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Malignant melanoma of the nasal cavities: A case report

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Abstract
The malignant melanoma of the nasal cavities is a rare tumor characterized by an absence of specific clinical signs but confirmed by the contribution of immunohistochemistry. However, poor prognosis remains, requiring a complex radiosurgical support.
We present a case of malignant melanoma in a 48 years old male patient, chronic smoker, who is consulting for a nasal obstruction left unilateral evolving for 18 months complicated by anosmia and epistaxis repeatedly. The anterior rhinoscopy objectified a blackish fleshy polypoid mass at the expense of the nasal septum and the bottom left turbinate. The facial CT scan showed an aggressive tumor of the left nasal cavity with lysis of the upper maxilla. A biopsy of the mass had been done. The anatomopathological examination supported by the immunohistochemistry confirmed the diagnostic of malignant melanoma of the nasal cavity. The treatment featured a surgery by the paralateronasal way with large excision and followed by adjuvant radiotherapy. An endoscopic control after 6 months was done marking the satisfying evolution without any sign of local recurrence.

Keywords: Malignant melanoma of the nasal cavities- anterior rhinoscopy- large excision-prognosis

Introduction
Primitive melanoma of nasal cavities is a rare clinical event. Characteristics clinical symptoms are nasal obstruction and recurrent nose-bleeding. The diagnosis evoked by clinical examination (pigmented forms) is largely confirmed by pathological examination reinforced by imminoh is to chemical techniques. The treatment remains surgery and completed with radiotherapy but the prognosis remains unfavorable with a five-year survival rate of 10 to 40% [1].

Observation
A 48-year-old-man chronic smoker presented with recurrent epistaxis over 18 months associated to a left nasal obstruction complicated by anosmia and rhinolalia and algias of the left hemiface, all evolving in a context of alteration of the general state.
The anterior rhinos copy revealed a blackish fleshy polypoid mass at the expense of the nasal septum and the bottom left turbinate.
Nasal endoscopy showed an infiltration of the lining of the septum with bone lysis of the posterior part of the hard palate. Follow-up maxillofacial CT revealed a tumor of the aggressive left nasal cavities with antrochoanal filling, displacement of the nasal septum on the left and the inner wall of the maxillary sinus and maxillary sinus and ipsilateral anterior ethmoidal associated with lysis of the maxillary upper and exposed teeth [Figure1]
The cervical ultrasound showed bilateral jugulocarotidian and angulomandibular adenopathies of suspicious appearance.
A biopsy of the mass had been done. The anatomopathological examination supported by the immunohistochemistry confirmed the diagnostic of malignant melanoma of the nasal cavity. The immunohistochemical profile favored malignant melanoma with positive tumor cell positivity to anti-S100, antiMelan A and anti-HMB45 antibodies.
The remote expansion report was without anomalies. The surgical indication was justified by the aggressive character and rapidly evolutive. Progressive excision of the tumor, by paralateronasal way [Figure 4] associated with ablation of the maxillary sinus internal wall, ablation of the nasal cavity lining, anterior and posterior ethmoidectomy, sphenoidoto my and removal of the mucosa from the bone defect were performed [Figure2].
Postoperative follow-ups were simple. The anatomopathological study of the tumor of the left nasal fossa, the floor of the nasal fossa and the cartilage of the nasal septum diagnosed a submucosal malignant melanoma with limits of tumor exeresis.
Surgical revision was performed 15 days later, supplemented by adjuvant radiotherapy. The endoscopic and pathological monitoring was reconciled with a satisfactory evolution after a follow-up of 6 months, and then the patient was lost to follow-up.

Comments
Malignant melanoma of the nasal cavities is an aggressive and rare neoplasm with poor long-term outcomes. The paranasal sinuses and nasal cavity are the most common primary tumor sites. The average survival rate is 40% at five years. Adverse prognostic factors include age (large), tumor thickness, tumor ulceration, the importance of mitotic activity and the intensity of the inflammatory response [2]. It appears difficult to establish prognostic factors apart the tumor volume (thickness). It affects both men and women, aged 50 to 70 years [2-3]. It is however not exceptional in the young subject. The nasal septum represents the primary tumor site in 75% of the endonasal forms, in particular its anteroinferior part, followed by the external wall (inferior turbinate, then medium) [4]. The average time between the first symptoms and the clinical examination is four months (range: 12 to 24 months). This delay is eight months for Lee *et al*. [5] It was an average of eighteen months for our patient. Clinical signs,

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Nonspecific, rarely alarm the patient. It is mainly nasal obstruction (50%) unilateral and recurrent epistaxis (20%) [6]. Maxillary pain and anosmia can be associated especially in case of significant tumor volume. Sometimes it is peripheral lymphadenopathy or visceral metastasis that is revealing. Rhinoscopy shows a tumor mass, which can be pigmented or achromic (1/3 cases), sometimes with melanosis of the neighboring mucosa.

