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**Dr. Pankil Mota**
Assistant Professor, MS General Surgery, LTMGH, Mumbai, Maharashtra, India

**Dr. Vaishnavi Ruchinda Maske**
Reg. MS General Surgery, LTMGH, Mumbai, Maharashtra, India

**Dr. Ranjeet Kamble**
Associate Professor, HOU, MS General Surgery, LTMGH, Mumbai, Maharashtra, India

**Dr. Shwetambari Ingawale**
SR. MS General Surgery, LTMGH, Mumbai, Maharashtra, India

**Corresponding Author:**
**Dr. Pankil Mota**
Assistant Professor, MS General Surgery, LTMGH, Mumbai, Maharashtra, India

# Gluteal malignancy misdiagnosed as gluteal abscess

**Dr. Pankil Mota, Dr. Vaishnavi Ruchinda Maske, Dr. Ranjeet Kamble and Dr. Shwetambari Ingawale**

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**Abstract**
We hereby report 2 cases which were misdiagnosed as gluteal abscess for which incision and drainage was performed before referring patient to us. One of these was paediatric patient and another was adult male patient; which were reported as malignant germ cell tumour and cutaneous T cell lymphoma (high grade non-Hodgkin cell lymphoma) respectively.

**Keywords:** Gluteal abscess, misdiagnosis, incision and drainage

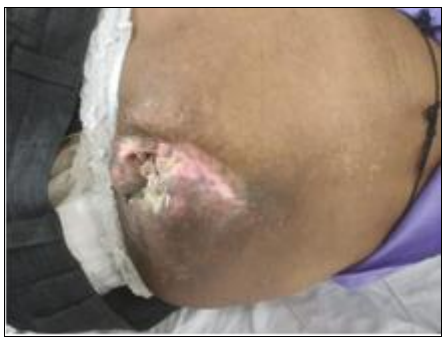
## Introduction
Extragonadal germ cell tumors (EGGCTs) are uncommon neoplasms, which arise in anatomical locations other than gonads. The pathogenesis of these neoplasms is still poorly understood, and it is a matter of debate if they really represent extragonadal primary neoplasms or rather extragonadal metastasis from occult gonadal neoplasms. The actual observations suggest that EGGCTs represent a unique entity, so their biology and behavior are substantially different from gonadal counterparts. The diagnosis of EGGCT and is often challenging, and differential diagnosis is particularly wide [5].
Non-Hodgkins lymphoma presenting in gluteal muscle is rare [6]. T-cell malignant lymphoma with a complication of a secondary infection can mimic perianal abscess or gluteal abscess [4].

## Case Presentation
**Here we are discussing the 2 cases**
**Case 1**
A 7yr/F, malnourished from rural areas of Uttar Pradesh, came with history of gluteal abscess of Right Buttock 1 month back for which I&D was performed by another doctor. The parents did not take child to follow up and brought a patient to us on exploration under anesthesia we found 8 pieces of gauze inside the wound covered with pus and Slough. Thorough wash was given. Tissue for culture sensitivity was sent and reported as Acinetobacter species; Sensitive to: Amikacin, Ceftriaxone; same Injectable antibiotics were started. After many days of cleaning and dressing wound started to look healthy. After this relatives asked for discharge, on request patient was discharged in condition to that patient will do daily dressing. After about 4 months the patient was brought to us with the given picture with formation of the lump over the gluteal area. This time biopsy was sent. Then USG was done. It was suggestive of Mild hepatomegaly with inhomogeneous echo texture of liver parenchyma. Left side Grade 1 echogenic kidney with hydroureteronephrosis. Ill-defined heterogenous mixed echogenic (Predominantly hypoechoic) lesion noted in pelvic region 82 x 67 mm. The biopsy report was suggestive of malignant germ cell tumour.
The relatives were not affording for any further treatment; therefore requested to take patient to hometown. And patient sent home on request. Out of curiosity telephonic conversation when made to the patient; relatives informed that the patient succumbed to the disease and forwarded following document of CT report suggestive of large ill-defined abdomino-pelvic soft tissue attenuation mass lesion 85x74x161 mm with internal calcification as well as cystic areas & few areas of fat attenuation. Urinary bladder displaced anteriorly, recto-sigmoid displaced with ill-defined fat planes, inferiorly extending along pre-sacral & pre-coccygeal space involving half of perineum incl. Rt ischio-rectal fossa. Overlying skin also involved. Poor fat planes with pelvic floor muscles, focal involvement Rt. Gluteal muscles causing compression b/l lower ureter,

sacrum & coccyx normal. Enlarged Rt. Inguinal and rt. Iliac lymph nodes max 12x16 mm. Impression: sacrococcygeal teratoma with LN metastasis.
Histopathology with IHC report suggestive of immature teratoma of sacrococcygeal region.

