

# Anorectal melanoma: An uncommon and aggressive disease

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## CASE PRESENTATION

A 74-year-old woman was admitted to hospital in August 2010 for community-acquired pneumonia. Laboratory investigations revealed iron deficiency anemia (hemoglobin 104 g/L) and a thoracic computed tomography scan revealed scattered bilateral nodular opacities compatible with pulmonary metastasis of unknown primary site. In the diagnostic workup, the colonoscopy revealed a 40 mm vegetating lesion with a brownish surface at the distal rectum involving the anorectal transition (Figures 1 and 2). Histological analysis revealed an ulcerated malignancy with pleomorphic epithelioid cells and abundant melanophages (Figures 3 and 4). Immunohistochemical staining was positive for S-100, HMB-45 and Melan-A proteins, establishing the diagnosis of anorectal melanoma. She also had brain metastases. Due to the global status, symptomatic treatment was proposed. The patient died six months later.

## DISCUSSION

Primary anorectal melanoma is a rare and aggressive disease, representing <1% of all melanomas, and approximately 0.5% to 2% of all anorectal malignancies (1). It is slightly more predominant in females, primarily in the fifth and sixth decades of life (1). The tumour can arise directly from melanocytes located above the dentate line, where there are abundant lymphatics and blood vessels that enable the tumour to grow and metastasize quickly (2). It usually presents with symptoms such as rectal bleeding, anorectal pain, rectal mass or change in bowel habits (1). It has a very poor prognosis. The mean survival after diagnosis is 15 to 25 months. At diagnosis, >20% have distant metastases (3).

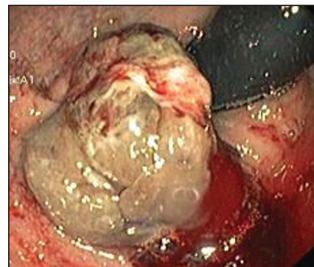
The optimal treatment is controversial. Surgical resection is the conventional therapy and includes abdominoperineal resection and wide local excision with or without adjuvant therapy (1,3).

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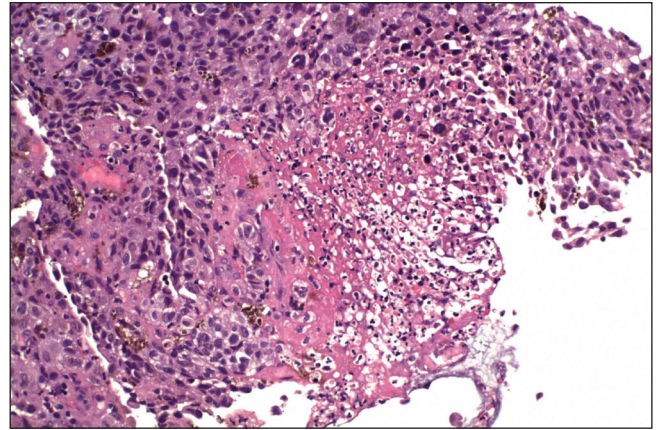
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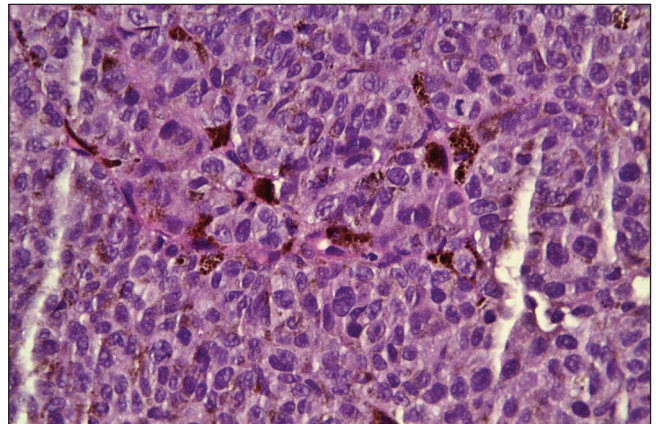
**Figure 1)** Tumour with brownish surface at the distal rectum



**Figure 2)** Endoscopic view showing easy bleeding



**Figure 3)** Poorly differentiated cell population with necrosis and ulceration (hematoxylin and eosin stain, original magnification  $\times 200$ )



**Figure 4)** Detail of poorly differentiated cell population with melanophages and mitosis (hematoxylin and eosin stain, original magnification  $\times 400$ )

## REFERENCES

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