

Retrorectal Tumors - A Presacral Dermoid: A Case report

Bharatam KK*, Baviskar PK**, Verma AK***, Jorwekar G***, Jain R*, Chaudhari S*

Introduction

Retro-rectal tumors are rare. They present above the recto- sacral fascia between the upper third of rectum and the sacrum. The retro-rectal space, the retroperitoneal extension into the pelvis, is a loose areolar plane between the fascia propria of the rectum and the presacral space. It contains multiple embryologic remnants derived from a variety of tissues viz. the neuroectoderm, the notochord, and the hindgut. A majority of lesions in the retrorectal spaces are congenital, the others that coexist are tumors derived from neurogenic, osseous, inflammatory, and miscellaneous origins.

Case Report

A 4 year old female child was brought by her father with complaints of constipation, distension of abdomen and an umbilical hernia, since birth. The father was in fact administering enemas regularly to his child for the same problem since the onset of constipation. The abdomen revealed generalized distension and an umbilical hernia. On digital rectal examination, a diffuse bulge in the posterior wall of rectum could be palpated. Barium enema study revealed a large mass in the presacral region causing external compression along with grossly dilated sigmoid colon and rectum.



Fig 1: Barium enema showing filling defect.

* PG Student,

** HOD and Professor, *** Asstt. Professor,

Corresponding Author :

Dr. Bharatam KK, PG Students,
Dept. of Surgery, Rural Medical College, Loni, Tal. Rahata,
Dist. Ahmednagar (MS)

CT Scan of the pelvis revealed a large multilobulated presacral lesion (?dermoid) extending to the left side of the pelvis causing displacement and compression over the lower point of rectum and anal canal.



Fig 2 : CT Scan of the pelvis showing the presacral mass - Dermoid cyst.

The gross dilatation of the sigmoid colon and rectum led the radiologists to suspect Hirschsprung's disease. An exploratory laparotomy - transabdominal approach was chosen and the presacral lesion was completely excised. The radiologic suspicion of Hirschsprung's disease was completely ruled out. The umbilical hernia was repaired. Histopathology report confirmed the cystic mass as a Presacral Dermoid Cyst.



Fig 3 : Intraoperative photograph of the presacral dermoid

Postoperative recovery was uneventful. The child passed normal stools on the third post operative day with return of normal bowel habit of passing daily stools since. The child was discharged after he was able to consume normal diet.

Discussion

Most of the lesions in the retrorectal spaces are congenital (2/3rd) and the rest comprise of neurogenic, osseous,

inflammatory and miscellaneous lesions. Uhlig and Johnson noted 63 patients treated over a 30 year period in a major metropolitan area. Jao et al reported on 120 patients with primary retrorectal tumors treated at Mayo's clinic over a 20 year period from 1960 -1979. The retrorectal tumors represented about 1 per 40,000 hospital admissions. Cleaveland clinic reported 43 cases of sacral and retrorectal tumors between 1980 and 1998, with a predominance of congenital lesions.

The retrorectal lesions may be listed as:

1. Dermoid cysts
2. Epidermoid cysts
3. Enterogenous cysts: Arising from the primitive gut.
These may present as duplication cysts of the rectum, colon or as tail gut cysts.
4. Anterior meningocele or meningo-myelocoele.
5. Teratoma: Type IV: Sacro-coccygeal teratomas
6. Chordomas
7. Neurogenic lesions:
 - (a) Neurofibromas
 - (b) Neurilemmomas
 - (c) Ganglioneuromas
 - (d) Ependymomas
8. Osseous lesions: (affecting the sacrum)
 - (a) Osteomas
 - (b) Aneurysmal bone cyst
 - (c) Giant cell tumors
 - (d) Osteogenic sarcomas
 - (e) Ewing's tumor
 - (f) Chondromyxosarcoma

The risk of malignancy in these lesions is high (60%) in solid ones and low (10%) in cystic ones. Gastrointestinal,

Urinary tract, and lower limb and pelvic complaints are the only presenting features. Such lesions may be palpable on digital rectal evaluation. X-ray, CT Scan, MRI Scan, and Myelogram study may be used as ancillary diagnostic modalities. A biopsy is not necessary if the lesion is resectable because of the risk of infection and seeding of malignancy if present. Surgical resection is the rule with the choice of approach depending upon the nature of lesion and the location. Trans-abdominal, trans-sacral or a combined approach may be chosen accordingly.

We encountered a case of chronic constipation, diagnosed it appropriately as a retrorectal lesion and could successfully operate and confirm the lesion histopathologically as a presacral dermoid. The complaints of the patient was relieved completely.

A rare case, a common complaint, and a successful treatment all were the basis of this discussion.

References

1. Pediatric surgery, 5th edition Edited by James O Neill, Marc I Powe, Jay L Grosfeld, Eric W Fonkalsrud, and Arnold G Coran. Pg :- 447 - 454,1257 -1264,1455,1849.
2. Campbell's orthopaedic surgeries, 10th edition, Edited by S Terry Canale. Pg:- 733 - 859, 1921 - 1927, 1569 - 2061.
3. Maingot's Abdominal Operations, 10th edition, Edited by Michael J Zinner, Seymour I Schwartz, Harold Ellis, Stanley W Ashley, and David W Mac Fadden. Pg: 1494 - 1495.
4. A concise textbook of Surgery, Somen Das, 4th edition, Pg: 98-101.
5. Schwartz's Principles of Surgery 8* edition, Edited by F. Charles Brunnicardi, Dana K. Andersen, Timothy R. Bffliar, David L. Dunn, John G Hunter, Raphael E. Pollock. Pg: 1095.
6. Article on retro rectal tumors by Julio Garcia-Aguilar, MD, PhD in the annals of the American society of colo-rectal surgeons.