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Case Report

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A rare presentation of abdominal pain as cloacal cyst: A case report

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Abstract

Retrorectal hamartoma or tailgut cyst is an uncommon congenital disease of presacral and retrorectal space and is embryologically part of some forms of enteric cysts. The rarity of this disease leads to difficulty in diagnosis and surgical management. Complete surgical excision is the treatment of choice for tailgut cysts. We present a case of a 40-year-old man, who presented to us with abdominal pain for four months, which had become more prominent while defecation and after eating. Abdominal computed tomography demonstrated a cyst in the lower interperitoneal cavity. Surgical complete excision of the mass was done with midline laparotomy. Histopathology confirmed cloacal cyst.

Keywords: Cloacal cyst, Congenital disease, Surgical management.

Introduction

Tailgut cyst is a rare congenital cystic lesion arising from the remnants of the embryonic postanal gut. It occurs exclusively within the retrorectal space and rarely in the perirenal area or in the subcutaneous tissue. A prerectal and retrovesical location of tailgut cyst is extremely rare [1]. These cysts are characterized by several variants of intestinal epithelial tissue, most often by columnar epithelium. They are generally benign, but malignant transformation has been reported on rare occasions [2]. Tail gut cysts are usually asymptomatic, but in rare cases they may cause local rectal compression, constipation, and urinary symptoms [2]. However, the main problems associated with these cysts are bleeding, infection, and malignant transformation [3]. Half of the patients present with symptoms such as low back or rectal pain, pain during defecation, rectal bleeding, urinary frequency. Furthermore, retrorectal lesions in women can mimic gynecological pathology [4]. Complete surgical resection with negative margins still remains the cornerstone of surgical treatment [5]. Cloacal cyst is a rare type of tailgut cyst which is introduced in this report.

Case report

A forty-year-old man presented with complaints of hypogastric abdominal pain for about four months. The pain was occasionally after eating and at the time of defecation without any radiation to other parts of body. Also constipation in this duration was reported. No history of dysuria or other urinary problems were reported. On physical examination there was no abnormality. Routine laboratory tests were within normal limits. Ultrasonography for abdomen and pelvic demonstrated fluid collection near the rectosigmoid colon and also a tubular region 22*23 mm in size containing echogenic content 16 mm in size. The treatment was open surgery under general anesthesia through a small lower midline incision. During the operation a 3*3 cm solid mass con-

nected to the anti-mesenteric side of recto-sigmoidal junction through a bundle, was found. Also two 4*4 cm cystic masses containing chocolate color liquid were found in the Douglas pouch joining the first mass. All the lesions were excised and sent to the pathology. The patient got discharged the next day with no post-operative complications, after tolerating PO intake and defecation with a prescription of painkillers. Pathology results revealed cloacal cyst with no evidence of malignancy.

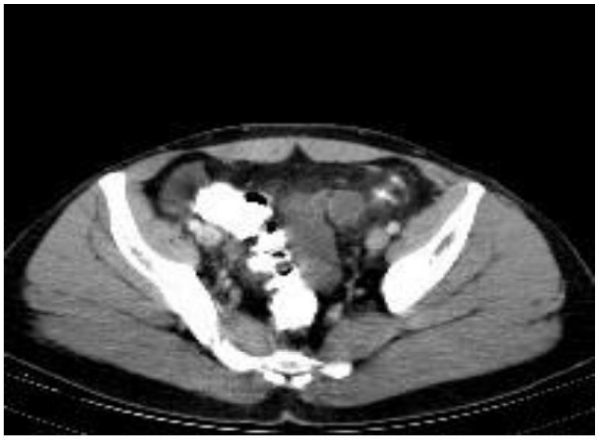

Figure 1: Abdominal computed tomography revealing cloacal cyst in hypogastric fossa.

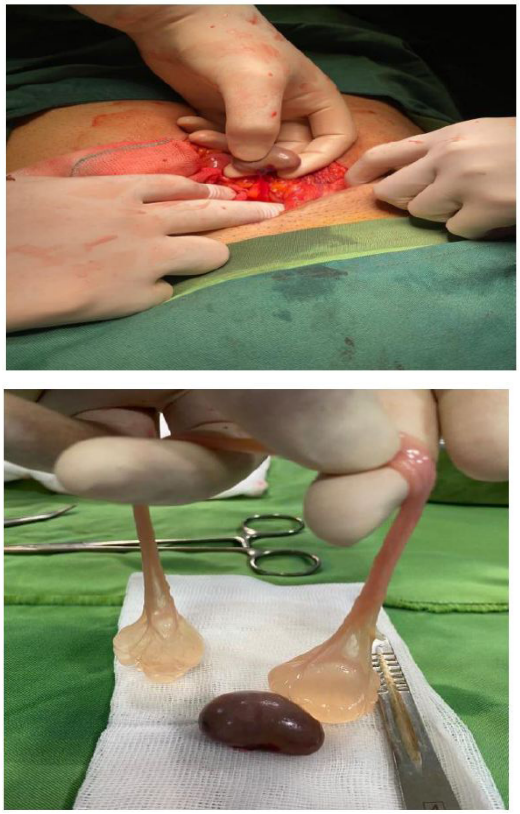

Figure 2: Intra operative appearance of cysts.

