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An Anal Polyp Presetting as Malignant Melanoma- A Rare Case Report

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Abstract: ***Anorectal melanoma is an uncommon and aggressive mucosal melanocytic malignancy. Due to its rarity, the pre - operative diagnosis remains difficult. The first symptoms are non - specific such as anal bleeding, anal mass or pain. Although it carries a poor prognosis; optimal therapeutics strategies are unclear. Surgical resection remains the mainstay of treatment. We report a case with malignant melanoma of anal canal.***

Keywords: Malignant melanoma, mucosal melanoma, anorectal tumors, anorectal melanoma, treatment, ARMM

1. Introduction

Ano - rectal malignant melanoma (ARMM) is an extremely rare and very aggressive disease. This entity constitutes only 0.5 - 4% of all anorectal malignancies and less than 1% of all melanomas. Patients, typically present with local symptoms in the fifth or sixth decade of life. Malignant melanoma has a strong association with the Caucasian race. Cutaneous melanoma is 20 times more common in Caucasians than in African Americans, but there is no such evidence for anal melanomas. Patients often present with nonspecific complaints such as rectal bleeding, mass per rectum or anal pain. ARMM is often misdiagnosed in about two thirds of patients and most often as hemorrhoids, adenocarcinoma polyps and rectal cancer. A timely diagnosis of anal melanoma is made even more difficult by the fact that up to 80% of lesions lack obvious pigmentation and up to 20% of tumors are even histologically amelanotic. Prognosis is very poor with a median survival of 24 months and a 5 - year survival of 10 - 15%. Presently, there is no consensus on which surgical approach is favorable. Anorectal malignant melanomas spread along submucosal planes., Therefore, they are often beyond complete resection at the time of diagnosis and almost all patients die because of metastases. We report a rare case of ARMM.

2. Case Presentation

A 59 - year - old male, presented to surgery OPD with chief complaint of pain in the anal region gradually progressive since 6 months with mass per anum before defecation.

Patient is a K/C/O hypertension on oral medications. Not a K/C/O DM/TB/Thyroid disorder. The patient was well built and nourished with normal bowel bladder movements and nil habits. On local examination 3X2 cm blackish growth was present in the anal canal with no active bleeding or discharge.

Baseline investigations including a complete hemogram, renal function test, liver function test, and chest Xray was done. All within normal limits.

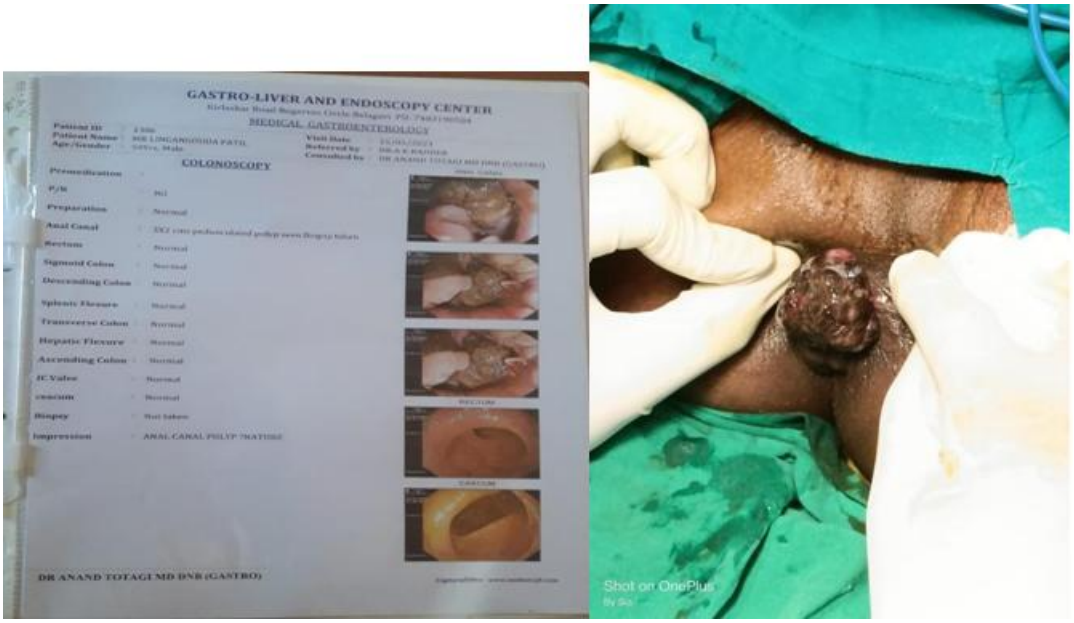
Colonoscopy was done for the patient which showed – ANAL CANAL POLYP and biopsy was taken which showed – "features are suggestive of melanoma"

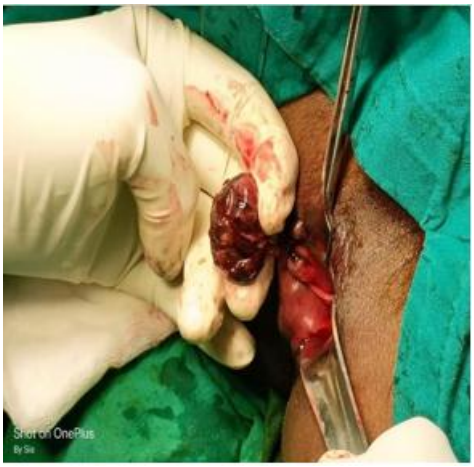
Patient was taken for surgical excision under spinal anesthesia after physician fitness. The mass was excised and sent for HPR.

