Antiphospholipid Antibodies and Melanoma: A Link?

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Sir,

In November 1988, we began a survey of cutaneous manifestations in consecutive patients referred to the hematologic department of our hospital for assessing antiphospholipid antibodies. Indications for the test included thrombotic episodes, repeated abortions, occasional evidence of prolonged activated partial thromboplastin time or falsely positive VDRL. For each patient, both lupus anticoagulant and anticardiolipin antibodies were looked for by previously described procedures [1]. The anticardiolipin antibody test was reported in immunoglobulin G phospholipid (GPL) standard units [2], and normal values were considered to be lower than 15 units. Cutaneous examinations were performed by a dermatologist unaware of the results of serologic tests and were focused on evidence of cutaneous vascular abnormalities (e.g. livedo reticularis, ulcers). Up to September 1990, 60 patients had been tested, 20 of whom had lupus anticoagulant and/or anticardiolipin antibodies.

A case of melanoma was observed unexpectedly in association with antiphospholipid antibodies. This was a 44-year-old woman with a history of recurrent abortion and cerebrovascular accidents, without evidence of systemic lupus erythematosus (SLE). Both lupus anticoagulant and anticardiolipin antibodies (50 units) were positive, and assays for protein C and S gave normal values. A diagnosis of oral leukoplakia had been made 3 years before. The patient had never taken

immunosuppressive drugs or corticosteroids. On physical examination, a few acquired irregularly shaped melanocytic nevi were seen scattered over the trunk, and ephelids were found on the trunk and face. On the right thigh there was a pigmented lesion which was revealed by histologic examination to be a superficial spreading malignant melanoma (thickness. 0.18 mm). This case prompted us to review 97 consecutive cases of melanoma, diagnosed between January 1989 and September 1990 in our institution. We looked for false-positive VDRL, prolonged activated partial thromboplastin time or thrombocytopenia and searched for antiphospholipid antibodies. In this way, we found one additional case with high levels of anticardiolipin antibodies (20 units) and a false-positive VDRL. During the study period, the overall prevalence

of a positive anticardiolipin antibody test (15 units or more) in a sample of unselected patients from our hospital was estimated to be about 1:1.000 [unpubl. data].

Taken together, these observations suggest that there is an association (never reported before) between malignant melanoma and antiphospholipid antibodies. Interestingly, tumors, including solid ones, were listed as clinical manifestations of lupus anticoagulant in patients without SLE in one of the first reports on this subject [3], and, subsequently, tumors in association with antiphospholipid antibodies were reported

sporadically. Antiphospholipid antibodies are present in a subset of patients with SLE, and several types of tumors, including melanoma [4], have been reported during the course of SLE. Abnormalities of host immunologic defenses may be associated with melanoma and with both antiphospholipid antibody syndrome and SLE.

In conclusion, we feel that formal studies are needed to test the hypothesis that antiphospholipid antibodies and their manifestations occur with increased frequency in patients with selected neoplastic diseases.

References

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