

ANORECTAL MELANOMA

Epidemiology

- uncommon
- most cases of GI tract involvement from melanoma due to metastatic cutaneous primary
- third most common site after cutaneous and ocular
- SEER data: anorectal melanoma 0.048% of all colorectal malignancies, 1% of all anal cancers
- specific risk factors unknown but HIV may increase risk

Presentation

- most arise from mucocutaneous junction. Can also arise from:
 - skin of anal verge
 - transitional epithelium of anal canal
 - rectal mucosa
- typically present with bleeding, a perianal mass, pain, change in bowel habits
 - pigmentation of mass in only 1/3 cases
 - rest are amelanotic
 - occasionally found incidentally on evaluation of hemorrhoidectomy or anal polyp specimen
 - most lesions >2mm thick
 - distant metastases present at diagnosis 29% and eventually develop in 60%
 - inguinal lymph nodes, liver, lung, bone



Treatment

- Wide local excision (WLE) vs. APR
 - APR traditional treatment but changing in the literature
- no survival benefit shown with chemotherapy (dacarbazine, BCG, levamisole, INF alpha, vinblastin, cisplatin, IL-2) or radiation

Prognosis

- Five-year survival approximately 6-22%
- most recurrences within first 30 months
- local recurrence almost always associated with or followed by regional or disseminated disease

Wide local excision vs. APR

- Brady et al. Dis Colon Rectum (Feb 1995)
 - Sloan Kettering retrospective study 1929-1993 (N=85)
 - 71 patients with resectable disease: 5 year DF survival more favorable for APR than WLE (27% v 5% but not statistically significant p= 0.11)
 - APR more likely to survive long term (p<0.05), 10 long term survivors (9/10 APR, 1/10 WLE). Of the 9 APR patients. only one had positive mesenteric nodes

and median tumor size was 2.5 cm vs. 4.0 cm in patient who did not survive long term

- recommended APR for localized anorectal melanoma without evidence nodal spread
- Thibault et al. Dis Colon Rectum (June 1997)
 - Mayo Clinic retrospective study 1939-1993 (N=50)
 - 5 yr survival and recurrence rates identical after APR or WLE
 - WLE with at least negative margin of at least 1cm treatment of choice,
 - APR reserved for tumor not amenable to local resection or for palliative treatment
- Bullard et al. Journal American College of Surgeons (Feb 2003)
 - retrospective study 1988-2002
 - patients with distant metastases excluded
 - endpoints: overall survival, disease-free survival, local/ regional/ systemic recurrence
 - 15 patients: 4 underwent APR, 11 underwent WLE (1-2 cm gross margin)
 - F/u 6 months to 13 years
 - tumor depths equally distributed between APR group and WLE group
 - 8/15 patients alive (53%); 7 disease free. All long-term survivors underwent WLE
 - tumor depth did not correlate with survival or pattern of recurrence
 - no differences in rate of local/systemic recurrence, DF survival or overall survival between WLE and APR group
- Pessaux et al. British Journal of Surgery (2004)
 - retrospective study 1977-2002
 - 40 patients: stage I (localized disease) stage II (inguinal or pelvic LN mets) stage III (distant mets)
 - Stage III: (4 local surgery, 6 no treatment), Stage II: (2 WLE, 4 APR), Stage I: (19 WLE, 5 APR)
 - 18/40 patients alive, 9 no evidence of disease
 - local recurrence seen more with WLE (10/21) than APR (2/9)
 - No significant difference in survival following APR vs. WLE (30 and 19% respectively p= 0.402)
- Malik et al. Int. J. Colorectal Diseases (2004)
 - Cleveland Clinic retrospective study 1983-2001
 - 19 patients : 10 WLE, 7 APR, 2 other (WLE followed by APR, palliative ex lap)
 - no statistical analysis due to small number, 2/19 currently living (both Stage I, and both WLE)
 - local recurrence in 2/10 WLE
 - survival longer than 20m: 70% WLE, 43% APR

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