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A rare entity in the rectum: Malignant melanoma

Rektumda nadir bir oluşum: Malign melanom

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Malignant melanoma is a rare entity in the rectum. Long-term survival is rare, as most patients die of disseminated systemic disease regardless of treatment. For this reason, some authors do not consider extensive radical surgery as the treatment of choice. We describe here a case of this rare entity.

Key words: Malignant melanoma, rectum

Malign melanoma rektumdaki nadir oluşumlardandır. Uzun dönemde hayatta kalma süresi, hastalığın tanı konduğunda yayılması sebebiyle çok düşüktür. Bu sebepten dolayı, bazı yazarlar bu hastalarda tedavi seçeneği olarak radikal cerrahinin düşünülmemesi görüşündedirler. Bu olgumuz, bu nadir oluşuma bir örnektir,

Anahtar kelimeler: Malign melanom, rektum

INTRODUCTION

Moore was the first person to report melanoma of the anus and rectum in 1857 (1). Rectal malignant melanoma accounts for 0.2%-3% (2) of all malignant melanoma cases and 0,l%-4.6% of malignant tumors of the rectum and anus (3, 4). This makes melanoma the third most common malignancy of the anorectal area (5).

The treatment is not well defined since it is such a rare condition. In order to have statistically significant outcomes, the data must be collected over a long period of time (6). This case is a sample of this rare entity.

CASE REPORT

A 60-year-old female presented with an episode of recurrent rectal bleeding. Digital examination of the rectum revealed a mass, 6 cm in diameter, in the anterior wall of the rectum. Lymph nodes could not be palpated. Colonoscopy revealed a polypoid mass (3x5 cm) surrounded by fragile ulcers located at the sixth centimeter from the anal verge (Figure 1). Obtained biopsies were routinely processed with conventional paraffin embedding and were later sectioned and stained with hematoxylin and eosin (HE). Microscopic examination of biopsy material in HE sections showed alveolar pattern tumor under the surface ulceration. Tumor contained atypical cells with obvious nucleolus and hyperchromatic nucleus. Immunohistochemical staining of the tumor cells was positive for S-100 protein. With this histomorphological finding the case was diagnosed as non-pigmented malignant melanoma (Figures 2-4). We planned simple local excision for the treatment,

DISCUSSION

Studies with large series have confirmed a female predominance for rectal malignant melanoma (2, 4, 6, 7), The lesion was most often discovered in the fifth and sixth decades of life (8), as was also seen in our case.

Rectal bleeding is the most common presenting symptom (2, 6, 7, 9, 10). Our case was admitted to emergency with recurrent rectal bleeding. Five-year survival is rarely seen, as the large series have shown it to be less than 5% (11, 12, 13, 14). The Mayo Clinic reported five-year survival as 22% and cure as 16% in their patient population (4). A

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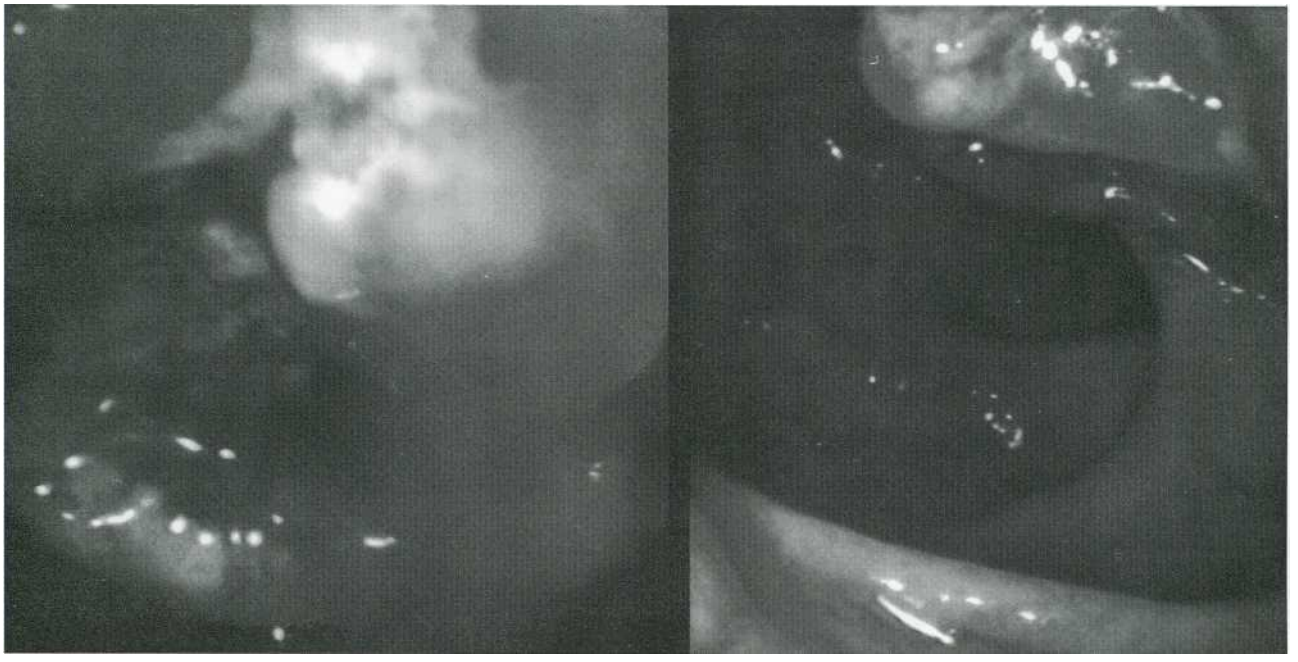

