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Letters to the Editor

Clinical presentation of anal duct adenocarcinoma as benign anal stenosis

Key words: Anal cancer. Laparoscopic surgery. Anal stricture. Anal radiotherapy.

Dear Editor,

Anal cancer represents 2 % of digestive tumors, with anal duct cancer making up fewer than 10 % of anal malignancies (1). This is a rare neoplasm of CK7 (+) cells from the anal ducts. Since its initial description by Hermann in 1880 (2), 5-year survival rates have been estimated around 5 %-40 % (3-5), and one reason for this poor prognosis is delayed diagnosis due to overlapping with benign conditions.

Case report

We report the case of a 53-year-old male with anal pain, anal bleeding, and fecal volume changes for 6 months who was studied in another institution, where he underwent a colonoscopy and magnetic resonance scan that revealed an anorectal mass, and then an endoscopic ultrasonography that showed a stenotic ring with significant inflammatory changes leading to loss of wall structure with uncertain infiltration; biopsies found chronic inflammation without dysplasia, consistent with solitary rectal ulcer. Two anorectoplasties, a Z-flap, and then dilatations were performed in that center, with persistent chronic pain. In our institution the patient presented with poorly controlled severe pain despite high-dose opioids, severe rectal incontinence, and a stricture 1 cm away from the pectineal line that hardly allowed a finger through it. In view of the above a laparoscopic ultralow anterior resection was decided upon. An endonal pulltrough is performed intraoperatively at the expense of definitive histology, with a result of CD7(+)/CD20(-)/PSA(-) adenocarcinoma of the anal glands with no mucinous areas, T3 N0, with involved radial and distal margins, which led to complete therapy by means of laparoscopic cylindrical abdominoperineal amputation. The patient remains alive and disease-free at 12 months following the procedure (Fig. 1).

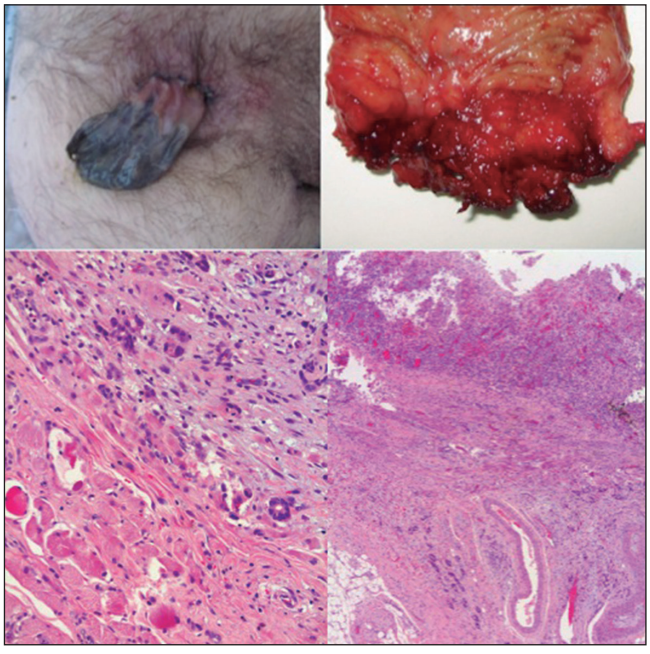

Fig. 1.

Discussion

Two theories exist on the origin of these tumors: They either occur at the dentate line transitional epithelium or derive from perianal apocrine or intramuscular glands. Diagnosis requires: Localization in the area where glands are usually present; exclusion of a different origin; transition from normal gland to carcinoma, preferrably with dysplastic transitional tissue and typical microscopic appearance (6).

Clinical manifestations include pain crises, bleeding, incontinence, weight loss, and/or sphincter induration for long periods of time, which makes differentiation from other benign conditions challenging.

The presence of lymphatic spread varies among series from 13.5 % to 62 % (3-5).

The ideal therapy is controversial, with abdominoperineal amputation being most common. Tarazi and Nelson have shown a good response to chemotherapy followed by surgery (7). Unfortunately, most patients present with advanced disease, with adjuvancy providing no clear benefits (3,8).

Overall survival is poor despite aggressive management: From 5 % to 21 % at 5 years (3,8-10).

These neoplasms are highly aggressive and can only be cured when a high index of suspicion and an early diagnosis occur.

Iago Justo-Alonso[1], María García-Nebreda[1], Carmelo Loinaz-Segurola[1], Óscar Caso-Maestro[1], Félix Cambra-Molero[1], Alejandro Alberto Marcacuzco-Quinto[1], Begoña Casis-Herce[2] and Carlos Jiménez-Romero[1]

[1]Department of General Surgery, Digestive Diseases and Transplant of Abdominal Organs. [2]Department of Digestive Diseases. Hospital Universitario 12 de Octubre. Madrid, Spain

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