“ABDOMINOPERINEAL RESECTION FOR ANORECTAL MELANOMA: CASE REPORT.”

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INTRODUCTION

Mucosal melanoma accounts for approximately 1.3% of melanomas in the United States, with an incidence of 1,400 patients. The majority occur in the head and neck region (55%); however, it can also appear in the anorectal region (24%) and the vulvovaginal region (18%). The median age of onset is 70 years, predominantly in women.[3]

Perineal melanoma is a rare and lethal entity, with a median survival of approximately 15 to 21 months, making management decisions particularly challenging. Local resection and abdominoperineal resection have been proposed as treatment options for non-metastatic disease. However, the optimal approach remains controversial in terms of survival benefits for the patient.[4]

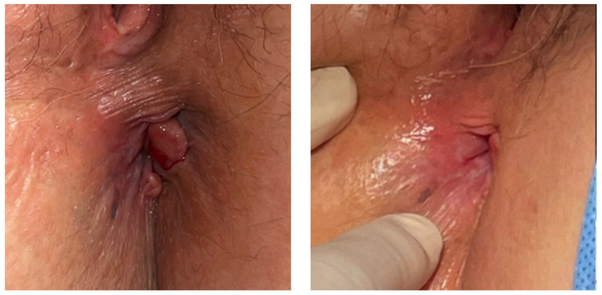
OBJECTIVE

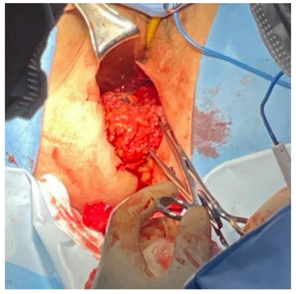
In this report, we present the case of an anal mucosal melanoma, without positive lymph nodes or distant metastasis, which underwent an abdominoperineal resection and the results of its treatment.

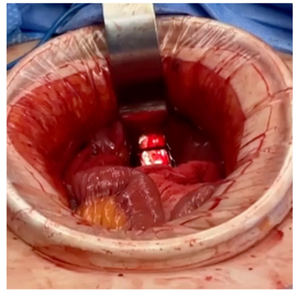
CASE PRESENTATION

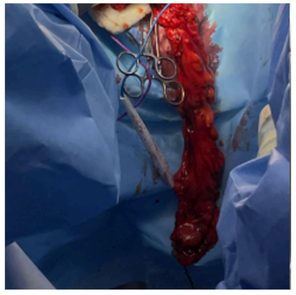
A 68-year-old female patient with a history of hypertension, eosinophilic colitis, and long-standing rheumatoid arthritis under medical treatment. Her current condition began four months prior to hospital admission, with an insidious onset of progressive perianal swelling, exacerbated by Valsalva maneuvers and alleviated with rest. This was associated with self-limited rectal bleeding occurring exclusively during defecation.

On physical examination, with the patient in the jackknife position, a hyperemic, tender perianal mass was observed at the 3 o’clock position relative to the anal clock, without evidence of purulent discharge.











She initially sought medical attention from an external provider, who recommended conservative management for presumed hemorrhoidal disease. However, due to persistent symptoms, an incisional biopsy was performed one month prior, revealing a diagnosis of subepithelial anal mucosal melanoma.

An abdominoperineal resection was planned and performed in a simultaneous two-team approach. With the patient in the lithotomy position, a perineal approach was undertaken, maintaining a perianal margin of approximately 2–3 cm. The dissection proceeded in a deep plane beyond the levator ani muscle, accessing the pelvic cavity and completing a circumferential resection. Concurrently, an abdominal approach was performed via a midline laparotomy to access the peritoneal cavity. Using advanced monopolar and bipolar energy devices, medial-to-lateral dissection of the sigmoid colon was carried out. Inferior mesenteric vessels were ligated at their base, followed by mobilization of the left hemicolon.

The procedure continued with a complete dissection of the mesorectum. The sigmoid colon was transected 8 cm from the rectosigmoid junction using a linear stapler, establishing continuity with the perineal dissection. Finally, a terminal colostomy was constructed.

The final histopathological analysis of the specimen confirmed anal melanoma with ulceration and the presence of microsatellites. Surgical margins were free of tumor involvement, with no evidence of lymphovascular invasion or perineural infiltration. Examination of eight regional lymph nodes revealed no metastatic involvement.

Currently, the patient remains stable and is under regular follow-up in the outpatient clinic, undergoing PET scans every three months for surveillance, with no signs of disease recurrence to date.

CONCLUSIONS

In the treatment of anorectal melanoma, surgical intervention offers the highest five-year survival rate, with its indications depending on the disease stage, the absence of lymphatic invasion, and the lack of metastatic disease. There are two surgical options: abdominoperineal resection or local excision. Over the years, the choice between these approaches remains a topic of debate, as no significant difference in survival outcomes has been demonstrated between them.

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