



A Rare Case of Unusual Malignant Melanoma

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ABSTRACT

This report presents a case of “Advanced anal verge melanoma with secondaries in left inguinal lymph node , liver and vesico-uterine angle”. A 55year old female presented with complain of bleeding per rectum for 2 years and mass coming out through anus for 8 days. Local examination revealed a pedunculated lobular growth from the perianal verge with blackish discolouration along with left inguinal lymphadenopathy. On ultrasonography and CT Scan metastatic deposits in liver and vesicouterine angle was detected. This case report demonstrates the aggressive nature of the disease and hence gives a message to have a high index of suspicion for any case of rectal bleeding with lightly pigmented or non pigmented polypoid lesion on proctoscopic examination for early diagnosis and treatment.

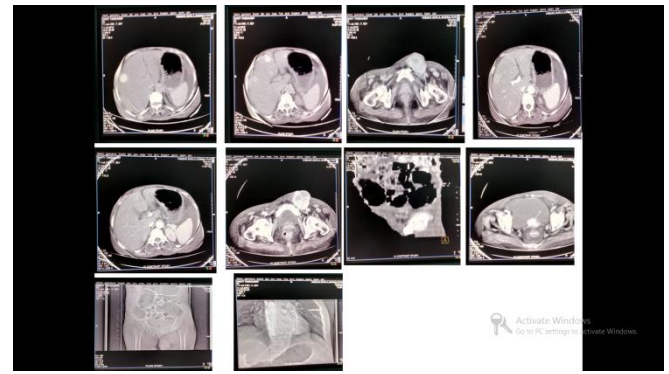
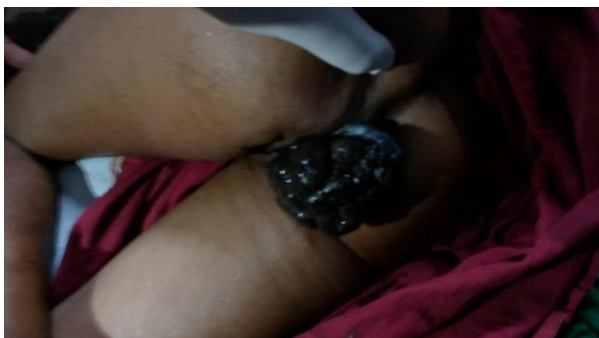
BACKGROUND

Ano-rectal melanoma is a rare tumor with an extremely poor prognosis. It represents less than 1% of all melanomas and accounts for 4% of anal malignancies.¹ the clinical diagnosis of anal melanoma is, at best, challenging. Patients often present with nonspecific complaints such as rectal bleeding (most common) or anal pain. Furthermore, a significant minority (34%) of lesions may lack pigment, thus requiring biopsy for a definitive diagnosis. Although many patients present with what initially appears to be curable localized disease, undetected regional or distant metastases are common. Metastases occur via lymphatic and hematogenous routes and it has

been reported that 38% of patients have already metastatic disease at the time of diagnosis. Lymphatic spread to mesenteric nodes is more common than to inguinal nodes while lungs, liver and bones are the most frequent sites of distant metastases. Even with aggressive surgical resection, more than 80% of patients will die of distant metastatic disease within 5 years. Prompt surgery seems to be the only treatment option since current chemotherapy and radiotherapy alone have been proved ineffective. The development of novel therapies to treat malignant melanoma will hopefully improve the clinical outcome.

CASE REPORT

A 55 year old female patient was admitted to our department with chief complain of bleeding per rectum and generalised weakness for 2 years, swelling in left inguinal region for last 6 months and a mass coming out of anus for last 8 days. General examination revealed severe pallor and wasting of muscles. Local examination revealed a pedunculated lobular growth from perianal verge of size 12cm x 10cm diameter with blackish discolouration and serous discharge without any tenderness. In left inguinal region a swelling of size 7cm x 5 cm was found which was non tender, hard, matted and fixed. On abdominal examination shifting dullness was found to be positive suggesting free peritoneal fluid collection. Haematological examination revealed Hb% 5.0 gm %. Ultrasonography revealed liver metastasis and also metastatic deposit in vesico-uterine angle with moderate peritoneal collection and sarcoma in left ilio-inguinal region. In CT scan we got metastatic deposit in segment vi and vii of liver, vesicouterine angle left ilio-inguinal node, obturator node which was hyperdense on plain CT and hypervascular in CECT with ascites. We got evidence of metastatic deposit in left lung also. Unfortunately the patient died before taking biopsy.



CONSENT

A written informed consent was obtained from the patient for the publication of this case report with the accompanying images.

