



# 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 normal liver function tests and revealed 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;



**FIGURE 1. 64-YEAR-OLD PATIENT PRESENTING WITH LARGE FUNGATING RECTAL MASS**

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

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