Case presentation of a diagnostic and therapeutic conundrum of a retrorectal mass

Jasmine Ladlad1, Frederick H Koh1, Min-Hoe Chew1
1 Colorectal Service, Department of Surgery, Sengkang General Hospital, Singapore

INTRODUCTION AND AIMS

Retrorectal lesions are rare and majority are benign. According to their size and location they may cause compressive symptoms including urological, neurological, and defecation difficulties. Differential diagnoses can be divided into congenital, neurogenic, vascular, osseous, and inflammatory. We present case of a diagnostic and therapeutic conundrum of a retrorectal mass.

METHODS

Case review of a middle-aged gentlemen presenting with obstructive defecation from a retrorectal lesion.

RESULTS

A 55-year old gentleman presented with chronic abdominal pain and change in bowel habits. In 2017 he was admitted for Hinchey 1 sigmoid diverticulitis. His CT scan of the abdomen and pelvis also showed a 3 cm retrorectal lesion abutting the rectum. Over the next 3 years he had increasing difficulty in defecation.

Colonoscopy showed no luminal involvement. A CT-guided biopsy showed fibromuscular stroma with no evidence of malignancy. He underwent elective preoperative bilateral ureteric stenting, ultralow anterior resection, resection of the retrorectal tumor, and defunctioning ileostomy. Pathological examination revealed a retrorectal epidermoid cyst.

An MRI rectum performed in 2020 showed that the mass had increased to 8cm and was indenting the rectum and abutting the sacrum and coccyx.

Fig 1.CT images showing the retrorectal lesion progressively increasing in size (left image in 2017, right image in 2020)

CONCLUSION

This case demonstrates the limitations of history, physical examination and various imaging modalities in the diagnosis of retrorectal lesions. Most are benign with epidermoid cyst being the commonest. Surgical approach can be transabdominal, trans-sacral (Kraske’s Technique) or the combined abdomino-sacral approach. Proctectomy may not always be necessary but in our patient’s case, the 8cm lesion was tethered to the rectum, precluding a safe excision without disrupting the blood supply to the rectum.

REFERENCES