Dear Editor,

The appearance of cutaneous metastases in the perianal region from adenocarcinoma of colon and rectum is an uncommon feature, and its presence usually implies a worse prognosis as a disseminated disease. Occasionally, they present with no evidence of visceral involvement, therefore their diagnosis and treatment can significantly modify the course of the disease. We present 3 patients with perianal implants of colorectal cancer treated surgically with good long-term results, emphasizing that in one of them the implant was discovered before the primary tumor.

Case reports

Case 1. A 54-year-old male presented a hemorrhoidal thrombosis resistant to anti-inflammatory treatment that was biopsied with the diagnosis of adenocarcinoma. Preoperative tests showed a sigmoid colon neoplasm with lymphonodes and a small mass in low rectum-anal canal infiltrating sphincters and puborectalis muscle (T4 N1 M1) (Fig. 1 A and B). Abdominoperineal amputation was done including the sigmoid tumor and their anal canal implant. Two years after surgery, the patient is malignancy free.

Case 2. A 55-year-old male who underwent surgery for a well-differentiated low rectal carcinoma with a coloanal hand-sewn anastomosis showed a perianal tumor after two years. The patient remains asymptomatic 16 years after its complete removal with cutaneous adenocarcinoma metastasis diagnosis.

Case 3. An 83 year-old male underwent surgery for rectal vil-lous tumor using a Lone-Star retractor, with diagnosis of an invasive adenocarcinoma. Then, a rectal resection without anastomosis was done. A year later, a perianal tumor developed and it was resected, with biopsy of adenocarcinoma (Fig. 1 C). The patient died two years later of a heart attack, with no evidence of tumor relapse.

Discussion

The appearance of cutaneous metastasis from colorectal cancer is an uncommon fact (4%) (1). After tumor diagnosis, the average interval of the development of implants is 4.9 years, although they may appear at any time (2).

The most common ways of cutaneous tumor dissemination are hematic or lymphatic spread. The hypothetical potential of implant exfoliated tumoral cells, was first time published by Charles Ryall (3). Subsequently has been demonstrated that exfoliated tumor cells are viable (4), requiring a mucosal damage for their implantation and growing (5).

In the first patient, some mucosal fraction of his hemorrhoidal thrombosis was the base of cells implant from a hidden sigmoid neoplasia. It is the first case described in medical publications. In the second case, after hand-sewn coloanal anastomosis, the implant was most likely done during surgery (6). The third patient’s metastasis appeared probably in the small wounds made by the Lone-Star retractor used during the tumor resection, like has been previously published (7).

Implants of malignant cells have been reported on benign anal lesions during colorectal cancer surgery (2), colonoscopy with biopsy (8), at the site of laparoscopic ports (1), or even in the injured perianal area during the introduction of an EEA stapling device to carry out a mechanical anastomosis (9).

The appearance of perianal metastasis usually implies a worse prognosis, because it is a disseminated disease with 18-20 months survival rate (7). However, none of our patients presented recurrence.
There are several measures to control tumor dissemination during surgery, although their real effect has not been well proved, but irrigation of rectal stump with tumoricidal agents before the anastomosis (10) is recommended. The perianal cutaneous metastases treatment ranges from limited local resection (1,7,9) to a more aggressive approach (2). In conclusion, we recommend using preventive measures for cutaneous implants in colorectal surgery, to rule out an intestinal origin of a perianal tumor with diagnosis of, and a complete exeresis of perianal implants without evidence of distant disease.

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References


