Journal of Women's Health Care

OPEN ACCESS Freely available online

Case Report

A Rare Cause of Pelvic Pain: Tailgut Cyst

Arzu Dinc Yavas*

Department of School of Medicine, Istanbul Aydin University, Istanbul, Turkey

ABSTRACT

Tailgut cyst or retrorectal cystic hamartoma is a congenital lesion located in the retrorectal-presacral space and is a remnant of the embryonic hindgut. It is more common between the ages of 30-60 and in women (f/e=5/1). Although it is usually asymptomatic, it may cause abdominal pain or constipation. Our aim is to highlight this rare cause of pelvic floor pain through 2 cases.

Keywords: Constipation, Pelvic floor pain, Tailgut cyst

INTRODUCTION

Masses in the retrorectal region are rarely seen and their incidence is reported as 1/40,000–63,000 [1]. Tailgut cyst or retrorectal cystic hamartoma is a rare congenital lesion located in the retrorectal-presacral space and is a remnant of the embryonic hindgut. The tailgut undergoes regression in the 8th week of embryological life; Tailgut cysts form as a result of the regression defect in this period [2]. Tailgut cysts are seen more frequently between the ages of 30-60 and in women (f/e=5/1) [3]. Although it is usually asymptomatic, it may rarely cause abdominal pain and constipation [4].

Case 1: A 44-year-old female patient came with hip and groin pain. There was a gastroenterology application due to constipation in her medical history, but no pathology was detected. The musculoskeletal system examination was unremarkable. In the contrast-enhanced pelvic MRI examination, a 29*14*16 mm non-contrast cystic formation in the right posterolateral rectum was reported as a tailgut cyst [Figure 1].

Case 2: A 36-year-old female patient came with left hip pain. On examination, the hip joint was open and there was pain radiating to the perineal area. There was no neurological deficit. In the contrast-enhanced hip magnetic resonance (MR) image, a septate cystic formation of 47*42*27 mm in size, located on the right posterolateral side, deviating the rectum to the left, appearing hyper intense on T2 and hypo intense on T1, was reported in favor of a tailgut cyst [Figure 2].

Both patients signed an informed consent form and were referred to general surgery. Case 1 was lost to follow-up. Case 2 was operated; there was no pain in the postoperative period.

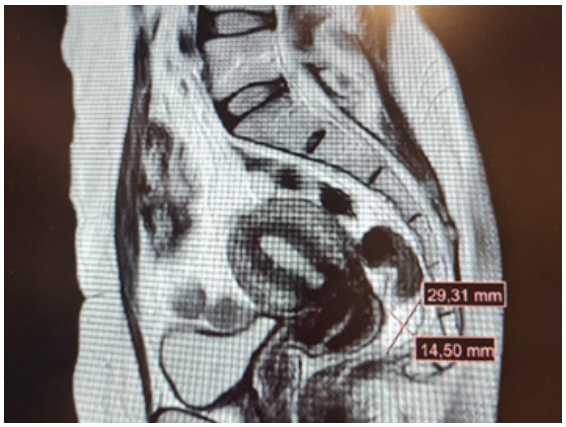

Figure 1. Case 1 Cystic formation in Pelvis MRI sagittal image.

***Correspondence to:** Arzu Dinc Yavas, Department of School of Medicine, Istanbul Aydin University, Istanbul, Turkey. E-mail: arzudinc0111@gmail.com

Received: 25-Jan-2024, Manuscript No. JWH-24-29349; **Editor assigned:** 29-Jan-2024, PreQC No. JWH-24-29349 (PQ); **Reviewed:** 12-Feb-2024, QC No. JWH-24-29349; **Revised:** 16-Feb-2024, Manuscript No. JWH-24-29349 (R); **Published:** 24-Feb-2024, DOI: 10.35248/2167-0420.24.13.710

Citation: Yavas AD (2024) A Rare Cause of Pelvic Pain: Tailgut Cyst. 13(2):710.

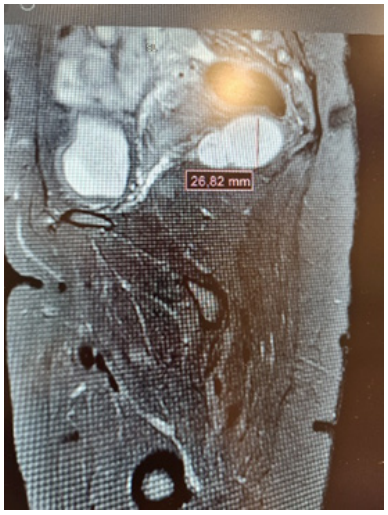

Figure 2. Case 2 Cystic formation in hip MRI sagittal view.

