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## International Journal of Surgery Case Reports

journal homepage: [www.casereports.com](http://www.casereports.com)

## Colorectal intussusception secondary to primary rectal melanoma: A novel case report

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## ARTICLE INFO

## Article history:

Received 29 November 2017

Received in revised form 8 February 2018

Accepted 11 February 2018

Available online 14 February 2018

## Keywords:

Case report

Rectal cancer

Melanoma

Rectum

Intussusception

Surgical oncology

## ABSTRACT

**INTRODUCTION:** Intussusception in adults is a rare condition, accounting for just 5% of all cases. Approximately 50% of cases of large intestine intussusception occur due to a malignant neoplasm. We present here a novel case report of colo-rectal intussusception arising secondary to a primary rectal melanoma. **PRESENTATION OF CASE:** We present the case of an 85 year-old patient, who underwent a colonoscopy for investigation of weight loss and altered bowel habit. At colonoscopy, a pigmented polypoid mass was visualised in the upper third of the rectum. The lesion was causing colo-rectal intussusception. Initial biopsies of the specimen stained positive for S-100. The patient had an MRI (magnetic resonance imaging) pelvis, which demonstrated a mass at the rectosigmoid junction, which was diffusely high signal on the fat sat T1 weighted sequence. The patient proceeded to a laparoscopic anterior resection and had an uncomplicated post-operative course. The resected specimen was sent for pathological analysis. The morphological and immunohistochemical profile was consistent with malignant melanoma. There was no evidence of cutaneous melanoma following a full skin examination.

**DISCUSSION:** Rectal melanoma is a rare condition. We present a novel case report of colo-rectal intussusception arising secondary to rectal melanoma.

**CONCLUSION:** This is a rare entity. This patient's pre-operative MRI and biopsy samples suggested this lesion was a rectal melanoma, which was subsequently confirmed on analysis of the resected specimen. Surgical resection of such neoplasms should be attempted where possible.

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## 1. Introduction

Intussusception describes the condition whereby a segment of bowel invaginates into an adjacent segment. The underlying aetiology, clinical presentation and management differ greatly in the adult population when compared to children. Well recognised in paediatrics, intussusception in adults accounts for just 5% of all cases [1–3]. An underlying pathology can be demonstrated in 70–90% of adult cases of intussusception [3–6]. Adults with intussusception can present acutely, subacutely or with a chronic history, most often with obstructive type symptoms [7]. Surgical intervention is often required in this population. In line with the SCARE criteria [8], we present here a novel case report of colorectal intussusception secondary to a primary rectal melanoma. The patient was diagnosed and managed at our institution; a tertiary referral university teaching hospital.

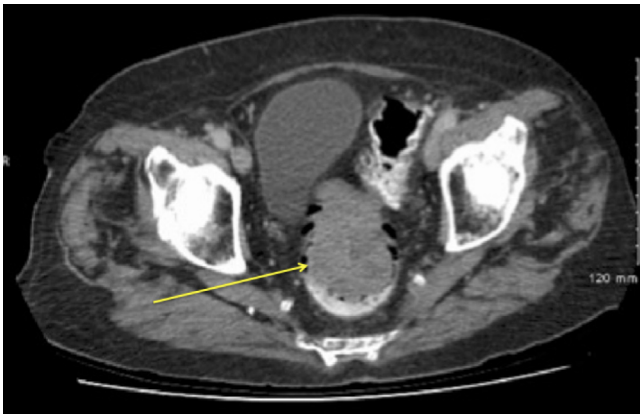
## 2. Presentation of case

We present the case of an 85 year-old retired male who underwent a colonoscopy for the investigation of an 8-week history of altered bowel habit and a 3 month history of weight loss. His primary care physician had referred the patient. His past medical history was of note for hypertension and dyslipidemia. The patient had spent some years working in equatorial territories but had no known previous history of melanoma. The patient was a non-smoker and had no family history of colorectal cancer. Physical examination was largely unremarkable. There was no mass or organomegaly appreciated on examination of the abdomen. No mass was felt on digital rectal examination. At colonoscopy, a partially obstructing polypoid pigmented lesion was visualised on the anterior wall at the rectosigmoid junction. The patient was admitted to the hospital from the endoscopy suite.