Figure I. Colonoscopic appearance of malignant melanoma

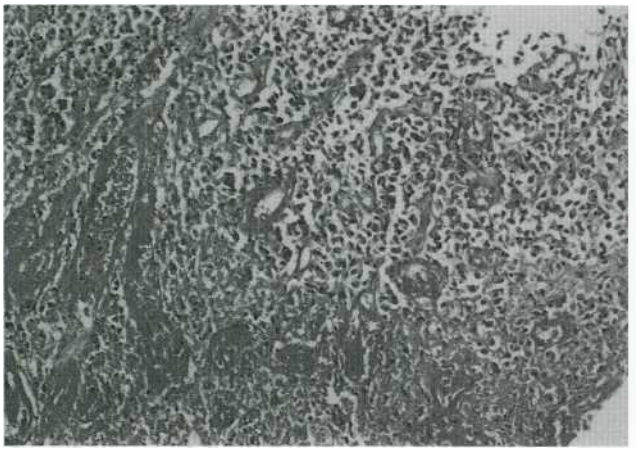

Figure 2. Tumor cells that shows alveolar pattern under the ulcer surface (HE, x40)

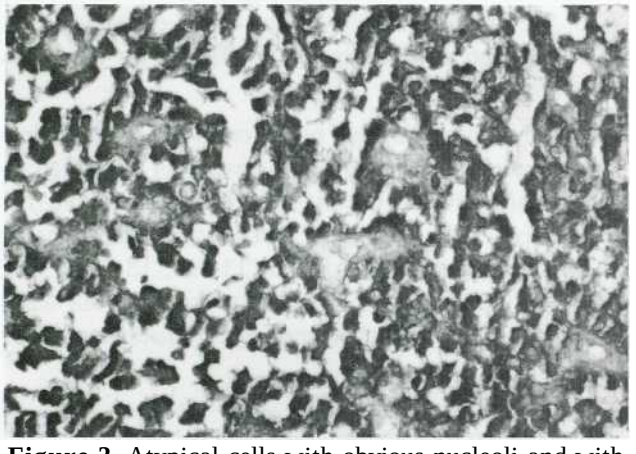

Figure 3. Atypical cells with obvious nucleoli and with hyperchromatic nucleus that formed alveolar pattern (HE, x200)

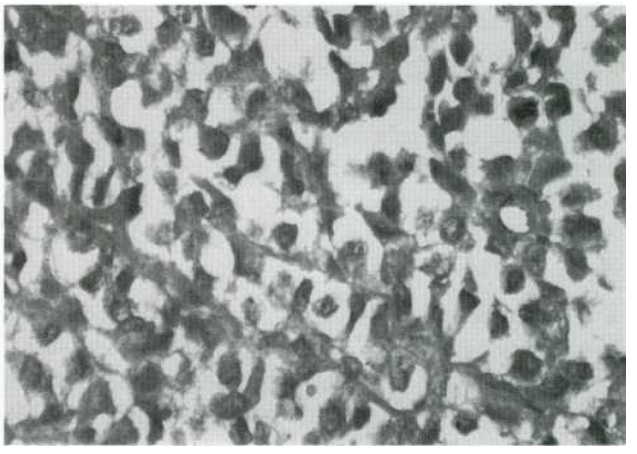

Figure 4. Malignant melanoma showing strong nuclear and cytoplasmic immunoreactivity for S100 prokin (ICH, x100)

patient treated by more radical surgery was unfortunately lost to follow-up (15).

One study did not find any difference in survival between patients who had had abdominoperineal resection and those who had had wide local excision. Reviews on the treatment of the lesions, again pertaining to anorectal melanomas rather than those of pure anal or rectal origin, are divided as to whether radical surgery is required or simple local excision is sufficient (16-19).

Long-term survival is rare, as most patients die of disseminated systemic disease regardless of treat-

ment; for this reason, some authors do not consider extensive radical surgery to be the treatment of choice (6).

Slingluff and Cooper reported that five-year survival was lower than 10% (7, 20) and that surgical treatment did not change this. In the literature, some authors have found no difference in overall survival and the disease-free interval between patients who had curative abdominoperineal resection and those who were treated with wide local excision (3, 7). However, adjuvant or neo-adjuvant and immunotherapy might offer a more effective way of treating this disease (6, 8).

The factors that may account for the poor prognosis include: the advanced nature of the disease when diagnosed, ulceration, the rich vascularity of the rectal mucosa, heightened risk of hematogenous metastasis, and the probable high biological aggressiveness of the tumors (6). Also, high metastatic potential has been reported to explain the incidence of both diffuse visceral metastasis and massive pelvic extension.

In conclusion, clinicians should remember anorectal melanoma when a case is admited with recurrent rectal bleeding. Unfortunately, early diagnosis has not changed the long-term survival rate. In view of the dismal prognosis predicted on the basis of distant metastases, it would seem reasonable to employ conservative surgical therapy for the local lesion. Thus, local resection or fulguration for palliation should be considered the procedure of choice in melanoma arising in the anorectal area (5).

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