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Case Report

Malignant Melanoma Rectum

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ABSTRACT

Melanoma of the Anorectum is the third most among melanomas after skin and retina. Rectal melanoma accounts for 0.4to 3% of all malignant melanomas and it is a rare disease. We are presenting a case of malignant melanoma rectum in a young man presented as a mass coming out on defecation and bleeding per rectum. Malignant melanomas are diagnosed after histological confirmation only. In this case the diagnosis was certain by Trans Rectal Ultra sound and confirmed by histology of operated specimen after abdominoperineal resection.

Key words: Malignant melanoma, Rectum Trans Rectal Ultra sound Abdominoperineal resection.

INTRODUCTION

Malignant melanoma is a neoplasm arising from melanocytes. Most commonly it occurs in skin but can also occurs in many other organs. Melanoma in rectum is a rare presentation. [1] Anorectal melanoma first reported by Moore 1857. [2] Anorectum is the third most common site for the malignant melanoma, after skin and retina. [3] Incidence of rectal melanoma is 0.4 -3.0% of all malignant melanomas. Five year survival rate of malignant melanoma is 6%-15% after surgery. [4] Various treatment options for the malignant melanoma in rectum are: surgery, immunotherapy, chemotherapy, radiotherapy, but among these chemo and radiotherapy are shows poor response.

CASE REPORT

A 37 year old male presented with bleeding per rectum from 6 months and associated with mass per rectum while stool passage from 3 months. Patient was pale and anaemic.

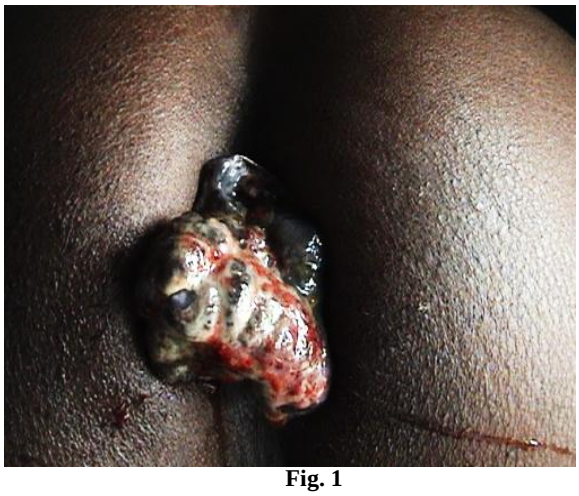

Fig. 1

On rectal examination a, mass was felt in right half of the rectum. It was polypoidal; mobile, upper border was not reachable, non tender, and bleeding on digital examination. (Fig-1)

Patient was subjected to endoscopy (Fig- 2 & 3) and Trans Rectal Ultrasound (TRUS). On endoscopy an eccentric exophytic growth was present at anorectum extending up to 6cmform anal verge and blackish in color Fig-1.

TRUS revealed extensive invasion involving rectal wall musculature (Fig-3). There were metastases in liver. (Fig-4)

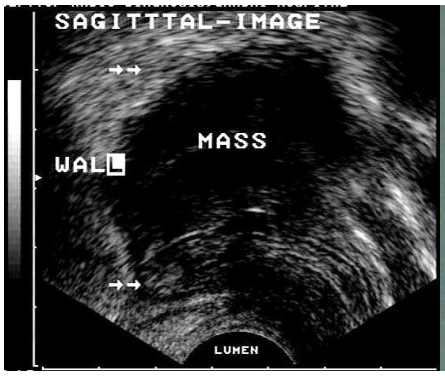

Fig-2

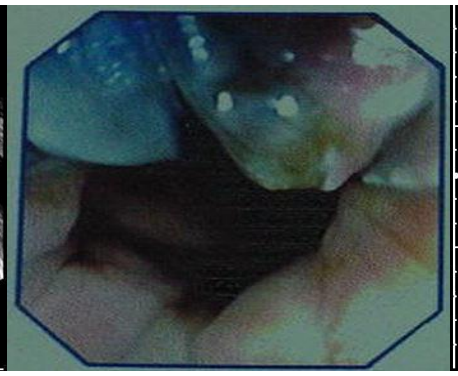

Fig-3

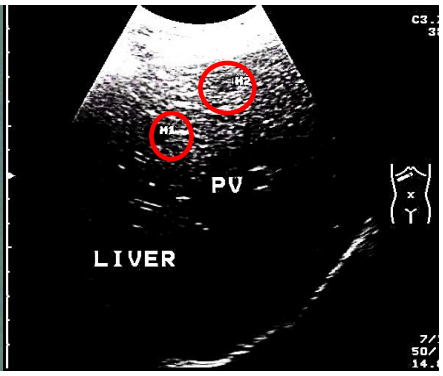

Fig-4

Abdominoperineal resection was done.

Malignant melanoma was confirmed on histopathology. (Melanin pigment was seen and on bleaching with potassium permanganate and oxalic acid no color is seen on tumor side of the slide.) Figs. 5 & 6.

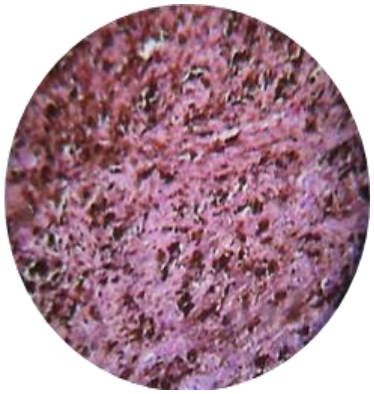

Fig- 5

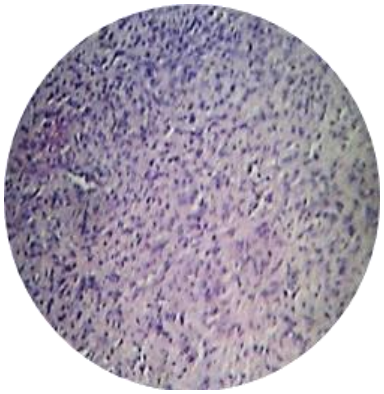

Fig- 6

DISCUSSION

Malignant melanoma in rectum is rare malignancy accounting for 1% of all anorectal malignancies. [5] It is the third most common site for malignant melanoma after skin and retina; more common in women in 5th& 6th decades. [6,7] Malignant melanoma rectum usually presents as rectal bleeding or a change in bowel habit. [6,7] Exposure to Ultra violet light is not a risk factor for melanoma rectum in contrast to skin melanoma.

The malignant melanoma rectum usually located at anorectum, followed by the anal canal and analverge. [8] In this case it presented as polypoidal mass at anorectal region and presented with bleeding per rectum. On straining the mass was protruding out through the anal canal. These lesions are often misdiagnosed as hemorrhoids. Microscopically the tumor cells are arranged innests with characteristic immune staining specific for melanosome protein. [9,10]

Usually the diagnosis of melanoma is made after histological confirmation; but in this case the malignant melanoma of rectum was suspected during endoscopy of anorectum. Then TRUS was done to detect the depth of invasion into the mucosa and adjacent structure. In this case abdominoperineal resection as done and histopathology confirmed the diagnosis of malignant melanoma.

The overall 5 year survival after surgical resection is 15%. The treatment of choice for the malignant melanoma rectum is radical abdominoperineal resection. [11]

The tumor is resistant to the chemotherapy and radiotherapy. The prognostic factors include tumor size, depth of invasion, stage of the disease, nodal status. [12]

CONCLUSION

A rare case of Malignant Melanoma Rectum in a young patient of 37 years is presented. The diagnosis was by TRUS and confirmed by histopathology of operated specimen.

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