

4.6 Mucosal Melanoma of the Head and Neck

Introduction

0.5 – 2% of all malignant melanomas occur in the mucosa of the upper aero digestive tract with the remainder originating in the skin. Melanomas of the head and neck are most common in people in their 50s and 60s. The nasal cavity is the most common site in the head and neck where mucosal melanoma account for 15% of all nasal cavity malignancies. Other common sites include paranasal sinuses and oral cavity.

Histology and Pathology

One-third can be amelanotic, which some suggest has an even worse prognosis. Immunostaining with S100 and HMB45 aids in confirming the histology. Electromicroscopy can be helpful with fresh tissue.

Staging

Spread is common which is often extensive and associated with bone destruction. Regional spread to lymph nodes occurs about 20% of the time at diagnosis and a further 15-

20% at a subsequent point in the natural history. Although only 5-10% have evidence of distant metastasis at diagnosis, there is a very high risk of subsequent distant metastatic spread during the natural course of the disease; usually to lung and liver and occasionally brain and subcutaneous sites as well.

Mucosal melanoma often presents with bleeding and obstructive symptoms and a polypoid mass that is often dark in colour.

A deep incisional biopsy confirms the diagnosis. Pathologic microstaging (as in cutaneous malignant melanoma) is of little use in mucosal melanomas.

After complete history and physical examination, radiological studies including plain X-rays and CT scans of the primary site, lungs and liver are appropriate. Based on this, clinical staging is the following:

- I – disease confined to the primary site
- II – regional nodal metastasis evident
- III – distant metastasis is evident.

Practice Pathway for the Management of Mucosal Melanoma

