ORIGINAL RESEARCH PAPER

Primary Care Medicine

HIDDEN MELANOMA- APPROACH OF A CASE REPORT

KEY WORDS: Anorectal Disorders, Anorectal Cancer, Anorectal Melanoma, Family Medicine

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ABSTRACT

Anal mucosal melanoma is rare and is associated with a poor prognosis. The unusual and ambiguous symptoms often account for the late diagnosis and poor prognosis of anal melanoma. An 83-year-old woman presented to our family doctor with a pigmented swelling of the anal margin. She was examined and was referred to the hospital. The diagnosis evidenced an anal malignant melanoma, after the complementary diagnostic tests prescribes by family physician. Our observation underscores the importance of early detection and diagnosis of a malignant disease and the importance of a family physician in accuracy observation patient

BACKGROUND

Malignant melanoma of the anal canal is a rare and aggressive disease, in which early diagnosis is difficult. (1,2,3) It mostly affects individuals between 60 and 80 years old, with a higher incidence in caucasians, presenting nonspecific symptoms that can simulate other anorectal diseases. The most common symptoms are pain, bleeding, discomfort after defecation, changes in bowel habits and prolapse. (4,5) It has a poor prognosis and is often associated with metastization. Due to its rarity, knowledge of its pathogenesis and risk factors are still insufficient. Surgery is the treatment of choice and adjuvant and neoadjuvant therapies may also be used. Survival depends on early diagnosis of the disease. (3,6,7)

The family physician has many skills and abilities. He has the competence simultaneously manage multiple complaints and pathologies, the chronic and acute health problems of each individual, with an person-centred approach. He has to selectively gather and interpret information from history-taking, physical examination, and investigations and apply it to an appropriate management plan in collaboration with the patient. So, in the end, is necessary a holistic approach. (8,9)

CASE PRESENTATION

This case report describes a woman, an 83-year-old, caucasian, is a retired farmer, with autonomy in activities of daily living (ADL). She was married, and has two sons. She belongs to a nuclear family, Duvall cycle class VIII, Graffar class IV, Family APGAR by Smilkstein: functional family, Segovia-Dreyer risk scale: low risk. With comorbilities: class 2 obesity, arterial hypertension, cardiac insufficiency, type 2 diabetes mellitus, dyslipidemia, chronic renal failure (grade 3), iron deficiency anemia, chronic gastritis and gastric ulcers. The medication is carvedilol 6.25mg, losartan 100mg, lercanidipine 10mg, insulin glargine 100U/ml, metformin plus sitagliptin 850mg+50mg, atorvastatin 40mg, pantoprazole 40mg, ferric hydroxide-polymaltose complex 357mg. Without cancers in her family.

She went to the family physician (FP) for pigmented anal swelling that had evolved for two weeks, which was painful, with the onset of rectorrhage on that day. Upon anal inspection, a prolapsed lesion in the anal canal, was identified. It was measuring about 3 cm, hardened consistency, with bright red blood. It was not possible to perform digital rectal examination because of the pain. She denied tiredness and other symptoms.

The patient was referred to the Emergency Service (ES) for evaluation and guidance. In the ES, they described a prolapsed neoplastic lesion with a thrombus. On digital rectal examination, a vegetative lesion was found on the posterior surface of the anal canal and rectum, palpable up to 6-7 cm, with continuity, very hard and irregular surface. Thrombectomy and biopsy were performed. She was referred to the MF for diagnostic exams.

In the same week, thoracic-abdominal-pelvic computed tomography (TAP-CT) was performed, which evidences a volumous tumor mass in the area of the rectum wall and anal canal, measuring 114x63x57milimeters, which at the level of the rectum became transmural, compatible with neoplasia. Metastasis to the lung, liver, left inguinal region and pelvic excavation around the rectum was evident.

A colonoscopy was performed that confirms a bulging, dark mass (melanoma) at the anal margin. After diagnosis, the patient was referred to the oncology unit for guidance by a multidisciplinary team. She is being evaluated by palliative care due to the decline in her general condition and need for care. The family was a major support in the end of life this patient. The family physician was always present in this patient's family, maintaining regular contact and therapeutic listening.

CONCLUSIONS

This case evidences the importance of the family physician performing a careful objective examination. The observation directed to the symptoms was fundamental for the diagnosis of a rare and malignant pathology. Despite the complaints pointing to hemorrhoidal pathology, the observation raised doubts and motivated the referral.

The advanced oncological pathology led to the patient's loss of autonomy, currently with moderate dependence for ADLs. All this context had a great impact at the family level.

The articulation of the FD with the hospital for the follow-up of patients with pathologies that require an assessment by multidisciplinary teams and personalized follow-up is evident.

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