Intractable coccygodynia is frequently labelled as being idiopathic or post-traumatic in the literature (1, 2). Herein, we report a case of epidermal inclusion cyst in the precoccygeal region causing severe pelvic and coccygeal pain.

Case report

A 33-year-old pregnant woman was admitted to our hospital complaining of severe pelvic and coccygeal pain. Her medical examination and laboratory tests were found within normal limits. In order to explain her pain, initially a pelvic ultrasound was performed which revealed a huge hypoechoic cystic mass in the precoccygeal-presacral region. She then underwent a pelvic magnetic resonance imaging (MRI) examination in order to better delineate the characteristics and extension of this huge mass. On these images the mass was hypointense on T1 weighted images and extremely hyperintense on T2 weighted images. We also performed a diffusion weighted sequence which exhibited high signal intensity for the mass. We thought that this finding could be suggestive of an epidermal inclusion cyst similar to that of a brain epidermoid cyst which shows bright signal intensity on diffusion weighted images. The patient was operated and the cystic mass removed from the precoccygeal region. Histopathological examination confirmed the diagnosis of epidermal inclusion cyst. This case report suggests that an epidermal inclusion cyst should be considered in the differential diagnosis of intractable pelvic and coccygeal pain. MRI can help to establish the correct diagnosis.

Key-word: Coccyx.

In this case report, we are presenting a 33 year-old pregnant woman who suffered from pelvic and coccygeal pain. Her medical examination and laboratory tests were found within normal limits. In order to explain her pain, initially a pelvic ultrasound was performed which revealed a huge hypoechoic cystic mass in the precoccygeal-presacral region. She then underwent a pelvic magnetic resonance imaging (MRI) examination in order to better delineate the characteristics and extension of this huge mass. On these images the mass was hypointense on T1 weighted images and extremely hyperintense on T2 weighted images. We also performed a diffusion weighted sequence which exhibited high signal intensity for the mass. We thought that this finding could be suggestive of an epidermal inclusion cyst similar to that of a brain epidermoid cyst which shows bright signal intensity on diffusion weighted images. The patient was operated and the cystic mass removed from the precoccygeal region. Histopathological examination confirmed the diagnosis of epidermal inclusion cyst. This case report suggests that an epidermal inclusion cyst should be considered in the differential diagnosis of intractable pelvic and coccygeal pain. MRI can help to establish the correct diagnosis.

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From: 1. Department of Radiology, Sisli Etfal Training and Research Hospital, Sisli, Istanbul, Turkey.

Address for correspondence: Dr A.M. Halefoglu, Department of Radiology, 34360, Sisli Etfal Training and Research Hospital, Sisli, Istanbul, Turkey.
E-mail: halefoglu@hotmail.com
Carcinoid), glomus tumors of the
pericoccygeal tissue, lumbosacral intradural tumors (schwannoma,
ependymoma, arachnoid cysts), perineural cyst, intraosseous lipoma,
infected diseases (tuberculosis), anal duct/gland cyst, and avascular
necrosis of the coccyx.

In our case report, US examination revealed a huge cystic mass in
the precoccygeal—presacral region. Histopathological examination of the lesion
confirmed our diagnosis of epidermal inclusion cyst.

Discussion

Despite coccygeal pain being often regarded as a disease, it in fact is a symptom. Although it is mostly regarded as idiopathic or traumatic in origin, various unusual pathological conditions have been described as a cause for coccygeal pain (3, 4).

Since coccygeal pain usually develops after a local injury, trauma has been accepted widely as the aetiologic factor. Antecedent trauma due to falls or difficult vaginal delivery can directly injure sacrococcygeal synchondrosis. Some rare pathological conditions which can be manifested as coccygeal pain include recent fracture (post-traumatic or intrapartum), dislocation, tumors of the sacrum and coccyx (haemangioma, carcinoid), glomus tumors of the

On this sequence the mass exhibited very high signal intensity related to its water restriction. This finding led us to consider that this mass could be representative of an epidermal inclusion cyst. Similar findings are also present for brain epidermoid cysts on diffusion weighted images. Following MRI examination, the patient was operated and the cystic mass removed from the precoccygeal—presacral region. Histopathological examination of the lesion confirmed our diagnosis of epidermal inclusion cyst.

Despite coccygeal pain being often regarded as a disease, it in fact is a symptom. Although it is mostly regarded as idiopathic or traumatic in origin, various unusual pathological conditions have been described as a cause for coccygeal pain (3, 4).

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In the literature, we encountered only one case report published by

Malignancy must be ruled out. Rarely, some malignancies including basal cell carcinoma, Bowen’s disease, squamous cell carcinoma and even mycosis fungoides can be developed in epidermal cysts (8).
Tokunaga et al. (9) reported a presacral epidermoid inclusion cyst in a 63 year-old Japanese man with a high CEA content. Histological examination showed that the tumor wall was made of keratinized stratified squamous epithelium without any cutaneous adnexal structure and therefore it was diagnosed as an epidermal inclusion cyst. CEA was identified in these benign epithelial cells by immunoperoxidase staining using a monoclonal antibody. This patient was the first reported case of an adult male with a presacral epidermoid cyst.

Finally, we can state that an epidermal inclusion cyst in the pre-coccygeal-presacral region is an extremly rare pathology and can cause intractable pain. Correct diagnosis carries a crucial role for the treatment and MRI plays an important role for establishing a correct diagnosis. Epidermal inclusion cysts should be considered in the differential diagnosis of coccygeal pain together with other pathologies.

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