent (6 patients). This phenomenon of contralateral inguinal lymph node metastasis in patients with melanoma of the lower limb after ipsilateral radical groin dissection has previously been noted [1]. It is thought to be due to diversion of lymphatic flow, since Jonk and associates [1] reported drainage to the opposite groin in 13 of 16 patients undergoing lymphoscintigraphy following previous ipsilateral groin dissection for lower limb melanoma.

We report the demonstration of a "sentinel" lymph node [2, 3] containing micrometastatic melanoma in the left groin of a 73-year-old man who developed primary melanoma in his right calf 10 years after simple excision-biopsy of a lymph node in the right groin. This had revealed non-Hodgkin's lymphoma, which was successfully treated with systemic chemotherapy. Prior to surgical treatment of his melanoma, a lymphoscintigram was performed by intradermal injection of radiolabelled colloid around the primary site [4]. Unexpectedly, this showed rapid, direct lymphatic drainage from the right calf to the left groin, where two definite sentinel nodes were identified, as well as drainage to two sentinel nodes in the right groin (Figure 1). After injection of Patent Blue dye intradermally around the primary

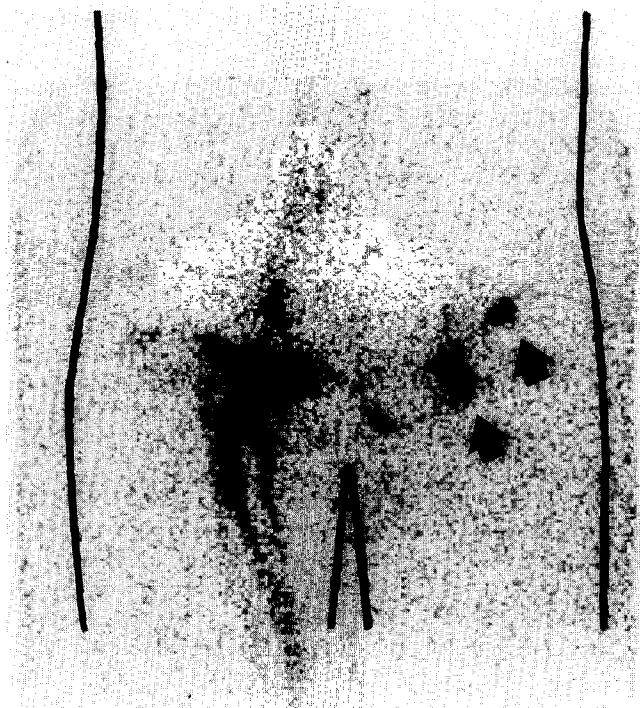


Figure 1. Initial lymphoscintigram image after intradermal injection of technetium-labelled antimony trisulphide colloid around primary melanoma site on calf, showing two lymphatic channels in the right thigh and trans-pubic drainage to sentinel nodes (arrowed) in the left groin.

melanoma site, it was widely excised and the sentinel nodes in both groins were located and removed. Two blue-stained lymphatic channels were observed entering the left groin from subcutaneous tissue anterior to the pubis, and each was traced to a blue-stained sentinel node. Histological examination revealed no evidence of metastatic disease in the sentinel nodes from the right (ipsilateral) groin, but metastatic melanoma in one of the nodes from the left (contralateral) groin. A full radical lymph node dissection on the left side was, therefore, performed. No evidence of additional metastatic disease was found in any of the nodes in the groin dissection specimen. The patient is well and clinically disease free 16 months later.

It is thus apparent that direct lymphatic drainage from a lower limb site to nodes in the contralateral groin can occur if lymphatic anatomy in the ipsilateral groin has been disturbed by previous surgery of any kind. This finding has two important implications. Firstly, follow-up of all patients with lower limb melanoma who have had either a node biopsy or a full groin dissection on that side must include careful and regular review of the opposite groin, and secondly, if metastasis to contralateral groin nodes does occur and there is no evidence of systemic dissemination, a full groin dissection with curative intent is indicated, since the disease may still be locoregionally confined.

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Has Radiation Therapy Any Role in Signet-ring Cell Breast Adenocarcinoma?

