Case Report

Uncommon presentation of anorectal melanoma

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ABSTRACT

Malignant melanoma is the malignancy derived from melanocytes. Cutaneous melanoma is more common than mucosal melanoma. Anorectal malignant melanoma is a rare tumor with a poor prognosis. It is <1% of all anorectal malignancies and 1 to 2% of melanoma. In view of the late presentation and natural course of the disease, most of the cases reported in an advanced stage. In this report of 35-year-old female admitted with features of inguinal mass and deep vein thrombosis (DVT) due to anorectal melanoma. The most common presentation of anorectal melanoma was hematochezia and mass in the anal canal. Till now few cases reported with DVT.

Key words: Anorectal melanoma, deep vein thrombosis, inguinal mass

INTRODUCTION

Anorectal melanoma is a rare tumor of the anal canal. Only a few patients presented at an early stage. However, most of the patients are presented in an advanced stage as a locoregional or metastatic disease. The patients often presented with nonspecific complaints such as bleeding per rectum (most commonly) or altered bowel habits.[1] Only a few reported anorectal melanoma presented with deep vein thrombosis (DVT).[2] DVT due to melanoma usually extending from femor-popliteal vein to iliac veins and even up to pulmonary vasculature. DVT reported mostly in stage IV melanoma. Recommended treatment for stage IV melanoma is chemotherapy along with heparin prophylaxis. Half of the patients with DVT were prone to develop pulmonary embolism in stage IV melanoma.[3]

CASE REPORT

A 35-year-old female patient presented with complaints of mass in the right inguinal region for 3 months duration and swelling of the right lower limb for 3 months duration. History of pain in the right inguinal region for 3 months. History of occasional bleeding per rectum for 3 months and there was no history of altered bowel habits. Inguinal examination showed 20 cm × 18 cm an irregular fungating mass with ulceration present in the right inguinal region [Figure 1]. Lower limb examination showed swelling of the right lower limb with warmth and tenderness [Figure 2]. Per rectal examination showed an irregular mass from the anterior surface of the anal canal from 10 to 2′o clock position. The mass was black in color, hard in consistency, and bleeds on touch.

Investigations showed anemia with altered renal function test. A colonoscopy could not be passed beyond 5 cm due to tight narrowing caused by the proliferative lesion. Biopsy from the anal growth showed spindle-shaped, melanocytic cells invading into the muscularis propria. Immunohistochemical staining showed strongly positive staining with HMB-45, MART-1, and S100 [Figure 3]. Fine-needle aspiration of the inguinal mass showed secondary deposits of malignant melanoma. Ultrasound abdomen and inguinal region showed right hydroureteronephrosis with multiple liver secondaries. A large mass noted posterior to the bladder measuring 16 cm × 8 cm, the mass encasing right iliac vessel and right iliopsoas muscle appears bulky.

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Doppler right lower limb showed thrombosis of the right common femoral vein [Figure 4]. Computed tomography of the chest, abdomen, and brain revealed a large irregular mass lesion measuring 10.20 cm × 07.30 cm × 12.70 cm noted in the anal canal extending up to rectum 09.60 cm × 12.20 cm × 13.60 cm heterogeneously encasing enlarged lymph node noted in the right iliac group encasing right iliac vessels. 07.90 cm × 07.80 cm similar enlarged lymph node noted in the right obturator group. Enlarged heterogeneously enlarged pararectal and superficial inguinal nodes measuring 13.70 cm × 16.30 cm noted on the right side. Right hydroureteronephrosis, ureter enlarged up to the lymph node mass.

DISCUSSION

Anorectal melanoma is an unusual tumor of the anal canal, comprising <1% of all anorectal malignancies and 1 to 2% of melanoma.[1] It is the most common melanoma following cutaneous and ocular melanoma. Commonly affect female sex with, male: female ratio 0.75.[4] Anorectal melanoma located on the anal canal or at the anal verge (65%), remaining 35% located in distal rectum.[5] Etiology remains controversial. Cutaneous melanoma mostly occurs in the sun-exposed area, but anorectal melanoma occurs in nonsum exposed area, so ultraviolet radiation may not be a risk factor. However, some studies showed relationship with retroviral infection and human papilloma virus association with anorectal melanoma.[6]

The most common presentation was bleeding per rectum or anal discomfort, altered bowel habit, anorectal mass. Pigmentation may or may not be there because amelanotic melanoma can also arise from the anorectal region.[7] The majority of anorectal melanoma presented at an advanced stage, with presenting lesion more than 2 mm in thickness.[8] Prognostic factors for anorectal melanoma were perineural invasion, tumor necrosis, nodal status, and amelanotic melanoma by histology.[9]

Most of the time diagnosis made by digital rectal examination with biopsy. Additional investigations required such as endoscopy, ultrasound, contrast computed tomography abdomen to identify nodal and visceral metastasis, and stage of the disease. In view of the late presentation and lack

