

# Malignant melanoma of the glans penis and male urethra

*Glans penis ve erkek üretrasının primer malign melanomu*

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Malignant melanoma (MM) of the penis is rare and accounts for a small percentage of malignant melanomas and of malignant penile lesions. The problem of the therapeutic approach is still unsolved. In general prognosis is poor and most patients die within a few years because of the distant metastasis.

**Key words:** *Malignant melanoma, penis, urethra*

Bu makalede glans penis ve eksternal meatusunda MM'ü olan 73 yaşındaki erkek hasta yayınlandı. Penis'in MM'ü oldukça nadirdir ve MM'ların ve penisin malign lezyonlarının oldukça az bir kısmını kapsar. Tedavi yaklaşımındaki sorun hala giderilememiştir. Genelde prognozu kötüdür ve hastaların çoğu uzak metastas nedeniyle birkaç yıl içinde ölmektedir.

**Anahtar sözcükler:** *Malign melanom, penis, üretra*

**P**rimary MM of the penis and male urethra are uncommon neoplasms. MM of the urethral meatus, the glans penis, the prepuce and the penile shaft are cutaneous forms, while melanomas of the rest of the urethra are mucosal forms. The diagnosis is often delayed by the patient's reluctance to consult a physician and by the intrinsic difficulty of such a rare neoplasm. We present a case of malignant melanoma of glans penis and urethral meatus.

## Case report

The patient, 73 years old, presented to the urology department of our hospital with pigmented plaque on his glans penis, which had been present for 1 year and rapidly increasing in the last 4 months. Physical examination revealed an approximately 1 cm diameter, unevenly black pigmented, poorly circumscribed, flat lesion on glans penis situated around the meatus externus and merges in the distal part of the urethra. Bilateral palpable inguinal lymphadenopathy was present. There was an approximately 0.5 cm diameter, soft nodule on the left side of the penile shaft (Figure 1). Chest radiography, sonography of the liver did not show evidence of metastatic disease, but bilateral inguinal lymph node metastases showed by computerized tomography of the lower abdomen. Incisional biopsy was done to penile lesions and inguinal lenf node. The histologic diagnosis was: cutaneus lentiginous MM of the glans (Figure 2a, 2b), 5.64 mm in thickness, with multiple conglomerated lenf node metastasis. Patient refuse the all treatment modalities, and died six months later.

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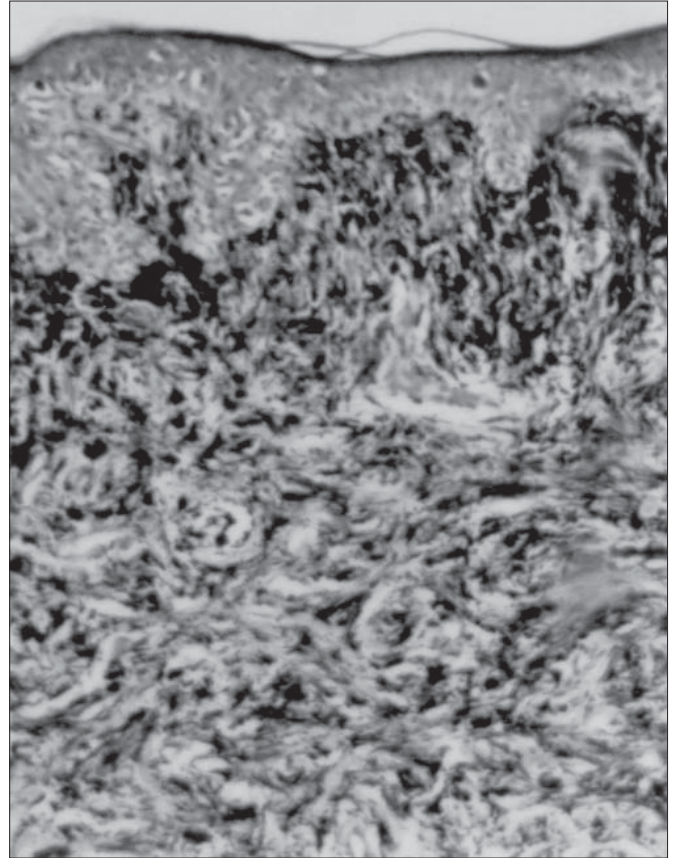
**Figure 1.** The malignant melanoma of the glans penis and urethra with inguinal lymphadenopathies.

