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Metastatic Melanoma to the Stomach: A Rare Cause of Upper Gastrointestinal Bleeding

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INTRODUCTION

Upper gastrointestinal (GI) bleeding is a common diagnosis with annual incidence of hospitalization reported as 100 per 100,000 individuals and etiologies are many. The most common causes are generally recognized to be esophageal varices or peptic ulcer disease. Neoplasm in the stomach is a less common cause, and is usually due to primary gastric adenocarcinoma. The gastrointestinal tract can also be a site of metastases, however malignant melanoma is a relatively rare cause of upper gastrointestinal bleeding, accounting for less than 3% of all severe cases of bleeding.

CASE REPORT

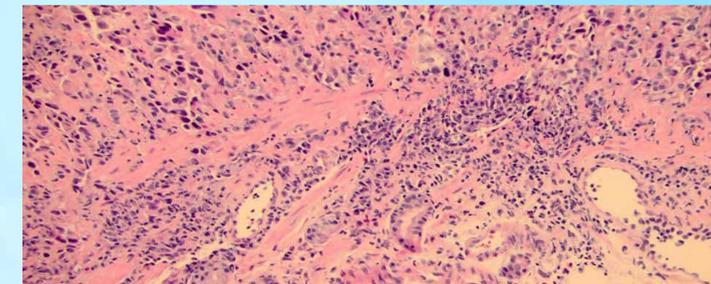
The patient is a 76-year-old male with a history of coronary artery disease status post drug-eluting stent, ischemic cardiomyopathy, hyperlipidemia and melanoma of the face treated thirty years prior, who presented to the emergency department (ED) with hematemesis and melena for 2-3 days prior to admission along with progressively worsening dyspnea on exertion and fatigue. The patient had recently started aspirin and clopidogrel following drug eluting stent placement. Upon evaluation in the ED, the patient was found to have blood pressure 119/78, heart rate 98, respiration rate 18, oxygen saturation 97% on 2 liters via nasal cannula. A physical exam revealed pallor with poor capillary refill. There was no abdominal tenderness. Lab work revealed hemoglobin 5.6, white blood cells 13.3, serum creatinine 1.35, troponin 0.26 → 0.37. In the ED, the patient was given two units of packed red blood cells (pRBC) and intravenous fluids for volume resuscitation and repeat blood work showed a hemoglobin of 7.6. The patient was evaluated by gastroenterology who recommended esophagogastroduodenoscopy (EGD). The patient was admitted to low level monitoring for continued blood transfusion requirement.

RESULTS

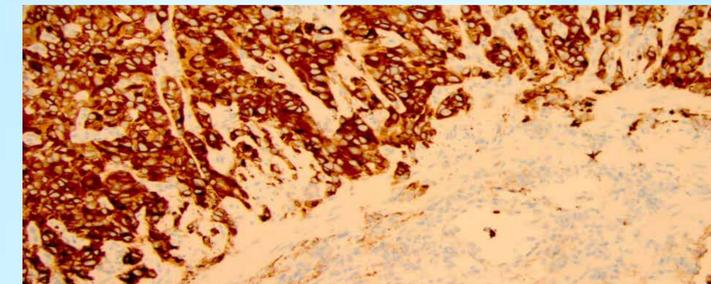
The patient was initially managed with volume resuscitation using crystalloids and blood products. EGD showed large gastric ulcer with heaped margins along the greater curvature of the stomach with a red the center. An endo clip was placed for hemostasis. Biopsies were obtained which later revealed to be metastatic malignant melanoma with S100 and MART1 positivity. Next-generation sequencing was performed demonstrating negativity for BRAF, NRAS, and KIT mutations. Computed tomography of the head showed an enhancing spherical lesion in the right basal ganglia concerning for metastatic disease.

CONCLUSION

Patients with metastatic melanoma to the GI tract have an overall poor prognosis with life expectancy as short as four months. With the rising incidence of melanoma and its subsequent GI metastasis, it is important to recognize metastatic disease early and potentially decrease the chance of life-threatening complications, which may lead to an early death. Only approximately 4% of patients with gastrointestinal melanoma are diagnosed prior to death. Prophylactic evaluation with endoscopy may be a powerful detection technique in patients diagnosed with melanoma and could detect early disease and provide treatment options to patients.



Stomach cold forceps biopsy



MART – 1 staining showing melanoma cells



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