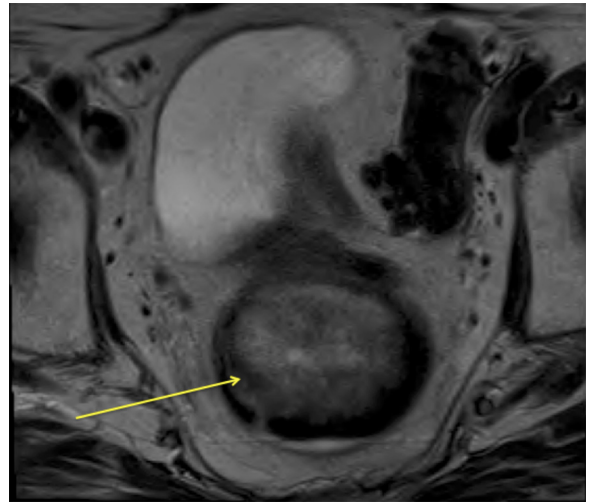
The patient underwent a staging CT (Computed Tomography) scan of his thorax, abdomen & pelvis (TAP), as well as an MRI (Magnetic Resonance Imaging) pelvis. CT imaging demonstrated an exophytic soft tissue mass on the anterior wall of the rectum

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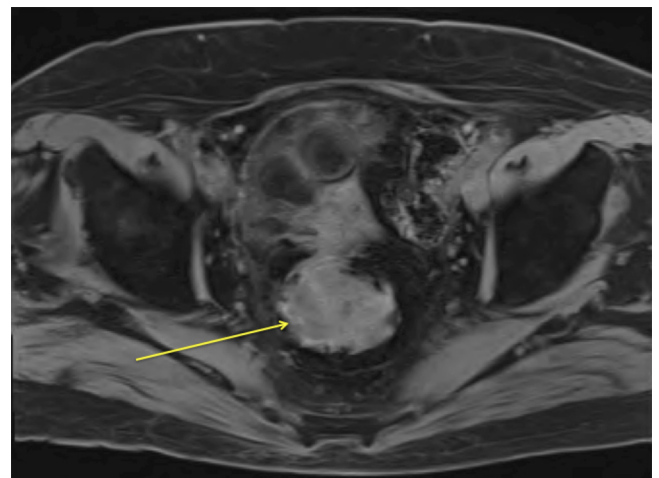
**Fig. 1.** Axial CT pelvis post administration of IV and oral contrast, demonstrating an exophytic mass (Yellow arrow) involving the anterior aspect of the mid and upper rectum.



**Fig. 3.** Axial T2 weighted MRI pelvis at the level of the rectum, demonstrating an endoluminal soft tissue rectal mass (Yellow arrow), which has a mixed heterogenous signal.



**Fig. 2.** Sagittal T2 weighted MRI pelvis, demonstrating an intussusception of the rectosigmoid colon (Broken yellow arrow) secondary to an endoluminal soft tissue mass, which has a mixed heterogenous signal (Solid yellow arrow).



**Fig. 4.** Axial fat-saturated T1 weighted MRI at the level of the rectum. There is an endoluminal soft tissue mass (Yellow arrow) which is diffusely high signal, due to the melanin content of the tumour.

(Fig. 1). There was no radiological evidence of metastatic disease. MRI of the pelvis demonstrated an 8.2 cm × 4.9 cm × 5.4 cm intraluminal mass causing a partial intussusception of the rectosigmoid colon (Fig. 2). The mass was diffusely high signal on the fat sat T1 weighted sequence (Fig. 3), due to the melanin content of the tumour (Fig. 4). There was extension of the mass outside the bowel wall at the rectosigmoid junction, in keeping with T3 disease. This patient's radiological staging was T3N0M0, given that there was no suspicious lymphadenopathy or metastatic deposits.

The case was discussed at the gastro-intestinal multi-disciplinary team meeting at our institution. The patient underwent an anaesthetic pre-operative assessment and subsequently proceeded to a laparoscopic anterior resection, with primary end-to-end anastomosis and a de-functioning loop ileostomy. A de-functioning loop ileostomy was performed as it was felt to be in this patient's best medical interest. The procedure was performed in the standard lithotomy position. A consultant colorectal surgeon, assisted by two surgical trainees, performed the procedure. The patient's post-operative course was uncomplicated and he was discharged home well on post-operative day 6.

The resected specimen was sent for histopathological analysis (Fig. 5). The morphological and immunohistochemical profile was consistent with malignant melanoma (Figs. 6–8).

There was no evidence of cutaneous melanoma identified following a full skin examination.

The patient remained well at outpatient follow-up after surgery. He will undergo surveillance endoscopy as an outpatient to monitor for any evidence of recurrence.

### 3. Discussion

Intussusception can occur with intraluminal lesions when peristalsis causes the lesion to advance forward, pulling with it its attached bowel. Clinical diagnosis of intestinal intussusception in the adult is difficult, owing to the relative rarity of the condition as well as the somewhat variable clinical presentation. Data suggest that intussusception in adults represents as little as 0.02% of all hospital admissions [4]. It may present with an acute, subacute or chronic history. Obstructive features predominate in presentation [7]. The classic triad of currant-jelly stool, abdominal pain and a palpable abdominal mass is rarely seen.

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