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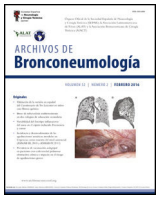

Clinical Image

Pleural Metastatic Melanoma

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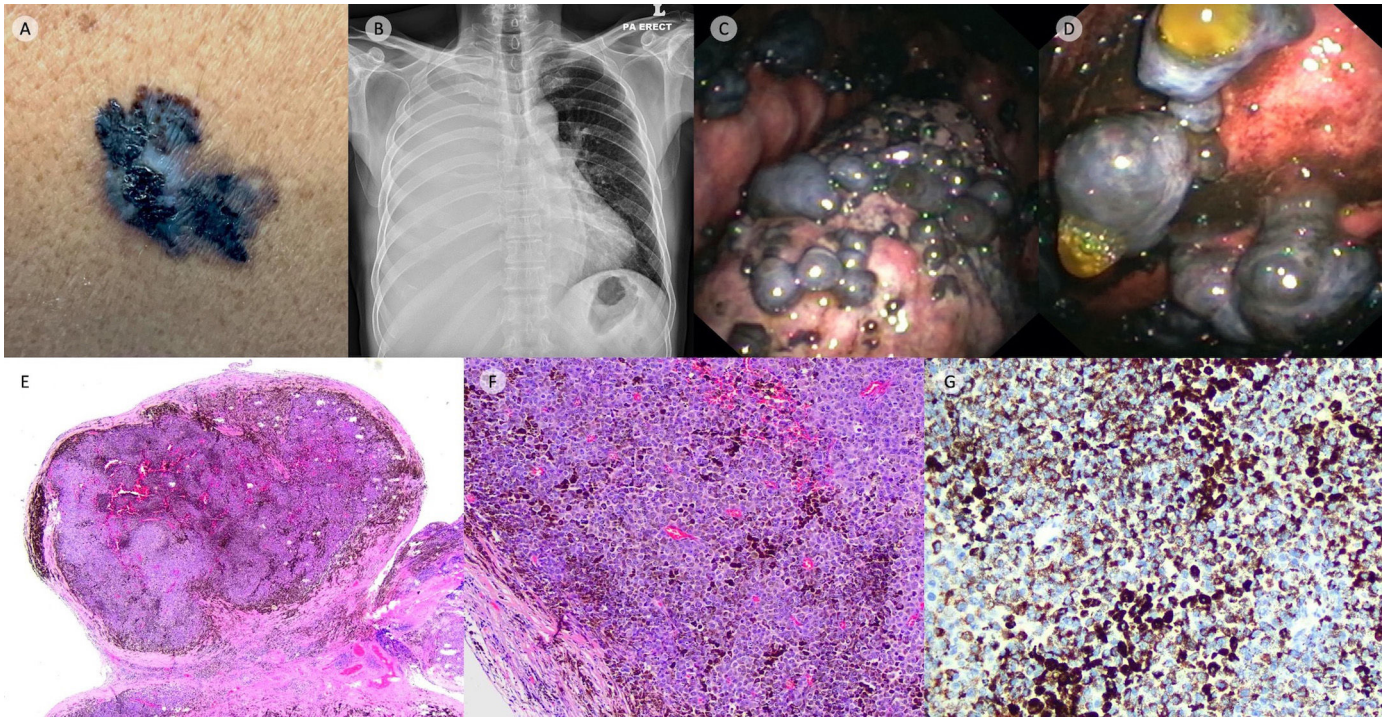

Fig. 1. *Panel A*: An asymmetrical, irregular-edged, hyperpigmented ulcerated plaque with colour variation measured around 2.5 cm × 1.5 cm at the left posterior trunk; *Panel B*: Large right pleural effusion; *Panels C and D*: Medical thoracoscopy revealed multiple discrete blackish pleural nodules and masses on both the parietal and visceral pleura. Biopsy of the lesions showed metastatic tumour nodules with heavily pigmented cytoplasm in low power (*Panel E, hematoxylin & eosin, 20× magnification*) and high power (*Panel F, hematoxylin & eosin, 100× magnification*) which were positive for HMB-45 stain (*Panel G, HMB-45 stain, 200× magnification*) confirming metastatic melanoma.

A 69-year-old male farmer from a tropical region, who had been farming without proper sun protection, presented with constitutional symptoms and progressively worsening breathlessness over the past four weeks. Physical examination revealed stony dullness over the right hemithorax and an asymmetrical, irregular-edged, hyperpigmented ulcerated plaque with colour variation at his left posterior trunk (Fig. 1, *Panel A*). Chest X-ray (*Panel B*) and transthoracic ultrasound confirmed the presence of massive right pleural effusion. Diagnostic thoracocentesis revealed an exudative pleural effusion, and cytology was negative for malignancy. Medical thoracoscopy showed multiple discrete blackish pleural nodules and masses over the parietal and visceral pleura (*Panels C and D*, Video 1), with biopsy confirming metastatic melanoma (*Panels E–G*). The patient was started on immunotherapy with nivolumab and ipilimumab. Pleural metastatic

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melanoma is a rare entity and, unfortunately, a poor prognostic factor.[1,2] Its thoracoscopic appearance has rarely been described in the literature, highlighting the importance of awareness in its recognition. When consistent with clinical suspicion, the distinctive appearance of black pleural nodules and masses can almost confirm the diagnosis, as demonstrated in our case.[2]

CRediT Authorship Contribution Statement

SSK initiated the idea for manuscript submission and prepared the final draft. SSK also performed the medical thoracoscopic procedure. SSK and JSW acquired the clinical data and were involved in the initial care of the patient. JC was the pathologist in charge and FYH was the primary oncologist. All authors have read and approved the final manuscript.

Declaration of Generative AI and AI-assisted Technologies in the Writing Process

The authors declare that no artificial intelligence software was used in the preparation of this manuscript.

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Conflicts of Interest

The authors have no conflicts of interests to declare.

Appendix A. Supplementary Data

Supplementary data associated with this article can be found in the online version available at https://doi.org/10.1016/j.arbres.2025.03.023.

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