Primary Anal Canal Mucinous Adenocarcinoma: About Two Cases And A Review of The Literature

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Summary:
Introduction: Anal tumors are rare neoplasms of the digestive tube that represent 1.5% of gastrointestinal tumors. They present a more aggressive natural history, with shorter survival times and higher rates of local as well as distant relapse. It is difficult to distinguish from adenocarcinoma of the lower rectum invading the anal canal.

Case Report: The two patients were female with a long medical history of proctologic disease such as anal fistula, anal prolapse, hemorrhoids and bleeding.

Patient one: a 71 year old woman. She presented with, bulging mass in the anal canal. The biopsies concluded to a medially differentiated adenocarcinoma. The patient did not show up for a year due to personal reasons. The patient got a flash radiation followed by Abdomino perineal resection (APR). The anatomopathology concluded to a mucinous adenocarcinoma. The patient died within a month after surgery due to a deteriorated heart condition.

Patient2: A 62 year old female patient. She presented in april 2007 with a 4 cm mobile, bulging mass in the anal canal with 3 anal fistula. The patient had neoadjuvant chemoradiation followed by an APR. The histology concluded to a mucinous adenocarcinoma of the anal glands. The follow up of the patient until 08/09/2015 showed no sign of recurrence.

Conclusion: The diagnosis is often late, in an advanced stage of the sickness. Recurrent or non recurrent fistula-in-ano requires multiple biopsies for pathology analysis in order to screen a related cancer. Early suspicion is crucial to avoid delayed diagnosis and treatment.

Keywords: Adenocarcinoma, Anal canal, Mucinous adenocarcinoma, Abdominoperineal resection, Radiation therapy, Colorectal cancer

I. Introduction

Anal tumors are rare neoplasms of the digestive tube that represent 5% of all anorectal neoplasms and 1.5% of gastrointestinal tumors (1). The most frequent lesion in both anal canal and perianal skin is squamous cell carcinoma (2). Around 10% of all malignant anal lesions are anal adenocarcinoma (ADC) that present a more aggressive natural history than squamous carcinoma, with shorter survival time and higher rates of local as well as distant relapse (2–4). In our study, we present two cases of mucinous adenocarcinoma of the anal gland treated in the Salah Azaiez institute of oncology, both with long proctologic medical history but with two different outcomes.

II. Case report

Case one:
A 73-year-old woman, presented to the outpatient clinic in April 2005, with anal swelling in the last 6 months. The patient had a long medical history of anal prolapse, hemorrhoids and bleeding. In the physical examination, there was a 3 cm mobile, bulging mass developed 1 cm from the anal verge in the right wall of the anal canal. The colonoscopy found a suspicious tumor of the anal canal measuring 3 cm. The biopsies of the tumor concluded to a moderately differentiated adenocarcinoma. The carcinoembryonic antigen (CEA) was 8.2 ng/ml. The chest X ray and the abdominopelvic sonography found no abnormalities. The patient was lost of view during one year. The patient reconsulted and the physical examination did found the same bulging mass. A new colonoscopy, chest radiograph and computed tomography didn’t reveal any other localization. Patient was managed with Flash radiotherapy (gy in 5 times from the 7/8/2006 to 11/8/2006) followed by radical surgery consisting on an abdomino-perineal amputation (APA). Histopathologically, the anal tumor was composed of disorganized and infiltrative tubular glands infiltrating the anal wall and the perianal musculature (Fig 1). On immunohistochemical study, tumour cells expressed cytokeratin 7 and 20. One month after surgery, the patient died from a heart failure.
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greatest difference observed in stage IV (13% for patients with ADC and 29% for those with squamous cell cancer) (1). There are independent prognostic factors such as the tumor size, lymph node invasion and the therapeutic management of the patient that interfere with the overall survival (15). The overall five years survival is estimated to 39% go to from 79% for T1 tumors to 9% for T4 (6).

IV. Conclusion

Anal canal adenocarcinoma is a rare entity that is occasionally difficult to distinguish from adenocarcinoma of the lower rectum with extension to the anal canal. Early suspicion is crucial to avoid delayed diagnosis and treatment. Although there is no proven therapeutic approach for the treatment of anal canal ADC, the current recommended approach is preoperative CRT followed by radical surgery (APA), with subsequent adjuvant therapy for the prevention of micrometastasis. CRT used alone should be reserved for those patients who would not tolerate radical surgery and, according to some authors, when there are proven inguinal lymph node metastases.

V. Declaration

Ethics approval and consent to participate I declare no conflicts of interest between the author And that this work was made with all the due respect to the code of ethics under the supervision of the medical and ethic committee of the Tahar Mammouri Hospital. Written informed consent was obtained from the patient for publication of this case report and any accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal.”

Data and supporting materials section:
Google scholar have been used searching for the articles cited in the reference list
Zotero was used for referencing.

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I declare no competing interests

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Fig.1: tumoral glands infiltrating and ulcerating squamous anal mucosa


**Authors’ contribution:**

Mg,Oj,Nb: data collection, review of the littérature and drafted the manuscript

Zb,Mc,Td: review of the litterature and drafted the manuscript

Km,Kr: drafted the manuscript

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