BACKGROUND: About 10% of the initial cutaneous melanomas are not cured, although appropriate treatment. The involvement of sentinel lymph node, even just in immunohistochemical exam, indicates the need for additional lymphadenectomy. The Multicenter Selective Lymphadenectomy Trial II (MSLTII) intends to identify a subgroup of patients with sentinel node compromised that would not benefit from lymphadenectomy. We present a patient with microscopic involvement of a lymph node (only few melanoma cells diagnosed by immunohistochemistry), who had progressed to lethal metastatic disease.

HYPOTHESIS: melanoma micrometastasis diagnosed by immunohistochemical must really be considered as a significant prognostic factor.

METHODS: In September 2008, a male patient, 63 years old, white, presented with a right tight tumor of about 2.0 cm, which had growing in the last 3 months. No other major complaints. On clinical exam, it was a subcutaneous tumor with no other significant findings. The MRI exhibited a solid mass lesion affecting the skin and subcutaneous layers, with surrounding edema. After the withdrawal of this tumor, the pathology exam showed a malignancy of melanocytic origin, located in the deep dermis and hypodermis, with no connection to the epidermis. Chest and upper abdomen CT scan and DHL dosage were normal. Patient became oncological follow up every 4 months, and in March 2009, PET-CT revealed a lesion in the left calf (fig 1). Through radio-guided surgery, the lesion was removed showing a lymph node with micro metastasis diagnosed by histopathology examination along with immunohistochemistry by using S100 and HMB 45 (Figure 2). New PET-CT, about 30 days after this surgery was normal. Continued follow-up, and PET-CT in 2014 showed the presence of lung, hepatic, bone and skin lesions, whose biopsies confirmed melanoma. He underwent treatment with ipilimumab, evolving to death in July 2015 (Figure 3).

RESULTS:
These findings strengthen the prognostic value of melanoma micro metastases, even with few melanoma cells. These patients need complementary treatment beyond surgery. Nowadays, the amount of micro metastasis into the sentinel node has been checked looking for selection of a subgroup of patients that don’t need lymphadenectomy, neither other treatment (MSLT II). The new approved adjuvant ipilimumab was based on a trial that considered patients with at least 1 mm of micro metastasis into sentinel node. These case report emphasize the significance of few melanoma cells metastasis.