INTRODUCTION
The incidence of malignant melanoma including melanomas of the head and neck is on the rise worldwide. The incidence in the Subcontinent is not known. Typically, the tumour presents as an enlarging mole, changing colour, an atypical mole or naevus. Staging depends on tumour thickness (Breslow’s measurement) and histological depth of invasion (Clark’s level). The commonest site of metastasis is regional lymph nodes of the head and neck followed by lungs, brain, bone and liver. Treatment is surgical removal combined with regional nodes clearance. Localized metastasis can be removed surgically as well.

No standard postoperative adjuvant chemotherapy has shown any beneficial impact on survival. The current regimens are CVD (cisplatin, vinblastine and dacarbazine) regimen and Dartmouth regimen which utilizes a combination of cisplatin, carmustine, tamoxifen and dacarbazine. Recent trials with immunotherapy (interferon alpha 2 b) have shown improved results in patients who are free of disease but are at high risk for recurrence.1

This case report describes an extensive melanoma of face and neck skin which developed early metastases after surgery.

CASE REPORT
A 22 years aged, fair skinned female came to ENT OPD seeking medical attention for the huge, irregular, cauliflower-like multiple pigmented growths over the right side of her face and neck with disfigurement. There was a mole in front of the right ear tragus since birth. Initially the borders of the lesion became irregular, increased in size and took nodular appearance with brownish black pigmentation. Then it became a huge growth extending from the right side of mid face to the upper two third of the neck. During the last 6 months the growth had developed ulcerating margins, discharging pus and blood with pain and restricted movement of head and neck on right side for three months. She had also noticed a smooth bean-sized swelling on the left lateral side of upper neck for two and a half months. A punch biopsy of the lesion two years back had reported malignant neoplastic cells with prominent melanin pigment deposition. Immunohistochemical stains reported positively for S-100 and HMB-45, diagnose being malignant melanoma. She was advised surgical excision, but she refused and went under the treatment of a homeopathic personnel for some 18 months. However, the lesion kept growing. Her family history was negative for any such disease.

On examination, there were multiple well-formed fungating growths of varying sizes. The smallest at right pre-auricular was about 2 x 3 cm and the largest was on the right upper neck measuring 6 x 7 cm with ulcerating margins and discharging foul smelling pus and blood. This growth had also everted the ear lobule upward and obliterated the external auditory canal (Figure 1). On the left side of neck, a firm swelling of 1 x 1 cm covered with intact normal skin palpable at level II. Rest of the head and neck examination was unremarkable. Fibre-optic endoscopy revealed no mucosal lesion. No visceromegaly was found on abdominal palpation nor any skin lesion was found elsewhere on the body including scalp.

Baseline haematological investigations showed anaemia (Hb = 7.7 gm%). Her biochemical profile was normal including liver and renal function tests. Ophthalmologic assessment was negative for any suspicion of uveal melanoma. CT scan of head, neck, chest and abdomen revealed the lesion at right pre-auricular site measuring 6 x 7 cm with ulcerating margins. The lesions in the neck and chest were involving regional lymph nodes.

ABSTRACT
Management of extensive cutaneous malignant melanomas of head and neck is usually a challenging problem especially if the tumour has nodal metastasis. A young female presented with fungating growth of right side of face extending up to the neck. Two months after surgery, she developed brain and lung metastasis. The oncological control at this advance stage is far difficult with surgical excision. In such cases, reconstruction of head and neck becomes questionable at times.

18×21×17 mm in transverse, antero-posterior and crano-caudal dimensions respectively (Figure 2). It was attached to the skin by a very thin stalk. The large nodal mass from the right parotid measured 8.3 x 6.4 x 8.3 cm in size. On the right side level I, III, IV and V nodes were enlarged, the largest being 36 x 32 mm at level III. On the left side, enlarged lymph nodes were present at levels I and V. No definite pulmonary or visceral metastasis were seen. OPG (orthopantomogram) did not show any bony erosion.

