Primary anorectal melanoma

Primer anorektal melanoma

To the Editor,

Primary anorectal melanoma (ARM) is extremely rare, representing less than 0.05% of colorectal malignancies and 2% of melanomas (1-3). It is the most common site of primary melanoma in the gastrointestinal tract and the third most overall (2). ARM occurs late in life and is more common in females (4,5). A 78-year-old male presented with three weeks of painless hematochezia. His medical history included adenomatous colonic polyps. General physical examination was unremarkable. At colonoscopy, a 3 cm amelanotic sessile polyp at the anal verge was palpated and later snare-resected (Figure 1a and b). Histopathology revealed melanoma with immunohistochemical staining for S-100 confirming the diagnosis (Fig 2a and b). Total body CT/PET scan did not reveal metastatic disease. The patient underwent a wide transanal local excision (LE) revealing in situ melanoma with focal submucosal invasion. Four lymph nodes resected from the left groin were negative for melanoma. Adjuvant chemotherapy with interferon was given for 4 weeks. The patient did well until 1 year later when multiple hepatic hypermetabolic lesions were found on CT/PET imaging. He was started on carboplatin and taxol as salvage chemotherapy.

Rectal bleeding is the most common presenting symptom (2,6). ARM arises from melanocytes within the rectal mucosa, squamous and/or transitional anal epithelium. Endoscopically, 70% of ARMs appear as black pigmented nodules or dark brown polypoid lesions; however, ARM may be amelanotic (3,4). Histologically, these tumors may or may not show intracellular melanin. Immunohistochemical stains not melanin-dependent confirm the diagnosis. Primary ARM is an uncommon but highly aggressive tumor with a five-year survival of 25% (2,3,6). Since 1985, a proportional increase in women and trend towards bimodal age distribution has been noted (3,7). The higher peak, among patients older than 60 years, included 72% women; the lower, aged 29-59 years, included 63% men, and suggested a relationship between human immunodeficiency virus (HIV) disease and primary ARM (3). Options for patients lacking me-

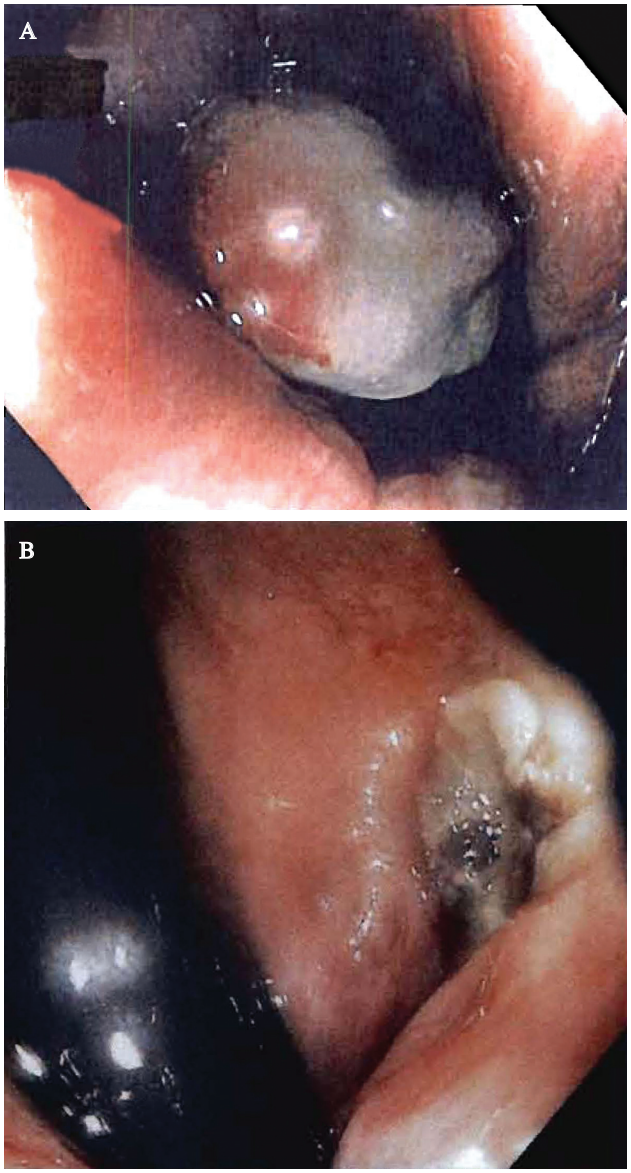

Figure 1. Endoscopic views. **A.** Rectal mass, 3 cm, at the anal verge. **B.** Area after transanal local excision.

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tastatic disease include LE and abdominoperineal resection (APR) with or without inguinal and pelvic lymphadenectomy followed by adjuvant radiotherapy or chemotherapy. Wide LE followed by adjuvant radiation produces equivalent five-year survival to that of APR (2,6,7). However, improved local control for large lesions and long-term survival for lesions smaller than 2 mm are seen after APR (7). No systemic chemotherapy regimen for metastatic ARM is the standard of care. In conclusion, primary ARM is a rare, aggressive malignancy with a poor prognosis.

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Acquisition time: A key point of hepatitis C virus-related liver disease in renal transplant recipients

Renal transplant alıcılarında hepatit C virüsü ile ilişkili karaciğer hastalığında anahtar bir nokta: Enfeksiyonu edinme zamanı

To the Editor,

I read with great interest the article entitled "The impact of hepatitis C virus infection on long-term outcome in renal transplant patients" by Ruhi Ç, et al. (1) that highlights the impact of hepatitis C virus (HCV) infection on long-term outcome in renal transplant (RT) recipients. To address this aim, the investigators conducted a retrospective study among 1811 patients who received RT between 1999 and 2009 in Akdeniz University Organ Transplantation Center. One hundred patients (5.5%), all of whom acquired the infection during the pre-RT period, were found to be HCV-seropositive. For a median follow-up of 35.7 months, graft survival was lower in anti-HCV-positive patients, but patient survival was similar between the anti-HCV-positive and -negative groups. As the authors pointed out, the apparently higher rate of graft loss in the anti-HCV-positive patients could

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