Giant dorsal sacral meningocele in a child

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ABSTRACT
Sacral meningoceles are uncommon congenital lesions, usually described in the anterior or lateral position, and they typically are asymptomatic [1,7]. A nine-years male child presented with a progressively increasing swelling over the lumbosacral region since birth.

Sacral meningoceles are uncommon congenital lesions, usually described in anterior or lateral position and are typically asymptomatic.1-7 A nine-year-old male child presented with a progressively increasing swelling over the lumbosacral region since birth. There was no history of any bowel or bladder dysfunctions. Motor and sensory examination was normal. Planters were flexor. Rectal tone was normal. Gait was normal. Results of her sensory, rectal tone and lower limbs motor exams were within normal limits. There were no abnormal skin lesions, skeletal deformities, abnormal sinus or swellings. A physical examination of the patient showed a soft, 4 x 4-cm fluctuant and non-pulsatile mass over sacral region, completely with normal skin without any stigmata. The transillumination test was positive. Routine blood investigations were normal. Magnetic resonance imaging (MRI) of the lumbosacral spine showed a large, well-defined cystic over sacrum without any evidence of internal echoes, solid component or septae (Figure-1 and 2). There was evidence of communication between the cyst and the spinal canal. The patient underwent surgical excision of the swelling and repair of the sac. The large cyst was entered and found to contain clear CSF in a terminal continuation of the spinal subarachnoid space. There was no neural tissue in the sac. And there was no evidence of tethering. Postoperatively, the child had normal neurological and urological function. CT of the brain did not show any evidence of hydrocephalus. He developed CSF leak in post-operative and the defect was repaired with pedicel graft.

A meningocele a developmental defect in the dura resulting in an outpouching of leptomeninges through defect covered with only a layer of skin. 4 Most of the sacral meningoceles are asymptomatic with a soft tissue mass; they produce clinical symptoms depending on their

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sacral meningocele, lipomyelomeningocele, MRI, meningocele, sacral mass

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proximity to the spinal cord and nerve roots (e.g. unexplained radiating or low back pain, or sensory or motor deficits, atypical bowel dysfunction). The differential diagnosis for the mass lesions in children in sacro-coccygeal area includes meningocele, myelomeningocele, myelocystocele, teratoma, lipoma, hamartoma, lymphangioma, hemangioma, chordoma, and ependymoma. MRI is the investigation of choice as it will better delineate the details of the sac and its contents. Also it will help to know the extent of the spinal cord and position of the nerve roots. Radiographs may reveal erosion and widening in the sacral bone, scalloping of the pedicles, laminae and vertebral bodies adjacent to the meningocele resulting in an enlargement of the spinal canal.

Indications for surgical repair include clinically symptomatic patients or if the lesions located in an area where it has greater risk of mechanical trauma or rupture (as in the present case).

References