



ANAL CANAL TUMOUR PRESENTING AS GLUTEAL ULCER

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ABSTRACT

Anal canal tumour presentation can vary and often mimics common benign anal pathology, thereby delaying diagnosis and appropriate and timely treatment. We are reporting a rare presentation of anal canal cancer, presenting as gluteus ulcer with altered bowel habits, who underwent sigmoid colostomy and wide excision of stenosing distal anal canal growth. Biopsy shows basaloid squamous cell carcinoma with glandular differentiation.

KEYWORDS:

Anal squamous cell carcinoma, Transitional cloacogenic tumours, Nigro regimen, abdomino perineal resection

INTRODUCTION:

Anal cancer is a rare tumor of the gastrointestinal tract representing only 2% of all anorectal malignancies. A variety of different histologies can be distinguished, including squamous cell cancer, adenocarcinoma, cloacogenic or basaloid carcinoma, melanoma. Transitional cloacogenic carcinoma is the manifestation of squamous cell carcinoma. It form a spectrum that ranges from pure transitional cloacogenic tumours to lesions with mixture of squamous elements to those with purely SCC differentiation¹.

Case report:

A 70 year old male patient came to the hospital with complaint of non healing ulcer over right gluteal and perineal region(fig1) since 1 month associated with loss of appetite since 3 months and irregular bowel habits since 1 month. He was admitted in the hospital with diagnosis as non healing ulcer. On day 2 of admission, patient suddenly developed abdominal distension and on complete clinical examination, a single ulcer of size 5*4 cm was observed in the right gluteal region with induration extending onto anal margin, with everted edges and irregular margins. PR showed complete stenosing growth, was not admitting the tip of little finger, and was bleeding on touch. Subcentric multiple bilateral inguinal nodes were palpable, and were non tender.

Fig1:clinical photo



X-ray of erect abdomen showed large bowel obstruction and US abdomen showed dilated bowel loops with sluggish peristalsis posted for end colostomy. Operative findings were dilated colon from caecum to rectum and there was no palpable growth. Liver and peritoneum appears normal with no free fluid. Sigmoid colostomy(fig2) and Hartmann's procedure were done for anal canal growth. Wide excision was done for biopsy. On digital examination, growth was confined only to distal 2cm. Wedge biopsy from multiple sites over gluteal ulcer were sent for HPE.

Fig2:colostomy



Post operative period was uneventful. CECT(fig3) shows large heterogenous enhancing mass lesion at the anal verge causing anal

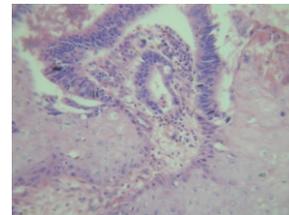
wall stenosis, perianal and perirectal fat infiltration, no lytic bone lesions, few perirectal, perianal, mesenteric, inguinal lymph nodes.

Fig3:CECT ABDOMEN AND PELVIS



Biopsy shows basaloid squamous cell carcinoma with glandular differentiation(fig4). Patient was referred to higher centre.

Fig4:basaloid squamous cell carcinoma



Discussion:

Squamous Cell Carcinoma of the Anal canal

The most frequent tumor of the anal canal and perianal skin is squamous cell carcinoma (SCC). Perianal squamous cancers tend to grow locally. They may extend into the anal canal. When there is doubt about the site of origin, it is conventional to classify the cancer as arising in the canal². A major breakthrough has been the discovery of human papillomavirus (HPV) infection as a major aetiology along with prior radiotherapy, chronic anal fistula, crohn's disease, smoking, cervical carcinoma, HPV infection, hodgkin's disease, renal

transplantation, promiscuity, HSV2, HIV, male homosexuality³, anoreceptive intercourse, anal condylomata, and syphilis. The most common presenting symptom is bleeding, which occurs in >50% of patients. Unfortunately, most patients are diagnosed late, with up to 55% of patients being misdiagnosed at the time of presentation.

Complete anorectal examination with external inspection of the anoderm, digital examination, anoscopy and proctoscopy, in addition to examination of inguinal areas is mandatory. An endoanal/endorectal ultrasound⁴ is done to assess the depth of the tumour, presence of perirectal lymph nodes, and invasion of adjacent organs. CT scan or magnetic resonance imaging (MRI) of the abdomen and pelvis can add to locoregional staging as well as evaluating for liver metastasis. A chest X-ray is used as a screening tool for lung lesions and, if suspicious, a chest CT should be performed. Positron emission tomography (PET) scans are primarily useful for assessing persistent or residual disease after treatment. Colonoscopy can exclude any associated lesions proximal to the anal canal.

Spread of anal cancer is mainly local and regional. Anal canal cancer grows circumferentially and this feature results in narrowing and stenosis of the anal sphincter. When the sphincter is invaded, the tumour spreads into the ischiorectal fossae⁵. Cases of metastasis to distant organs like brain and iris are reported in literature.

Local excision is performed in those who could not tolerate an abdominal operation, who refuse a permanent colostomy, for small, well-differentiated tumors⁶, and carcinoma confined to the mucosa and submucosa. For carcinoma in-situ, wide local excision with or without anoplasty will usually be curative. **Abdomino-perineal resection** is done in those who cannot tolerate radiation therapy or chemoradiation, who are incontinent, in those with prior pelvic radiation treatment, or active inflammatory bowel disease affecting the rectum or anal region. Results of sentinel lymph node procedure may have a role in directing a different approach to management, found in 8 patients (67%).

NEOADJUVANT THERAPY (Nigro protocol):

In 1974, Nigro and associates reported dramatic results in the treatment of epidermoid carcinoma of the anus by means of preoperative radiation therapy and chemotherapy. Its remarkable success in the management of locally extensive tumors or in the individuals with regional node metastasis has revolutionized the approach to the management of this condition.

The anatomic extent, extrapelvic metastasis, men 7, spread to regional lymph nodes⁸, HB% 10 g/L or less are bad prognosis. Biopsy of scar site may be performed 6 weeks after the completion of the regimen. If no tumour is found, the patient is observed at intervals of 2-3 months. Residual or recurrent disease localized to the pelvis after chemoradiation can be treated with salvage therapy.

Conclusion:

Anal canal cancer is rare and bleeding is the usual manifestation but in our case presenting complaint was gluteal non healing ulcer. Patient developed intestinal obstruction from anal stenosing growth on 2nd day of admission which changed our provisional diagnosis to anal-canal stenosing growth with local invasion to gluteal region. Our conclusion is no other investigation will surpass complete clinical examination.

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