

A Rare Case of Acute Intestinal Obstruction due to Small Bowel Intussusception Caused by Metastasis of Cutaneous Melanoma

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Abstract

Case Report

Cutaneous melanoma frequently metastasizes to the gastrointestinal tract, although clinical manifestations are uncommon. Acute intestinal obstruction due to small bowel intussusception caused by metastatic melanoma is a rare and life-threatening presentation. We report the case of a 51-year-old man with a history of cutaneous melanoma who presented with acute bowel obstruction. Abdominal computed tomography revealed small bowel intussusception with upstream dilation, associated with diffuse hepatic and peritoneal metastases. Emergency laparotomy confirmed intussusception caused by a metastatic small bowel lesion. Segmental small bowel resection with double-barrel ileostomy and peritoneal biopsies was performed. Histopathological analysis confirmed metastatic melanoma. Small bowel metastases from melanoma are often clinically silent and rarely diagnosed preoperatively. Computed tomography plays a pivotal role in diagnosis, allowing detection of intussusception and assessment of disease extent. Surgical intervention remains essential for managing acute complications and improving quality of life, despite the generally poor prognosis in metastatic disease. Although rare, small bowel intussusception should be considered in patients with melanoma presenting with acute intestinal obstruction. Prompt computed tomography diagnosis and surgical management are crucial in emergency settings.

Keywords: Cutaneous melanoma, small bowel metastasis, intussusception, acute intestinal obstruction, gastrointestinal melanoma.

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INTRODUCTION

Cutaneous melanoma is a malignancy with poor prognosis at the metastatic stage. Within the gastrointestinal tract, the most frequently involved sites, in increasing order, are the colon, stomach, and small intestine [1, 2]. Post-mortem examinations of patients with melanoma reveal gastrointestinal involvement in 50–60% of cases [3, 4].

Intestinal obstruction caused by small bowel intussusception secondary to melanoma metastases, although the small bowel is a frequent site of secondary tumors, remains a rare and severe condition in which a segment of the intestine telescopes into another due to metastatic melanoma nodules [5].

The rarity of studies focusing on intestinal metastases from cutaneous melanoma presenting as acute bowel obstruction by intussusception leads to significant diagnostic challenges prior to surgical exploration, particularly before histopathological examination. A thorough radioclinical assessment is essential for both diagnostic and therapeutic decision-making, and surgical consultation is mandatory in all cases to determine operative indications [6, 7].

The aim of this report is to describe a rare case of acute intestinal obstruction caused by small bowel intussusception secondary to metastatic cutaneous melanoma and to contribute to the existing knowledge for clinicians involved in emergency care.

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CASE PRESENTATION

We report the case of a 51-year-old male patient followed for cutaneous melanoma for one year, initially diagnosed by histopathological examination of a left inguinal lymph node. He had no other significant medical history and no previous surgical history.

Two days prior to admission, the patient presented with cessation of stool and gas passage, associated with vomiting, abdominal distension, and

generalized abdominal pain in the context of impaired general condition. Clinical examination revealed a left inguinal scar, a distended and tympanic abdomen, and a normal digital rectal examination.

Abdominal computed tomography demonstrated small bowel obstruction due to secondary-appearing small bowel intussusception, a liver diffusely infiltrated with metastatic nodules, and the presence of peritoneal carcinomatosis nodules.

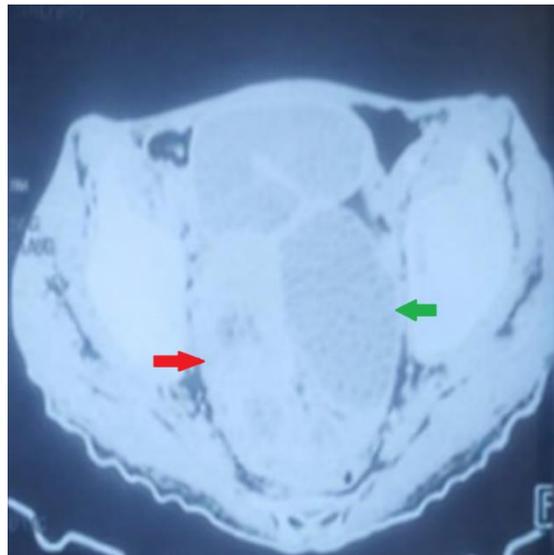


Figure 1: Computed tomography scan showing the small bowel intussusception “target sign” (red arrow) with upstream small bowel distension (green arrow).

