MELANOMA RELAPSE OF THE UPPER THIRD OF THE VAGINA TREATED WITH BCG AND BETA-INTERFERON

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Summary: Faced with a vaginal melanoma relapse in an old cardiac patient operated in May 1985 for melanoma in the upper 3rd of the vagina, we had to solve a therapeutic problem in view of the impossibility of excising a lesion larger than the preceding one and because the patient refused every type of surgery.

So we then chose the combined treatment of intralesional BCG and intravenous β-Interferon.

Monthly intravenous administration of β-Interferon has reached a total of 8,000,000 I/U, while the BCG has been inoculated intralesionally in the submucosa in doses of 0.1 ml after observing the negative result of the PPD test.

Our aim was to achieve double immunological stimulation by combining two drugs that are often used separately with satisfactory results.

Before and after every therapy cycle, the immunological status was established, and showed a small but constant and permanent increase in T-lymphocytes, both helper and suppressor.

Histological results before and after therapy and immunological responses are reported, and the case distinguishes itself by its brilliant results.

Having had a hysterectomy 10 years earlier, an old patient with a vaginal melanoma relapse and heart disease, who was operated in May 1985 for vaginal melanoma, presented a therapeutic problem in view of the impossibility of excising an area larger than the preceding one and performing surgery, since the patient refused every type of surgery.

Thus we, selected the combined treatment of BCG-Beta-Interferon as follows: the patient was immediately given BCG intralesionally (0.1 ml every two weeks for a total of 3 injections) always in the absence of a positive PPD test ([1, 3, 4, 7]).

We then administered a monthly intravenous dose of Beta-Interferon of 8,000,000 I.U. (each dose stretched over a week), and the whole cycle was repeated another five times ([5]).

Our aim was to achieve double immunological stimulation by combining the two drugs, the second of which was much less effective in avoiding metastasis, since it was always used with local relapses.

CLINICAL CASE

S. P., 75-years-old, hysterectomized in 1975 for metrorrhagia, operated on 17th May 1985 to remove a 1.5 cm-diameter neoformation on the upper third of the vagina which easily bled. Histological examination showed it to be a case of ulcerated nodular melanoma (Clark III, Breslow 1.8). The patient then had a period of relative well-being.

On 19-12-1985 she came for a gynecological check-up due to blood loss, and we observed a pigmented cutaneous lesion relapse with dimensions and characteristics almost equal to the primitive tumour (fig. 1 and 5).

New staging showed the lesion to be completely negative. So we decided, in harmony with the patient's wishes, to perform local therapy with BCG whose action against melanoma has been amply demonstrated ([3, 4]).

The patient tolerated the BCG intralesional inoculation well, and a new biopsy for histological examination was carried out disappearance of melanoma (figs. 1, 2, 3).

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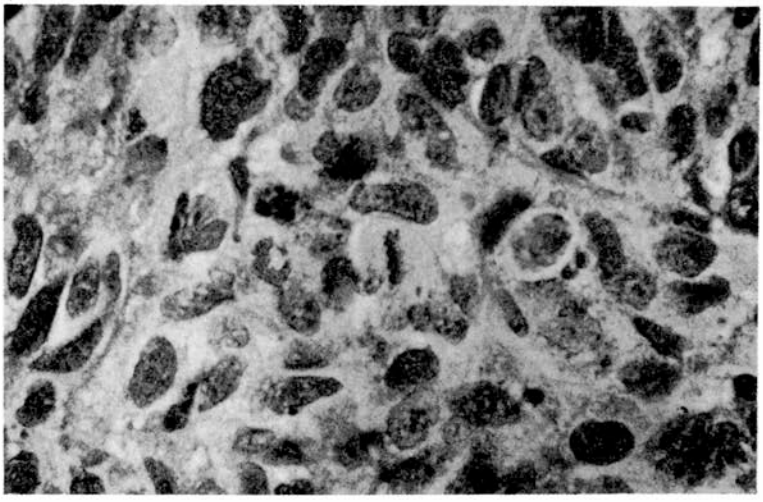


Fig. 1. — Malignant melanoma: mitoses, cellular atypias and melanotic pigment.

Finally we passed on to the systemic administering of Beta-Interferon in order to build up major organism protection.

