

# Anal carcinoma presenting as gluteal mass: A rare experience

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## ABSTRACT

An isolated gluteal mass as a sole signature of underlying anal carcinoma has never been addressed in any surgical literature till to date. In our case report, we have shared our clinical experience of coming across through such a scenario where a 45-year-old lady initially presenting with an isolated apparently innocuous right gluteal mass later proved to be having an anal carcinoma is being discussed in brief. This entails a very cautious approach to any gluteal mass by a treating surgeon as an anal carcinoma may hide itself in this apparently benign rarely malignant surgical entity.

**Key words:** Anal carcinoma, gluteal mass, rare presentation

## INTRODUCTION

Anal cancer is an uncommon malignancy, accounting for only about 4% of all cancers of the lower alimentary tract.<sup>[1]</sup> The annual incidence is about 1 in 100,000. The incidence is higher in women and is increasing. Anal margin tumors are usually well differentiated. They are more common in men and have a good prognosis. On the contrary anal canal tumors are usually poorly differentiated; they are more common in women and have a worse prognosis. Perianal pain and bleeding (45%),<sup>[2,3]</sup> a palpable lesion (30%),<sup>[2,3]</sup> and fecal incontinence are the usual local presentations of anal carcinoma. In neglected cases, it may present with rectovaginal or rectovesical fistula. Rarely anal carcinoma may signature its presence through some rare presentations like intractable pruritus ani, recurrent non-healing perianal fistula, pelvic abscess, and profuse anal discharge or even isolated enlarged inguinal lymphadenopathy. Presentation of anal carcinoma in the camouflage of an isolated gluteal mass is not yet addressed in the literature.

## CASE REPORT

A 45-year-old lady presented with a firm globular non-tender swelling in her right buttock measuring 10 × 8 cm<sup>2</sup> in dimensions for last 2 months which was insidious in onset and gradually increasing in size [Figure 1]. There was no history suggestive of bleeding per rectum or vagina, change in bowel habit, hematuria, or weight loss. She gave a history of a 2-month-old trivial trauma on her right back. On per rectal examination a growth was found in the anal canal encroaching into the rectum and posterior vaginal wall and could be traced to be continuous with the gluteal mass as obviated and confirmed on bimanual examination. Fine needle aspiration cytology (FNAC) from the gluteal mass came out



Figure 1: 45 year old lady presenting with gluteal mass

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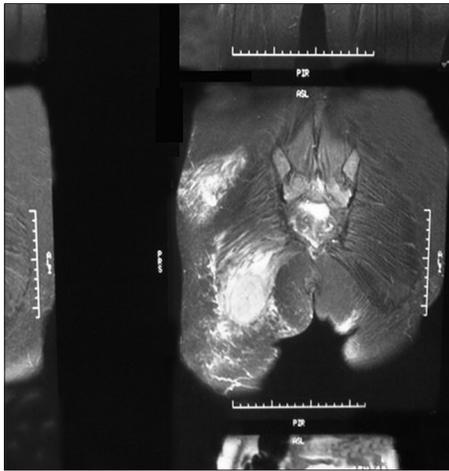
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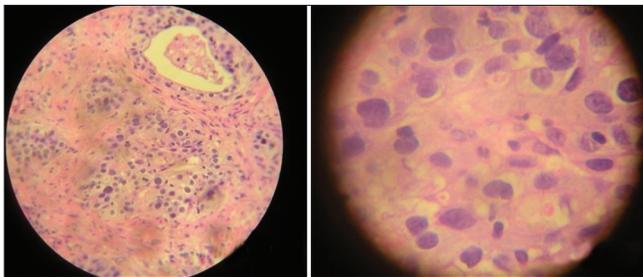
DOI:

10.4103/2278-0513.130218

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**Figure 2:** MRI Pelvis showing two space occupying lesions in anorectal canal and in right gluteal region



**Figure 3:** Punch biopsy from the vaginal and anal wall growth showing moderately differentiated infiltrating squamous cell carcinoma with some cell nests showing acanthocytosis

to be poorly differentiated carcinoma. CAT scan of right thigh showed right gluteal intramuscular well-defined enhancing soft tissue density lesion with central hypoenhancement with right lateral anorectal wall thickening pointing toward right gluteal hematoma. Colonoscopy showed proliferative mass lesion with ulceronodular mucosal growth in circumferential pattern. CEA level was 85.99 ng/ml-1. MRI pelvis showed large SOL in anorectal canal measuring  $5 \times 4 \times 4$  cm in dimensions with perirectal invasion extending anteriorly to encase vagina. MRI also detected another similar intensity SOL measuring  $5.6 \times 5.6 \times 4.4$  cm<sup>3</sup> in dimensions located intramuscularly in right gluteal region with gross perilesional edema without any bony invasion, iliac vessel encasement, or pelvic lymphadenopathy with single enlarged right inguinal lymphnode sized 1.5 cm, concluding with a radiological diagnosis of anorectal neoplasm with soft tissue deposit in right buttock [Figure 2]. Punch biopsy from the vaginal and anal wall growth were surprisingly similar and were moderately differentiated infiltrating squamous cell carcinoma with some cell nests showing acanthocytosis [Figure 3] metastatic workup revealed no distant spread of malignancy.

Patient was being put on Nigro's chemotherapy regime with 5FU and Mitomycin-C. After two cycles of chemotherapy patient developed a fungating mass over the right gluteal

lesion. Unfortunately patient died due to acute renal failure while on the treatment.

## DISCUSSION

Anal carcinoma is a rare malignant neoplasm of lower alimentary tract. Anal cancers are about one-tenth as common as cancers of the rectum. Cancers arise in the canal three to four times more frequently than in the perianal skin. The median age at diagnosis is from 60 to 65 years. There is considerable geographic variation in both the incidence rates and histological types of anal cancer. For example, in North America and Western Europe, squamous cell cancers make up about 80% of anal cancers, but in Japan only 20% are squamous cancers, the remainder being mainly adenocarcinomas. Most annual incidence rates for invasive cancers lie in the range 0.5-1.0 per 100,000 among women, and 0.3-0.8 per 100,000 among men.<sup>[3]</sup> Squamous cancers of the anal canal are about 1.5-4 times more common in women, although this difference appears to have arisen only in the last 50 years and is declining.<sup>[4]</sup> This entity has been classified into two separate entity namely-anal margin tumor and anal canal tumor. Besides its usual local presentations it may portray its presence through a number of uncommon apparently unrelated entities like recurrent intractable perianal fistula, perianal abscess, intractable pruritus, or isolatedly enlarged inguinal lymphnode(s).<sup>[5]</sup> Anal carcinoma presenting as an isolated gluteal mass has never been addressed in any literature or peer reviews as published till today in any well-recognised index medicus. In this regard our experience of a case of gluteal mass camouflaging an anal carcinoma is really an uncommon one and requires special mention.

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**Cite this article as:** Saha D, Mandal D, Mondal S, Saha S, Mandal S, Prakash S. Anal carcinoma presenting as gluteal mass: A rare experience. *Clin Cancer Investig J* 2014;3:168-9.

**Source of Support:** Nil, **Conflict of Interest:** None declared.