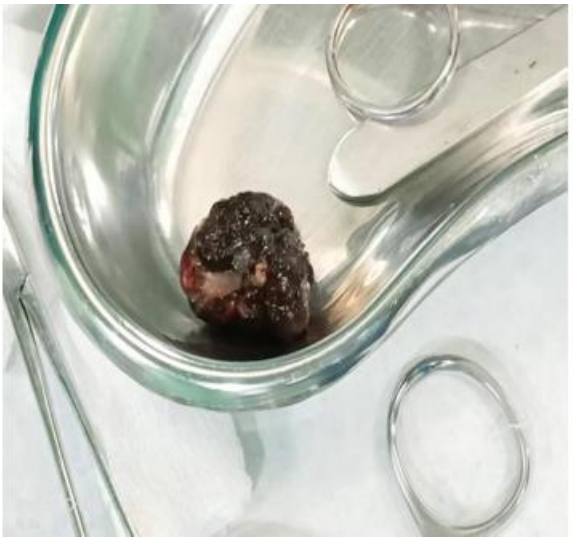
Post operative CECT (ABDOMEN + PELVIS) - Fatty liver with no evidence of metastasis. Post operative HRCT THORAX - Emphysematous changes in bilateral lower lobes.

HPR report - features suggestive of Malignant melanoma with clear margins.

In the view of above findings patient was diagnosed as Ano - rectal malignant melanoma. The patient was discharged.







3. Discussion

All melanomas, whether cutaneous or mucosal in origin, originate from melanocytes, which are cells derived from the embryological neural crest. During fetal development, these cells migrate to many sites throughout the body, primarily to the skin.

However, melanocytes also reside in the eyes (retina and uveal tract) and mucosal surfaces. Therefore, cutaneous melanomas are by far the most common form of the disease, comprising more than 90% of all melanomas. Of the remaining (<10%) forms of melanoma, ocular melanoma accounts for 5%, melanoma of unknown origin for 2%, and mucosal melanoma for 1%. Melanocytes may undergo malignant transformation when exposed to ultraviolet UVB

light, which is a carcinogenic stimulus. However, this relationship is not apparent in anorectal melanoma. There is a likely role of immunology in the development of anorectal melanoma as the incidence is higher in patients with Human Papilloma virus (HPV) and HIV infections. In the rectum, melanocytes are located at the anal transition zone and squamous zone. Most anorectal melanomas arise from the dentate line and 65% are located within the anal canal or at the anal verge. The most common presenting complaints are bleeding, anorectal discomfort or pain, an appreciable anorectal mass, or change in bowel habits. Other symptoms include pruritis, tenesmus, prolapsed hemorrhoid, change in stool habits, and diarrhea. Patients who have metastasis at the time of presentation may additionally have fatigue, weight loss, and anemia. Lesions are most commonly found at the anorectum, followed by the anal canal and anal verge. These lesions are often discounted as being benign hemorrhoids or polyps.

A sigmoid - colonoscopy is essential both for evaluation of the cause of symptoms and obtaining a tissue biopsy from a suspicious lesion.

Anal melanoma is staged on a clinical basis, focusing on loco - regional and distant spread. Stage I is local disease only, Stage II is a local disease with increased thickness and ulcerations, Stage III is local disease with involvement of regional lymph nodes, and Stage IV shows distant metastatic disease.

Stage	Spread	Depth (mm)
IA	Localized	0.75
IB	Localized	0.76-1.5
IIA	Localized	1.5-4.0
IIB	Localized	>4.0
III	Regional nodes	x
IV	Distant metastasis	x

There are no standards regarding systemic therapy for disseminated disease. Chemotherapy, radiation therapy, and immune therapy have a limited role. The medications used in adjuvant therapy are cisplatin, vinblastine, dacarbazine, interferon B, and Interleukins IL - 2 - 8.

Dacarbazine is the most commonly used single agent and usually initiates a partial response in 20% of patients in 4 - 6 months after treatment. Recent studies show that wide local excision (WLE) combined with adjuvant loco - regional radiotherapy result in comparable loco - regional control with less loss of function compared to APR.

4. Conclusion

Malignant melanoma of the rectum is extremely rare, highly aggressive, and difficult to diagnose. Bulky fungating masses in the distal rectum obscuring the lumen without causing significant obstruction raise the possibility of anorectal malignant melanoma. Although biopsy and histopathological examination is essential for diagnosis, distinct radiological features on CT, and MRI may suggest possibility of malignant melanoma. Major role of CT and MRI is in preoperative staging of the tumor.

Although surgery remains the cornerstone of treatment, the exact procedure remains controversial. Role of adjuvant therapies is minimal. The diagnosis of anorectal mucosal melanoma (ARMM) portends a particularly poor prognosis and a standardized evidence - based treatment approach is not well - defined due to the rarity of this disease. The only hope of improved survival lies in early diagnosis and treatment. Since, the complaints are usually non - specific; this is possible with a high index of suspicion followed by early sigmoidoscopy and biopsy.

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