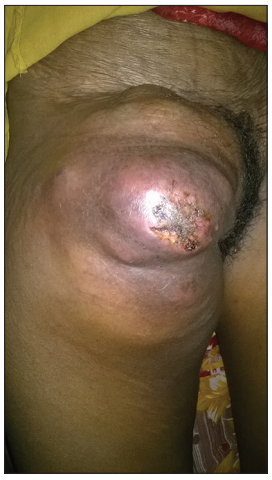

Figure 1: An irregular fungating mass with ulceration present in right inguinal region

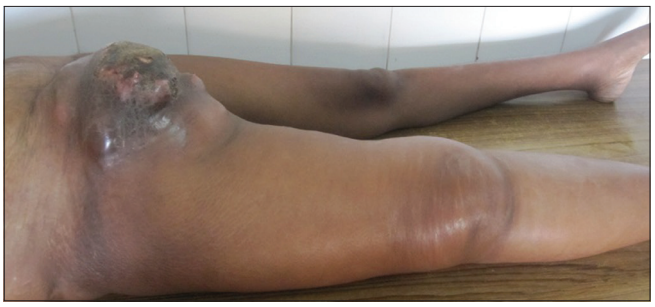

Figure 2: Lower limb examination showed swelling of right lower limb with deep vein thrombosis

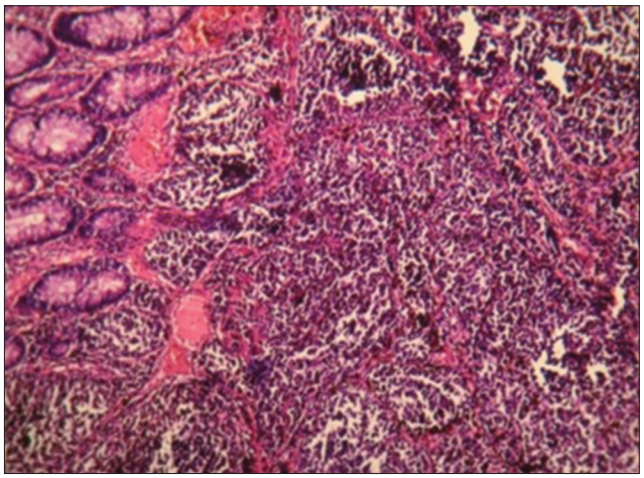

Figure 3: Biopsy from the anal growth showed spindle-shaped, melanotic cells invading into the muscularis propria

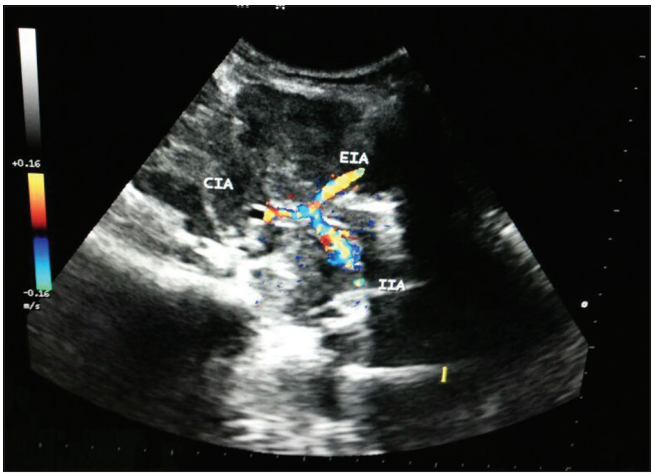

Figure 4: Doppler right lower limb showed thrombosis of the right common femoral vein

of control trial, no specific treatment strategy was created for anorectal melanoma. Surgery was the main modality of treatment; either wide local excision or abdominoperineal resection with colostomy. Most of the studies showed no significant difference in either procedure by means recurrence, survival benefit and distance metastasis without lymphadenectomy. However, abdominoperineal resection produces more morbidity to the patient compared to wide local excision.[10]

Surgical management of lymphadenectomy remains controversial. In view of the morbidity and mortality following regional lymphadenectomy is very high. Some studies support regional lymphadenectomy for a palpable lymph node. The role of prophylactic lymphadenectomy for nonpalpable lymph node is not warranted; because it does not improve survival. The role of sentinel lymph node biopsy yet to be evaluated.[11]

Other modality of treatment for anorectal melanoma was chemotherapy, immunotherapy, and radiotherapy. The most common chemotherapeutic agent was dacarbazine. Immunotherapy by means of interferon-alpha, and interleukin-2.[12] Malignant melanoma is relatively chemoresistant, but radiation can be used for unresectable tumor, locally recurrent, metastatic disease, spinal cord collapse, and central nervous system dysfunction due to brain metastasis.

CONCLUSION

Anorectal melanoma is a rare entity with poor prognosis. Most of the time presentation will be late, even with the early presentation; the prognosis will be poor due to early regional and distant metastasis. Malignant melanoma anal canal can present with varying presentation. Here, the patient presentation was an inguinal mass with DVT. Hence, any patient presenting with DVT with inguinal secondaries screen for the anal primary by detailed evaluation.

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Conflicts of interest

There are no conflicts of interest.

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