Case Report

We report the case of a 49-year-old unmarried patient complaining of perineal masses evolving for 10 years with no menstrual disorders. She also reported constipation. The rate of growth of these masses was slow. Clinical examination shows two perineal masses lifting the skin of firm consistency on both sides of the vulva and near the anus. These masses had a diameter of 8 and 9 cm, respectively (Fig. 1). At this stage, diagnostic difficulties were: the presumption of benignity or malignancy, and contiguity relations to the anus and vascular structures. Pelvic ultrasonography did not show any abnormality in uterus or adnexa. An exploration by MRI was performed and showed a non-invasive muscular resonance process below the levator ani muscle. These perineal formations were presumed benign for: the slow clinical evolution and the absence of malignancy criteria on MRI.

The patient was operated on the 24th February 2014: first, by laparoscopy; there was not any mass protruding into the pelvis. The exeresis was performed through bilateral incision in the crease of the thigh. Dissection was relatively easy (Figs. 2 and 3). Two solid formations of 10 and 8 cm were removed with no evidence of locoregional invasion, including the anus. Some bleeding points in the cavities required ligature. After the resection the sphincter mechanism was noted to be intact. Histological examination confirmed the purely myomatous nature of these formations. The postoperative course was uneventful. The patient was seen a month later, she had a good perineal healing and no longer complains about constipation.

Comment

Soft-tissue tumors of the perineum are rare and usually diagnosed in male patients. Liposarcoma and aggressive angiomyxoma are the most frequent histological subtypes.
Few cases of perineal myomas were reported exclusively in male by London in 1953 and Galvan in 1972 [2, 3]. Perineal leiomyomas are extremely rare with an incidence of 3.8% of all benign soft-tissue tumors [4].

Rare cases of unilateral perineal myoma in female patients were reported in the literature [4–8]. This case report is historical: it’s, in fact, the first case of bilateral perineal myoma in female reported in literature. The first case of perineal myoma was published by McCann in 1912 [5]. The patient was 54-year-old female with a large pendulous perineal tumor. The operation was carried out with two incisions: abdominal and perineal. After removing the myoma by supravaginal hysterectomy, a swelling was found occupying the left side of the pelvis anteriorly. As the enucleation proceeded the tumor was found to be continuous with the perineal growth and appeared to pass through a large foramen in the pelvic fascia. The tumor was gradually enucleated. He stated that the tumor had probably originated from the visceral layer of the pelvic fascia.

More recent publications suggest the diagnostic difficulties in managing perineal masses. For Von Waagner and al, a low-grade sarcoma should be considered as a differential diagnosis [6]. For the same author, magnetic resonance imaging with intravenous contrast (MRI) is an excellent imaging tool for the characterization and diagnosis of perineal soft-tissue lesions. However, perineal leiomyomas can have variable and misleading MRI presentations [7].

Most perineal myomas reported in the literature were managed by perineal incisions. For Sistal and al an abdominoperineal surgical approach is recommended for such a lesion [8]. We recommend performing a laparoscopy prior to perineal surgery.

In our case report, the patient had perineal formations evolving for 10 years. This case had presented to us diagnostic difficulties that have been partially resolved by imaging techniques (MRI). Diagnostic difficulties were the presumption of benignity or malignancy, and contiguity relations to the anus and vascular structures. In our opinion, achieving an MRI in perineal formations is necessary to predict the complete resectability of the tumor, rather than to presume of its nature.

**Conflict of Interest**

None declared.

**References**

1. Behranwala, K. A., M. A. Clark, and J. M. Thomas. 2002. Soft-tissue tumours of the perineum. Eur. J. Surg. Oncol. 28:437–442.
2. London, M. Z. 1953. Perineal myoma. Calif. Med. 78:63–64.
3. Galvan, E. S. 1972. Giant fibroma of the perineum. Am. J. Proctol. 23:68–71.
4. Oliveira Brito, L. G., L. Falcão Motoki, P. S. Magnani, M. M. Sabino-de-Freitas, G. A. Magnani Landell, and S. M. Quintana. 2011. Giant perineal leiomyoma incidentally manifested at a recent episiotomy site: case report. J. Minim. Invasive Gynecol. 18:267–269.
5. McCann, F. J. 1912. Fibroma of the pelvic fascia forming a large perineal tumour. Proc. R. Soc. Med. 5:38–41.
6. Von-Waagner, W., H. Liu, and A. I. Picon. 2014. Giant perineal leiomyoma: a case report and review of the literature. Case Rep. Surg. 2014: doi: 10.1155/2014/629672.
7. Koc, O., N. Sengul, and S. Gurel. 2010. Perineal leiomyoma mimicking complex Bartholin mass. Int. Urogynecol. J. 21:495–497.
8. Sistla, S. C., R. Reddy, G. Sankar, and S. Elangovan. 2009. Pelvic leiomyoma presenting as perineal hernia. Hernia 13:213–215.