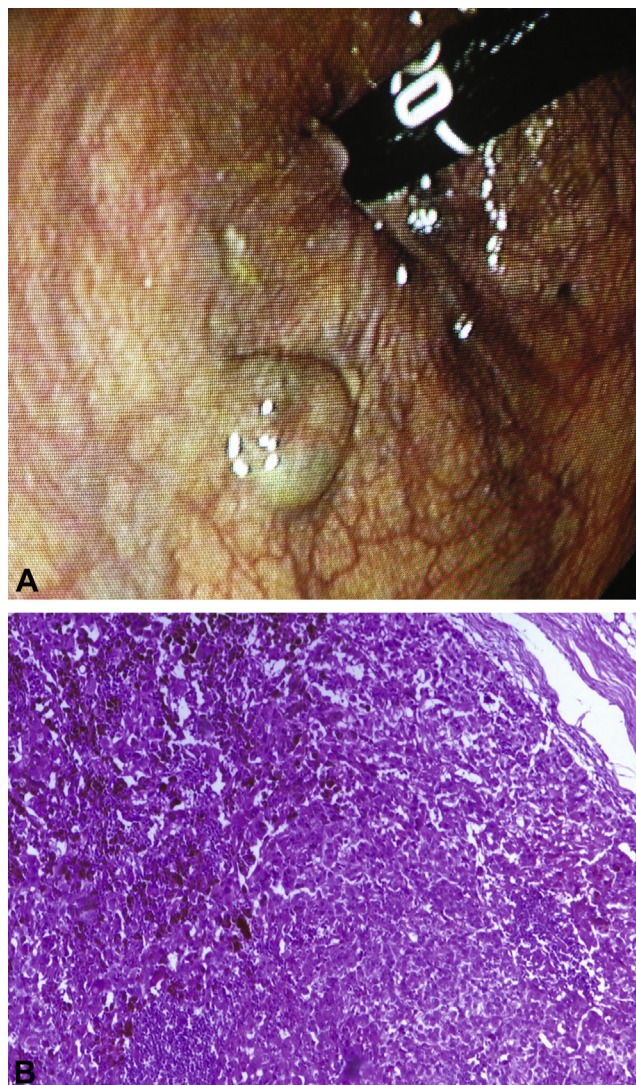


closure, has been a welcome addition to our endoscopic repair toolbox. This is true especially in confined spaces like the duodenum (or my studio apartment), where placement of traditional through-the-scope clips simply may not be possible.

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Endoscopic view of malignant melanoma of the rectum



A 56-year-old patient with no history of melanoma was admitted for evaluation of palpable left inguinal adenopathy consisting of several lymph nodes 1 to 1.5 cm in size. Clinical examination did not reveal any cutaneous lesions. The patient had no specific GI symptoms. Digital

rectal examination identified a small (1 cm) tumor 3 to 4 cm from the anus. A direct view of the tumor (**A**) was possible by using a flexible video colonoscope, which was retroflexed. The tumor was thought to be a melanoma, which was also confirmed by biopsy of the tumor and of

an inguinal lymph node. An abdominoperineal excision of the rectum with lymph node dissection was performed. Histopathologic examination of the specimen confirmed melanoma and revealed that 3 inguinal lymph nodes also contained melanoma (**B**). The patient was referred to the oncology department for postoperative radiotherapy. Evaluation 9 months after the surgical procedure has shown no sign of recurrence.

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Commentary

Primary anorectal melanoma (ARM) is a rare and aggressive disease with a less than 20% survival rate 5 years after diagnosis. ARM accounts for 1% of anorectal malignancies, and the anorectum is the third most common location of malignant melanoma after the skin and retina. ARM typically affects women in the fifth or sixth decade and usually presents with rectal bleeding; other symptoms include local pain or discomfort, pruritus, tenesmus, prolapse, change in bowel habit, and diarrhea. ARM is usually polypoid and pigmented, although in some series, as many as one half may be amelanotic. Symptoms are often discounted as being from hemorrhoids with resultant delay in diagnosis and poor prognosis. Immunohistochemical studies, of which S-100 protein is most sensitive, are useful to establish the melanocytic origin of the tumor; others markers include HMB-45, MART-1/Melan-A, MITF, and tyrosinase. Because of delayed diagnosis, the rich vascular and lymphatic channels in the anus, and rapid tumor progression, ARM may be accompanied by distant metastases in 60% of patients at the time of final diagnosis. In contrast to squamous cell carcinoma of the anus, which has a predilection for inguinal lymph nodes, ARM favors the mesorectal lymph nodes; distant metastases include liver, lung, brain, and bones. Multimodality treatments including surgery, chemotherapy, and radiotherapy are used for ARM. Surgery is the main treatment, and although the choice of wide local excision or abdominoperineal resection is controversial, these procedures can help to control symptoms and improve quality of life. ARM is resistant to radiotherapy and shows a poor response to chemotherapy. The most important predictors of prognosis are disease stage, symptom duration, tumor size, and nodal status. Early detection of ARM is critical for reducing the mortality rate. This patient is unusual in several regards: male sex, age, the presence of inguinal adenopathy, and what seems, at least so far, to be a favorable course. We all are painfully aware that digital rectal examination is a dying if not dead art and so, my compliments to the author for palpating the lesion. As for viewing it on retroflexion, I believe, with some support from the literature, that a carefully and artistically performed prograde examination precludes, in most instances, the need for retroflexion with its attendant discomfort and potential risks. In contrast to cutaneous melanoma, ARM is not associated with exposure to ultraviolet light, and many of us spend large parts of the day in a place "where the sun don't shine." I hope, however, that this man's journey is one filled with sunshine and that he continues to do well.

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