Volume : 5 | Issue : 5 | May 2016 • ISSN No 2277 - 8179 | IF : 3.508 | IC Value : 69.48

Recto-Anal Melanoma: A Rare Case Report

Medical Science

KEYWORDS : Melanoma(APR) abdominal perineal resection, (WLE) wide local excision, sentinel lymph node (SLN)

Dr. Sharma Ankit shridatt	Resident, Dept. of General Surgery, SMS Medical College, Jaipur
Dr.Rajendra Bagree	Professor , Dept. of General Surgery ,SMS Medical College, Jaipur
Dr.Ankur Patni	Resident, Dept. of General Surgery, SMS Medical College, Jaipur
Dr.Darpan Dadheech	Resident, Dept. of General Surgery, SMS Medical College, Jaipur
Dr.Prabha Om	Professor , Dept. of General Surgery ,SMS Medical College, Jaipur

ABSTRACT

Rectoanal melanoma is a rare tumour and usually presents with advanced disease. Rectoanal melanoma is more commonly seen in women, and the median age at diagnosis is 60 years. Most patients seek medical attention for peri- anal discomfort or bleeding per rectum. Frequently the lesions are misdiagnosed as haemorrhoids and treated conservatively before the diagnosis is made. Up to 25% of lesions can be amelanotic. Unlike cutaneous melanoma, no known risk factors are present. Surgical excision remains the cornerstone of therapy. There are no trials definitively proving abdominal perineal resection (APR) or wide local excision (WLE) to yield superior long-term survival. APR may offer a higher rate of local control, whereas WLE offers a much less morbid operation .Median survival is 20 months.

CASE REPORT:

A 65 years old male patient farmer by occupation, presented with chief complaints of bleeding during defecation since last 3-4 months .Bleeding was bright red in colour and had increased in frequency since then, it was associated with decrease in appetite and loss of weight .He also complained of some mass coming out of anal verge since 3-4 weeks which was reddish in color and was reposited by finger.There was no significant past medical or any other surgical history .He was a smokers since 20 year and smoked 10 beedis a day. Patient was conscious well oriented to time, place, person moderately built and moderately nourished. Pallor was present on examination. Patient's vitals were within normal range. There was no significant finding on per-abdomen examination. Per rectal examination: On inspection skin nodule was present at 3 o clock position. No other obvious growth was found. On digital rectal examination: Growth was felt from 3 o clock position to 9 o clock position at about 3-4 cm from anal verge it was hard, & tender.

All routine Blood investigations were normal except Hb – 10.7mg/dl .CEA - 1.04 ng /ml. CECT abdomen showed heterogeneous soft tissue density mass (5.9x7.1x6.2 cm) in lumen of lower end of rectum causing narrowing of lumen, Likely malignant?. *Colonoscopy*: On colonoscopy Pedenculated polyp was seen just below the splenic flexure and scope could not be negotiated beyond that. A large friable growth with sloughed up surface (occupying more than 50% surface of circumference) was present in rectum about 4-8 cm from the anal verge. Colonoscopy biopsy suggestive of malignant melanoma. On the basis of clinical history, digital rectal examinations, colonosopic and radiological finding a diagnosis of anorectal mass was made, possibly malignant which was confirmed by colonosopic biopsy as malignant melanoma . Abdominal Perineal Resection under general anaesthesia was performed. Per operatively, there was a 5x7 cm polypoidal growth found, about 3cm from anal verge. (figure1) Multiple perirectal nodes and lymph nodes which were present along external and common illiac vessels were black in colour. Histopathological report was suggestive of malignant melanoma (figure 2) and 14 out of 22 dissected lymph nodes were found to be positive for metastasis.IHC could not be done because patient was not able to afford the amount.

Figure 1: Resected specimen & Intra operative photograph

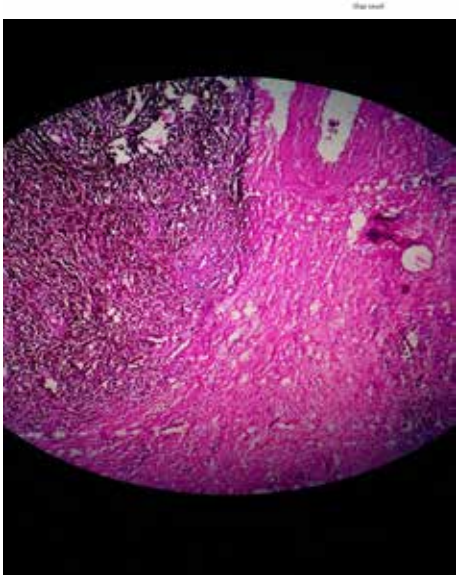

Figure 2.Histopathological view of specimen

DISCUSSION:

