



Asynchronous abdomino-parasacral resection of a giant pelvic lipoma protruding to the left buttock



Masanori Sato^{a,*}, Yuichiro Miyaki^a, Koji Inamori^a, Junpei Tochikubo^a, Yoji Shido^b, Norihiko Shiya^a, Hidetoshi Wada^a

^a First Department of Surgery, Hamamatsu University School of Medicine, 1-20-1 Handayama, Higashiku, Hamamatsu, Shizuoka 431-3192, Japan

^b Department of Orthopedic Surgery, Hamamatsu University School of Medicine, 1-20-1 Handayama, Higashiku, Hamamatsu, Shizuoka 431-3192, Japan

ARTICLE INFO

Article history:

Received 8 January 2014

Accepted 7 October 2014

Available online 17 October 2014

Keywords:

Giant lipoma
Pelvic tumor
Buttock tumor
Parasacral approach
Sciatic foramen

ABSTRACT

INTRODUCTION: Few reports detail adequate surgical management of giant pelvic tumors that traverse the sciatic foramen.

PRESENTATION OF CASE: We present a case of a giant retroperitoneal pelvic lipoma that presented with a dumbbell shape on imaging, occupying the entire lesser pelvis and protruding to the gluteus through the sciatic foramen. Surgery was performed for *en bloc* resection of the tumor.

DISCUSSION: A parasacral approach with the patient in the prone position was necessary to dissect the tumor in the buttock, manipulate around the sciatic foramen and preserve collateral blood flow for the gluteal muscle. An abdominal approach was also essential to ligate the internal iliac vessels involved in the tumor. Accordingly changing the position of the patient during the operation were required. Division of the sacrotuberous and sacrospinous ligaments and packing of the soft tumor into a plastic bag were useful to pass the buttock portion through the foramen without the tumor breaking off.

CONCLUSION: The asynchronous abdomino-parasacral approach with several turnings of the patient's body and plastic bag packing of the tumor were advantageous to manage *en bloc* resection of the giant pelvic lipoma presented in this case study.

© 2014 The Authors. Published by Elsevier Ltd. on behalf of Surgical Associates Ltd. This is an open access article under the CC BY-NC-SA license (<http://creativecommons.org/licenses/by-nc-sa/3.0/>).

1. Introduction

Orthopedic or general surgical procedures rarely present situations where one must synchronously manipulate in both the pelvic and buttock regions astride the sciatic foramen. In this case study, we detail a patient with a giant lipoma occupying the entire lesser pelvis and protruding to the left buttock through the sciatic foramen. For a case like this, few reports provide surgical management options regarding incision approaches, the patient's body position, and other tips to permit *en bloc* resection of such a tumor.

2. Presentation of case

A 60-year-old woman presented with a 7-year history of a dull lump on her left buttock; she started to suffer from buttock and perineal pain while walking a half year ago. She was referred to our hospital for surgery. On examination, a vague bordered large mass

with mild tenderness was palpable on her left gluteal region, but with no identified neurologic abnormalities involving her left leg.

A MDCT (multi-detector-row CT) examination revealed a huge, the maximum diameter was 21 cm in size, well-defined mass that occupied almost all of the pelvic space and extended to the left buttock through the greater sciatic foramen (Fig. 1). Magnetic resonance imaging showed that the mass had an iso-intensity equivalent to that of fat, suggesting an atypical lipoma or well-differentiated liposarcoma.

The patient's care team included orthopedists and general surgeons. The patient was placed in the prone position after insertion of a double-J stent into the left ureter. The skin was incised along the left margin of the sacrum and the sacral side of the gluteus maximus muscle was divided to expose the tumor following marginal dissection of the gluteal part of the tumor (Fig. 2a). The sacrotuberous and sacrospinous ligaments and coccygeal muscle were divided to enlarge the sciatic foramen. The pelvic part of the tumor was bluntly dissected as long as a finger reached through the enlarged foramen. The dissected portion of the tumor in the left buttock was put in a plastic bag before transient closure of the wound. The patient was then placed in a lithotomy position to open the abdomen. The involved left internal iliac artery was

* Corresponding author. Tel.: +81 53 435 2276; fax: +81 53 435 2272.
E-mail address: msnrsato@hama-med.ac.jp (M. Sato).

