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Intussusception in an Adult Secondary to Metastasis of Cutaneous Melanoma[☆]

Invaginación intestinal en el adulto secundaria a metástasis de melanoma cutáneo

To the Editor:

Intussusception is the infolding of one portion of the bowel within another and is the most common cause of intestinal obstruction in early childhood. Adult intussusception accounts for fewer than 5% of all intussusceptions and only 1% of all bowel obstructions.¹ The symptoms are those of partial or complete mechanical bowel obstruction, and in partial cases, the course can be intermittent or chronic.²

Cutaneous melanoma is rarely diagnosed as the etiology of intussusception in adults and is therefore not usually suspected when obstructive symptoms appear.

We describe a 47-year-old woman diagnosed with superficial spreading cutaneous melanoma on the left shoulder. The lesion showed no ulceration and had a diameter of 8 mm, a Breslow depth of 4 mm, and a Clark level of III. Following surgical resection and the detection of positive sentinel lymph nodes, axillary lymphadenectomy was performed; histology was negative. The patient received adjuvant therapy with interferon, but experienced recurrence in the left supraclavicular lymph nodes 2 years later. After 3 doses of fotemustine, the left supraclavicular lymph nodes were resected en bloc; 3 of these nodes were positive. The patient received radiation therapy to the surgical site.

Some months later, the patient was urgently referred to the general surgery department for colicky abdominal pain, digestive intolerance, loose stools, and macrocytic anemia. Computed tomography (CT) revealed bowel obstruction (Fig. 1), and probable intestinal metastasis of the cutaneous melanoma was suspected.

During surgery, intussusception was observed and the head was found to consist of a bluish mass; the intussuscepted jejunum (Fig. 2) and all visible blue lymph nodes were resected en bloc.

Macroscopically, the small bowel specimen was 39 cm in length, with intussusception at 14.5 cm caused by a blackish tumor of 4 × 7 cm that occluded the entire lumen. The microscopic report described melanoma infiltrating the muscularis propria; 5 of the 17 lymph nodes isolated in the mesocolon were positive. The resection borders were free of tumor.

The postoperative course was unremarkable, and the patient was referred to the oncology department for follow-up.

Intussusception in an adult is a potentially serious condition that is usually secondary to an intestinal wall lesion: benign or malignant tumor, inflammatory lesion (appendicitis, Meckel diverticulum), or even a foreign body in the small bowel. Therefore, it almost always occurs in the ileocecal area, but is less common in the jejunojejunal or ileocecolic areas.

The preoperative diagnostic techniques of choice are CT and ultrasound. Recent studies recommend that patients with cutaneous melanoma who develop gastrointestinal symptoms should undergo contrast-enhanced studies (enteroclysis, opaque enema, etc.), complemented by CT, depending on the result.³

The definitive diagnosis is established after surgery and histology. In general, immunohistochemical staining of the

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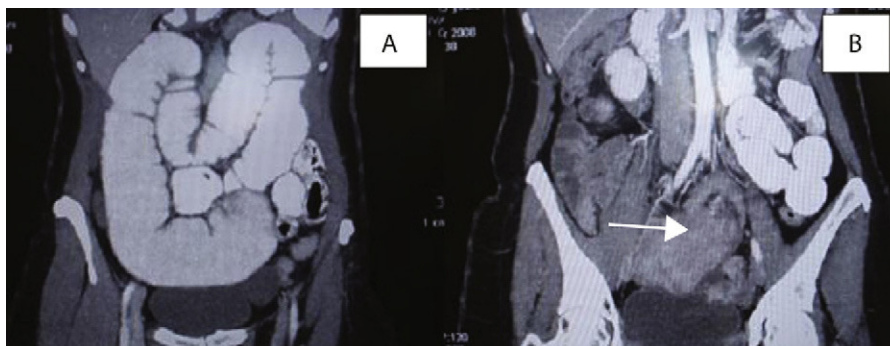


Figure 1 Computed tomography. A, Small-bowel dilatation consistent with intestinal obstruction. B, Jejunum. Image of multiple concentric rings with a central lesion (bull's-eye image).