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SIGNET-RING CELL carcinoma of the breast is a rare entity (2–4%), containing intracytoplasmatic PAS-positive mucin. “Pure” signet-ring cell carcinoma variant is exceptional with local and lymph node invasion, serosal avidity with unusual metastatic pattern. Mean age of presentation is 50 years old, the breast mass has a median tumour size of 5 cm (range 3–15 cm), with pain being the most frequent symptom due to the tumour’s infiltrative pattern. Although surgery is the treatment of choice, when feasible, other therapeutic alternatives must be considered since the clinical initial presentation may not always allow a therapeutic approach with curative intent [1, 2]. The role of radiotherapy as a palliative treatment has not been clearly defined in this entity. We present a case of a 64-year-old woman with a local, painful, breast mass, with ulcerative and necrotic macroscopic elements. A biopsy was performed and a “pure” signet-ring cell adenocarcinoma was diagnosed. Staging examination was negative. Her tumour progressed even with chemo-hormonal therapy treatment, when the patient was referred to our hospital. Physical examination revealed a bulky (24 × 24 cm), locally extensive, presternal mass, with involved bilateral axillary lymph nodes, and infiltration of both breast and pericardium, soft tissues, sternum and first and second ribs was confirmed by computed tomography (CT scan) and magnetic resonance imaging (MRI); surgical treatment was rejected. A palliative irradiation treatment was administered through a linear accelerator with 6 MV photon beam energy, giving a total dose of 39.6 Gy, 1.8 Gy/fraction, five fractions per week. A boost with a 20 MeV electron beam up to a total dose of 28 Gy, 2 Gy per fraction was later performed. Complete resolution of the pain was obtained and all the external components of the tumoral mass disappeared (Figure 1a,b).

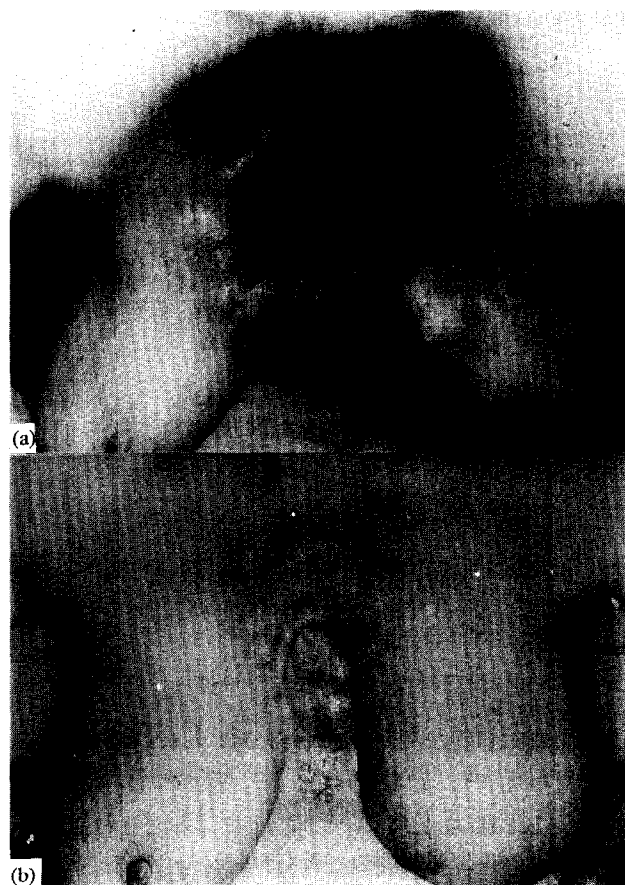


Figure 1. Signet-ring cell breast adenocarcinoma (a) before and (b) after radiotherapy treatment.

For 10 months, the patient remained asymptomatic and free of disease progression with a good quality of life. Subsequently, the patient had uncontrolled distant metastases and died, aged 68 years. In spite of the well-known clinico-pathological pattern and treatment of ductal infiltrating carcinoma, a pure signet-ring cell adenocarcinoma in breast requires special attention due to its local invasion and axillary positive nodes (73% of cases). Mortality is high (53% of cases), despite standard surgical treatment [3]. Surgery is not recommended in bulky disease at presentation, so that both chemotherapy and hormonal treatment are the most frequent alternative treatments employed, in spite of the poor response observed in positive receptor tumours treated with tamoxifen [4].

The role of radiotherapy as a palliative treatment is a well-known and effective modality in solid tumours [5], but in signet-ring cell adenocarcinoma, it has not been clearly described as shown in the literature reviewed. The only intention of treatment in this patient was to improve symptoms and to diminish the tumour mass.

In conclusion, radiotherapy should be considered as an effective, alternative, palliative treatment in signet-ring cell breast adenocarcinoma, even in a bulky infiltrate tumour mass which has progressed following chemo-hormonal treatment.

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