## Discussion

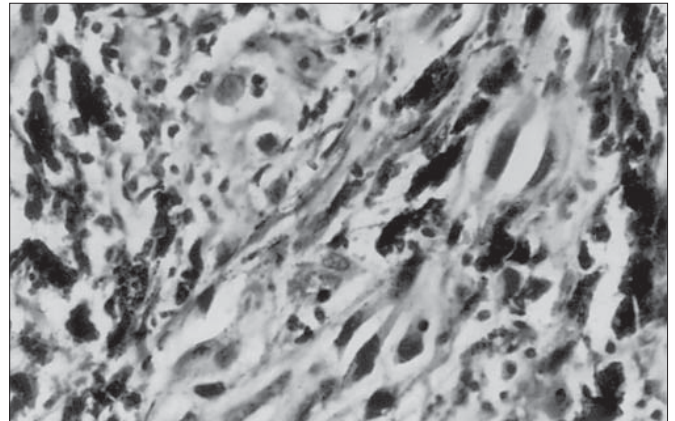
MM of the penis accounts for less than 1% of all primary penile malignant lesions (1) and for less than 0,2% of all malignant melanomas in men (2-3). It is usually localized in the glans penis (82%), followed by the prepuce, the urethral meatus and the penile shaft (3). The peak incidence is seen in the sixth to seventh decade (4,5). In advanced stages of the disease, patients may present symptoms of dysuria, obstruction, haematuria, discharge and occasionally melanuria and fistula formation. As happens with other neoplasms of the penis, there is often a long interval between first symptoms and the definitive diagnosis. In fact, the diagnosis is often delayed by the patient's reluctance to consult a physician and by the intrinsic difficulty in clinical diagnosis of such a rare neoplasm (2,3).

MM present clinically as approximately 1 cm. in diameter, blue-black to reddish-brown pigmented papule, plaque or ulceration. The clinical differential diagnoses includes junctional melanocytic naevus, penile melanosis, penile lentigo and atypical pigmented penile macules (6). These completely benign lesions are usually clinically indistinguishable from MM. Therefore, in order to establish a definitive diagnosis and to avoid large and useless surgical removal in any case of suspected pigmented genital lesion a incisinal biopsy with subsequent histologic examination should be performed.

In cases of penile MM, stage I disease is confined to the penis, stage II is metastatic to regional lymph nodes and



**Figure 2a.** malignant melanoma of penis 5.64mm in thickness (H.E.magnification 100x).



**Figure 2b.** Malignant melanoma cells (H.E. magnification x400).

stage III is disseminated disease (7). At presentation, 43-60% of the cases have lymph node involvement (1-4).

The best treatment for penile melanoma is unclear. Whereas some authors recommended an aggressive surgical approach with total amputation of the penis, perineal urethrostomy and radical inguinal, iliac and obturator lymph node dissection (8,9,10). But Stillwell et al, believe that conservative penile surgery (local excision with 3 to 5 cm margin or distal partial penectomy) with an appropriate

margin when inguinal nodes are nonpalpable in a patient with thin lesions (less than 1.5 mm) and prophylactic superficial inguinal node dissection for those greater than 1.5 mm<sup>3</sup> thick and most authors agree with these treatment (11,12,13). Some others reported that sentinel lymphadenectomy using radiocolloid mapping and dye localization avoided potential morbidity of bilateral superficial inguinal node dissections and allowed accurate staging for further treatment and prognosis (14,15).

Chemotherapy is indicated for disseminated melanoma. The combination chemotherapy consisting of six cycles DTIC, BCNU, cisplatin and tamoxifen gives the best result. The respond rate changes between %15 to %45 (11-16). There has been reported other treatment options; such as radiotherapy, immunotherapy with BCG, endolymphatic iodine- iodized oil infusion but the result are not superior to chemotherapy (2).

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