Ex-President Jimmy Carter has Cancer to Brain and Liver

Dr. Kevin Buckman MD August 20, 2015

In a press conference this morning, the Carter Center revealed that the ex-president has been diagnosed with both liver and brain cancer.

(Newswire.net -- August 20, 2015) --The Carter Center today said Carter held a press conference this morning at its offices in Atlanta.

President Carter, now age 90, announced today that liver surgery found cancer that has spread to other parts of his body including several small spots in the brain. He will be getting radiation therapy to the brain and he has already had liver surgery to remove the cancer. Mr. Carter indicated that the cancer has spread, but did not identify its type or say where it originated. He did confirm today that it was due to melanoma. He will continue to get more diagnostic tests to look for other metastatic lesions in other parts of the body using CT and PET scans.

He has melanoma that has spread inside his body without known skin melanoma, which can occur and around 2 percent of cases of melanoma.

The incidence of melanoma is increasing

The incidence of skin cancer is increasing by epidemic proportions. Basal cell cancer remains the most common skin neoplasm, and simple excision is generally curative.

Skin cancers are among the least dangerous of cancers, except for skin cancers that spread to other parts of the body. Most of them are only locally aggressive, and although they can be disfiguring, they are seldom life-threatening. The exception to this general rule is malignant melanoma. The melanomas, tumors that arise from cells are called melanocytes, these cells are among the most malignant of all cancers, metastasizing to any part of the body.

Melanoma can affect various parts of the body, not just skin cancer

Mucosal melanoma occurs on the mucous membranes. This can be in the oral cavity or vaginal region. Mucosal melanoma is a rare cutaneous condition. Melanomas may arise from the mucosal epithelium lining the respiratory, alimentary, and genitourinary tracts, all of which contain melanocytes, as well as from the skin.

Mucosal melanomas generally carry a worse prognosis than those arising from cutaneous sites. Because of the rarity of mucosal melanoma, and because of the unique biology and clinical challenges of mucosal melanoma arising from each anatomic location, our understanding of these malignancies and their optimal management remains limited.

Mucosal melanoma, as well as the specific approach to patients with mucosal melanomas arising in the head and neck, vulvovaginal, and anorectal regions can occur, as well has internal cancer like those of Jimmy Carter.

Death can follow within months of the diagnosis of melanoma in some cases. Melanoma can even spread on occasion from a pregnant mother to her fetus. It also readily spreads to the brain and spinal cord.

Mucosal melanoma represents a distinct variant of the much more common superficial, cutaneous (skin) melanoma. Mucosal melanoma, because it occurs in areas that are not visible, is often not diagnosed until it is relatively far advanced.

Before techniques of lymphatic mapping and sentinel node biopsy were perfected, patients were routinely subjected to a much more extensive procedure called ELND – elective lymph node dissection – during which all of the lymph nodes in the drainage region around a primary melanoma were surgically excised.

This procedure remains highly controversial. Not only does it have a high complication and recurrence rate, it has also been shown to confer no survival benefit for patients with no known metastases, or those with micro-metastases that are not clinically detectable (in-transit metastases).
Diagnosis

These days, for melanomas greater than 1 mm thick, sentinel node biopsy is the standard of treatment, followed by wider lymph node dissection only if the sentinel node is found to be positive.

While PET scans may be useful in evaluating patients with more advanced melanoma, the use of PET scans to detect early metastatic deposits in patients with stages I and II melanoma has been shown to be not as effective as lymphatic mapping and node biopsy.

Increasingly sophisticated new techniques such as polymerase chain reaction (PCR) and reverse transcription PCR have been developed to detect even sub-microscopic deposits of metastatic tumor cells in regional lymph nodes. These tools may permit the detection of submicroscopic deposits in sentinel nodes which appear to be negative when evaluated using normal microscopic and histological techniques.

Mucosal melanomas

These are rare and account for approximately 1 percent of all melanomas. Mucosal melanomas arise primarily in the head and neck, anorectal, and vulvovaginal regions. Rarer sites of origin include the urinary tract, gall bladder, liver and small intestine.

In general, patients diagnosed with mucosal melanomas are older, with a median age of 70 years, although mucosal melanoma of the oral cavity frequently presents at a younger age and mucosal melanoma is more common in females than males, primarily due to the location of disease in the genital tract.

Malignant melanoma

This type of tumor is the most malignant and it spreads faster to almost all parts of the body. This type of cancer is fatal in most of the cases and the death may even happen with in few months. This melanoma can even spread to the fetus from the affected pregnant women. This type spread immediately to the brain and spinal cord also.

Vulvar melanoma

Vulvar melanoma is the prime example for mucosal melanoma which is totally differentiated from other types of superficial skin melanomas. Mucosal melanoma normally affects the parts of the body that are not visible, so it is very difficult to diagnose this type until it reaches advanced stage.

An extensive procedure called elective lymph node dissection can be performed on patients during which all the lymph nodes that are in the drainage region surrounding the primary melanoma were surgically excised. This extensive procedure was not accepted by many and is still in controversy. This not only has high recurrence rate and complications, but chances of survival are also less as micro metastases are difficult to be detected clinically.

Detect microscopic deposits of tumor cells

With advent of new tests like polymerase chain reaction and reverse transcription, doctors can detect sub microscopic deposits of tumor cells. These tools are more advanced in evaluating the deposits in lymph nodes which normally appears negative under testing techniques and normal microscopic evaluation.

About the Author

Dr. Buckman is the Chief Medical Officer of Viratech Corp, Viratech, Corp. (OTC: VIRA), a software company focusing on developing disruptor based applications in the communication broadcasting, work flow management, crowd sourced labor and biotechnology fields.

Dr. Buckman has over 39 years of Health Care Experience in a variety of areas of medicine, including research. Dr. Buckman has presented research, published articles and books in the field of medicine, and has given lectures at numerous hospitals and at Medical Conferences. During the last 35 years he has worked to advance a number of medical technologies with a focus on Non-Harmful early detection of disease, with a primary focus on Breast Cancer and Diabetes. He is currently serving on the Industry Advisory Board for the University of Pacific School of Engineering.
and Computer Science and a Visiting Professor. He has decades of hospital Medical Director experience and has served on over many hospital committees for 35 years, and has served as Medical Director or Associate Director at Multiple Institutions.