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Letters to the Editor

Retrorectal tumors - A diagnostic-therapeutic challenge

Key words: Retrorectal. Presacral. Rectum. Kraske.

Dear Editor,

Retrorectal tumors are an uncommon, heterogeneous group of lesions that occur in the presacral region. Both diagnosis and treatment represent a challenge for colorectal surgeons. They must be resected because of their potential malignity and risk of infection (1).

Case report

A 74-year-old male with ischemic heart disease, four bypasses, and nonspecific perianal discomfort had a growth palpated at around 5 cm from the anal margin. A CT scan found a presacral space occupying lesion without infiltration of the sacrum, rectum, or bladder. MRI revealed a well-delimited mass with no infiltration of neighboring organs and 12 cm in length (Fig. 1). A mixed (abdominal-perineal) approach was selected for surgery. Histopathology classified the lesion as a desmoid tumor. On the third day after surgery the patient had an acute myocardial infarction that required a prolonged stay in the ICU. He was discharged one month after admission. Presently he has no symptoms and no evidence of relapse.

Discussion

Retrorectal masses have an incidence of 2 cases/year. Congenital masses are most common (66%). They are usually asymptomatic or present with nonspecific manifestations; furthermore, their location in a difficult-to-access anatomical region requires expertise regarding their diagnostic-therapeutic approach in order to deliver appropriate treatment (2). Their clinical presentation results from their mass effect, superinfection (in cystic growths), or organ invasion (in malignancies) (3), with pain being the most common symptom. Digital rectal examination, which is mandatory, may identify the lesion as a mass palpated in the rectum's posterior aspect (4). Pelvic MRI is now essential, this being the study with the highest specificity. It informs on the relation of the tumor to the sacrum and neighboring structures, differentiates solid from cystic growths, and suggests the lesion's benign or malignant nature. Preoperative biopsy is advised against, given the risk for tumor spread

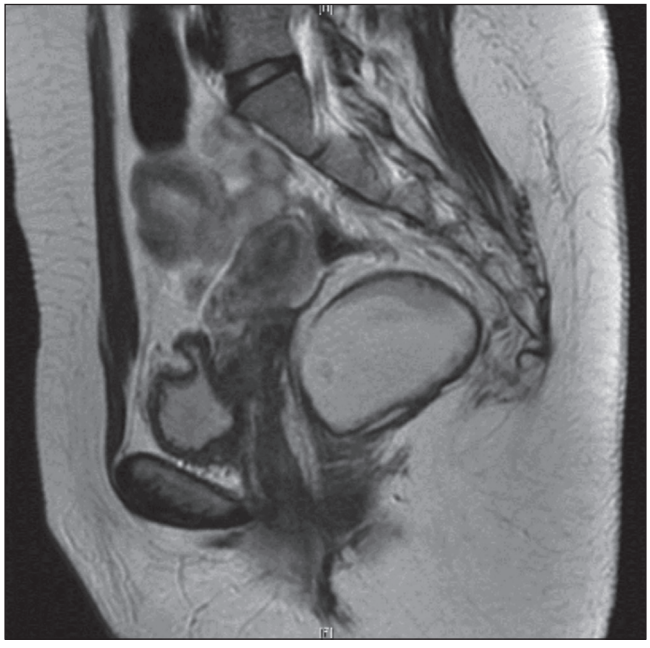

Fig. 1. MRI: A presacral growth is clearly seen.

and local infection. Management is always surgical (5). Surgical approach depends on tumor location; accessible lesions with an upper border lower than the third sacral vertebra may be approached posteriorly (transacral or Kraske posterior approach) (6). Bigger tumors and tumors above S3 may require an abdominal or combined approach. They may be approached with laparoscopy, the advantages being identical to those seen in other surgical scenarios (7). Of late, transanal endoscopic microsurgery (TEM) is used for benign, smaller tumors (8,9). Patients with complete benign tumor resection have a 5-year survival of 90%, with recurring lesions in 0-15% of cases. For malignancies, recurrence rates are higher (42-100%) and survival is lower (50-69%) (10).

To conclude, presacral tumors are rare and their diagnosis is challenging. Treatment should be delivered by a team with expertise in pelvic and cancer surgery in order to obtain the best possible outcomes with the lowest morbidity and mortality.

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