



AN UNUSUAL PRESENTATION OF PERIRECTAL ABSCESS

Surgery

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ABSTRACT

Here we report a case of an unusual presentation of a perirectal abscess which presented with features of intestinal obstruction and on investigations and intra-operatively turned out to be a perirectal abscess with retroperitoneal spread. Hence depicting the importance of thorough prior radiological investigation and clinical suspicion before intervening surgically.

KEYWORDS

Perirectal abscess, Retroperitoneal spread, contrast enhanced CT in retroperitoneal diseases, infective retroperitoneal disease.

Introduction

Perirectal abscess is a manifestation of infected anal gland present in cryptoglandular epithelium lining the anal canal.

Internal anal sphincter is believed to serve as a barrier to infection preventing its deeper extension in to the perirectal tissue.[1] This barrier can be breached through the crypts of Morgagni thus extending to various planes as described by Parks[2] i.e. Intersphincteric(70%), Ischorectal(23%), Extrasphincteric(5%), supralelevator(2%).

Supralelevator is reportedly the least common and most serious. We report one such perirectal abscess extending to retroperitoneal space.



Case report

A 45 year old male patient presented with 2 weeks history of pain and swelling in left gluteal region with intermittent fever with chills for which he was managed conservatively in a primary care center. Now he presented with progressive left sided pain in abdomen and history of abdominal distension, constipation and vomiting. No history of any co-morbidities or previous surgeries



On examination patient was febrile (101°F), had tachycardia. Abdomen was distended with guarding and bowel sounds were absent. A 6x6 cm abscess was noted in left perianal region.

Investigations: WBC count was 19200/cumm (predominantly neutrophilic).

- Abdominal radiography showed dilated large and small bowel loops.
- Contrast enhanced CT scan showed perineal abscess with multiple internal air loculations causing spreading cellulitis involving left pelvic musculature, abdominal musculature, Ilio-psoas muscle, retroperitoneal region and left gluteal region.

Figure 1: Contrast enhanced CT In the view of above findings patient was taken up for emergency **exploratory laparotomy** under GA on the same day.

Figure 2: Intra operative retroperitoneal collection

- Intra operatively, bowel loops were dilated. A left retroperitoneal collection extending to perites was noted, bowel loops were adherent to abdominal wall near this collection. Retroperitoneal space was opened, foul smelling purulent fluid was drained (Approx-400ml)
- After thorough abdominal lavage an intraperitoneal drain was kept. Perianal abscess was drained through separate perianal incision. No definite communication with retro-peritoneal abscess could be demonstrated during surgery.
- Post operatively patient made an uneventful recovery. Though the perianal drainage site kept on discharging pus for about 16 days. Patient was discharged on POD 19.

Discussion

- Infective disease of the peri-rectum is a common clinical problem. In most of the cases infection is usually located below the level of the pubo-rectalis muscle (Infra-levator). If not treated during this stage, they might rupture extending in to deeper planes as explained by Parks[2].
- Whenever there is suspicion of a retroperitoneal spread, prior thorough radiological investigation is mandatory before proceeding for intervention. CT was found to be best the imaging technique that produced the most reliable and rapid diagnosis in case series 66 cases of retroperitoneal abscess by Manjón.[3]
- Spread of anorectal abscess to the retro-peritoneum is very rare. Lindell et al[4] and Goldenberg[5] in their series of 58 cases and 400 cases respectively have not reported a single case of retroperitoneal extension. Hanley has described one such case in his series of 33 patients of anorectal supralelevator abscess.
- An anorectal abscess with spread restricted to the supralelevator spaces in the pelvis, can be drained by making an incision through the fossa ischio-rectalis. For potentially lethal spread into the retroperitoneum lumbar incision or trans-abdominal approach is required to achieve adequate drainage and irrigation.
- Abdominal symptoms are rare in ischio-rectal abscess, but they must be kept in mind. Proper diagnosis prior to intervention avoids chances of negative laparotomy and helps in reducing duration of morbidity while preventing advancement of the disease.[6]

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