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Primary Malignant Melanoma of the Bladder

Ahmad Khodadad*

Department of Pediatrics, Tehran University of Medical Sciences, Tehran, Iran

✉ ***Ahmad Khodadad***
Department of Pediatric,
Tehran University of Medical Sciences,
Tehran, Iran
E-mail: khodadadahmad32@gmail.com
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Description

Although urethral melanoma has been well characterised, malignant melanoma that originates from the urine bladder is exceedingly uncommon. The most typical secondary manifestation of patients with extensive metastatic melanoma originating from the skin is melanoma of the bladder. To confirm primary bladder melanoma, additional melanoma sites must be ruled out.

It is generally known that the genitourinary tract can develop malignant melanoma. The most frequent secondary cause is melanoma that develops in other places. There have been numerous reports of primary melanoma of the urinary bladder in the past. To determine the primary nature of the tumour in such circumstances, a thorough medical history, examination of the patient's skin, and investigation for other visceral primary sites are required.

Primary bladder melanoma's histogenesis is unknown, but neural crest cells have been suggested as its possible origin.

Ainsworth and colleagues were the first researchers to carefully outline the definitional standards for primary malignant melanoma of the urinary bladder in 1976. These consist of,

1. Meticulous physical examination, excluding cutaneous melanoma by using Wood's light on the skin, together with a thorough history.

2.Exclusion of visceral melanoma after thorough analysis.

3. Recurrence pattern indicating primary melanoma of the urinary bladder.

4. Primary atypical melanocytes that were demonstrated histologically.

Wheelock was the first to report a primary bladder melanoma in 1942, followed by Su with one case and Anichkov and Nikonov with two cases. However, in neither of these cases were thorough investigations done to rule out primary melanoma at other sites. Since primary bladder melanoma is incredibly uncommon, it is likely that none of the previously recorded instances actually originated in the bladder.

In order to deal with such a rare tumour, several treatments were suggested. Bladder melanoma has been treated by transurethral resection, partial cystectomy, radical cystectomy, chemotherapy, and radiation therapy. Although to date none of the patients have survived more than three years after having a cystectomy, which is indicative of the tumor's poor prognosis, aggressive surgery appears to be the treatment of choice for all patients with localised tumours.

Adjuvant chemotherapy combined with radiotherapy may increase patient survival because the tumour often returns after local excision. Another option for treating

melanoma is interferon, which exhibited a 10% remission rate in metastatic cutaneous melanomas.

The prognosis is poor despite the wide range of therapy available. After undergoing a major cystectomy, chemotherapy, and radiotherapy, Ainsworth's patient experienced a local recurrence 14 months later. Recently, two months after diagnosis, our patient passed away from a broad illness. However, Neiderberger reported that a primary bladder melanoma patient who underwent a radical cystectomy alone was disease-free for 18 months.

The tumour was deeply penetrating the muscle in all recorded cases, which may explain the very poor prognosis.

Conclusion

Most frequently, patients with extensive metastatic melanoma originating from the skin present with bladder melanoma. We have demonstrated the rarity of primary bladder melanoma and the necessity of meeting all the Ainsworth criteria in order to confirm the diagnosis. Radical surgery should be part of the bladder primary melanoma treatment plan. A cautious prognosis is given.