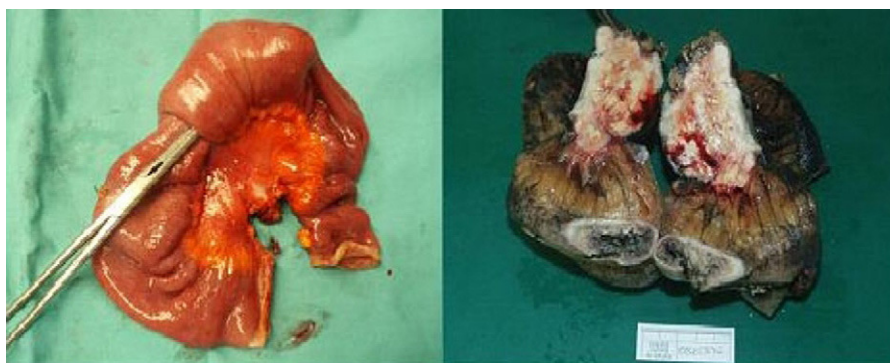


Figure 2 Surgical specimen.

material obtained is essential for the diagnosis of metastatic tumors.⁴

Bowel resection is the surgical technique of choice because of its increased safety and adherence to oncologic principles. The intussusception should only be reduced first when there is a potential benefit to the patient.²

Other groups advocate conservative treatment when the etiology of intussusception is not clear; such treatment will depend on the type of intussusception and on the clinical signs and symptoms and should always be accompanied by follow-up.⁵

Intussusception can now be diagnosed and treated laparoscopically, although in cases of complete bowel obstruction, the technique is complicated by the distension of the intestinal loops and the fragility of the intestinal wall.

The head of the intussusception is often a malignant lesion (52% of cases),⁶ and there are cases where this lesion is a metastasis of a cutaneous melanoma.⁷

The presence of an early complication caused by bowel obstruction, investigated by appropriate diagnostic methods, can lead to the early diagnosis of metastatic spread of a melanoma,⁸ as in the case we describe.

Once metastasis is diagnosed, surgery is the only option for treating complications of bowel obstruction due to melanoma (e.g. chronic anemia, episodes of partial bowel obstruction) and improving survival rates and quality of life in these patients.⁹

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Efficacy of Topical Imiquimod 5% in a Patient with Chronic Radiodermatitis on the Hands[☆]

Eficacia de imiquimod tópico al 5% en paciente con radiodermatitis crónica en las manos

To the Editor:

Chronic radiodermatitis is defined as a chronic inflammation of the skin associated with exposure to ionizing radiation. It usually presents in individuals who, because of their profession, have been repeatedly exposed to low doses of radiation over a long period of time without appropriate protection.

Several treatments have been described, including topical 5-fluorouracil, dermabrasion, ablative laser, photodynamic therapy, and surgery.¹ In 2006 Sachse et al. described the use of imiquimod in a 60-year-old patient with chronic thoracic radiodermatitis.²

We report the case of a 69-year-old male radiologist referred to our clinic for assessment of skin lesions that had appeared 2 years earlier on the dorsum of the fingers of both hands. The patient had performed fluoroscopy in clinical practice for 25 years without wearing gloves or using other recommended protective measures.

Physical examination revealed skin atrophy, poikiloderma, loss of skin adnexa, ulcerations, and hyperkeratotic lesions on the dorsum of several fingers of both hands with nail involvement (Fig. 1).

Several of the lesions were biopsied. Histologic findings in the specimen taken from the third finger of the left hand were compatible with actinic keratosis, and the changes observed in the specimen taken from the third finger of the right hand were conclusive for squamous cell carcinoma.

After informing the patient of the treatment options, a 4-week cycle of imiquimod cream, 5% was prescribed to reduce the number of lesions, with application 3 times a week. Tolerance was good and the number of lesions had decreased significantly by the end of the cycle (Fig. 2). Because the lesion on the third finger of his left hand persisted, the patient was referred to the traumatology department, where the distal phalanx of the affected finger was amputated.

Imiquimod (Aldara) is an immune response modulator belonging to the family of imidazoquinolines. Topical imiquimod stimulates the innate and acquired immune



Figure 1 Clinical image before treatment with imiquimod, showing hyperkeratosis and ulcerations on the fingers of both hands.



Figure 2 Clinical image after treatment with imiquimod cream, 5%.

responses.³ By binding to toll-like receptor 7, this drug activates immune cells, inducing the secretion of numerous cytokines with a potential antitumor effect, such as interferon α , tumor necrosis factor α , and interleukin 12.⁴ In vitro studies have shown that, in addition to its antitumor activity, imiquimod also has anti-inflammatory, proapoptotic, and antiangiogenic properties.⁵

Topical imiquimod has been approved for the treatment of actinic keratosis, some subtypes of basal cell carcinoma, and papillomavirus infections.⁶ However, in clinical practice it has been reported to be effective in Bowen disease, in situ

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