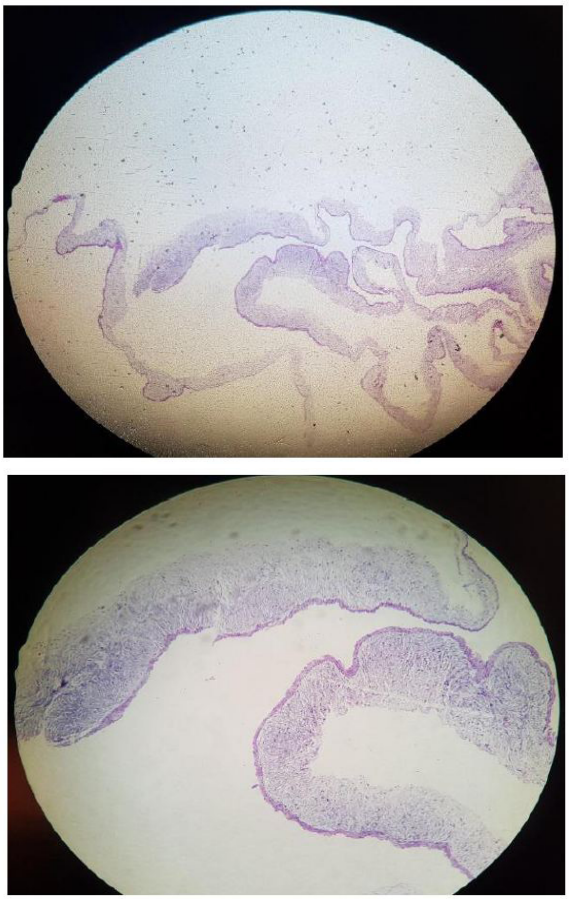

Figure 3: Histopathology showing intestinal glands within cyst wall confirming cloacal cyst.

Discussion

Among retrorectal tumors, tailgut cysts arise from the remnants of the hind gut. Tailgut cysts are rare and have a female predominance with a female to male ratio of 3:1 to 9:1. Tailgut cysts commonly develop in the fifth decade of life; however, they can occur at any age [6]. Nevertheless, malignant tumors occur more frequently in men, they are rare and have been reported as adenocarcinomas, carcinoid tumors, neuroendocrine carcinomas, endometrioid carcinomas, adenosquamous carcinomas, squamous cell carcinomas, and sarcomas [7]. One of the types of tailgut cysts are cloacal cysts that are very rare.

Tail gut cyst presentation and the subsequent clinical picture can range from an asymptomatic incidental finding on imaging to a prolapsing cyst through the anus; this has been reported in the literature to have been misdiagnosed as hemorrhoids. Compression of the nearby organs can cause an array of symptoms, including urological, neurological, and defecation difficulties. Other acute presentations, such as acute urinary retention and obstipation, have been reported with large tailgut cysts. Symptoms include rectal pain, constipation, obstructed defecation, tenes-

mus, painless rectal bleeding, dysuria, urinary frequency, lower abdominal pain, back pain, and lower limb neurological problems due to compression of the sacral plexus [6,8]. The main differential diagnoses of the prerectal tailgut cyst include the utricle cyst in the prostate, the rectal duplication and the simple cyst in the seminal vesicle [1]. Tailgut cyst lining can exhibit different types of epithelium including columnar, transitional and squamous. The presence of some glandular or transitional epithelium differentiates them from epidermoid and dermoid cysts, which can communicate with the skin [8]. Immunohistochemically, the cyst lining epithelial cells show immunoreactivity for PSA and the neuroendocrine cells show immunoreactivity for chromogranin A [1]. Radiological investigation is carried out by TRUS, CT and MRI. Needle biopsy of cystic pre-sacral lesions is not recommended as a diagnostic tool because of the risk of life-threatening infections [2]. Excision of tailgut cyst is advised not only as a treatment option for symptomatic patients but also for asymptomatic patients, as those silent masses carry a considerable risk for presenting with serious illnesses when left untreated [8]. Choice of surgical method for cloacal cysts is laparoscopy. Also trans-abdominal approach assures visualization of the important structures and thus a better oncological resection for cases with suspected malignancy.

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