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In addition, an immunohistochemical analysis was performed, which showed the following immunoprofile: Melan A (+), S-100 (+) HMB45 (+), Vimentin (+), Desmin (-), SMA (-), CK 20 (-), CD X2(-)

DISCUSSION

All melanomas, whether cutaneous or mucosal in origin, originate from melanocytes, which are cells derived from the embryonic neural crest.(4,5)

These cells migrate to many places throughout the body, primarily the skin. But, melanocytes are also found in the eyes and mucosal surfaces. Of the remaining (<10%) forms of melanoma, 5% are ocular melanomas, 2% are of unknown origin, and mucosal melanoma 1%. Malignant transformation can happen to melanocytes when exposed to ultraviolet UVB light, which is a carcinogenic stimulus, but this case is not evident in anorectal melanoma. In the development of anorectal melanoma, immunology has an important role, because the incidence is higher in patients with human papilloma virus (HPV) and HIV infections. (6) Different methods should be used for diagnosis, as in our case, it is seen how sigmoid-colonoscopy is essential for evaluating the cause of the symptoms and to obtain a tissue biopsy from a suspicious lesion. CT scan with contrast enables the characterization and assessment of the extent of the tumor. On CT scans, primary rectal malignant melanomas appear as voluminous intraluminal masses in the distal rectum, the same as the CT finding of our patient, with focal enlargement and opacification of the lumen without causing obstruction, with perirectal infiltration and often enlarged lymph nodes.(7,8)

Malignant melanoma of the rectum is a rare and very aggressive rectal tumor.(9) Lymphatic spread to the inguinal or lower mesenteric nodes is common. The most common sites for metastases are inguinal lymph nodes, mesenteric lymph nodes, hypogastric lymph nodes, para-aortic lymph nodes, liver, lungs, skin, and brain. Incidence rates for locoregional lymph node metastases at initial presentation are nearly 60%. At the time of diagnosis, distant metastases are identified in 26-38% of patients.(10)

The success of the treatment of anal melanoma is only moderate. Surgery stands still as the best kind of treatment. The 5-year survival rate can range from 16 to 34%, but if the patients have metastases at the time of diagnosis, it may drop to 16% from 22%. It is still in

discussion whether abdominoperineal resection (APR) or wide local excision (WLE) is the more adequate kind of treatment. (11) APR, although a very morbid operation, is considered as the best treatment.(12) Recently, there have several studies have shown that WLE can be able to control the disease while minimizing the morbidity of surgery because anorectal melanoma, when diagnosed, is considered as a systematic disease, so no matter how aggressive the surgery plan is, the outcome could not be changed.(13) Dissection of lymph nodes with sentinel lymph node (SLN) techniques is used for identification of occult diseases.(14)

Malignant melanoma of rectum is quite resistant to radiotherapy and shows a poor response to chemotherapy, the same can be seen in our patient's CT findings before and after radiochemotherapy, there is no significant difference.(15) The role of adjuvant chemotherapy has not been established. (16) The prognosis is poor regardless of any therapy, and the most important predictors of prognosis are disease stage, duration of symptoms, tumor size, and nodal status.(17)

CONCLUSION

Malignant melanoma of the rectum is extremely rare, very aggressive and difficult to diagnose.

The only hope for improving survival lies in early diagnosis and treatment. Because complaints are usually non-specific; this is only possible with a high index of suspicion followed by early sigmoidoscopy and biopsy.

Although biopsy and histopathological examination are essential for diagnosis, the different radiological features of CT and MRI may suggest the possibility of malignant melanoma.

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