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Case Report

Ischiorectal lipoma: Case Report

Jaya Maheshwari*

Minimal Access Surgery and Laser Proctology, Jyothi Nursing Home Pvt. Ltd., India

***Corresponding Author:** Jaya Maheshwari, Minimal Access Surgery and Laser Proctology, Jyothi Nursing Home Pvt. Ltd., India.

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Abstract

Ischiorectal fossa tumors are one of the rare tumors and hence, a very few cases have been reported. The accurate diagnosis cannot be established pre-operatively, but the size and anatomical relationships of the lesions can be defined by imaging examinations such as computed tomography (CT) and especially magnetic resonance imaging (MRI). Due to the difficult access of the region, surgical treatment is challenging and hence is preferably performed by posterior approach. Non-inflammatory lesions of the ischiorectal fossa, with no involvement of rectum or levator ani muscle, are mostly benign lesions which are completely excised by a posterior approach.

Keywords: Ischiorectal Fossa; Lipoma; MRI

Introduction

Ischiorectal fossa (IRF) or as some authors term it as ischioanal fossa, is a fat-containing space which allows expansion of the anal canal. The huge numbers of lesion involving IRF are cystic and benign [1]. Whereas chances of malignancies are less which usually appear as solid aggressive masses. Some of the incidents like surgical procedure, bleeding disorder, birth delivery, hemorrhage can affect IRF either completely or secondarily by forming extension through any border [2]. The ischiorectal fossa can get infected, forming ischiorectal abscess which may need surgical intervention. A wide spectrum of diseases such as congenital and developmental lesions, inflammatory, traumatic, and hemorrhagic conditions; primary tumor; and pathologic conditions outside the ischiorectal fossa and secondary involvement of the fossa affect the ischiorectal fossa [2]. Traditionally IRF diseases can be classified as inflammatory, infectious, neoplastic and congenital. The ischiorectal fossa contains only a few tissue components; therefore, most pathologic conditions that affect the IRF develop by direct extension from a bordering structure rather than intrinsic pathology within the fossa. Surgical technique is quit challenging because of access to the site and hence, posterior approach may be used to perform surgery. The histological diagnosis of tumor of the ischiorectal fossa depend on their embryological origin. They can be neoplastic, acquired and congenital [1,3]. The treatment to anorectal fossa is early, adequate and dependent on drainage and in some cases surgical intervention is needed.

Case Report

A 47-year-old patient reported to the clinic with complaints of swelling from last 5 years which increased in size gradually and led to inconvenience in walking and sitting. The patient reported to the clinic with low pain. On clinical examination, a huge sized lump was seen in the left butt area. No associated problem was reported. Accurate diagnosis mostly cannot be done pre-operatively and technique such as magnetic resonance imaging (MRI) is used to define the size and anatomy of the lesion. Patient was advised for MRI and Fine Needle Aspiration Cytology (FNAC), which confirmed the diagnosis for ischiorectal lipoma. Reports showed the evidence of a large T1/T2 hyperintense soft tissue lesion of size 18.4*6.8*7.2 cm in the left ischioanal and perirectal region with supralevator

extension causing compression over the anorectum with luminal narrowing. This lesion shows suppression of signal on fat saturated images likely fat containing lesions. The differential diagnosis included lipoma and epidermoid cyst. Excision of lipoma was done under spinal anesthesia. Further specimen was sent for histopathological examination. The patient was followed up for the next 6 months. The patient presented with no complications during the follow-up period.

Figure 1

Figure 2

Figure 3

Figure 4

Figure 5

Figure 6

Discussion

The largest space of the anorectal region is ischiorectal fossa, which is a pyramidal shape space, communicating posteriorly through the post anal deep space, located between the levator ani and the anococcygeus ligament.[6] The anterior border of the IRF is triangular and formed by the convergence of the medial urogenitalia and the lateral musculoskeletal structures. The posterior border is at the base of this triangle and is distinct, comprising the sacrum, sacrotuberous ligament, and the lower aspect of the gluteus muscles [1].

Various pathological lesions are likely to occur in this area, which is not accessible through an abdominal approach [6]. A posterior, local perineal approach can be done based on the location as defined by a pelvic MRI and sometimes by the histology. MRI is currently the most useful way for investigation. As many study suggested that MRI is marked as gold standard, which not only help in accurately demonstrating disease extension but also help for predicting diagnosis, selecting therapy or treatment plan and further monitoring of the therapy [4,5]. A retrospective study was done Bush., *et al*. suggested that non inflammatory masses in the ischiorectal fossa are rare, but they are commonly malignant. MRI should be advised and unless the radiographic appearances are diagnostic, percutaneous diagnostic is recommended [7].

Biopsy is not always necessary unless there's a suspicion of a malignancy or invasion of adjacent structures, and only in that case a biopsy should be made, because in some of them, a neo- adjuvant treatment can be useful to reduce the tumor and to perform an R0 resection [8].

Surgical resection remains the mainstay of treatment for soft tissue sarcomas and wide resections with clear margins are the gold standard. CT results have shown lipomas to appear similar as lesions of subcutaneous tissue. The choice of the surgical approach to be selected is an important issue and a posterior approach should be selected preferably except in cases of an infiltration of the levator ani or the superior extension of the tumor. An abdomino-perineal approach should be done in such cases. The radiological findings help to decide the surgical approach to be used. The increased risks of local recurrence, metastases, and mortality have been shown to be associated with surgical resections involving positive approach. A R0 resection helps to avoid local recurrences, mainly in malignant tumours or locally aggressive tumours. Along with these the utilization of neoadjuvant and adjuvant therapies for treatment of sarcomas show optimal outcomes.

A recent study of 65 patients with confirmed diagnosis of retrorectal tumors (the largest series published till date) in New Zealand, comprised 29% of malignant tumors. The benign and malignant tumors were differentiated with the MRI with 95% sensitivity. The surgeons performed a biopsy only to the solid lesions, thus performing surgery only to 27 lesions. This study highlighted the importance of the use of MRI in the management of this type of lesion [9].

Conclusion

Ischiorectal fossa tumors are rare and their management has not been protocolized. MRI and CT scan implicate a crucial role in the evaluation, with MRI predominant because of its multiplanar capabilities and superior tissue contrast. Unless the radiological appearance is diagnostic a percutaneous biopsy is recommended.

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