Laboratory investigations revealed anemia with hemoglobin at 7.5 g/dL and hypoalbuminemia at 26 g/L. The patient underwent emergency surgery. Intraoperative exploration revealed a small bowel intussusception caused by a peritoneal carcinomatosis nodule located 140 cm from the duodenojejunal junction and 130 cm from the ileocecal junction, responsible for upstream dilation measuring 4.5 cm. The liver was

diffusely infiltrated with blackish carcinomatosis nodules, with a Sugarbaker Peritoneal Cancer Index of 13/39.

Surgical management consisted of segmental small bowel resection including the intussusception caused by the metastatic nodule, creation of a double-barrel ileostomy, and biopsy of the peritoneal nodules.

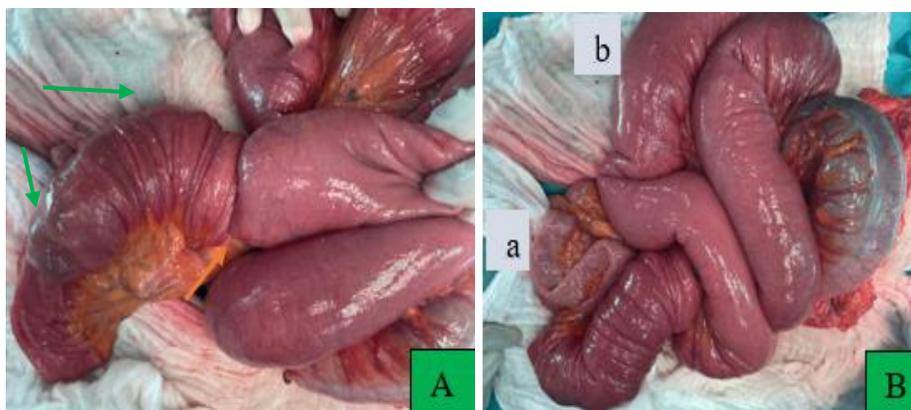


Figure 2: Intraoperative findings

- (A) Intussusception segment with peritoneal carcinomatosis (green arrow).
- (B) Non-distended downstream bowel loops (a) contrasted with dilated upstream loops (b).

Histopathological examination of the resected bowel specimen and peritoneal biopsies confirmed malignant tumor proliferation consistent with metastatic melanoma previously known in the patient.

DISCUSSION

Cutaneous melanoma carries a poor prognosis in the metastatic stage, and gastrointestinal melanomas are most often metastases from a primary cutaneous, ocular, or anal lesion. Primary gastrointestinal melanoma is exceptionally rare [8].

Gastrointestinal metastases predominantly involve the jejuno-ileal region in 50–60% of cases, followed by colonic involvement in approximately 30% [9, 10]. These metastases are frequently clinically silent and are diagnosed in only about 10% of cases.

In the present case, the diagnosis was made in the context of acute intestinal obstruction due to small bowel intussusception caused by a metastatic lesion.

Computed tomography is the imaging modality of choice, confirming intestinal obstruction due to an endoluminal metastatic lesion that may initiate intussusception or other complications requiring emergency surgical intervention. Computed tomography sensitivity for detecting peritoneal carcinomatosis nodules ranges from 60% to 70% [11].

Surgical resection should not be considered solely for symptom relief such as obstruction, bleeding, or severe pain. Other therapeutic modalities including chemotherapy, radiotherapy, and immunotherapy have been attempted but remain of limited efficacy in advanced disease [12, 13]. In our case, the patient underwent segmental small bowel resection with creation of a double-barrel ileostomy and was subsequently referred for medical oncologic management.

CONCLUSION

Gastrointestinal metastases from cutaneous melanoma are rare but should be considered in any patient with a history of melanoma presenting with digestive symptoms, particularly acute intestinal obstruction. Computed tomography is the diagnostic modality of choice, typically revealing an endoluminal lesion responsible for acute intussusception. Surgery remains the cornerstone of treatment for gastrointestinal metastases; however, incomplete resection should not be performed solely for symptomatic control.

Conflict of Interest: The authors declare no conflict of interest.

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