DISCUSSION

Retrorectal tumors can be divided into 5 categories: congenital, neurogenic, inflammatory, osseous and other tumors. Congenital tumors constitute 55-70% of all retrorectal tumors. Congenital tumors include chordoma (notochord remnant), teratomas, anterior sacral meningocele, and developmental cysts (dermoid, epidermoid, enteric duplication, or tailgut cysts) [5].

Although most of the tailgut cysts, which are developmental cysts, are found in the retrorectal area, they can also be found in the anterior rectal, perianal, perirenal and posterior sacral regions. They are congenital lesions originating from the embryological tailgut, which are generally benign and may rarely show malignant transformation [6-7].

It can be palpated during physical examination during digital rectal examination. Double-contrast colon radiography, transrectal ultrasonography, computed tomography and MRI can be used in the radiological diagnosis of tailgut cysts [8]. MR signal features of tailgut cyst appear as hypointense on T1W sequences and hyper intense on T2W sequences [9].

Although it is generally asymptomatic, it can cause urological conditions such as acute urinary retention due to abdominal pain or pressure on surrounding organs, neurological conditions such as nerve compression such as the sciatic nerve, and constipation and obstipation [4, 10, 11].

In the differential diagnosis, rectal duplication cyst, anterior meningocele, chordoma, teratoma, epidermal cyst, anal gland cyst and cystic lymphangiomas should be kept in mind [12]. The most important complications of tailgut cyst are infection and malignant degeneration of the cyst [13]. The treatment is surgical excision [7].

CONCLUSION

Tailgut cyst should also be investigated as a rare but possible cause in the differential diagnosis in female patients presenting with perineal pain.

REFERENCES

1. Hjermstad BM, Helwig EB. Tailgut cysts: report of 53 cases. Am J Clin Pathol. 1988;89(2):139-47.
2. Olcay ES, ARIKAN Y, Korkmaz S, Tokyol Ç, Karaveliolu E, Boyaci MG. Presakral kist: olgu sunumu. Kocatepe Tıp Dergisi. 2011;12(3):175-8.
3. Hood DL. Retrorectal cystic hamartoma; report of five cases with carcinoid tumor arising in two. Am J Clin Pathol. 1988;89:433.
4. Yang DM, Park CH, Jin W, Chang SK, Kim JE, Choi SJ, et al. Tailgut cyst: MRI evaluation. Am J Roentgenol. 2005;184(5):1519-23.
5. Mentel BB, Kurukahvecioglu O, Ege B, Karamercan A, Leventoglu S, Yazicioglu O, et al. Retrorectal tumors: a case series. Turk J Gastroenterol. 2008;19(1):40-4.
6. Unlu M, Ozbilgin M, Sokmen S, Sarioglu S. Seromüköz bez yapıları içeren bir Tailgut kisti: Olgu sunumu. Dokuz Eylül Üniversitesi Tıp Fakültesi Dergisi. 2010;24(3):143-7.
7. Killingsworth C, Gadacz TR. Tailgut cyst (retrorectal cystic hamartoma): report of a case and review of the literature. Am Surg. 2005;71(8):666-73.
8. Dhamanaskar KP, Thurston W, Wilson SR. Transvaginal sonography as an adjunct to endorectal sonography in the staging of rectal cancer in women. Am J Roentgenol. 2006;187(1):90-8.
9. Aflalo-Hazan V, Rousset P, Mourra N, Lewin M, Azizi L, Hoeffel C. Tailgut cysts: MRI findings. Eur Radiol. 2008;18:2586-93.
10. Abraham VJ, Peacock M, Mammen KJ. Acute urinary retention and obstipation: a rare cause. Indian J Surg. 2013;75:71-2.
11. Yakan S, Ilhan E, Cengiz F, Ustuner MA, Tanriverdi HO. Retrorectal cyst presenting with right sciatica. Eur J Surg Sci. 2012;3(2):59-61.
12. Johnson AR, Ros PR, Hjermstad BM. Tailgut cyst: diagnosis with CT and sonography. Am J Roentgenol. 1986;147(6):1309-11.
13. Sung MT, Ko SF, Niu CK, Hsieh CS, Huang HY. Perirenal tailgut cyst (cystic hamartoma). J Pediatr Surg. 2003;38(9):1404-6.