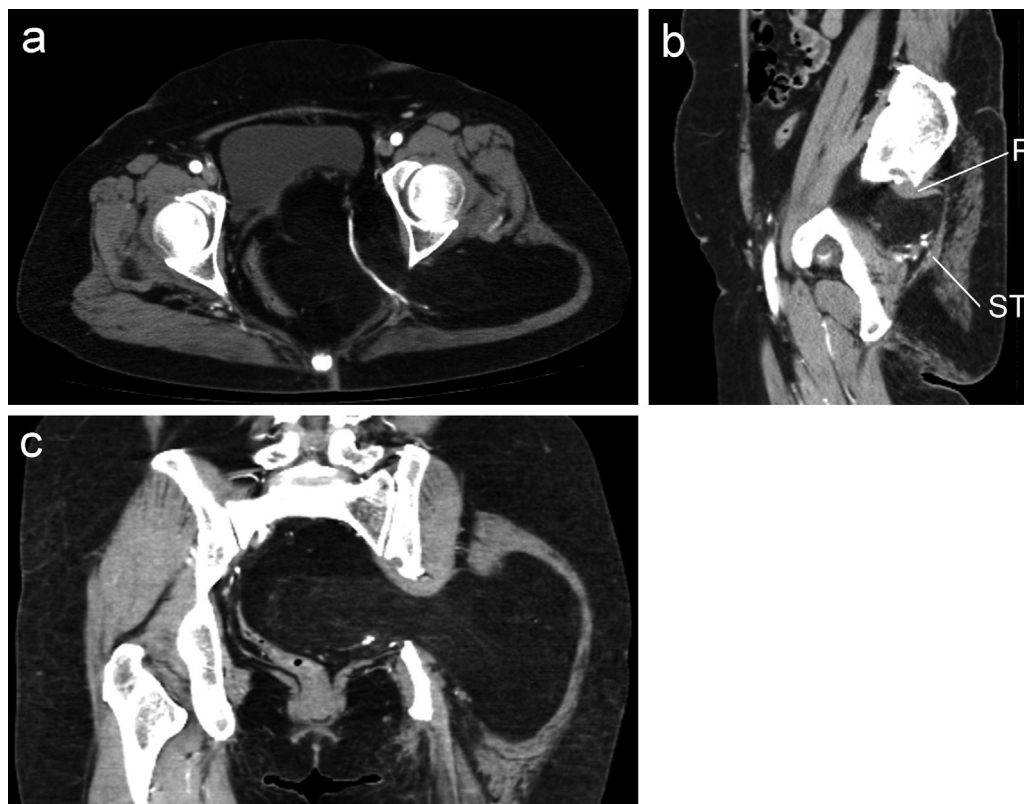


Fig. 1. Enhanced MDCT images of the tumor. (a) Axial view: the mass compressed the pelvic organs to displace the bladder anteriorly and the rectum to the right. The left internal iliac artery was involved in the tumor, and the inferior gluteal artery ran through the tumor. (b) Sagittal view: the mass passed through the infrapiriform foramen. (c) Coronal view: the mass extended to the left buttock and manifested with a dumbbell-like shape on the image. P: piriformis muscle, ST: sacrospinous ligament.

divided distal to the superior gluteal artery (Fig. 2b). The tumor was bluntly dissected until the edge of the plastic bag was pulped deep in the pelvis. After completion of the dissection, the plastic bag was raised up to the abdomen, resulting in complete removal of the whole tumor (Fig. 2c). The enlarged sciatic foramen was 5 cm × 3 cm and not covered with any prosthesis. For the last step, the patient was again placed in the prone position to reconstruct the sacrospinous ligament. The postoperative course was uneventful.

The tumor was a lobulated mass of adipose tissue measuring 21 × 17 × 3 cm in size, 860 g in weight (Fig. 3). Histologically, homogenous proliferation of mature adipocytes without obvious proliferation of immature adipoblasts was observed, corresponding to a diagnosis of well-differentiated lipoma.

The patient remained well for two years following her surgery and follow-up MDCT scans have demonstrated no recurrence and no hernia.