She underwent wide local excision of lesion with adequate margins including parotidectomy and removal of a part of pinna and external auditory canal. Peroperatively, the tumour appeared reaching the lower trunk of facial nerve over the parotid requiring sacrifice of facial nerve for tumour clearance followed by bilateral modified radical neck dissection. The defect was reconstructed with deltopectoral flap and rest of the defect was repaired with split skin graft.

Grossly the specimen was blackish brown fungating growths measuring 14 x 10 x 8 cm. No area of necrosis or extra capsular spread was found in any of the cervical nodes. She made an uneventful recovery. Biopsy confirmed the histopathology of malignant melanoma, while the surgical margins were tumour-free. Only six out of the ten lymph nodes showed tumour deposits, while the rest were found benign. No tumour invasion was present on vascular, salivary gland or muscular tissues on histopathology. She was referred to the Oncology Department for immunotherapy as she had a deep primary lesion with regional lymph nodes metastasis considered high risk for recurrence.

Two months later, she complained of persistent headache and fits. Second metastatic work up was done that found a metastatic lesion in the right parietal lobe of cerebrum measuring 4.0 x 3.0 cm on MRI. A solitary pulmonary nodule in left lower lobe of lung measuring 7 x 8 mm also appeared on chest CT scan. Whole body scintigraphy revealed focal metastasis in the right parietal bone as well. The neurosurgeon carried out right sided craniotomy with tumour mass excision. She also had left lower pulmonary lobectomy by the thoracic surgeon. Histopathology showed metastatic melanoma. The disease could not be arrested and she expired eleven months after her first surgery.

**DISCUSSION**

Management of advanced malignancy of head and neck is a challenging job. Even with very extensive surgery there is always a chance of haematogenous spread to lungs, liver, brain and bone. Distant metastasis in any organ may make the prognosis worse as in this patient. Within two months of tumour resection, metastasis occurred in brain and lung without recurrence at the primary site of lesion. Primary and regional lymph node metastasis can be controlled with radical or modified radical neck dissection (removal of all the lymphatic and non-lymphatic structures needed for tumour clearance). This was found quite effective as patient did not have the recurrence of melanoma at the site of first appeared tumour during her follow-up. Deltoplectoral flap also merged with normal skin margins at the local site that showed primary control. Increased tumour thickness increases the chances of haematogenous and perineural spread. Excision of brain metastases and pulmonary lobectomy failed to control the tumour spread because possibility of micro deposits can not be eliminated even with the most skillful surgery. No standard adjuvant therapy in the presence of distant micrometastasis has shown to have any beneficial impact on survival.

Wide and deep excision of a melanoma of head and neck combined with radical lymph nodes dissection may control local disease recurrence and lymphatic spread but no proven control for haematogenous spread. Ulceration of the surface of malignant melanoma is an ominous sign indicating the tumour cells penetrating the dermis.

All patients with high risk primaries (> 4 mm in thickness) or with regional lymph nodes involvement should be considered for adjuvant therapy. For stage IV advanced stage melanomas, the role of chemotherapy is evolving. The efficacy of adjuvant therapy, such as Interferon and vaccine therapy is still investigational for patients with unfavourable cutaneous melanomas. Although patients with positive neck nodes are likely to have distant metastasis, patients who obtain local-regional control after treatment may be more likely to survive long-term. Kienstra analyzed behaviour of head and neck melanoma and discussed controversies in treatment modalities including lymphoscintigraphy with sentinel node biopsy, nodal dissection, size of tumour margins clearance and effect of radiation therapy on melanoma. Author concluded that head and neck melanoma should be treated aggressively when risk of morbidity is not significantly high.

Positron emission tomography (PET) is another useful tool for detecting loco-regional as well as distant metastasis.
metastases in cutaneous melanoma. PET is also suitable for disease staging and can be utilized to check any possible residual recurrence of tumour.8

REFERENCES