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32 yrs Old Male Mr. Ram, Vegetable Vendor by Occupation, coming from Kundrathur, belonging to a low socio economic status came with the **chief complaints of pigmented lesion in inner aspect of right foot for 2 months**.

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HISTORY OF PRESENTING ILLNESS

The patient was apparently normal 2 months back after which he noticed a mole in inner aspect of right foot, initially smaller in size, progressed suddenly and attained the current size with change in colour from brown to black and it was associated with itching.

NO H/O Ulceration of lesion.

NO H/O Bleeding/discharge.

NO H/O Pain in the lesion.

NO H/O Long standing exposure to sun.

NO H/O New mole elsewhere in the body.

NO H/O Dark coloured urine.

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NO H/O Fever.

NO H/O loss of weight and appetite.

NO H/O Trauma.

NO H/O Visual Disturbances.

NO H/O Jaundice, Abdominal pain/Distension.

NO H/O Cough with hemoptysis.

NO H/O Chest pain.

NO H/O Bone pain.

NO H/O Headache, Seizures, Blurring of vision, Projectile vomiting.

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Past history

NO H/O Similar complaints in the past.

NO H/O HT/DM/TB/Asthma/Epilepsy/Jaundice/IHD.

NO H/O Any previous surgery and hospitalisation.

NO H/O Irradiation.

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Personal history

Consumes Non Vegetarian diet.

Normal bowel and bladder habits.

No addictive habits.

No H/O Allergic to food and drugs.

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Family history

No H/O Similar complaints in the family.

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SUMMARY

A 32 Yrs Old man, presented with complaints of pigmented lesion in the medial aspect of right foot for 2 months which progressed suddenly associated with the change in the color of lesion from brown to black and itching.

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General examination

After getting consent from the patient, the general examination was done.

He is Conscious, Oriented, Moderately built and Moderately nourished.

NO Pallor

NO Icterus

NO Cyanosis

NO Clubbing

NO Pedal edema

NO Generalised lymphadenopathy

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Scalp, Nail bed, Tongue, External auditory canal – Normal.

Eye – Normal.

External Genitalia – Normal.

} For Occult melanomas.

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Vital signs

PULSE RATE: 72/min ,regular in rhythm, normal in volume, no specific character, no vessel wall thickening, no radioradial/radiofemoral delay, all palpable peripheral pulses are felt on both sides.

RESPIRATORY RATE: 16/min, abdominothoracic type.

BLOOD PRESSURE: 130/80 mmHg measured in left upper arm in sitting posture.

PATIENT IS **AFEBRILE**.

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LOCAL EXAMINATION:
Examination of Right Foot:

INSPECTION:

A **Solitary** black pigmented **plaque** of size 4x3 cms, irregular in shape, irregular surface with well defined borders with a brown halo around the lesion.

Extending upper border 1cm below the medial malleolus, lower border 5cm below the medial malleolus, anterior border 8 cm and posterior border 5 cm from posterior end of foot.

Skin over the lesion is black pigmented.

NO Ulceration/Fungation/Crusting.

NO Discharge/Bleeding.

NO Scars, Sinuses, Dilated veins, Visible Pulsations.

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NO Satellite/ *'in-transit'* Nodules.

NO Visible Lymph Nodes.

NO Other similar lesions else where in the body.

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Palpation

Not Warm.

Not Tender.

Inspectory Findings of Site, Size, Shape, Extent are confirmed.

Firm in consistency, irregular surface, well defined border, mobile, surrounding area not indurated.

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Examination of regional lymph nodes:

RIGHT INGUINAL REGION:

A **Single Lymph node of Size 1x2 cms** is **palpated** in the Right inguinal region which is **non-tender, hard in consistency, mobile, smooth surface, skin pinchable belonging to lower vertical group of superficial Inguinal lymph nodes.**

NO OTHER LYMPH NODES PALPABLE.

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NO DISTAL FOCAL NEUROVASCULAR DEFICIT.

NO RESTRICTION OF JOINT MOVEMENTS.

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Systemic Examination

RESPIRATORY SYSTEM : Normal Vesicular Breath Sounds heard. No added sounds.

CARDIOVASCULAR SYSTEM: S1 S2 Heard. No Murmurs.

CENTRAL NERVOUS SYSTEM: No focal neurological deficit.

ABDOMEN: Soft, Non tender, No organomegaly, No free fluid, Hernial Orifices free, External Genitalia Normal.

SPINE AND CRANIUM: normal.

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Diagnosis

Malignant Melanoma of the right foot with no satellite nodules/ *'in – transit'* nodules with Right sided Lower Vertical inguinal lymph node enlargement.

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Investigations

BASELINE:

Complete blood count – TC, DC, ESR, Hb%, blood grouping and Typing, Blood sugar, urea, serum creatinine, **serum LDH**

Urine routine: albumin, sugar, deposits

X-ray chest, ECG

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Specific investigations:

Excision biopsy.

FNAC of lymph node.

US Abdomen, Popliteal region, Inguinal region.

CT Scan – Abdomen and Pelvis.

Urine for Melanuria.

Hand held magnifying lens – Assessment of pigment pattern and distribution.

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Tumour Markers

IHC markers:

S 100

HMB 45

MELAN-A

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Treatment

For Primary: **Handley's Wide Local Excision and clearance** margin depending on the tumour thickness(depth) and Primary closure/ Split Skin Graft / Local Flaps are used to cover the defect after Excision.

For Lymph node secondaries: **Ilioinguinal block dissection.**

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