3. Discussion

The preoperative discussion in this case centered around strategies for approaching dissection of the tumor. Because the tumor occupied most of the pelvis and involved the internal iliac vessels, it was essential to access the pelvis via peritoneal or retroperitoneal approach. Simultaneously, it was also necessary to perform a skin incision on the buttock to dissect the large part of the tumor that was localized there. A classic posterior Kocher-Langenbeck approach would allow the main blood flow to the gluteus maximus (from the inferior gluteal artery) to remain intact.¹ However, in our case, removal of the tumor

resulted in an interruption of the blood flow from the inferior gluteal artery. Therefore, gluteal muscle dissection along the sacrum was beneficial to preserve collateral blood flow for the muscle. Furthermore, a parasacral incision above the sciatic foramen, physically the closest way to the foramen and posterior pelvic dissection.^{1,2}

Subsequently, the next area discussed was which body position was appropriate for the patient. Patients with chordoma or recurrent rectal cancer have undergone operations performed in the right lateral position via a synchronous abdominosacral approach, that afforded adequate mobilization of the colon and exposure of the levator ani in the deep pelvis while obviating the need to change the position of the patient.^{3–5} However, with tumors occupying and/or involving the pelvis, an asynchronous abdominosacral approach with changing the position of the patient during the operation has been adopted.^{3,6} We employed an asynchronous abdomino-parasacral approach in order to secure a better surgical field and flexibility for surgical manipulations. Transferring the patient to another operating table that had already been prepared for the next posture to be used helped reduce the stress related to this labor.

Enlargement of the sciatic foramen and use of a plastic bag were advantageous to accomplish *en bloc* resection of the tumor. If a part of the tumor that was localized in the buttock was blindly pulled out into the pelvis, the tumor might have been torn apart because of its own softness and thickness, which was larger than that of the sciatic foramen. Packing the buttock part of the tumor in a plastic bag offered strong and smooth capsule to the tumor and prevented it torn apart.

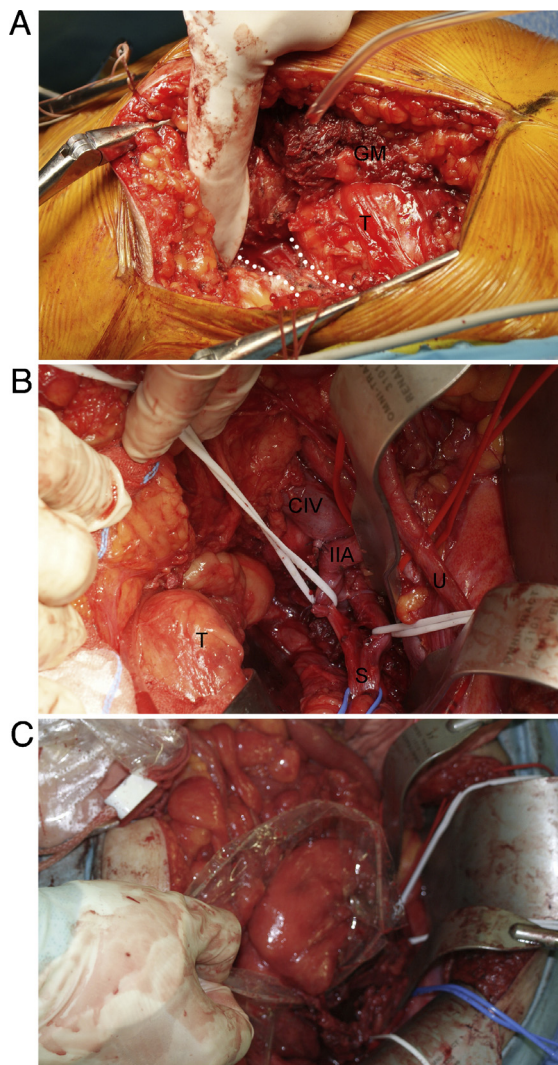


Fig. 2. Intraoperative view of the giant tumor. (a) View of the tumor through the buttock. The right side was directed cranially. The dot lines show the sacrotuberous ligaments below the tumor. (b) Pelvic view. The superior gluteal artery and sacral spinal nerves (S1, S2) were preserved. (c) A plastic bag was pulled out abdominally to remove the whole tumor. T: tumor, GM: gluteus maximus, CIV: common iliac vein, IIA: internal iliac artery, S: sacral spinal nerves, U: ureter.

