Formosan Journal of Surgery (2014) 47, 74–77

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journal homepage: www.e-fjs.com

CASE REPORT

Anal canal melanoma misdiagnosed and treated as prolapsed hemorrhoids in a male patient

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Received 1 October 2013; received in revised form 1 November 2013; accepted 20 November 2013
Available online 18 April 2014

KEYWORDS
anal canal melanoma;
melanoma antigen HMB-45;
protein S-100;
thrombosed hemorrhoids

Summary Malignant melanoma of the anal canal is a rare, but aggressive, tumor with a poor prognosis. It represents less than 1% of all melanomas and 4% of anorectal tumors. We are reporting this case because of its rarity in men and because, in this instance, the tumor was misdiagnosed as prolapsed thrombosed hemorrhoids and excised. Examination showed a visible exophytic irreducible growth measuring about 3 × 3 cm and protruding outside the anal verge and involving the anterior two-thirds of the circumference of the anal canal. A biopsy sample showed round to oval cells with prominent nucleoli and marked intracytoplasmic pigmentation. A magnetic resonance imaging scan showed a tumor with nearly complete luminal obstruction and liver metastasis. The patient received chemotherapy and radiotherapy, but the response was very poor and he died 2 months later.

1. Introduction

Melanoma of the anal canal is an uncommon but highly lethal tumor constituting less than 1% of all melanomas and 4% of anorectal tumors other than adenocarcinoma.[1] It has an unfavorable prognosis with a predilection for early infiltration and distant spread, resulting in poor overall survival.[2] These tumors commonly originate from the squamous epithelium of the anal canal or the squamocolumnar junction. About 0.4–1.6% of all melanomas arise in the anorectal region and the anal canal is the most frequent site for melanomas after the skin and retina.[3] It is more common in women and approximately 500 cases have been reported previously.[3–5] Melanoma of the anal canal

Conflicts of interest: All contributing authors declare no conflicts of interest.

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http://dx.doi.org/10.1016/j.fjs.2013.11.002

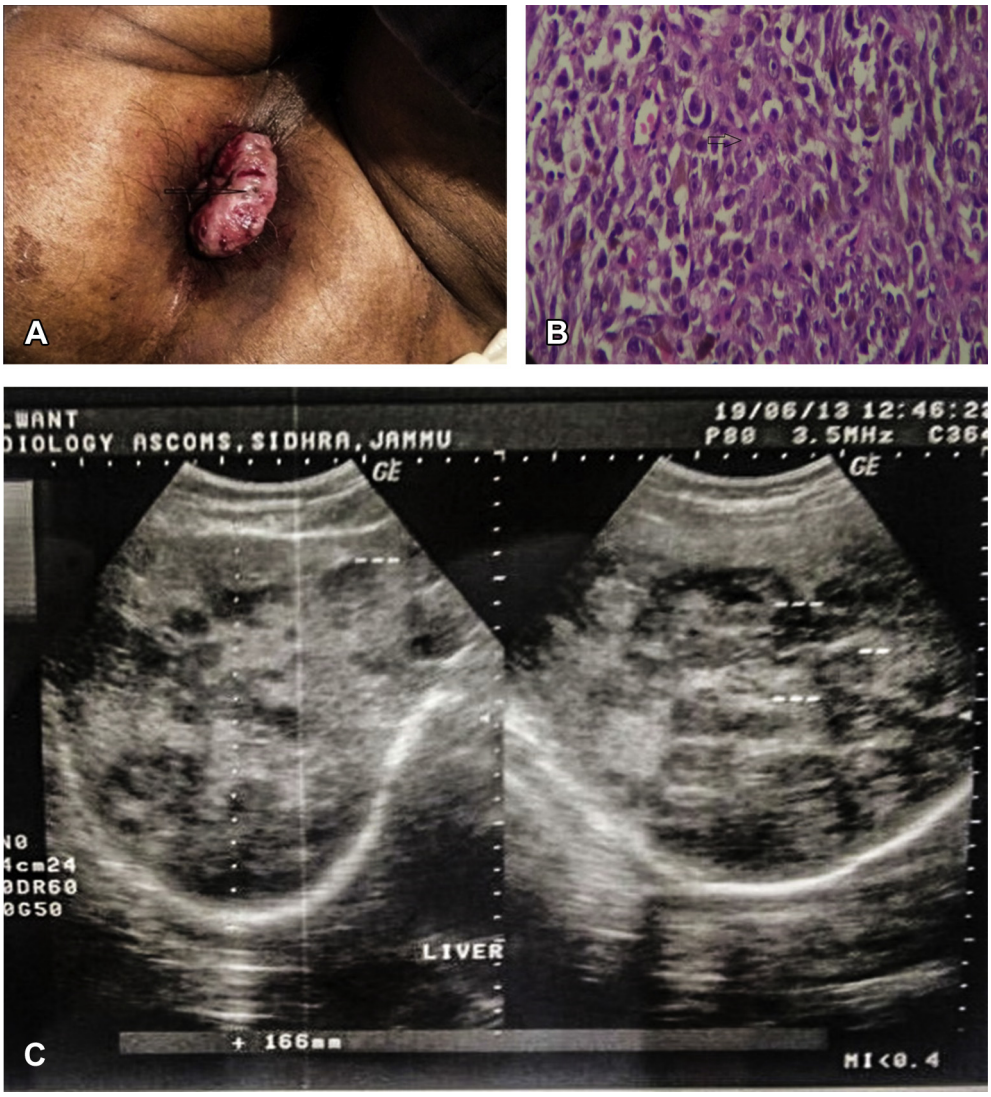

Figure 1 (A) Protruding anal mass with bluish black spots shown by black arrow. (B) Histological examination showed sheets of cells with intracytoplasmic pigmentation. (C) Abdominal sonography showed multiple intrahepatic mixed echogenic lesions with central necrosis.

usually occurs below the dentate line, although it sometimes occurs above the dentate line.[6]

2. Case report

A 66-year-old man presented with a history of recurrent bleeding from the rectum, a need to strain on defecation, and perianal pain for the last 3 consecutive months .The patient was neither diabetic nor hypertensive and had no history of constipation, altered bowel habits, weight loss, jaundice, or loss of appetite. He was diagnosed with prolapsed hemorrhoids for which a hemorrhoidectomy was performed in a peripheral hospital under spinal anesthesia. His postoperative period was uneventful and no histopathological examination of the excised hemorrhoidal tissues was carried out. He continued to have recurrent bleeding and perianal pain and a protruding mass was seen 1 month after surgery. The patient was examined and there was a visible exophytic growth protruding outside the anal verge, overlain with blackish spots (Fig. 1A).

On proctoscopy, a blackish growth was seen interiorly below the dentate line, involving two-thirds of the circumference of the anal canal and measuring 3 × 3 cm, with fresh bleeding on touch. The patient's hemoglobin was 9 gm%, and his kidney function and liver function tests were normal. A punch biopsy sample was taken from the growth and this showed sheets of round to oval cells with prominent nucleoli and cytoplasmic pleomorphism (perivascular) with marked intracytoplasmic pigmentation (Fig. 1B). No immunohistochemistry was performed as this was not available in our institution. Ultrasonography showed multiple intrahepatic mixed echogenic lesions with central necrosis (Fig. 1C). Pelvic and abdominal magnetic resonance imaging showed diffuse circumferential wall thickening of the distal rectum and anal canal with nearly complete obliteration of the lumen, along with perirectal, presacral, and bilateral inguinal lymph node enlargement