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Synchronous Primary Anorectal Melanoma, Sigmoid Multiple Early Cancers and Descending Adenocarcinoma: A Case Report

Ruiyin Ge[1], Aixia Gong[1], Kang Sun[1], Jingwen Zhang[1], Jing Ma[1]

[1]*Digestive Endoscopy of the First Affiliated Hospital of Dalian Medical University, Dalian, Liaoning, China*

Multiple colorectal cancers are extremely rare, few cases can be searched in the literature. Our group only found 6 cases published. We report a case where 3 diseases coexisted summarize the currently available literature. A 75-year-old man presented with changes in his bowel habits and hematochezia. After a colonoscopy with biopsies in a community hospital, he was diagnosed with a descending adenocarcinoma patient. To get further treatment, he came to our hospital. Colonoscopy revealed ulcerative lesions in the descending colon, 2 polypoid lesions in the sigmoid colon, and a protruded lesions in the anorectal. The ulcerative lesions were already diagnosed as adenocarcinoma at the descending colon. So biopsies were taken in the anorectal region, which revealed poorly differentiated melanoma of the anorectal. Computed tomography did not find distant metastases and regional lymphadenopathy. A laparoscopic resection was undertaken to relieve his symptoms and improve the quality of life. The mass showed descending adenocarcinoma, sigmoid multiple early cancers, and poorly differentiated melanoma of the anorectal region. What we can learn is that endoscopy doctors should always be aware of the possibilities of multiple primary cancers for this is important to the treatment and prognosis of patients, standard colonoscopy examination is necessary and returning a enteroscope from cecum should be more than 8 minutes.

Key words: Colorectal melanoma – Adenocarcinoma – Synchronous tumors – Multiple tumors

Anorectal melanoma is a rare cancer with a poor prognosis, which accounts for less than 1% of all melanomas and less than 3% of all anorectal cancers.[1,2] The incidence of multiple primary cancers identified in the colon and rectum is estimated to be about 2% to 11%.[7] Multiple colorectal cancers are extremely rare, few cases can be searched in the literature. Our group only found 6 cases published.

Corresponding author: Aixia Gong, PhD, Department of Digestive Endoscopy in the First Affiliated Hospital of Dalian Medical University, Dalian, Liaoning, China.
Tel.: +86041183635963-3250; Fax: 0411-83622844; E-mail: gongaixiadmu@163.com

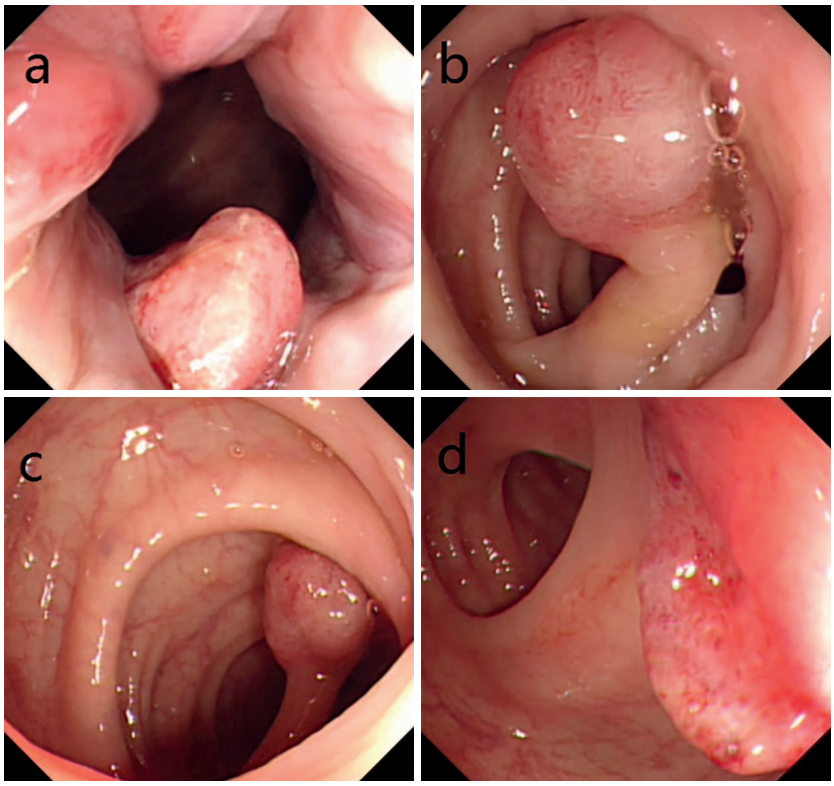

Fig. 1 (a) Anorectal melanoma, (b, c) sigmoid multiple early cancers, and (d) descending adenocarcinoma.

We report a case of synchronous primary anorectal melanoma, sigmoid multiple early cancers, and descending adenocarcinoma.

Case Report

A 75-year-old man presented on April 1, 2016, with changes in his bowel habits and hematochezia. After a colonoscopy with biopsies in a community hospital, he was diagnosed with descending adenocarcinoma. To get further treatment, he came to our hospital on April 8, 2016. He denied weight loss during the past year. His past medical history included hypertension and coronary heart disease. He denied any family history of colorectal cancers. He denied history of smoking and drinking.

He underwent another colonoscopy on April 14, 2016 in our hospital, which revealed ulcerative lesions in the descending colon, 2 polypoid lesions in the sigmoid colon, and protruded lesions in the anorectal region (Fig. 1). Biopsies were taken from the anorectal region, which revealed poorly differentiated melanoma of the anorectal region (Fig. 2). Computed tomography of the abdomen showed no metastasis.

