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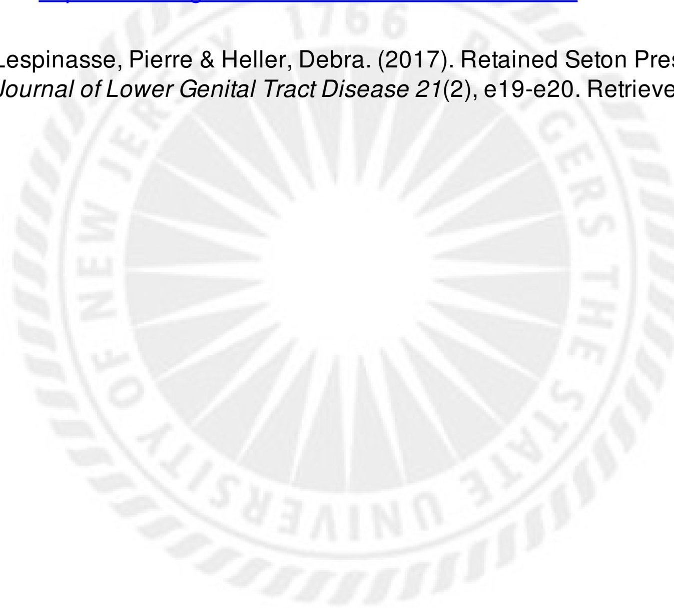

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Retained Seton Presenting as a Perineal Abscess

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Precis: A case of perineal abscess secondary to retained seton is presented.

Key words: Vulvar diseases, perineum, episiotomy, foreign body

Introduction:

A seton stitch is used in treatment of fistula-in-ano. It is usually part of a staged procedure, removed at the time of final surgery. A retained seton can be a foreign body. We present what we think is the first reported case of a retained seton presenting as a perineal abscess.

Case:

A multiparous woman in her thirties presented with persistent drainage from a perineal cyst for 4 months.

The patient was a sub-optimal historian, with multiple hospitals involved, and the history was difficult to put together. She reported onset of perineal cyst and pain 16 years ago, shortly after delivery of her second child. Episiotomy was performed at that delivery. Subsequently, she had recurrent cysts, usually on the right, and incision and drainage of Bartholin's cysts on 3 separate occasions, with placement of Word catheters. She was treated with antibiotics on several occasions. Last year, she reported undergoing evaluation for possible fistula, which was reportedly not identified. At the current presentation, there was a 1x1cm area of induration to the right of the introitus with a pinpoint opening that could not be probed. Purulent material could be expressed from the opening. A CT scan showed an intermediate density ring-like metallic structure within perineal soft tissues suspicious for foreign body and multiple ill-defined fluid collections within the perineal region compatible with small abscesses(Figure 1). The patient was discharged home with oral cephalexin and sulfamethoxazole/trimethoprim, and scheduled

for follow-up. One month later, examination under anesthesia revealed multiple fibrotic growths near the vestibule which were excised. Lacrimal duct dilators were used to find the abscess tract in the perineum, and the tract was opened. Suture material in a ringed shape was extracted from the superficial transverse perineal body(Figure 2). The abscess tract was completely evacuated and the wound was closed. There was subsequent wound breakdown of the surgical site, and the wound was packed and allowed to close by secondary intention. Cultures revealed many Gemella morbillorum, beta-lactamase negative.

Discussion:

This patient likely had a seton stitch placed previously for treatment of presumed fistula-in- ano, causing her symptoms. Fistula-in-ano occurs when an anorectal abscess is drained, either spontaneously or surgically, and does not heal completely. The fistula tract has an internal opening in the anal crypt at the dentate line, and an external opening on the skin. Fistula-in-ano is an uncommon complication of perineal laceration and episiotomy at vaginal delivery.

The principles of fistula treatment include establishment of adequate drainage and obliteration of the internal opening. One option for treatment of fistula is a staged procedure with the use of a seton, an encircling suture that stents the fistula open. It is passed through the lumen of the fistula tract in a loose fashion(1), to allow drainage of the purulent material. A cutting seton may also be used(2), where the stitch is sequentially tightened over a period of weeks, cutting through the sphincter and creating fibrosis. The cutting seton, however, significantly increases the risk of fecal incontinence. Approximately 6-12 weeks after the seton suture is placed, the patient returns to the operating room to have it removed, and the fistula tract ablated by fistulotomy, application of fibrin glue, or endoanal advancement flap for more complicated fistulas.

It is likely that the described patient, with her history of presenting to multiple hospitals, had a seton placed, but never removed. We found no similar reported case, utilizing a MEDLINE search of the English literature using “labia”, “vulva”,

“perineum”, “foreign body”, “suture”, and “suture material”, although a retained perineal suture needle has been reported(3).

Gemella morbillorum, formerly streptococcus moribillorum, may be found in the normal flora of the oropharyngeal area. It is rarely a cause of infection in humans(4). When infections do occur, they are similar to viridans streptococci. Endocarditis, liver abscess, sinusitis, pleural empyema, osteomyelitis, brain abscess and bacteremia have been reported. We were unable to locate reports of fistula-in-ano associated with gemella morbillorum.

Mimics of fistula-in-ano must be considered in the differential of a draining lesion on the perineum. It is important to establish a cause for a recurrent abscess, rather than merely continually draining it. MRI or CT are useful adjuncts, particularly in a case such as ours, with a sub-optimal clinical history available. It is important to rule out pilonidal sinus, Crohn’s disease, hidradenitis suppurativa, infected perianal cysts, and low rectal or anal cancers, which can mimic anal fistula.

In summary, this is a case of a retained seton suture the patient was unaware of causing persistent perineal abscess. A retained episiotomy suture, if non-absorbable, could have presented in a similar manner, however the thickness and twisting of the current suture, along with the history led us to our conclusion. The patient was not an optimal historian, and had a history of presenting to multiple hospitals, which further complicated establishing her diagnosis. Retained foreign body is a rare condition that should be considered in the differential diagnosis of a patient with a non-healing draining vulvar , Bartholin, or perineal lesion.

Abbreviations and Acronyms

CT-Computerized axial tomography

MRI-Magnetic Resonance Imaging

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