

Accessing the challenging pre-sacral abscess

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Dear Editor:

Drainage of pre-sacral collections transrectally or percutaneously can be challenging due to difficulty of access. Transanal endoscopic surgery is a well-established technique used to resect benign or early malignant rectal tumours, either using a binocular stereoscopic operating rectoscope or a monocular laparoscopic equivalent, and a number of additional indications have been described for their use, including pelvic anastomotic stricturoplasty, excision of extraluminal pre-sacral tumours as well as drainage of pre-sacral abscesses which may otherwise be inaccessible. Transanal endoscopic microsurgery uses the stereoscopic equipment (Richard Wolf Medical Instruments Corporation), while the alternative produced by Storz is less expensive and fully compatible with standard laparoscopic equipment, and is referred to as transanal endoscopic operation (TEOTM). Patients can expect minimal effect on anorectal function despite the use of a large diameter rectoscope.

TEO equipment was used to successfully drain an inaccessible pre-sacral abscess in a 53-year-old man with a body mass index of 28. He had undergone reversal of a Hartmann's procedure which had been performed 7 months earlier for complicated diverticular disease with a pelvic abscess, and a tight anastomotic stricture at 10 cm from the anal verge was subsequently diagnosed another 7 months later after he complained of pelvic discomfort and obstructive symptoms. Imaging ruled out recurrent pelvic sepsis and he underwent three anastomotic balloon dilatations over a 12-month period, resulting in a widely patent anastomosis and a significant improvement in symptoms. Two years after the last dilatation, he developed new symptoms of coccygeal pain on prolonged sitting, which worsened over 5 months, and he subsequently developed additional symptoms of night sweats. A magnetic resonance imaging (MRI) scan confirmed a 4-cm pre-sacral

abscess postero-superior to the anastomosis which remained widely patent. Long-term antibiotics did not improve his symptoms and little change in size was evident on repeat imaging, and transanal drainage was attempted under general anaesthesia. This was unsuccessful due to access difficulties related to the distance of the abscess from the anal canal and the patient's body habitus. The procedure was abandoned when no pus was able to be aspirated and a submucosal haematoma obscured the operative view. Symptoms persisted over 18 months despite repeated courses of antibiotics, until drainage was successfully achieved using TEOTM equipment.

With the patient in lithotomy position, the 4.0-cm diameter, 7.5-cm long operating rectoscope facilitated access, providing a magnified view of the extraperitoneal anastomosis which was incised posteriorly using an ultrasonic dissector, deroofting a pre-sacral cavity which contained pus and was lined with granulation tissue. He was discharged on oral antibiotics 1 day after surgery and was reviewed in an outpatient setting 1 month later. He described post-operative symptoms of faecal urgency and increased frequency, associated with ongoing night sweats and discharge of pus per rectum with minor bleeding, but all of these symptoms had fully resolved on further review 4 months later. The coccygeal pain also resolved post-operatively, and no incontinence was experienced. An MRI scan performed 5 months after surgery confirmed resolution of the chronic collection which measured 39 mm on imaging prior to the procedure.

This case illustrates chronic sepsis with a delayed presentation after anastomotic balloon dilatation and highlights the ease of access achievable using laparoscopic equipment via an operating rectoscope to manage pelvic pathology which would otherwise be inaccessible using alternative modalities.

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