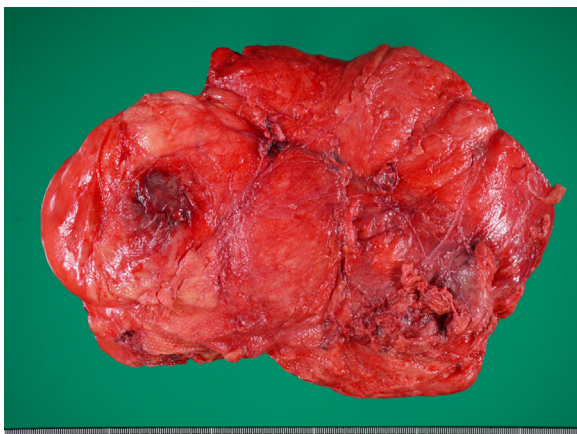


Fig. 3. Macroscopic view of the dissected specimen.

A defect in the sciatic foramen remained apparently large after tumor resection, but was unknown to develop into a sciatic hernia. Controversy has arisen concerning whether such a defect might also be fixed in the same way as a sciatic hernia.⁷ Mesh repair was preferred for fixing the sciatic hernias to prevent its recurrence, while mesh adhesions to the sciatic nerve might contribute to neuralgia.^{2,8} Furthermore, the tumor could potentially develop a local recurrence. If a mesh adhered near the recurrent tumor, the surgery would be tough and onerous; for this reason, we did not cover it with prosthetic mesh. Instead we reconstructed the sacrotuberous ligament and gathered the peritoneum tightly to make a new pelvic floor.

4. Conclusion

An asynchronous abdomino-parasacral approach with several turnings of the body and plastic bag packing of the tumor were advantageous to manage *en bloc* resection of a giant pelvic lipoma in our case study.

Conflict of interest statement

We certify that there is no conflict of interest with respect to receiving financial compensation for this work from third parties.

Funding

None.

Ethical approval

Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal on request.

Author contributions

Masanori Sato was an attending surgeon who was involved in this patient's management. He was also involved in drafting and revising the manuscript. Yuichiro Miyaki was an attending surgeon who was involved in this patient's management. He was also involved in drafting and revising the manuscript. Koji Inamori was a surgical fellow who was involved in this patient's management. He was also involved in drafting the manuscript. Junpei Tochikubo was a surgical fellow who was involved in reviewing the scientific literatures. He was also involved in revising the manuscript. Yoji Shido was the Orthopedic Surgery Consultant in charge of this patient's surgical management and involved in this patient's management. He was also involved in revising the manuscript. Norihiko Shiya was the Department Director in charge of this patient's surgical management. He was also involved in revising the manuscript. Hidetoshi Wada was the General Surgery Consultant in charge of this patient's surgical management. He was also involved in revising the manuscript.

References

- Hayashi N, Suwa T, Kimura F, Okuno A, Ishizuka M, Kakizaki S, et al. Radiographic diagnosis and surgical repair of a sciatic hernia: report of a case. *Surg Today* 1995;**25**(12):1066–8.
- Sadek HM, Kiss DR, Vasconcelos E. Sciatic hernia caused by a neurofibroma. Surgical repair with a stainless wire mesh. *Int Surg* 1970;**54**(2):135–41.
- Localio SA, Francis KC, Rossano PG. Abdominosacral resection of sacrococcygeal chordoma. *Ann Surg* 1967;**166**(3):394–402.
- Michel LA, De Cloedt P. Synchronous abdominal and transsacral approach for excision of sacrococcygeal chordoma. *Acta Chir Belg* 1989;**89**(6):316–9.

5. Donaldson GA, Rodkey GV, Behringer GE. Resection of the rectum with anal preservation. *Surg Gynecol Obstet* 1966;**123**(3):571–80.
6. Wanebo HJ, Marcove RC. Abdominal sacral resection of locally recurrent rectal cancer. *Ann Surg* 1981;**194**(4):458–71.
7. Skipworth RJ, Smith GH, Stewart KJ, Anderson DN. The tip of the iceberg: a giant pelvic atypical lipoma presenting as a sciatic hernia. *World J Surg Oncol* 2006;**4**:33.
8. Chaudhuri A, Chye KK, Marsh SK. Sciatic hernias: choice of optimal prosthetic repair material in preventing long-term morbidity. *Hernia* 1999;**3**(4):229–31.

Open Access

This article is published Open Access at scimedirect.com. It is distributed under the [IJSCR Supplemental terms and conditions](#), which permits unrestricted non commercial use, distribution, and reproduction in any medium, provided the original authors and source are credited.