**Case 2**
50yr old male came with past history of incision and drainage 5 months back with fresh per rectal bleed in a in a k/c/o diabetic and chronic alcoholic came along with h/o burning micturition and pain while defecation. H/o generalized weakness, loose stools, anorexia, weight loss.

**On Clinical examination:** 10 x 10 cm hard mass palpable circumferentially around anal canal with indurated skin, site of previous i&d shows unhealthy granulation tissue, slit like opening of the anal canal with active bleeding.
USG local was done was suggestive of ill-defined, heterogenous predominantly hypoechoic lesion size 9 x 4.5 cm not showing any vascularity, increased echogenicity of surrounding fat, denotes abscess formation at local site with inflammatory/ infective etiology. Then Patient followed up for 5 months; on routine basis repeat USG local done to look for any collection. IT was suggestive of ill-defined, heterogenous predominantly hypoechoic lesion with hyperechoic areas size 13×10×10 cm with raised internal vascularity, perianal region in subcutaneous and intramuscular plane f/s/o neoplastic etiology. In curiosity to investigating this case; USG abdomen was done Suggestive of mild ascitis, peri Rectal sub cm sized Lymph nodes, irregular circumferential bowel wall thickening involving Rectum and anal canal showing raised internal vascularity with max diameter 2cm, however, proximal bowel loops not dilated.
After noting above findings biopsy was taken suggestive of High-grade non-Hodgkin lymphoma cutaneous T cell Lymphoma. After this patient was sent to chemotherapy however patient lost to follow up.



**Discussion**
In a case 1 gluteal abscess biopsy was reported as germ cell tumor GCT (sacrococcygeal teratoma). Extragonadal germ cell tumor can produce wide range of clinical manifestations. These tumors can be found in midline particularly retroperitoneum, the anterior mediastinum, the Sacro coccyx, pineal gland. Other less common sites include orbits, suprasellar area, palate, thyroid, anterior abdominal wall, stomach, liver, vagina, prostate, etc. [7]
The classic theory suggests that GCTS are derived from local transformation of primordial germ cells misplaced during embryogenesis. Malignant transformation based on Target cell transformation (Zygotene-pachytene spermatocyte). In this stage chromatid exchange occurs by crossing over leading to multistep process of genetic changes consist of increase in 12p copies, overexpression of cyclinD2 and oncogenic effect of CCND2 gene. Sacrococcygeal tumours presents with pain and bowel change habits, severe arthropathy [7].
In a case 2 gluteal abscess biopsy was reported as cutaneous T cell lymphoma (CTCL). These group of disorders are characterized by abnormal accumulation of malignant T cell lymphocytes in the skin presented as rashes, plaques and tumors. There are 2 types of CTCL; mycosis fungoides (MF) and Sezary syndrome (SS). MF is a most common, slow growing type which mainly affects skin in a wide range. SS affects skin as well as lymph nodes. CTCL is due to deficient expression of function of negative regulators like SOCS3, SHP1 leads to dysregulation of Jak STAT pathway and IL independent proliferation of malignant T cells [2].
These malignancies result in morbidity, lowering life expectancy and finally mortality. Therefore, chronic abscess should not be neglected. Every abscess should be investigated further to rule out malignancy for early diagnosis and treatment of neoplasm. Biopsy should be considered while evaluating gluteal abscess to diagnose the possibility of malignancy for modification of planned extensive operation and ultimately multimodal therapy based on stage and histological type of disease.

**Conclusion**
High Index of suspicion to be borne in the mind in patients presenting with chronic abscess not healing with conventional methods & possibility of it being a neoplasia should always be ruled out.

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