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Case Report

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Buttock Mass: A Typical Feature of Fetal Extraperitoneal Rectal Perforation

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Brief Clinical Outline

Ultrasound at 38 gestational weeks in a female fetus revealed a previously undetected cystic pelvic mass that was confirmed by fetal magnetic resonance imaging. At full-term birth, the neonate had a mass on her right buttock-labium majus (Figure 1); 48 hours after birth, she developed a fever and elevated C-reactive protein, so antibiotic therapy was started. She remained clinically stable, breastfeeding successfully and showing frequent bowel movements. Ultrasound showed the mass communicated with the pre-sacral area. CT showed air-fluid levels probably extending to the perineum. Contrast enema showed a fistula between the rectum and the cystic mass (Figure 2). On the fourth day of life, a sigmoid loop colostomy with closed mucous fistula was fashioned, and the collection was drained. Rectal biopsy ruled out Hirschsprung disease. After an uneventful postoperative course, she was discharged on day 19 after surgery. A contrast enema is planned before closure of the colostomy.

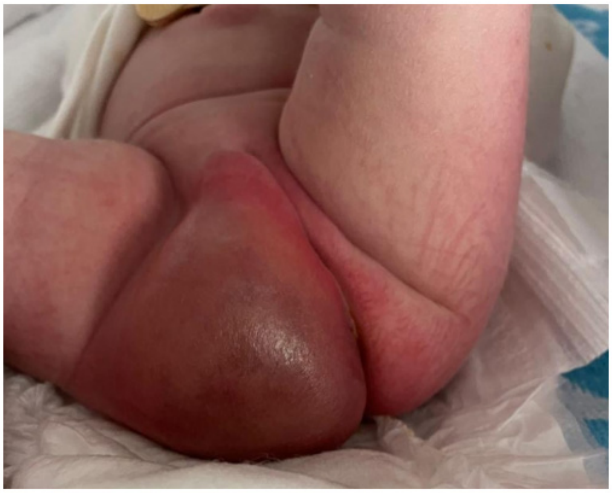

Figure 1: Large mass on the right buttock-labium majus.

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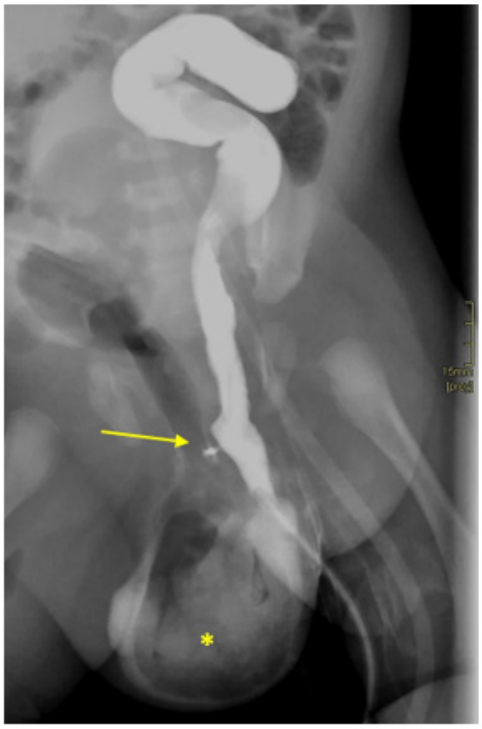

Figure 2: Contrast enema showing the rectal fistula (arrow) communicating with the cystic mass (asterisk).

Clinical Message or Learning Point

Fetal extraperitoneal rectal perforation is rare; however, its clinical features make it easily recognizable [1]. Plain abdominal X-rays obviate the need for further investigations [2,3]. Lack of experience led us to perform additional, probably unnecessary, radiological tests to confirm the diagnosis. Delayed treatment could cause fatal septic complications. Prompt recognition followed by a simple diversion of meconium and drainage of the collection results in good outcomes with normal anorectal function expected in the long-term [1]. The colostomy should be closed after 3 to 6 months [3,4].

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Patient Consent for Publication

Obtained.

Acknowledgment

None.

Conflict of Interest

None.

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