

significantly resistant to radiotherapy and shows a poor response to chemotherapy. Anorectal malignant melanomas spread along submucosal planes, for that reason, complete resection is impossible at the time of diagnosis. Almost all patients die from metastases.⁽³⁾

CASE DESCRIPTION

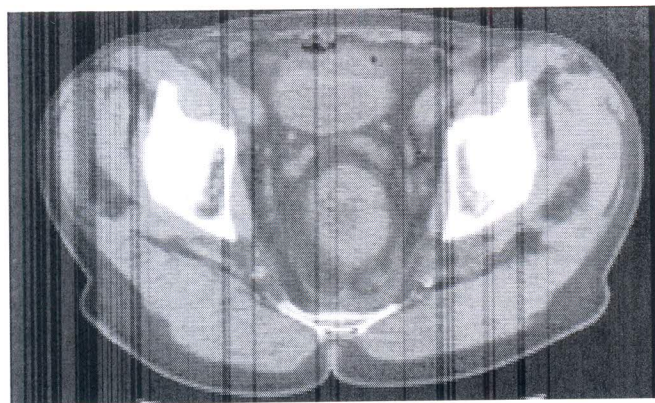
A 71-year-old patient presents for examination with a history of altered defecation and rectal bleeding. A set of laboratory analysis with TU Markers, abdominal CT with contrast, and rectosigmoidoscopy were performed.

On laboratory analysis, CEA < 0.50; CA 19-9 < 3.00

On rectal examination, a change in the distal rectum is palpated. On rectosigmoidoscopy, just behind the anal canal, a cauliflower-like infiltration can be seen on the wall, from where 5 biopsies were taken for histopathological examination. Pathohistology of the biopsy resulted in adenocarcinoma.

Computed tomography of the abdomen and pelvis revealed irregularly thickened, edematous rectal walls lightly compressing the prostate ventrally, without clear demarcation of the walls, so prostate infiltration could not be excluded. Mesorectally, several lymphatic nodes, the largest 13 mm. From the left-dorsal aspect, an enlarged lymphatic node 9 mm can be observed. Para-aortic small lymphatic nodes are noted, the largest infrarenal with a diameter of 10 mm. Bilaterally, morphologically altered nodes with a diameter of up to 28 mm are visible in the inguinal area. The ischiorectal pits are free.

Conclusion: Neoprocess of the rectum with possible infiltration of the prostate, morphologically changed lymphatic nodes mesorectally and immediately next to the m.obturator internus and bilaterally inguinal.



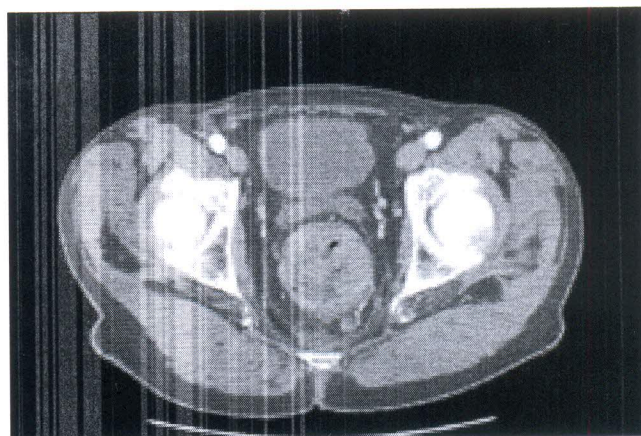
Picture no. 1 - CT scan of the abdomen before radiochemotherapy

The patient underwent preoperative radiochemotherapy for locally advanced rectal adenocarcinoma. Radiotherapy was carried out on a linear accelerator according to the previously prepared 3D conformal plan, whereby with standard fractionation, a total tumor dose of 45 Gy/1.8Gy fraction was realized in the area of the primary tumor and the locoregional lymph pool.

In competition with the radiation, an attempt was made to start chemotherapy with Tabl.Capecitabine, but due to the appearance of diarrhea immediately after the start, the therapy was stopped.

5 cycles of radiation therapy were carried out in the period from 08.08.2022 to 09.09.2022.

After radiation therapy, a control CT scan of the abdomen with contrast was performed, which shows the weak effect of radiation therapy on this type of cancer.



Picture no. 2 - CT scan of the abdomen after radiochemotherapy

2 months after radiotherapy, the patient underwent surgical treatment with resection of the sigmoid colon and TME with amputation of the rectum followed by the creation of a definitive colostomy (Resectio recti abdomino-perinealis sec. Miles. Peritonisatio.Colostoma definitiva).

The specimen was sent for a histopathological examination, where a malignant melanoma of the rectum was verified. Microscopic findings showed the wall of the large intestine showing tumor proliferation, made up of atypical epithelial cells, mainly in a solid, and in some places, nest-like arrangement.

A moderate to rich lymphocytic infiltrate is present in the surrounding tumor tissue. Out of the 14 lymph nodes isolated, in 2 lymph nodes, metastatic deposits were