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A case report of anorectal malignant melanoma with mucosal skipped lesion

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ABSTRACT

INTRODUCTION: We report our experience involving a case of relatively rare anorectal malignant melanoma with skipped lesion.
PRESENTATION OF CASE: The patient was a 72-year-old man who had visited a local clinic complaining of a mass in the anal region, whereupon he was referred to our hospital on suspicion of a malignant melanoma. Close examination revealed a 25-mm black type 1 tumor one-third the size of the circumference of the anal canal and located externally to it. We performed transanal resection of the tumor and confirmed a diagnosis of malignant melanoma. Notably, multiple macular black lesions spaced away from the main lesion were observed during surgery in half of the circumference of the anal canal, from the tumor to the pectinate line. A biopsy of the area also revealed malignant melanoma; therefore, we performed abdominoperineal resection. Pathological diagnosis indicated a submucosal depth; the patient was thus diagnosed with T4 N2c M0 stage IIIb malignant melanoma and was followed on an outpatient basis.
DISCUSSION: Patients with anorectal malignant melanoma have very poor prognoses owing to early lymph node metastasis and hematogenous metastasis. Our case illustrates that small anorectal malignant melanoma lesions can spread from the main lesion and invade the mucosa; examinations may sometimes miss such skipped lesions.
CONCLUSION: Skipped lesions can occur in anorectal melanomas; thus, careful scrutiny of such lesions is required. Moreover, lesion resection is critical for anorectal malignant melanomas.

1. Introduction

Anorectal malignant melanoma is a relatively rare disease that is prone to hematogenous and lymphatic metastasis, often resulting in distant metastasis by the time of diagnosis. In this study, we report our experience with a patient who underwent abdominoperineal resection for anorectal malignant melanoma. Cases in which skipped lesions are observed during surgery or pathological examination are considered rare; therefore, we report this case and discuss the relevant literature.

2. Presentation of case

The patient is a 72-year-old man who complained of a sensation of a mass in his anal region. He has a history of endocarditis but no remarkable family history. The patient first sensed a mass in the anal region one year prior and believed it to be a hemorrhoid. On exacerbation, he visited a physician who observed prolapse of a black pedunculated tumor during rectal examination and thus referred the patient to our department. Physical findings included a 20-mm black pedunculated tumor discovered external to the anal verge. Blood tests revealed no blood count or biochemical abnormalities. Carcinoembryonic antigen and carbohydrate

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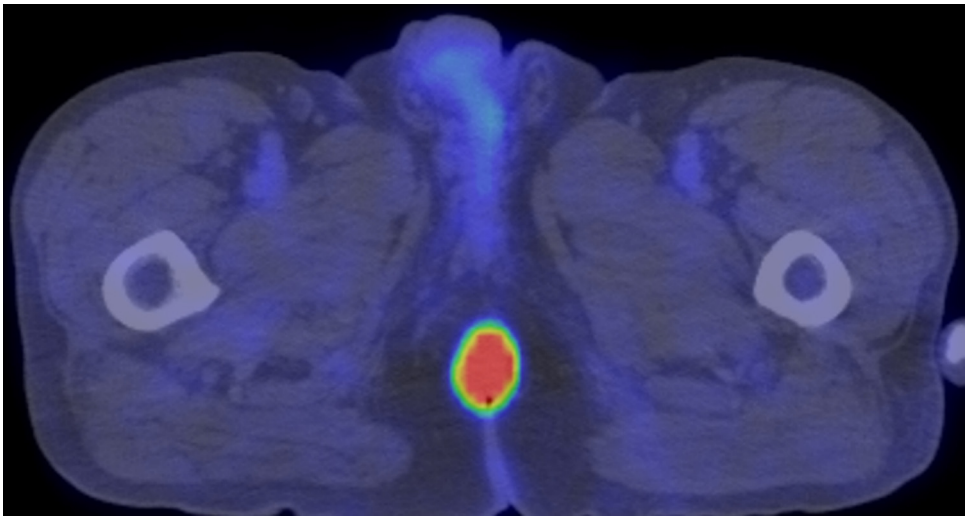

Fig. 1. Positron emission tomography-computed tomography: Abnormally high accumulation of fluorodeoxyglucose (25.1 SUV max) was found in the anal region.

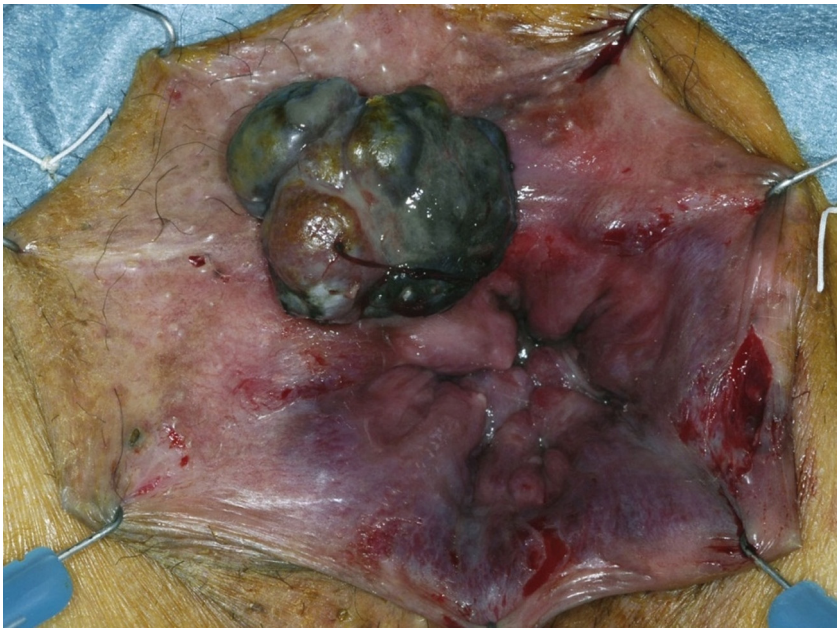

Fig. 2. Physical findings: The base of a black pedunculated raised lesion was found slightly distal to the pectinate line.

antigen 19-9 levels were also within normal ranges. On colonoscopy, a 20-mm pigmented tumor was discovered external to the anal canal. Lesions of the rectal mucosa and the anal canal were not observed. Contrast computed tomography detected no lymphadenopathy or distant metastasis other than the 20-mm tumor in the anal region. Magnetic resonance imaging detected a well-defined mass in the anal region. Positron emission tomography-computed tomography detected an abnormal accumulation (25.1 SUV max) consistent with a tumor (Fig. 1). Based on the above test results, we suspected an anal malignant melanoma and elected to perform an excisional biopsy; this was performed in the lithotomy position under lumbar anesthesia. When the anus was spread, mottled black changes approximately 1–2 mm in size that were non-contiguous with the main lesion were observed in over half of the circumference of the opening adjacent to the dentate line (Fig. 2). We resected the main lesion with a 1-cm horizontal margin, along with the deep portion at a depth that included a small portion of the internal sphincter muscle layer. Additionally, we performed a biopsy of the dentate line tissue containing the mottled black changes that were not contiguous with the main lesion (Fig. 3). Biopsy pathology revealed that the main lesion was a malignant melanoma (25 mm; sm, ly+, v−, HM+, VM−) while the mottled black changes were melanoma in situ. Due to the discovery of the latter, additional resection was deemed necessary. Laparoscopic abdominoperineal resection and D3 dissection were performed on day 35 post-biopsy. Surgical pathology revealed