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CASE REPORT

Ulcerative anal cancer masquerading as a chronic sacral sore.

Srinjoy Saha[1]

Introduction

A chronic wound is a breach in skin continuity that fails to progress through a normal orderly and timely sequence of repair processes, or in which the repair process fails to restore anatomic and functional integrity after three months [1]. Over the sacrum, constant pressure for excessive periods causes tissue ischemia, cessation of nutrition and oxygen supply to eventually cause pressure necrosis, leading to sacral sores [2]. However, empirically considering all sacral ulcers to be pressure sores would be erroneous, and may lead to an excessive delay in proper diagnosis and treatment.

Patient description

History. A 61-year-old unmarried woman came to the Department of Plastic Surgery, Apollo Gleneagles Hospital, Kolkata, India with a persistent sacral ulcer for the last one year, associated with severe pain and blood-tinged discharge during the previous two weeks. The patient became bed-ridden two months earlier with progressive weakness, even as the ulcer enlarged gradually. Throughout last year the ulcer's size had waxed and waned when treated empirically as a sacral pressure sore by her family physician, with good early results.

Initially, the patient received homeopathic treatments when nodules appeared perianally. A general physician was consulted later when small ulcers developed over her sacral region. Early on, the ulcer would heal up with triple-antibiotic ointment applications over the wound along with oral ciprofloxacin tablets and vitamin supplements. However, it would recur after a few weeks, and heal again after receiving conservative treatments. This cycle continued for a few months. For the last two months, the sacral ulcer did not heal even after repeated conservative treatments, but gradually progressed in size to reach its present state.

Findings. Physical examination revealed a 27×18 cm ulcero-proliferative growth over the sacral and perianal regions, with rolled everted granulating edges encompassing an unhealthy 10×5 cm central ulceration. Exophytic proliferations protruded outside in a cauliflower-like fashion and extended inferiorly while encircling the anal opening. The lesion was fixed to underlying structures, and a hyperpigmented smooth firm nodule was noticed superolaterally (Figure 1).

Severe anaemia and bilateral inguinal lymphadenopathy were associated. She had no

other symptoms and passed stools effortlessly. Significantly, she was deeply religious, with no history of any intercourse, and never experienced constipation, bloody stools, or dysuria. Anal orifice involvement precluded further per-rectal examination. Laboratory findings, including venereology, was unremarkable. Primary differential diagnoses were: ulceromatous anal cancer and carcinomatous long-duration sacral ulcer [3, 4].

Management. Well - differentiated squamous cell carcinoma of the anal margin was confirmed on tissue biopsy. Computed tomograms revealed the involvement of anal orifice and presacral space with progression towards genital muscles and vagina. The anorectal canal was uninvolved and distant metastases were absent. A combination of chemotherapy and radiotherapy was administered, which led to symptomatic improvements within the next six months. The patient was lost to follow-up afterwards.

