Case Report

Melanoma of Anal Canal

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Introduction:

Malignant melanoma is a neoplasm of melanocytes or of the cells that develop from melanocytes. Once considered an uncommon disease, the annual incidence of melanoma has increased dramatically over the last few decades.

Melanomas originate from melanocytes, which arise from the neural crest and migrate to the epidermis, uvea, meninges, and ectodermal mucosa. The melanocytes, which reside in the skin and produce a protective melanin, are contained within the basal layer of the epidermis, at the junction of the dermis and epidermis.

Melanomas may develop in or near a previously existing precursor lesion or in healthy-appearing skin. A malignant melanoma developing in healthy skin is said to arise de novo, without evidence of a precursor lesion. Many of these melanomas are induced by solar irradiation. The greatest risk of sun exposure-induced melanoma is associated with acute, intense, and intermittent blistering sunburns. This risk is in opposition to squamous and basal cell skin cancers, which are associated with prolonged, long-term sun exposure.

Melanoma also may occur in unexposed areas of the skin, including the palms, soles, and perineum. Certain lesions are considered to be precursor lesions of melanoma, which include the common acquired nevus, dysplastic nevus, congenital nevus, and cellular blue nevus.

Prognosis is related to the depth of invasion and to nodal status at diagnosis. Early-stage melanoma is curable; but, once the melanoma has metastasized, prognosis is grim, with a median survival of only 6-9 months. For this reason, physicians must be aware of the clinical characteristics of melanoma to make an early diagnosis. Prognosis is also related to the type of melanoma.

Case Report:

Bilqees bibi 40/F from Lahore presented on 5.10.04 with complaints of pain lower abdomen and lump in perianal region for last 6 months and painful defecation for two months. Lump was constantly increasing in size with associated complaint of low backache.

There was generalized weakness and pallor. Per-rectal and per-vaginal examination revealed a circumferential growth 1cm from anal verge involving posterior vaginal wall. Biopsy or anal growth revealed **malignant melanoma**. Barium enema showed irregular filling defect along posterior rectal wall with luminal narrowing. Colonoscopy

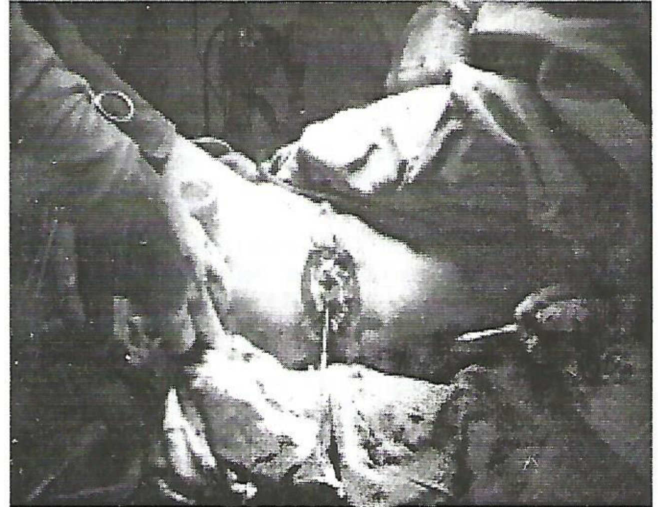

Fig 1 Patient on **table**

Patient was **operated** on 18.10.04 under G/A with ETI. Two teams were involved **abdominal team** opened abdomen with lower midline incision, assessed respectability. Liver was free of metastasis. Incisions were made on the peritoneal reflections on lateral mesorectum. Space was made behind the rectum. Dissection carried out till coccyx. **Perineal team** made a purse string around anus. Elliptical incision around the anus (taking tumor margins and posterior vaginal wall) was made. Perineal muscles cut and tumor excised.

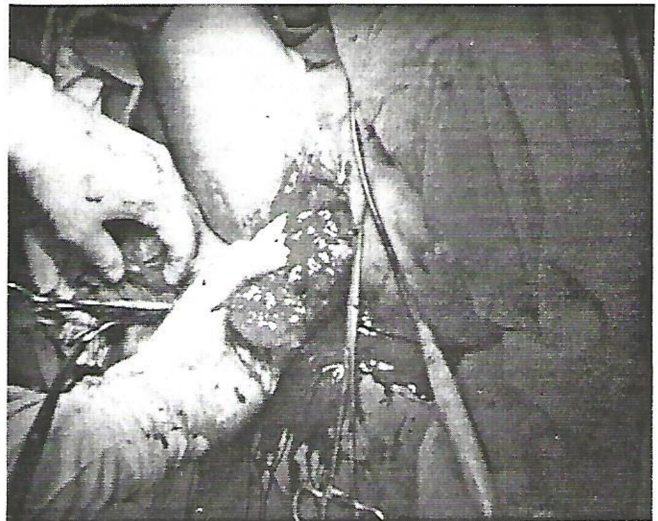

Fig 2 Specimen via perineum

Upper healthy margin of sigmoid colon brought out as end colostomy. Pelvic floor muscles stitched and perineal wound closed. Via abdomen suction drain placed in perineum and peritoneum closed over it. Drain placed in pelvis and abdominal wound closed. Recovery from anesthesia was smooth.

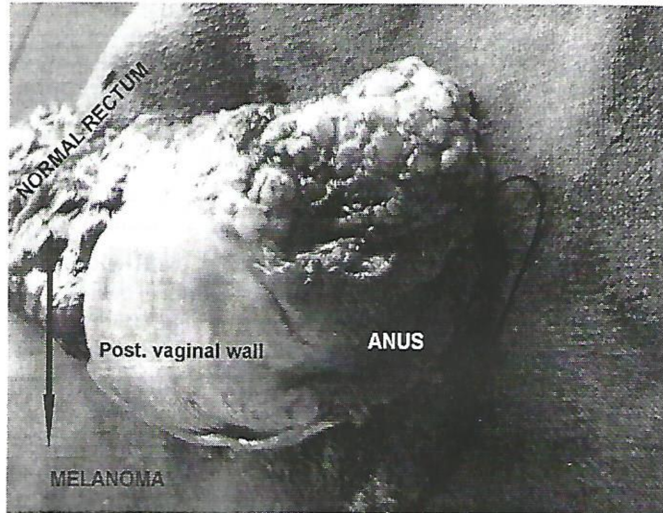

Fig 3 The resected specimen

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