

## Case Report

# Melanoma of anal canal

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### ABSTRACT

Melanomas are primarily tumours of the skin, but rarely occur at other sites like retina and anal canal. Anorectal melanoma is an uncommon condition associated with a very poor prognosis. The patient usually presents with per rectal bleed or mass. These are often misdiagnosed on presentation. Diagnosis is confirmed by biopsy. Treatment is abdominoperineal resection or wide local excision if tumour free margins can be obtained. We present a case of a 60 years old female who presented to the outpatient department with per rectal mass and bleed since 4 to 5 months and was diagnosed with melanoma anal canal on biopsy. CT scan abdomen and pelvis was done. Patient underwent abdominoperineal resection as wide local excision with sphincter saving was not possible due to the location and extent of tumour as seen on CT scan. Patient had an uneventful recovery after the procedure.

**Keywords:** Melanoma, Melanoma anal canal, APR, Wide local excision

### INTRODUCTION

Anal cancers are relatively uncommon of all gastrointestinal cancers, accounting for 1-2% of all colorectal and anal malignancies. The anorectum is the third most common site for primary melanoma after the skin and retina. It accounts for 0.2-3% of all melanomas.<sup>1</sup>

Caucasians have the highest mortality rates, whereas Asians have the lowest mortality rates. For mucosal melanomas, the distribution of head and neck, female genital tract, anal/rectal, and urinary tract sites was 55.4%, 18.0%, 23.8%, and 2.8%, respectively.<sup>2</sup>

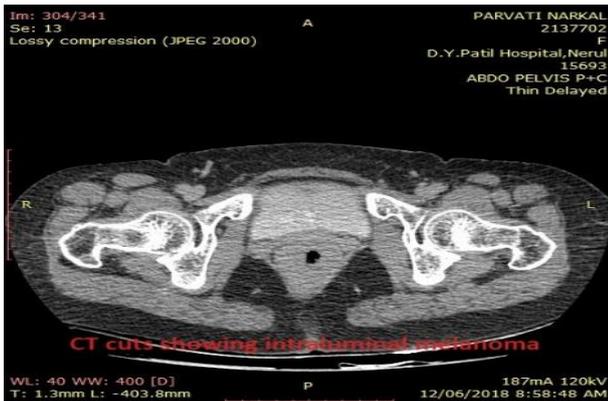
Treatment for melanomas is surgical excision by either wide local excision or abdominoperineal resection with limited role of chemoradiotherapy.

### CASE REPORT

60 years old female presented to OPD with complaints of per rectal bleed on and off since, 4-5 months, which had become continuous since past 10 days.

Patient also complained of a mass per rectum and loss of weight and appetite over the last 3 months. On PR examination, she had a hard mass extending from 3-6 o'clock, just above anal verge. A biopsy was taken from the mass which was suggestive of mucosal malignant melanoma. CT scan abdomen and pelvis were performed, which was suggestive of circumferential wall thickening of rectum and anal canal extending up to anal verge. Length of involved segment was 6 cm and maximum thickness of 18 mm. It showed heterogenous enhancement on post contrast studies. An abdominoperineal resection was performed with end colostomy. Intra operatively patient had a large omental lymph node, few mesenteric lymph nodes and lymph

nodes on mesorectum were noted. No evidence of liver metastases intraoperatively. On histopathology, ulceroproiferative circumferential tumour 8×4×2 cm was seen 14 cm from proximal and 1 cm from distal resection margin. The tumour was at dentate line and below. It involved bowel circumferentially. 13 lymph nodes were isolated from peri rectal fat out of which 5 were positive. Due to limited role of chemotherapy, patient was sent for radiotherapy. However, patient denied any further treatment.



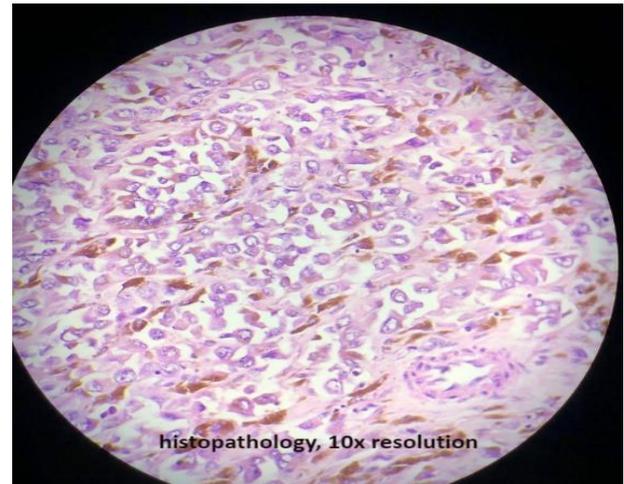
**Figure 1: CECT pelvis showing tumour in anal canal.**



**Figure 2: Intraoperative picture with melanotic lymph node.**



**Figure 3: Abdomino-perineal resection gross specimen.**



**Figure 4: Histopathology image of melanoma anal canal.**

## DISCUSSION

The first case of anorectal melanoma was reported by Moore in 1857, and there have been around 500 cases reported in literature. It has a higher female preponderance.<sup>3</sup> Clinical presentation of anal cancer can be variable and may be as bleeding, pain, sensation of a mass, itching, anal discharge, tenesmus, and a sense of fullness or a lump in the anal canal. Commonest presentation is as PR bleed.<sup>4</sup>

Advanced lesions may present with additional symptoms like incontinence, passage of gas or stool from the vagina if there is formation of a communicating fistula with the vagina. Patient may present with inguinal lymphadenopathy.

Anal canal melanoma is often misdiagnosed due to its location and rarity. Symptoms may often be dismissed as hemorrhoids or other benign causes, hence proper examination is essential.<sup>5</sup> Any mass should be biopsied for a diagnosis. In contrast to cutaneous melanomas, the lesions are often not pigmented.

About 38% patients have metastasis at time of presentation. Radiologically a CT, MRI or endorectal ultrasound can be done to know the extent, involvement of adjacent structures and to plan the surgical procedure accordingly. On histopathology the tumour stains positive for HMB-453.

Treatment is radical excision in the form of abdominoperineal excision after ruling out metastatic disease, however wide local excision can also be performed. No studies have yet shown a significant difference in outcome with either methods.<sup>6</sup> There has been no proven benefit of inguinal lymphadenectomy.<sup>7</sup>

Abdomino-perineal resection (APR) is preferred because it can control lymphatic spread (mainly to mesenteric lymph nodes) and guarantee a larger negative margin for local control. Locoregional recurrence of AMM occurs more at the inguinal lymph nodes than at the pelvic lymph nodes. Neither APR nor WLE affect any of the inguinal lymph nodes, therefore neither of them offers an advantage in controlling locoregional recurrence. The depth and size of tumor is one of the important prognostic factors. If the lesion is thick (>3 mm) and large (>30 mm), curative surgery cannot be achieved. In this case, conservative local excision and adjuvant therapy can result in a better prognosis. At the time of diagnosis, if AMM is already in the advanced stage, surgical options should be selected based on quality of life. For advanced stage, WLE with adjuvant radiotherapy and biochemotherapy could be done concerning favourable functional outcome and longer median survival. One- and five-years survival rates are 21% and 37% respectively. Nodal status and presentation with either bowel obstruction or perforation were associated with a reduction in survival time. Surgical excision has better outcomes than adjuvant therapy alone.<sup>8</sup>

## CONCLUSION

Melanoma of anal canal is a rare tumour with poor prognosis. It is often misdiagnosed. Early detection with biopsy to confirm diagnosis and surgical excision with wide local excision or APR is the treatment of choice.

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