The therapeutic course was documented by colposcopic imaging which we wish to demonstrate. We were obliged to choose the local method of administering BCG to our case. In view of the already known effects, and seeing that most development occurs at the expense of local defenses, we did not think it appropriate to add also Beta-Interferon which was administered systematically with the aim of further protecting the patient from possible relapse or distant metastasis.

The method of administration chosen was intravenous: a million a day for 8 days to be repeated after 4 weeks for 5 cycles.

Contemporaneously we carried out immuno-

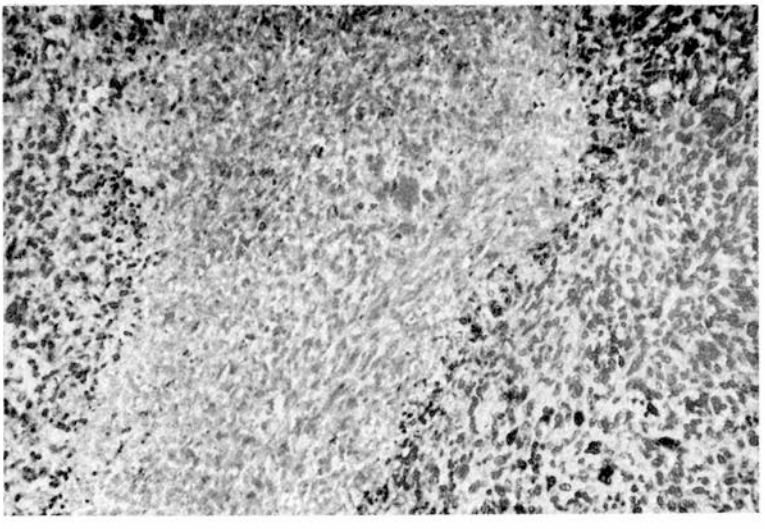


Fig. 2. — Widespread necrosis within neoplastic tissue.

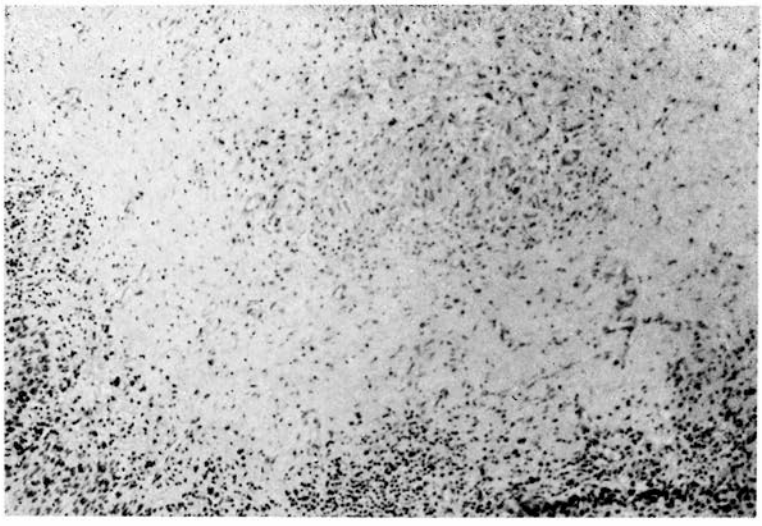
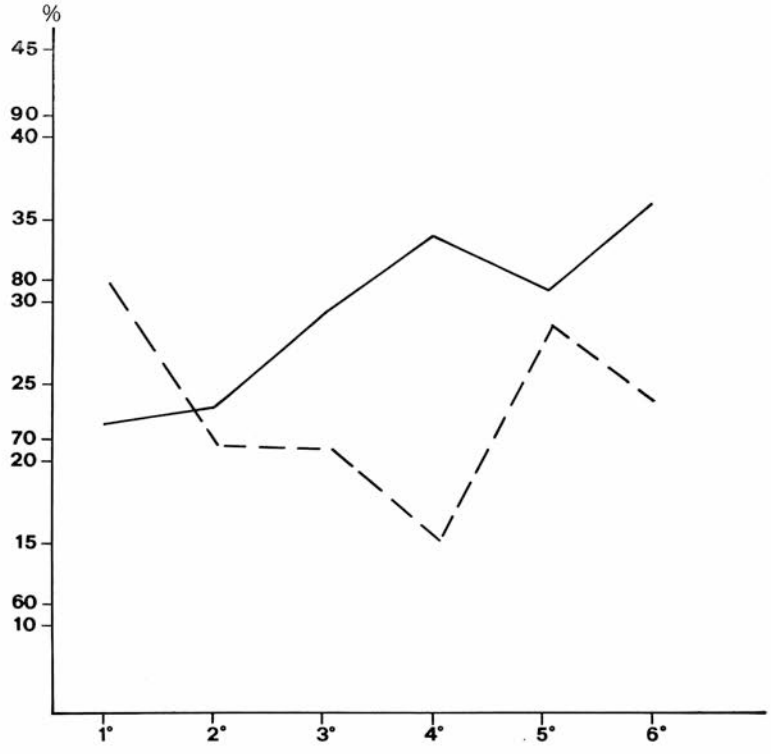


