Large Hyperpigmented Perianal Tumor

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Case Study

Ms. H, a 64-year-old widowed female, presented to the emergency department complaining of severe fatigue and weakness with intermittent rectal bleeding lasting several weeks. The patient’s son reported that over the past four months she had experienced a 20-pound weight loss and had been bed-bound because of severe diabetes-induced peripheral neuropathy. On physical examination, a large hyperpigmented lesion measuring 6 x 7 cm was found on the right lateral aspect of the anus (see Figure 1). The patient stated that the mass was painless and had been present for six months; however, it had increased in size. The lesion was foul-smelling and necrotic, fungating, and highly vascular; it bled easily when manipulated during examination. Initial laboratory work included a significantly decreased hematocrit level of 16%. Ms. H underwent a sigmoidoscopic examination under general anesthesia and a 7 cm mass with circumferential involvement of the anus and rectum was visualized. The depth of the tumor locally was greater than 3–4 mm. Staging included a computerized tomography scan that revealed multiple enlarged iliac lymph nodes and several nodules in the lung bases bilaterally consistent with metastatic disease. The patient was not considered to be a candidate for abdominoperineal resection because of the presence of distant metastases. The differential diagnosis included squamous cell tumor, adenocarcinoma of the anus, squamous cloacogenic carcinoma, lymphoma, sarcoma, or anorectal melanoma.

Discussion

Cancers of the anal region account for 1%–2% of all large bowel cancers in the United States (Rogers & Gibson, 1997; Shank, Cunningham, & Kelsen, 1997). Most of these tumors are epidermoid carcinoma with almost one-half of the cases diagnosed as squamous cell carcinoma; however, transitional cloacogenic carcinoma is the second most frequently occurring tumor type and may carry a slightly better prognosis (Shank et al.). Anorectal adenocarcinomas occur rarely, and leiomyosarcomas of the anal canal also are very uncommon (Wang & Chung, 1998). Gastrointestinal non-Hodgkin’s lymphomas occurring in the anorectal region are found more frequently in patients with AIDS (Place, Huber, & Simmang, 2000). Small cell cancers of the anal canal are rare and have a poor prognosis (Shank et al.). The incidence of anorectal melanoma occurs in approximately 1% of all patients with anorectal malignant lesions and accounts for less than 1% of all malignant melanomas (Rogers & Gibson).

Pathology revealed loosely packed sheets of pleomorphic cells (cellular tissue containing cells of many different shapes and forms) with an increase of pigment-containing melanotic cells, and the patient was diagnosed with anorectal melanoma. Malignant melanomas can occur in any site on the skin or mucous membranes. The melanocytes normally residing in the squamous mucosa of the anal area are believed to be the cells of origin for the tumor’s development (Felz, Winburn, Kallab, & Lee, 2001). Although cutaneous areas exposed to sunlight are at increased risk for developing melanoma, rare variants can appear in unusual sites and may present a diagnostic challenge for healthcare providers (Rogers & Gibson, 1997).

Melanomas of the vulva, vagina, male genitalia, or anorectal areas carry a poor prognosis, and early detection is essential to improve survival (Rogers & Gibson, 1997; Wu & Golitz, 2000). Pigmented nevi can occur infrequently in oral mucosa and may look like oral mucosal melanomas but are not associated with such a poor prognosis (Rogers & Gibson). Primary anorectal melanoma is a relatively uncommon tumor that usually presents with early dissemination of disease (Thibault, Sagar, Nivatvongs, Ilstrup, & Wolff, 1997). It is diagnosed more often in women, and patients usually are in
Patients with anorectal melanoma may complain of rectal discomfort or pain, constipation, or a protruding mass (Miller et al., 1997). The most common presenting symptom of anorectal melanoma is rectal bleeding, and at first, many patients attribute the bleeding to hemorrhoids or rectal polyps, which delays initial diagnosis (Ceccopieri et al., 2000; Felz et al., 2001). Although anorectal melanomas usually present as hyperpigmented rectal masses, the lesions can be amelanotic or lightly pigmented as well (Ooi, Eu, & Seow–Choen, 2001). Definitive surgical treatment of anorectal melanoma is controversial. abdominoperineal resection and local wide excision procedures have been performed with similar patient outcomes (Ooi et al.; Thibault et al., 1997). Distant metastases often occur despite more aggressive surgical options. Although case reports have suggested treatment with chemotherapy, biotherapy (see Figure 2), a combination of chemotherapy and biotherapy, and radiation therapy, early diagnosis and successful surgical resection remain the mainstay for treatment (Gupta, Sharma, & Bose, 2000). Some patients with anorectal melanoma and liver metastases reportedly have been treated with regional chemotherapy and immunotherapy (Koksal, Muftuoglu, Gunerhan, & Uskent, 2000).

Because Ms. H required frequent blood transfusions, she received local radiation therapy to decrease blood transfusion dependency and reduce the size of the lesion (see Figure 3). Although she remained essentially continent of bowel and bladder, the enterostomal therapy nurse was consulted to help with wound management and pressure ulcer care. Adding one-quarter strength Dakin’s solution to cleanse the wound reduced the foul odor from the lesion. Anti-diarrheals were ordered to help manage diarrhea associated with radiation therapy. The patient developed a left femoral deep vein thrombosis during her hospitalization that necessitated placement of a vena cava filter (anticoagulant therapy was contraindicated because of the risk of bleeding from the lesion). Because the patient lived alone without home support, she was transferred to a skilled nursing facility where she finished her radiation therapy treatments. Although the radiation therapy palliated Ms. H’s symptoms, she ultimately died of multiple brain metastases approximately three months after the initial presentation of the disease.

Nurses regularly teach patients about the importance of breast self-examinations; however, self-examination of the skin is gaining prominence in patient education. Research study findings have supported the need to teach nurses more about skin cancer (Maguire-Eisen & Frost, 1994; McCormick, Masse, Cummings, & Burke, 1999). As nurses add to their knowledge base about skin cancer and the growing health problem of melanoma, they can educate colleagues, patients, and the public about the importance of skin cancer screening and self-examination.

### Summary
Anorectal melanomas are rare tumors that occur more frequently with advancing age and peak in the sixth and seventh decades (Felz et al., 2001). Surgery is considered to be optimal therapy; however, chemotherapy and immunotherapy have been shown to be effective in a small number of patients.

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Combinations of these therapies, possibly with the addition of radiation therapy, need to be studied further to improve survival for patients with this unusual tumor. Routine rectal examinations for those patients at highest risk, along with prompt biopsies of suspicious or pigmented lesions, should be performed to reduce the mortality of patients with anorectal melanoma (Felz et al.). Rectal bleeding, although a common symptom in the presence of hemorrhoids, should be evaluated thoroughly in all patients.

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References


