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SQUAMOUS CELL CARCINOMA OF PERIANAL REGION:A CASE REPORT

Surgery

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ABSTRACT

Squamous Cell CA of perianal region is a rather rare entity, which is treated as any other cutaneous SCC. Here we present a case of perianal SCC which was being managed conservatively as a case of fistula in ano. In ourr case, A 55yr old male with pain, swelling & watery discharge from perianal region for 8 months, on examination found to have fistula in ano. After the HPE showed moderately differentiated SCC, wide local excision with rotational gluteal flap repair with left inguinal LN disection was done. SCC of the perianal skin are rare and often misdiagnosed. Not all perianal squamous cell carcinoma or condylomas are associated with HPV infection. Surgical resection with wide local excision for small tumors or abdominoperineal resection (APR) for larger, invasive tumors has been the traditional method of treatment.

KEYWORDS

INTRODUCTION-

Malignancies of the anal margin and perianal skin are relatively uncommon lesions. Perianal malignancies accounts for 3–4% of all anorectal malignancies and are five times less common than anal canal neoplasms.5 Commonly included in this group of cancers are Bowen's disease (intraepithelial squamous cell cancer), perianal Paget's disease (intraepithelial adenocarcinoma), invasive squamous cell cancer, basal cell cancer, and malignant melanoma.1 Intraanal lesions cannot be visualized in their entirety or are incompletely visualized while gentle traction is applied to the buttocks. Perianal lesions can be visualized with gentle traction on the buttocks and lie within 5 cm radius of the anus, whereas skin lesions lie outside a 5 cm radius from the anal opening.10 Perianal SCC are treated as any other cutaneous squamous cell carcinomas.6

Case Report-

A 55yr old male presented with pain in perianal region for 8 months and swelling and watery discharge from perianal region for 8 months with no associated fever, altered bladder/bowel habit, no altered stool consistency/form, malena or weight loss. He was being managed conservatively by oral medications, laxatives when he presented in the OPD.

On general examination, the patient was vitally stable with pulse rate 88/min BP 112/72mm Hg, SpO2 99% on RA, respiratory rate of 16/min afebrile & with a Karnofsky score of 100.

On local examination, a fistula in ano was found with internal opening 1cm from anal verge at 6 o'clock and external opening at 9 o'clock with associated tenderness, surrounding induration, mucoid discharge and multiple tracts palpable on both sides of the anal opening.

After Oncosurgery opinion, a MRI pelvis was suggestive of fistula in ano with internal opening at 6 o'clock just above the anal verge with multiple tracts arising from the same. Tract 1 extended inferiorly in the intersphincteric space ending blindly in the right ischio-anal fossa. Tract 2 extends in the intersphincteric space branching into 3 subdivisions- one exteriorising along the left side of natal cleft, another ending blindly just above the skin and the third communicating with tract 1 on the right side of the natal cleft.

HPE suggested features consistent with squamous cell carcinoma, moderately differentiated.the patient was planned for surgery after the mets workup was found to be negative and wide local excision with rotational gluteal flap repair along with left inguinal LN dissection was done under GA. Post op period was uneventful & the patient was discharged with proper advise & regular follow up.

DISCUSSION-

SCC of the perianal skin are rare and often misdiagnosed as anal fissure, eczema or haemorrhoids.6 Perianal SCC probably belongs to the spectrum of different biological subtypes of cSCC and might share pathogenic mechanisms with cSCC of non-sun-exposed areas.2 Not all perianal squamous cell carcinoma or condylomas are associated with HPV infection.4 The duration of symptoms prior to diagnosis ranges from 2 to 60 months.8 Presenting symptoms can include a painful mass, bleeding, pruritus, tenesmus, discharge, or a change in bowel habits.9,10 The development of anal cancer or pre-cancerous lesions are associated with patient's number of sexual partners, human immunodeficiency virus (HIV) infection, receptive anal intercourse and anal HPV infection, particularly infection with HPV16.3 Excisional biopsies, however, should only be performed when it is clear that adequate margins can be achieved.8 For most cases, surgery is first-line therapy, in contrast to the more aggressive approach in anal canal SCC. Surgical resection with wide local excision for small tumors or abdominoperineal resection (APR) for larger, invasive tumors has been the traditional method of treatment.7 However, local excision can result in high local recurrence rates (18 to 63%) and should be reserved for tumors that can be excised with 1 cm margins, are less than 2 cm in greatest dimension, and do not involve the sphincter. 8,10 The defect is closed primarily if possible with or without the use of various flaps; however, a skin graft may be needed for large surgical defects under assistance of a plastic surgeon.1

CONCLUSION-

Usual malignancy found in fistula in ano is adenocarcinoma. Rarely squamous cell carcinoma may also present as fistula in ano that may change the treatment guideline. Usually SCC of perianal region presents as a case of fistula in ano or hemorrhoids.

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