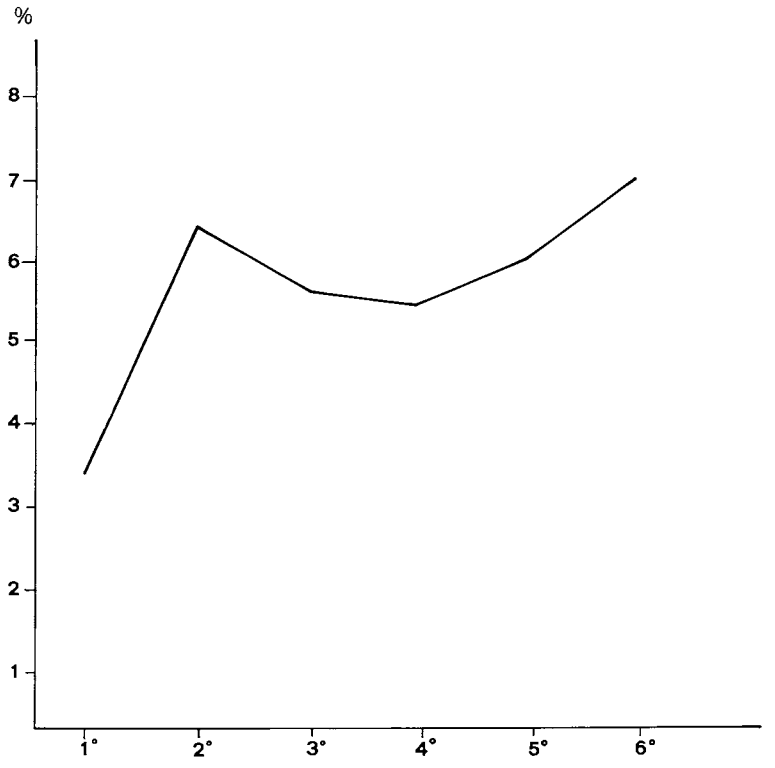
Fig. 3. — « Restitutio ad integrum »: normal tissue without melanoma.

Table 1. — *Peripheral lymphocytes T.* (normal values 72-83%). *Peripheral macrophages - monocytes* (normal values 14-25%).



Blood samples taken before administering β interferon I.V.

Table 2. — *Leukocytes* (normal values 4-8.5 × 1000/microliter).



Blood samples taken before administering β interferon I.V.

logical monitoring in order also to check the patient and obtain some parameters, as can be seen from the chart where white corpuscles, peripheral T lymphocytes and macrophages/monocytes are taken into consideration (table 1).

COMMENT AND CONCLUSIONS

Vaginal melanoma is rather rare; it represents 2% of malignant tumours of that area ([5]).

Symptomatology and histological aspect are analogous with those of other localizations.

Surgical therapy is elective, while, in addition to chemotherapy, aspecific and specific immunotherapy were introduced as complementary treatments. Survival up to 5 years is still, however, rather rare in view of precocious invasion of the submucous stroma, which represents an unfavourable factor in prognosis, as De Laurentis *et al.* affirm.

Among therapies proposed, the immunological one is today gathering consent ([1, 3, 4, 7]), so that applying Beta-Interferon to enhance natural "killer", cells and macrophages received strong support.

Applying a therapy which is, so to speak, anomalous to such pathology, and obtaining useful results up to this moment, has given rise to various questions:

1) Is this BCG-Beta-Interferon association advisable?

2) Is the systemic administering of Be-

ta-Interferon efficient at these doses, and for how long must it be continued?

3) Is there really a greater immunological protection? According to the immunological parameters we examined, this is probably true except for one case. We observed positive results but how long will this last? In other words, can we consider our work satisfactory or have we been lucky? The patient is certainly content and tranquil.

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