Typically, melanoma presents as a blackish tumor, bleeding, sometimes pediculate. Nasal endoscopy allows a topographic assessment (seat), an assessment of tumor extension (posterior to the nasopharynx) and the practice of biopsies. The most common tumor site is the nasal septum, and the intersinu-nasal septum [7]. Maxillofacial CT refine the bone relationships and help predict the limits of excision and especially strengthens some conservative choices (orbit, maxillary infrastructure). MRI is more efficient to specify the limits of extensions in sinus cavities. Histopathologically, melanoma is characterized by a polymorphism that is a source of diagnostic error [9]. However, two types of architecture are most often encountered: the sarcomatous appearance and the pseudo-epitheliomatous appearance [9]. The use of immunohistochemical techniques, using antiprotein S100, especially anti-HMB 45, a protein associated with premelanosomes, is of considerable help in the diagnosis of forms with little or no differentiation [9]. Therapeutically, surgery remains the basic treatment, most often associated with postoperative radiotherapy [10]. All the authors favor the broad approaches of approach: paralateronasal, degloving, mixed ENT and neurosurgical ways in case of high extension. The resection must be wide. Ganglion dissection is necessary in cases of lymphadenopathy. It is done in the functional or non-conservative mode.

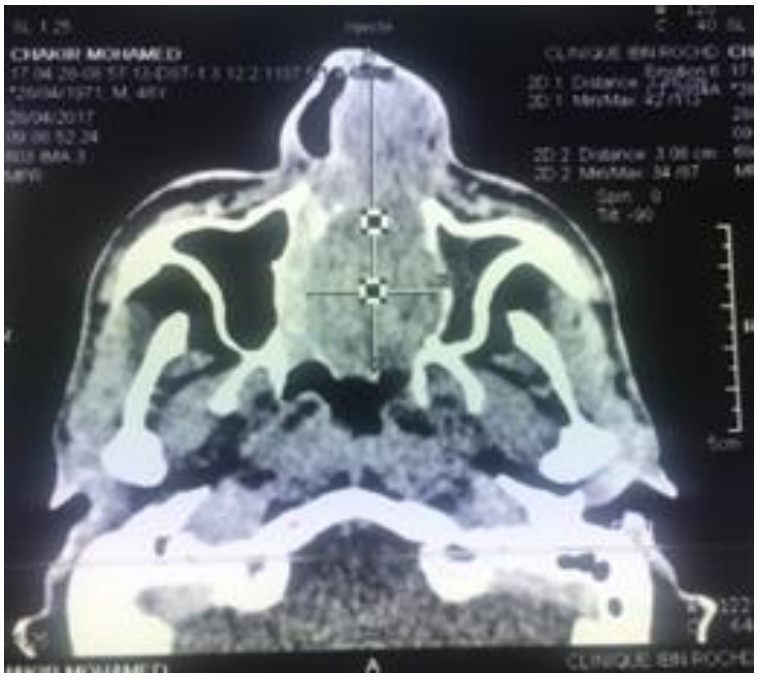

Fig 1: Tumor of left nasal fossa with antrochoanal filling and lysis of the upper left maxilla.

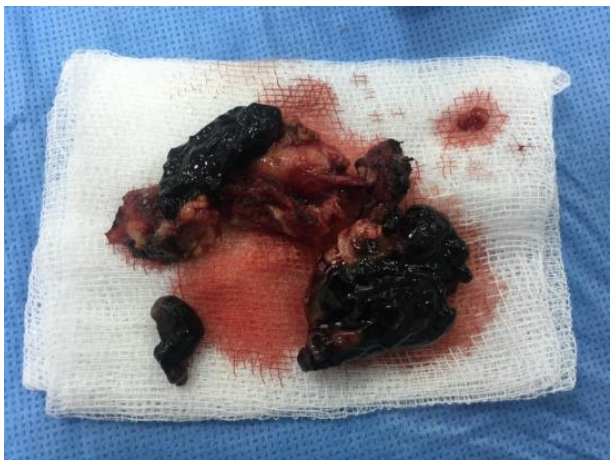

Fig 2: Operative part of the complete excision of the aggressive nasal tumor process

Conclusion

The prognosis of malignant melanoma of the nasal cavity is agressive and varies from 60 to 80% of deaths at 5 years. It is influenced by the age of the patient and especially the mitotic activity of the tumor.

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