

A case of Tailgut Cyst presented to the emergency department due to urinary retention

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ABSTRACT

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Tailgut cysts are infrequent tumors in the presacral area and most presacral tumors in the literature are single-case, these tumors constitute 1/40.000 of applications to hospital. A 27-year-old male presented to the emergency department with urinary and fecal retention. Abdominal pain and swelling had persisted for a week. At physical examination the abdomen was swollen and distended. Rectal examination revealed a mass exerting external pressure on the inferior wall of the anal canal. Computed tomography of the abdomen revealed a cystic lesion in the pelvis, 13x12x9 cm in size, containing thin septa and displacing the bladder to the anterior and the rectum to the right. This report describes a case of tailgut cyst in the presacral area and creating urination difficulty.

Keywords:

Abdominal pain
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1. Introduction

Developmental cysts, which represent 60% of all presacral tumors, arise from the embryonic layers. Morphologically, developmental cysts are classified as epidermoid cysts, dermoid cysts, cystic teratomas and tailgut cysts (TGC). TGCs are infrequent tumors in the presacral area and many presacral tumors in the literature are single-case, these tumors constitute 1/40.000 of applications to hospital (Hobson et al., 2005; Bullard Dunn, 2010). Presacral lesions may be classified as inflammatory, osseous, congenital, developmental cysts and rectal duplication TGC. While they can be seen at any age, they are four times more common in women (Akbulut, 2013). TGCs, also known as retrorectal hamartomas or mucus secreting cysts, are rare, benign cystic lesions of the presacral area. TGCs form in the presacral area, but cases have been reported in the perirenal, perianal, anterior rectal and posterior sacral regions (Akbulut, 2013). This case report describes a TGC in the presacral region causing dysuria.

2. Case

A 27-year-old man presented to the emergency department with urinary and fecal retention. Abdominal pain and swelling had been present for a week. At physical examination, the abdomen was swollen and distended. Rectal examination revealed a mass exerting external pressure on the inferior wall of the anal canal. Laboratory findings were as Hb: 15 g/dl, leukocyte: 12.000/mm³ and CRP: 12 mg/L. Other values were normal. Abdominal ultrasonography (USG) revealed a cystic lesion 12x10 cm in size in the lower abdomen. Computed tomography (CT) of the abdomen revealed a cystic lesion in the pelvis, 13x12x9 cm in size, containing thin septa and displacing the bladder to the anterior and the rectum to the right (Fig. 1). The patient underwent surgery by the general surgery department and discharged on the 7th day of surgery, without any complication.

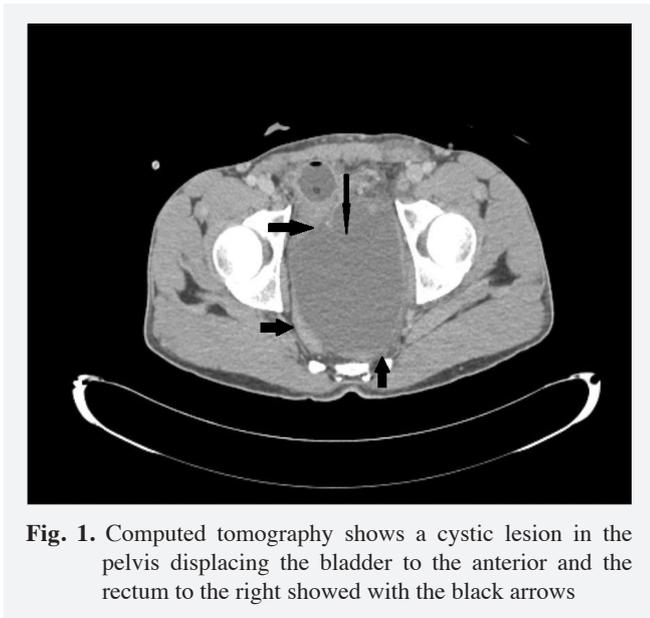


Fig. 1. Computed tomography shows a cystic lesion in the pelvis displacing the bladder to the anterior and the rectum to the right showed with the black arrows

3. Discussion

The presacral area lies in front of the sacrum and behind the rectum, beneath the peritoneal area, above the levator ani and laterally to the muscles of the coccyx. Congenital, neurogenic, osseous and inflammatory pathologies may be seen in this area. Congenital lesions are the most common type of tumor, representing 55-70% of all presacral tumors (Hobson et al., 2005). These tumors arise from the embryonic layers. They may be cystic (developmental cysts, rectal duplication cysts and anterior meningocele) and solid (chordomas, teratomas and adrenal tumors). Lesions in this region are classified as inflammatory, osseous, congenital, developmental cyst and

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rectal duplication TGCs (Hobson et al., 2005; Bullard Dunn, 2010; Akbulut, 2013).

Half of presacral TGCs are asymptomatic, and cysts are detected incidentally as a palpable mass during routine examination in more than half of patients (Akbulut, 2013). Rectal examination is therefore important for diagnosis. Symptomatic patients may present with constipation, a feeling of rectal fullness, rectal pain, painful bowel movements, lower abdominal pain and pain in the back or lower back or urinary obstruction. Some patients may arrive with diagnoses of recurrent retrorectal abscess or anal fistula abscess, or pilonidal sinus (Akbulut, 2013). In our case, the patient presented with urinary and fecal retention and abdominal swelling. The mass was detected at rectal examination.

Although transrectal USG, CT and magnetic resonance imaging (MRI) are adequate imaging techniques for differential diagnosis, the pathology is always needed for full and accurate diagnosis. CT shows a homogeneous retrorectal mass with a density close to that of fluid. MRI shows a hypointense lesion in T1 section and a homogeneous hyperintense lesion in T2 (Killingsworth and Gadacz, 2005; Akbulut, 2013). MRI is valuable in determining soft tissue margins in particular and in showing bone-nerve invasion (Killingsworth and Gadacz, 2005; Akbulut, 2013). In our case, a cystic lesion containing thin septa, displacing the bladder to the anterior and the rectum to the right was determined at CT.

Various pathologies may be considered at differential diagnosis in patients presenting to the emergency department with urinary and defecatory difficulty. Patients with TGC may present to the emergency department with these symptoms. Emergency physicians should keep TGC in mind in patients with such symptoms.