AMELANOTIC MELANOMA OF THE ANAL CANAL

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INTRODUCTION

Melanoma of the anal canal is a rare tumour that can present as a mass, pain or bleeding and/or can be amelanotic and identified by lype examination. It is an aggressive malignancy with unfavorable prognosis and a poor overall survival. Anal canal is the most frequent site of melanoma after the skin and retina. It constitutes 1% of anorectal malignancies out of which 25-30% are amelanotic. It was first described by Moore in 1857.

CASE REPORT

A 65 yr old woman presented with complaints of bleeding per rectum for a duration of two months. It was associated with pain during defecation and occasional loose stools which were blood stained.

Per rectal examination revealed an exophytic mass in the anal canal 1 cm from the anal verge extending up to about 6 cm in the left lateral wall of the anal canal which bled on touch.

CECT abdomen and pelvis demonstrated mass in the anal canal with no signs of lymph adenopathy or distant tissues. Colonoscopy was performed and apart from the anal canal mass 1 cm from anal verge extending up to 6 cm no other abnormality was found. Biopsy done. The pathology report came out as amelanotic melanoma. The patient underwent abdominoperineal resection.

Histopathological examination revealed spindled and round cells in vague short fascicles intervened by syncytium of cytoplasm. Islands of mature squamous cells with keratin pearl seen in between. IHC showed S 100 positivity.

The post operative period was uneventful. The patient was discharged on the 11th post operative day after educating her about self care of the stoma.

The type of surgical management of patients with anorectal melanoma is controversial. Radical surgery is, when possible, the most effective therapeutic option for the treatment of primary and metastatic melanomas. Abdominoperineal excision of the rectum (APER) is the first choice for patients with anorectal melanoma, particularly those with smaller tumours and no evidence of nodal metastases. Some studies have also described wide local excision as an effective surgical alternative.

Chemotherapy options are Dacarbazine (DTIC),Temozolomide (precursor of DTIC). The combination of chemotherapeutic agents such as BOLD (bleomycin, vincristine, Lomustine, and DTIC), CVD (Cisplatin, Vinblastine, and DTIC), Dartmouth regimen (DTIC, Cisplatin, Carmustine) have been tried.

Immunotherapy tried are Interferon α 2b (IFN α2b) and IL – 2. Radiation therapy is reserved for untreated disease, locally recurrent disease, metastatic disease with bone pain, spinal cord compression, tumour hemorrhage, cerebral metastasis. A combined modality of surgery, chemotherapy, immunotherapy and radiotherapy must be used in the management but results are limited.

DISCUSSION

Anorectal melanoma is an aggressive a rare cancer with an unfavourable prognosis. It is more common in females; the mean age of disease onset is 60 years. Amelanotic subtype is exceedingly rare (about 30% of all anal canal melanomas). The most common complaints are bleeding, rectal pain, tenesmus, and changes in bowel habits.

At the histological examination, the presence of protein S 100, melanoma antigen HMB 45, Melan A are highly suggestive of melanoma.

Prognosis is poor, irrespective of surgical treatment. 5 year survival rates depends on extent of disease. Neither age at diagnosis, performed operation, nor use of radiation significantly affect survival.

REFERENCES

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