He subsequently underwent an extended abdominoperineal resection (APR) with the help of laparoscope to relieve his symptoms and improve the quality of life. After operation, the anorectal mass was found to be approximately $1.5 \times 1.2 \times 0.6$ cm, with some invasion into the muscular layer and surrounding mucosa, but without invasion into the vessel and nerve. The sigmoid mass was found as 2 knots in tubular adenomas accompanied by high-grade intraepithelial neoplasia approximately 1.2 and 1.5 cm and did not invade the adjacent structures. The descending mass was approximately 0.6×0.5 cm and did not involve or invade the adjacent structures.

The mass showed moderate to well-differentiated adenocarcinoma of the descending, tubular adenomas accompanied by high grade intraepithelial neoplasia of the sigmoid and anorectal malignant melanoma (Fig. 2), no lymph node involvement. Immunohistochemistry performed on the anorectal tumor showed positive staining with anti-S-100 protein (S100), Vimentin, part of human melanoma black (HMB45) and antibodies to melan A.

Postoperatively, the patient's recovery was uneventful. He is well now. Computed tomography of

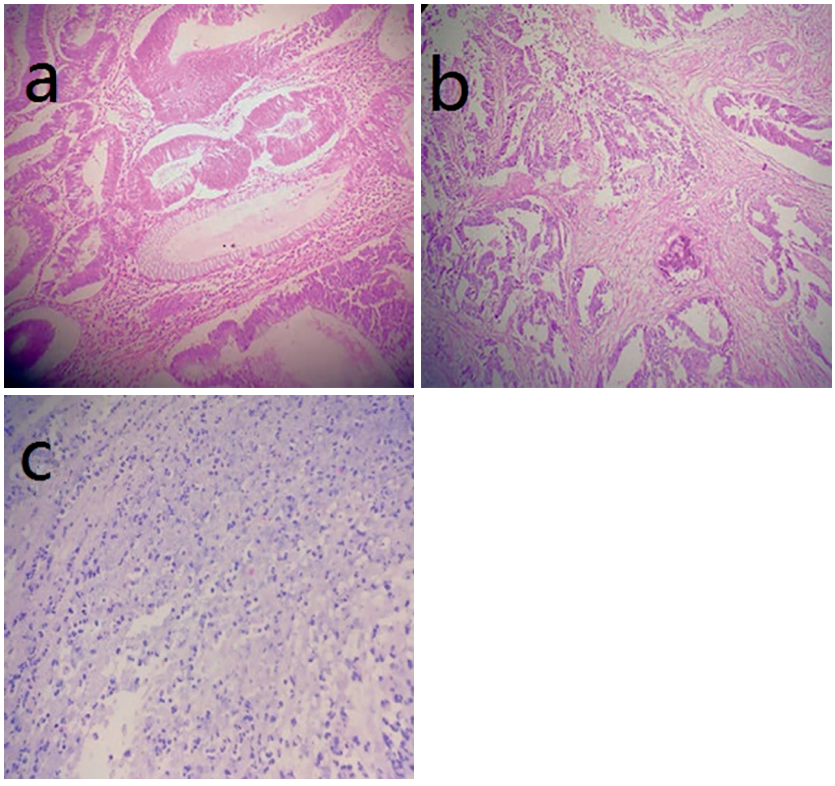

Fig. 2 Hematoxylin and eosin (H & E)–stained sigmoid lesion (×100). Tubular adenomas accompanied by (a) high-grade intraepithelial neoplasia H & E–stained descending lesion (×100); (b) moderate to well-differentiated adenocarcinoma; (c) H & E–stained anorectal lesion (×400): higher-powered view of melanoma.

the abdomen and the mass showed no metastasis, so he did not accepted further treatment.

Discussion

Anorectal malignant melanoma (AMM) is an extremely rare cancer, which was first reported by Moore DW in 1857.[2,3] AMM is mostly seen in the sixth or seventh decade of life, with a female predominance, and rectal bleeding is the most common symptom.[3,4,5] Changes in bowel movements, rectal pain, and inguinal mass may also be present.[3] Early diagnosis and a tailored, multidisciplinary treatment plan would likely improve the treatment result of AMM.[13] Differential diagnoses of anorectal melanoma include hemorrhoids, polyps, and other malignancies.[3] Anti-S-100 protein (S100), human melanoma black (HMB-45), and antibodies to melan-A are the most common "melanocyte specific" stains used in the diagnosis of malignant melanoma.[6]

Surgical excision remains the cornerstone of therapy.[12] However, standard operative procedures related to the area of resection and lymph dissection have yet to be established.[5] Wide local excision (WLE) and APR are 2 choices of operation. APR can reduce bleeding or colonic obstruction, resulting in improved quality of life.[1,3] However, neither WLE nor APR provides a survival benefit.[1,3]

The mean survival time for anorectal malignant melanoma is 20 months with treatment, and disease-free survival of 6.7% to 12% at 5 years.[1,11] The mean 5-year survival rate of both metastatic anorectal melanoma and colorectal cancer is poor, being 0% and 5.7%, respectively.[1,11]

In conclusion, synchronous primary anorectal melanoma, sigmoid multiple early cancers and descending adenocarcinoma is rare. What we can learn is that endoscopy doctors should always be aware of the possibilities of multiple primary cancers for this is important to the treatment and prognosis of patients, standard colonoscopy examination is necessary and returning a enteroscope from the cecum should be more than 8 minutes. Large-scale prospective clinical trials need to be done to find standard operative procedures for AMM.

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