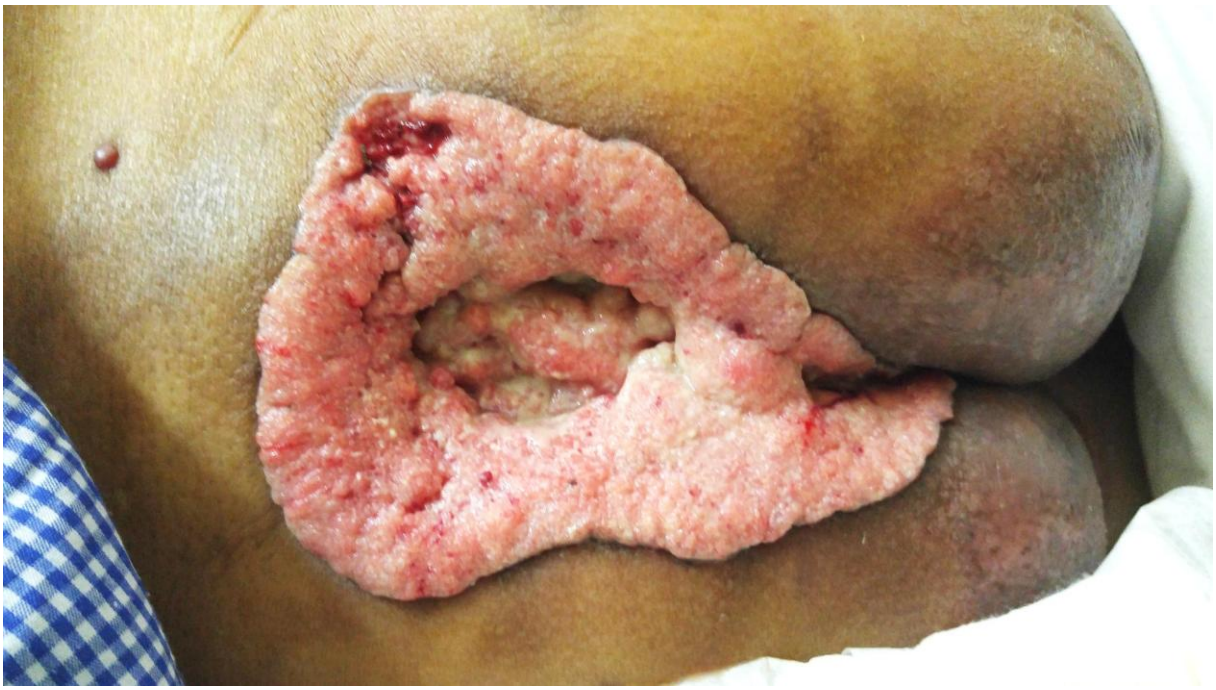

Figure 1. A chronic sacral ulcer was the initial presentation in the 61-year-old asymptomatic woman without any co-morbidities. The ulcer had rolled and everted margins, with an exophytic outgrowth protruding outside like a cauliflower. The outgrowth extended as a bridge of granulating tissues up to the anal orifice, involving it.

Discussion with conclusion

Squamous cell carcinoma of the anus is the most prevalent variant of anal cancer and arises from the squamous cells lining the anal margin and the anal canal. They are divided into two by their location:
– tumours of the anal canal, lying above the anal verge, and
– tumours of the anal margin, lying below the anal verge.
Both are lined by squamous cells, with one significant difference: only the anal marginal cells contain sweat glands and hair follicles [3]. Sometimes, anal cancers extend from one area to another, making it difficult to comment about their origin. Their incidence of invasiveness increases with age [3, 7]. Carcinoma of the anal margin is singularly rare, its frequently associated with human papillomavirus, HIV, anal intercourse, and chronic immunosuppression [3]. The primary physician commonly misses these ulcero-proliferative lesions in early stages, considering them to be inflammatory ulcers [5]. Therefore, proper treatment starts late, after considerable tumour growth has already occurred. Nodal involvement, cell differentiation, and tumour size correlate with survival rates [6]. Radiation therapy with concurrent 5-fluorouracil and mitomycin is the current standard of treatment, with high 5-year survival rates [5, 7].

Anal cancer occurs scarcely, forming 0.43% of all cancers [7]. Its presentation as an uncomplicated chronic sacral sore without any complications or other co-morbidities is exceptional. Still, its possibility must be kept in mind while managing non-healing long-duration sacral pressure sores. Early tissue biopsy from non-healing ulcer margins would improve the diagnosis and management of all patients.

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Dr Sharat Kumar Das, MD.

Authors' affiliations:
[1] Department of Plastic Surgery, Apollo Gleneagles Hospital, Kolkata, India.

Corresponding author:
Dr Srinjoy Saha, MBBS, MS, MRCS, MCh (Plast)
Apollo Gleneagles Hospital, Day Care Building 2nd Floor,
58 Canal Circular Road, Kolkata 700054,
India
Phone: +91 987 463 3896
e-mail : ss@medi.ac

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