CONCLUSION

Anorectal melanoma is a rare disease with a poor prognosis, even when apparently diagnosed at an early clinical stage due to its aggressive nature. Hence all the clinicians must always keep a high index of suspicion in mind as a differential diagnosis with patients presenting with complain of bleeding per rectum with any pigmented or lightly pigmented polypoid lesion on proctoscopic examination. The ultimate goal of surgical treatment should be to minimize patient morbidity and maximize quality of life. This case report is an example of how aggressive the disease could be. Thus early diagnosis could have saved the patient and might have given a good quality of life.

REFERENCES

1. Klas JV, Rothenberger DA, Wong WD, Madoff RD: Malignant tumors of the anal canal: the spectrum of disease, treatment, and outcomes. *Cancer* 1999, 85:1686-1693.
2. Chang AE, Karnell LH, Menck HR: The National Cancer Data Base report on cutaneous and noncutaneous melanoma: a summary of 84,836 cases from the past decade. The American College of Surgeons Commission on Cancer and the American Cancer Society. *Cancer* 1998, 83:1664-1678.

3. Helmke BM, Otto HF: Anorectal melanoma. A rare and highly malignant tumor entity of the anal canal. *Pathologie* 2004, 25:171-7.
4. Ishizone S, Koide N, Karasawa F, Akita N, Muranaka F, Uhara H, Miyagawa S: Surgical treatment for anorectal malignant melanoma: report of five cases and review of 79 Japanese cases. *Int J Colorectal Dis* 2008, 23:1257-1262.
5. Winburn GB: Anal carcinoma or "just hemorrhoids"? *Am Surg* 2001, 67:1048-58.
6. Hillenbrand A, Barth TFE, Henne-Bruns D, Formentini A: Anorectal amelanotic melanoma. *Colorectal Disease* 2007, 10:612-615.
7. Podnos YD, Tsai NC, Smith D, Joshua DI: Factors affecting survival in patients with anal melanoma. *Am Surgeon* 2006, 72:917-920.
8. Yeh JJ, Shia J, Hwu WJ, Busam KJ, Paty PB, Guillem JG, Coit DG, Wong WD, Weiser MR: The role of abdominoperineal resection as surgical therapy for anorectal melanoma. *Ann Surg* 2006, 244:1012-7.
9. Yap LB, Neary P: A comparison of wide local excision with abdominoperineal resection in anorectal melanoma. *Melanoma Res* 2004, 14:147-150.
10. Ballo MT, Gershenwald JE, Zagars GK, Lee JE, Mansfield PF, Strom EA, Bedikian AY, Kim KB, Papadopoulos NE, Prieto VG, Ross MI: Sphincter-sparing local excision and adjuvant radiation for anal-rectal melanoma. *J Clin Oncol* 2002, 20:4555-8.
11. Olsha O, Mintz A, Gimon Z, Gold Deutch R, Rabin I, Halevy A, Reissman P: Anal melanoma in the era of sentinel lymph node mapping: a diagnostic and therapeutic challenge. *Tech Coloproctol* 2005, 9:60-2.
12. Moozar KL, Wong CS, Couture J: Anorectal malignant melanoma: treatment with surgery or radiation therapy, or both. *Can J Surg* 2003, 46:345-9.
13. Ulmer A, Metzger S, Fierlbeck G: Successful palliation of stenosing anorectal melanoma by intratumoral injections with natura interferon-beta. *Melanoma Res* 2002, 12:395-8.
14. Yeh JJ, Weiser MR, Shia J, Hwu WJ: Response of stage IV anal mucosal melanoma to chemotherapy. *Lancet Oncol* 2005, 6:438-9.
15. Kim KB, Sanguino AM, Hodges C, Papadopoulos NE, Eton O, Camacho LH, Broemeling LD, Johnson MM, Ballo MT, Ross MI, et al.: Biochemotherapy in patients with metastatic anorectal mucosal melanoma. *Cancer* 2004, 100:1478-1483.
16. Ueno H, Hase K, Mochizuki H: Criteria for extramural perineural invasion as a prognostic factor in rectal cancer. *Br J Surg* 2001, 88:994-1000.
17. Weyandt GH, Eggert AO, Houf M, Raulf F, Bröcker EB, Becker JC: Anorectal melanoma: surgical management guidelines according to tumour thickness. *Br J Cancer* 2003, 89:2019-2022.
18. Guren MG, Eriksen MT, Wiig JN, Carlsen E, Nesbakken A, Sigurdsson HK, Wibe A, Tveit KM: Quality of life and functional outcome following anterior or abdominoperineal resection for rectal cancer. *Eur J Surg Oncol* 2005, 31:735-42.
19. Belli F, Gallino G, Tragni G, Andreola S, Leo E: Surgical and pathological prognostic factors in anorectal melanoma: The Experience of the National Cancer Institute of Milano. *Proceedings 12th Congress of the European Society of Surgical Oncology. Budapest* 2004:77.