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Letters to the Editor

Advances in the management of primary malignant melanoma of the rectum

Key words: Primary malignant melanoma. Rectum. Amelanotic anorectal melanoma.

Dear Editor,

Melanomas are malignant neoplasias mainly arising from the melanocyte cells of the skin that frequently cause blood metastasis in the gastrointestinal tract.

However, although much less prevalent, primary melanoma of the mucosa, which occurs in the mucosa of the genitourinary, respiratory and gastrointestinal tracts, is also known. Primary malignant melanoma of the rectum is exceptionally rare and is scarcely mentioned in the literature. (1, 2)

There are multiple studies which erroneously attribute the origin of rectal melanomas to the extension of a tumor lesion from anal melanocytes. This condition has been the object of discussion for many years, mainly due to the difficulty which often exists for excluding primary anal disease, an ambiguous definition of the anorectal union, and the complexity for demonstrating the presence of normal melanocytes in the rectal mucosa. However, it seems that, although in very few cases, primary malignant melanoma may arise from the melanocytes among columnar rectal epithelium. (3)

We present the clinical case of a man who underwent surgery for primary melanoma of the rectum and review the evolution of its management over the last 20 years.

A 77 year old patient, with no history of interest, who comes to us due to symptoms of constipation, rectal tenesmus, and occasional rectal bleeding for some 3 months evolution. The digital rectal examination reveals an anterior rectal mass.

Additional tests: The colonoscopy biopsy (Fig. 1) reveals a polypoid carcinoma in the recto-anal union compatible with an undifferentiated malignant tumor infiltrating the rectal mucosa. Given these findings, thoracic, abdominal and pelvic CT scans were carried out showing the presence of a polypoid lesion dependent on the anterior intraluminal rectal margin (T2, N0); MRI of the pelvis demonstrated a lower third polypoid rectal tumor (T1-2, N0), and an endoanal ultrasound scan displayed a lower third polypoid neoplasia of the rectum (uT2, N0) at 6 cm from the anal margin.

With the diagnosis of undifferentiated carcinoma of the inferior rectum a laparoscopic abdominoperineal amputation was carried out (Fig. 2a).

The anatomopathologic study revealed a stage III p malignant melanoma of the rectum (T2, N1, M0, with expression of protein S100, HMB-45 and Melan A by immunohistochemical

Fig. 1.

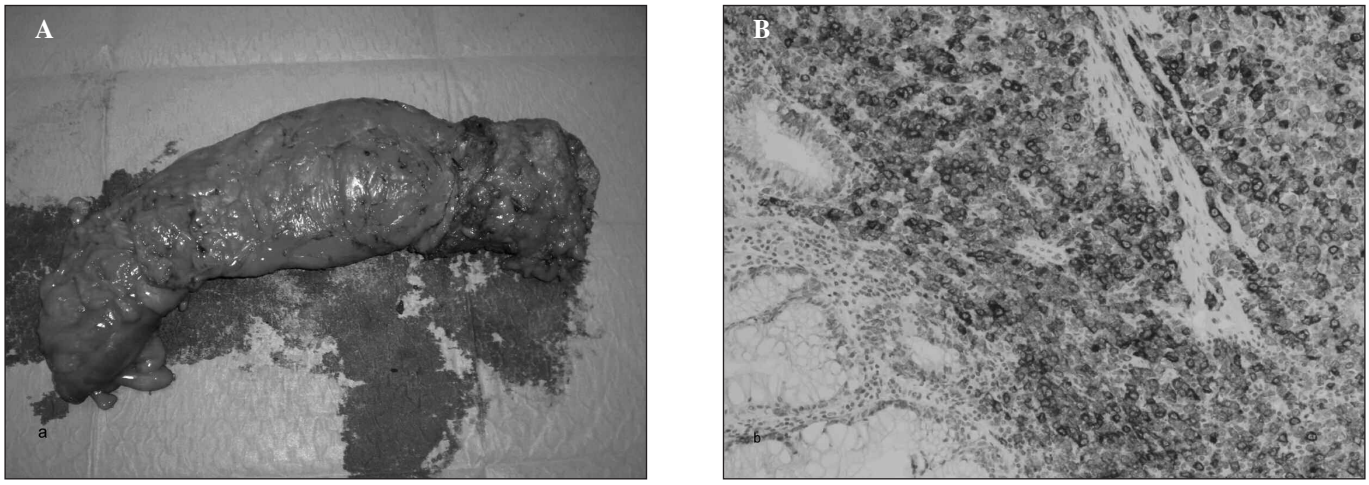

Fig. 2.

techniques 2b).

There were no complications during the postoperative period and the digestive tumors committee decided that the patient was not suitable for adjuvant treatment. A year later, the patient presents several intra-abdominal tumor implants from the primary melanoma of the rectum, which were responsible for several subocclusive episodes that were managed with a conservative treatment.

We reviewed the rectal tumors operated on in our hospital over the last 20 years and found only 2 other cases: one rectal metastatic melanoma and one anorectal melanoma. They were diagnosed by abdominal CT, colonoscopy and biopsy-rectoscopy and were treated with chemotherapy the fist case and with abdominoperineal amputation the second one. Survival: One month and three years, respectively.

Discussion

Primary rectal melanoma has a poor prognosis with a survival rate of less than 5 months when the disease has metastasized. The poor prognosis is mainly due to: the high metastic potential, the absence of a standardized treatment, and late diagnosis (4). Although it is clear that surgical treatment is the treatment of choice for localized rectal neoplasia, some authors have propose local excision combined with adjuvant loco-regional radiotherapy, for small tumor, while others favour abdominoperineal resection for large, obstructive tumors, alleging, despite higher morbidity, longer disease free survival. The evolution of diagnostic techniques (pelvic CT scan and endoanal ultrasound scan facilitates the preoperative staging of the disease and thus the choice of the most appropriate surgical technique for each case (4,5). Despite all this, it is the tumoral stage and the biological behavior of the tumor, rather than the type of surgery chosen, which determine survival (6).

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