Primary malignant melanoma with surrounding melanosis in the anorectum

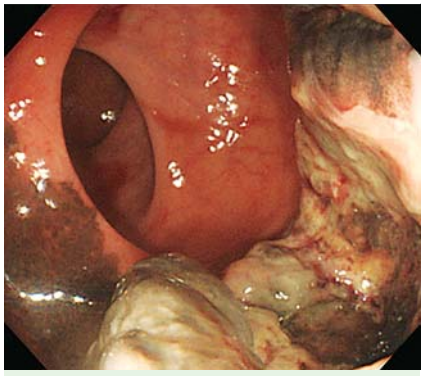

Fig. 1 Colonoscopy showing a large, dark-stained mass extending from the anus up to 3 cm above the anal verge on forward view.

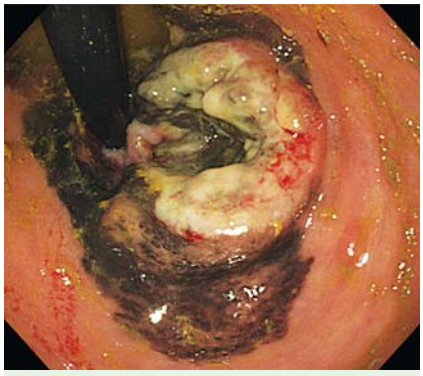

Fig. 2 The ulcerating mass surrounded by black pigmented mucosa on retroflexed view.

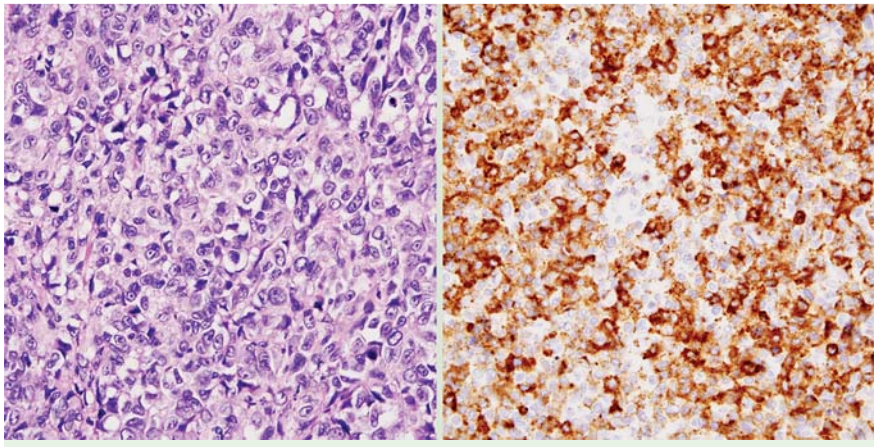

Fig. 3 Histologic section showing neoplastic cells (left) that proved to be malignant melanocytes and stained positive for HMB-45 (right).

A 76-year-old woman presented to the emergency room with hematochezia. Apart from a low hemoglobin level (8.9 g/dL), laboratory findings were unremarkable. On colonoscopy, a large mass with a dark-stained surface was observed extending from the anus up to 3 cm above the anal verge (▶ **Fig. 1**).

When the mass was examined after retroflexion, it was noted that the ulcerating mass itself was surrounded by black pigmented mucosa (▶ **Fig. 2**).

Biopsy samples were taken from both the darkly stained mass and the pigmented mucosa.

Histologic examination of the mass showed neoplastic cells with black pigmentation, which proved to be malignant melanocytes and were positive for HMB-45 and Melan-A on immunohistochemical staining. The surrounding pigmented mucosa was shown to be simple melanosis (▶ **Fig. 3**).

In order to exclude the possibility of the mass being a metastatic lesion rather than a primary lesion, a thorough physical examination and imaging studies were carried out. There was no evidence of any other primary lesions or distant metastases. Therefore the anorectal mass was diagnosed to be primary melanoma. The patient underwent abdominoperineal resection (▶ **Fig. 4**), and the histologic report was consistent with the previous findings: primary malignant melanoma surrounded by black pigmented mucosa.

The patient is currently on chemotherapy. Primary melanoma most frequently occurs in the skin and retina but it can also occur in the gastrointestinal tract, which is the third most common site. However, anorectal malignant melanoma is a rare neoplasm and has a poor prognosis [1]. It is important to rule out the possibility of the lesion being a metastasis rather than a primary focus. Although controversy still exists about the most appropriate therapeutic strategies, surgical excision remains the mainstay of treatment [2]. Adjuvant chemotherapy and radiation therapy have not been proved to have a significant role in increasing survival.

Fig. 4 The resection specimen showing a well-demarcated ulcerofungating mass, measuring 4 × 3.4 cm. A diffuse dark-grayish discolored area is surrounding the mass.

Endoscopy_UCTN_Code_CCL_1AD_2AC

J. Kim, B. Keum, Y. S. Seo, Y. S. Kim, Y. T. Jeen, H. J. Chun, S. H. Um, C. D. Kim, H. S. Ryu

Department of Internal Medicine, Institute of Digestive Disease and Nutrition, Korea University College of Medicine, Seoul, Korea

References

1 *Weinstock MA.* Epidemiology and prognosis of anorectal melanoma. Gastroenterology 1993; 104: 174 – 178

2 *Bullard KM, Tuttle TM, Rothenberger DA et al.* Surgical therapy for anorectal melanoma. J Am Coll Surg 2003; 196: 206 – 211

Bibliography

DOI 10.1055/s-0029-1215416
Endoscopy 2010; 42: E47

ISSN 0013-726X

Corresponding author

B. Keum, MD, PhD
Department of Internal Medicine,
Institute of Digestive Disease and Nutrition,
Korea University College of Medicine, Seoul
126-1 Anam-dong
5-ga Seongbuk-gu
Seoul 136-705
Korea
Fax: +82-2-9531943
borakeum@hanmail.net