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Case Report

Hemorrhoids or Malignant Melanoma? A Case Report

Yeap Jing Hui[1,3,4], Leow Yeen Chin[1], Chew Mianxin[2], Andee Dzulkarnaen Zakaria[3,4], Mohd Shahrulsalam Mohd Shah[3,4]

[1]Department of Surgery, Hospital Taiping, Perak, Malaysia
[2] Department of Pathology, Hospital Taiping, Perak, Malaysia
[3]Hospital Universiti Sains Malaysia, 16150 Kelantan, Malaysia
[4]Department of Surgery, School of Medical Sciences, Universiti Sains Malaysia, 16150 Kelantan, Malaysia

Corresponding authors*: shahrulsalam@usm.my

Abstract:
Anorectal malignant melanoma (ARMM) is an aggressive and rare tumour. It carries a poor prognosis due to its inherent aggressive systemic activity and advanced disease at the time of diagnosis. Surgery is the mainstay treatment which ranges from wide local excision to abdominoperineal resection (APR). Neither chemotherapy nor radiotherapy has proven benefits in increasing survival rate or reducing loco-regional recurrence. In this case report, we present a 52-year-old male patient with anorectal melanoma. Staging scans showed an anorectal tumour with nodal involvement. He underwent laparoscopic abdominoperineal resection in Hospital Taiping, Malaysia. He was discharged home well postoperatively.

***Keywords**: Anorectal malignant melanoma (ARMM), Abdominoperineal resection (APR)*
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Introduction

0.5-4% of malignancies in anorectal region are caused by ARMM, making it an extremely rare entity[1]. They are usually diagnosed among the population in their fifties and sixties with higher predisposition in females. Clinical presentation of ARMM can be non-specific. In up to one-third of cases, these lesions are mistaken for haemorrhoids or benign rectal polyps. In this article, we share our experience in managing ARMM and complement this with a brief review of the literature

Case Report

A 52-year-old male with no known medical illness complained of painful defecation tenesmus and per rectal bleeding for 1 year. He had a history of seeking treatment at a general practitioner and was treated as a haemorrhoid. Clinically there was no abdominal mass or inguinal lymph nodes palpable. A digital rectal examination showed a distal rectal mass about 3 cm from the anal verge. Colonoscopy showed a low rectal tumour about 3 cm from the anal verge with no synchronous tumour found. A biopsy of the tumour revealed melanoma. A staging computed tomography thorax, abdomen, and pelvis were done for him which showed low rectal mass with bilateral lung nodules of an indeterminate nature. Pre-operative MRI showed an anorectal tumour 1.5 cm from the anal verge with enlarged mesorectal lymph nodes. Two enhancing lymph nodes were seen over the right external iliac and left internal iliac. The radiological staging was T4b MRF+N2M0. He then underwent laparoscopic APR with an extra peritoneal sigmoid colostomy. He made an uneventful recovery. Histopathological examination of the specimen is consistent with mucosal melanoma of anus. The stage of the disease was T2N1(2/21) M0 with circumferential resection margin involvement.

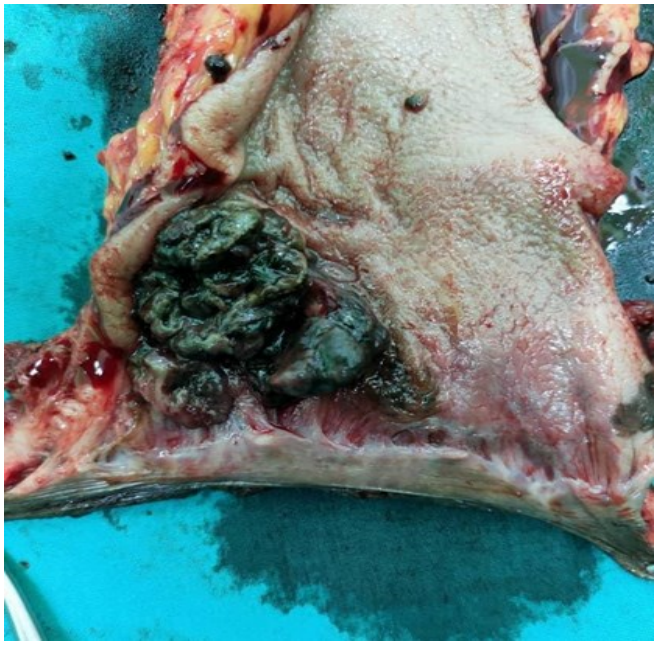

Figure 1: shows an APR specimen that has been cut open at the distal end revealing a fungating tumour. It measures about 3.8x2.7x2cm and has a dark brownish appearance.

Discussion

The diagnosis of ARMM remains difficult and requires a high index of suspicion due to its lack of pathognomonic features. Histology and immunochemistry remained the accurate diagnostic tools to confirm the diagnosis of ARMM.

Anal melanoma is usually suspected when brown or dark mucosal lesions invade the dentate line. However, up to one-third of malignant melanoma are non-pigmented. In cases where the diagnosis of ARMM is in doubt, Immunohistochemical evaluation using proteins such as SOX 10, HMB-45, Melanin A, and S 100 are indicated[2]. All of which were found in the immunohistochemistry examination of this patient.