Anal melanoma is rare tumour and it's incidence is 0.5 to 2%[1,2,3] of all malignancies in rectum canal . While talking about melanoma it is third most common type of melanoma first being cutaneous and second being ocular consisting of less than 2% of all melanomas. Gastrointestinal melanoma most commonly arise in anorectal area[4] .Neural crest cells form melanocytes which in turn are culprit of melanoma, including cutaneous ocular or mucosal. Ano rectal melanoma is supposed to be originate from squamous epithelium above dentate line which may harbour melanocytes .On histopathological examination about 20% of melanoma may lack melanin pigment i.e. they are amelanotic.[6] The basis for histological diagnosis is presence of melanin pigment in the malignant cells. The presence of junctional changes also aid in diagnosis. Junctional changes here refers to, the appearance of pleomorphic spindle cells or atypical epidermoid cells near the malignant tumour.[7] In the ulcerated lesions junctional changes are not easy to identify. Immunohistochemistry is helpful in diagnosis of cases in which melanin or junctional changes are not present in Histopathological examination. Immunohistochemistry in melanoma consist of antigens S-100, vimentin and HMB-45.Poorly differentiated epidermoid carcinoma can be differentiated from melanoma by polyclonal antiserum to carcinoembryonic antigen (CEA) and monoclonal antibodies to CEA.

Patients usually presents with bleeding per rectum, mass per rectally, pain, perianal discharge, itching perianal region, altered bowel habits, tenesmus, and feeling of something coming out per rectally. Anemia, fatigue, weight loss, mass in groin and pelvic region may indicate presence of advanced disease. Diagnosis can be made with inspection of perianal area, digital rectal examination, proctoscopy and anoscopy .Endoscopy and biopsy further aid in diagnosis, assessing symptoms and confirmation of diagnosis. CT scan is preferred diagnostic modality to identify lymphadenopathy in anorectal melanoma. Staging can be done by [2]Positron emission tomography (PET) & CT for assessing lymphadenopathy. Various differentials diagnosis to be kept in mind while assessing such case:Peri anal hematoma, Thrombosed hemorrhoids ,Anal or Rectal Polyp,Blackish mass protruding per anum,Bleeding PR with Tenesmus,Peri anal Pruritus alone. STAGING[8]**:**Stage **I** is local disease only(local disease),stage **II** is a local disease with regional lymph nodes(regional disease),stage **III** is distant metastatic disease (distant disease).

Various modalities such as chemotherapy, radiotherapy, surgery are being tried in the treatment of the anorectal melanoma. However only surgery offers some hope. Two type of surgery is being offered as part of the treatment wide local excision [WLE]) or radical excision (abdominal Perineal resection [APR]). No studies have so been able to prove which type of surgery is better, APR or WLE, in increasing life expectancy. Although APR carries the theoretical benefits of a wider excision and mesenteric lymphadenectomy .While patient undergoing WLE have an advantage that they do not have permanent colostomy and the procedure is less morbid as compared to APR also WLE preserves sphincter function. For patients having advanced disease WLE offer less morbid and colostomy free option. APR should be done when Local Excision cannot be done or if disease has recurred, or if sphincter is involved. Lymphadenectomy /Sentinel Lymph Node Dissection may be indicated in clinical apparent disease or for occult disease identified with sentinel lymph node (SLN) techniques. Various adjuvant drugs used in treatment High dose interlukin-2,Interferon alpha, Vinblastin, dacarbazine, Temozolamide, Paclitaxel, cisplatin.The role of chemotherapy for melanoma remains unclear.

CONCLUSION:

Rectoanal melanoma is rare tumour and aggressive malignancy. It is more commonly seen in women. The age of presentation is usually 60 years although the range is wide ranging from 29 to 91 years[5]. Patients presents with bleeding per rectum and often misdiagnosed as haemorrhoids. Patients frequently present with advanced disease. There are no long-term survivors of stage II or III disease. Median survival period of patient is 20 months. 3 to 22% [9] is the 5 year survival rate of anorectal melanoma patient. Early diagnosis is key to increase life span of the patient. Therefore special efforts must be made for early diagnosis of this disease.

REFERENCES:

1. Roumen R MH. Anorectal melanoma in the Netherlands: a report of 63 patients. Eur J SurgOncol. 1996;22:598–601.
2. Bullard K M, Tuttle T M, Rothenberger D A, et al. Surgical therapy for anorectal melanoma. J Am Coll Surg. 2003;196:206–11.
3. Molino D, Perrotti P, Antropoli C, et al. Primary anorectal melanoma. Chir Ital.2000;52:329–34.
4. Chang A E, Karnell L H, Menck H R. The National Cancer Data Base report on cutaneous and noncutaneous melanoma: a summary of 84,836 cases from the past decade.Cancer. 1998;83:1664–78.
5. Pack G T, Lenson N, Gerber D M. Regional distribution of moles and melanomas. Arch Surg. 1952;65:862–70.
6. Miller B J, Rutherford L F, McLeod G R, Cohen J R. Where the sun never shines: anorectal melanoma. Aust NZ J Surg. 1997;67:846–48.
7. Weinstock M. Epidemiology and prognosis of anorectal melanoma. Gastroenterology.1993;104:174–78.
8. Podnos YD, Tsai NC, Smith D, et al: Factors affecting survival in patients with anal melanoma. Am Surg 72: 2006,917–20.
9. Goldman S, Glimelius B, Pahlman L. Anorectal malignant melanoma in Sweden: report of 49 patients. Dis Colon Rectum. 1990;33:874–77.