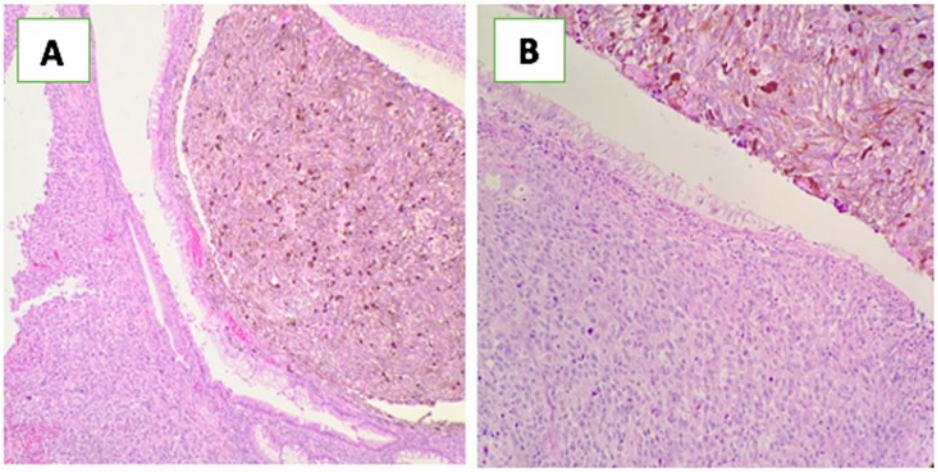

Figure 2: Mucosal melanoma of anus. A) Melanoma arising within anorectal mucosa. (H&E; x40) B) Malignant cells disposed of in diffuse sheets with marked nuclear pleomorphism and cytoplasmic fine melanin pigments. (H&E; x200)

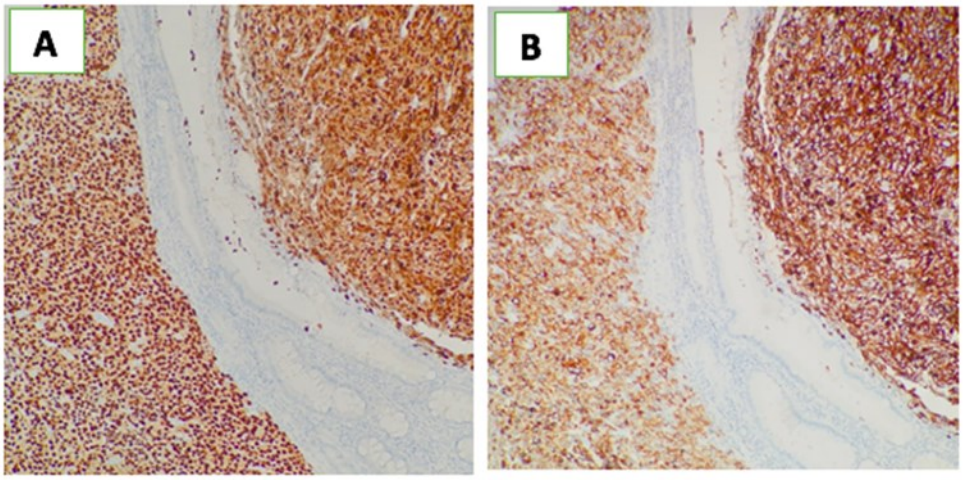

Figure 3: Immunohistochemistry study in mucosal melanoma of anus. (A) Nuclear positivity for SOX-10. (B) Cytoplasmic staining for HMB45.

Imaging studies such as computed tomography thorax, abdomen, and pelvis are usually done to assess for any evidence of distant metastasis and follow-up. MRI pelvis is also another important tool for disease staging and planning for surgery. ARMM is staged based on loco regional and distant metastasis. About 20% of patients with ARMM present with lymph node metastasis and 10% with distant metastasis at the time of diagnosis with a 5-year survival rate of about 20%[4]. ARMM is an aggressive malignant neoplasm that tends to metastasize early in the course of the disease. Coupled with the lack of specific clinical features and non-specific symptoms, the patient tends to present late when their symptoms fail to improve after presumably being treated for a benign cause. This leads to an overall poor prognosis.

Surgical resection has been the standard of care for ARMM. However, whether abdominoperineal resection (APR) or wide local excision (WLE) is the most appropriate surgical approach is still a debatable issue. There is no clinical trial to date that proves one method is superior to the other in terms of long-term survival due to the rarity of this disease. APR is thought to achieve a higher curative rate and better regional control while WLE is more favourable for its minimal invasiveness. However, R0 resection cannot be achieved with WLE if there is mesorectal and mesenteric lymph node metastasis [2]. In patients with locally advanced disease, it is also difficult to achieve R0 resection as there is no neoadjuvant treatment to downsize and downstage the tumour. The rate of recurrence is lower in radical surgery but there is no significant difference in prognosis in patients who underwent APR or WLE. Hence, treatment of ARMM should be individualized based on patient comorbidity and functional outcomes.

Conclusion

ARMM remains a malignancy with a very poor prognosis. Due to its rarity, there has not been a standardized treatment protocol for this illness since its discovery. The approach to surgery (WLE versus APR) remains debatable.

Consent

Patient verbally consented to put his case for educational purpose.

Conflict of interest

none

References

1. Leonard D, Beddy D, Dozois EJ. Neoplasms of the Anal Canal and Perianal Skin. Clinics in Colon and Rectal Surgery 2011; 24(1): 54–63.
2. Charifa A, Zhang X. Morphologic and Immunohistochemical Characteristics of Anorectal Melanoma. International Journal of Surgical Pathology 2018; 26(8): 725–729.
3. Singer M, Mutch M. Anal Melanoma. Clinics in Colon and Rectal Surgery 2006; 19(2): 78-87.

4. Pişkin E, Aydin O, Senlikci A, Ozgun MY, Oter V, Bostanci EB. Primary anorectal malignant melanomas: retrospective analysis of 11 cases in a single centre. Turkish Journal of Surgery 2021; 37(1): 63–67.
5. Ramalingam G, Gan EY, Kutt-Sing W. Laparoscopic Abdominoperineal Resection for Anorectal Melanoma. Surgical Laparoscopy Endoscopy & Percutaneous Techniques 2009; 19(4): e149e151.