Case Report

Rare case of deep pelvic retroperitoneal mature cystic teratoma

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INTRODUCTION

Teratomas are congenital tumours containing derivatives of all three germ layers generally arising from gonads, rarely in extragonadal sites. Primary retroperitoneal teratomas account for 1 – 11% of all retroperitoneal neoplasms and are childhood tumours. Less than 20% of these patients are over 30 yrs of age.1 Early diagnosis and surgery are the mainstay of treatment.

Here we describe a rare case of a deeply embedded pelvic retroperitoneal mature cystic teratoma in an adult patient, successfully removed surgically.

CASE REPORT

Mrs. XYZ, a 38 yr old lady came with complaints of severe abdominal pain which was present on and off for 2 months but increased in severity since 3 days. Patient complained of chronic constipation. She had mild tachycardia and mild pallor. Abdomen was soft with generalised tenderness. Speculum could not be introduced due to extreme vaginal fullness from an extensive and deep pelvic mass. On per vaginal examination, a large 8 x 10 cm mass was felt in the paravaginal region, extending in the presacral, pararectal area up to lateral pelvic wall, fluctuant, tender. Ultrasonography showed ovarian tumour with torsion. A provisional diagnosis was made after MRI scan and patient was posted for exploratory laparotomy. After extensive blunt and sharp dissection, the cyst wall could be separated from the surrounding structures and successfully excised. Histopathology confirmed the diagnosis. Being such a rare tumour, it is essential to have a high degree of suspicion in such cases that can be supported by advanced imaging modality. Early diagnosis and complete surgical removal are the mainstay of management that provide an excellent prognosis for such patients.

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ABSTRACT

Mature cystic retroperitoneal teratomas are typically rare childhood tumours. Less than 20% of these occur in adults more than 30 yrs of age. Our adult patient presented with such a tumour, which had grown to a disproportionately large extent. It was deeply embedded in the true pelvis extending laterally to the pelvic wall and inferiorly till the ischiorectal fossa and was adherent to the surrounding structures displacing all. A provisional diagnosis was made after MRI scan and patient was posted for exploratory laparotomy. After extensive blunt and sharp dissection, the cyst wall could be separated from the surrounding structures and successfully excised. Histopathology confirmed the diagnosis. Being such a rare tumour, it is essential to have a high degree of suspicion in such cases that can be supported by advanced imaging modality. Early diagnosis and complete surgical removal are the mainstay of management that provide an excellent prognosis for such patients.
Figure 1: MRI showing deep location, content and extent of cyst.

Figure 2: MRI showing lateral extent of cyst with displacement and compression of surrounding structures.

Figure 3: Gross picture of cyst contents.

Figure 4: Histopathology of cyst wall showing stratified squamous epithelium (epidermal origin).

Figure 5: Histopathology showing various elements of mesodermal and endodermal origin.

DISCUSSION

Teratomas are tumours arising from pluripotential embryonal cells. The migratory property of germ cells explains their occurrence in extragonadal sites, generally along the midline.\(^1\) The deep pelvic and lateral extension in this patient is a rarest of rare occurrence.

Retroperitoneal teratomas remain asymptomatic as this space is extensive enough to allow free growth. When the tumour grows large enough and compresses surrounding structures, patients have abdominal distension, pain and pressure symptoms. Acute abdomen as a presentation is rare as seen here.\(^2\)

Macroscopically teratomas are classified into cystic and solid. Cystic teratomas are typically benign in nature whereas solid are malignant.\(^3\)

The differential diagnosis can be divided into neoplastic (lymphangioma, mucinous cystadenoma, epidermoid cyst) and non-neoplastic (lymphocele, urinoma, hematoma). As clinical implications and therapeutic strategies differ for all, it is important to differentiate between these masses.\(^4\)

Among imaging modalities, CT scan gives specific information on the fat, proteinaceous fluid, calcification, tumour extent and cyst wall.\(^4\) MRI scan is superior to CT and USG for demonstrating relationship with adjacent structures and local spread.\(^5,6\)

Goal of treatment is complete surgical removal. If contiguous spread hasn’t occurred, the cure rate is high.\(^7\) However as it is possible that histologically mature teratomas may take a malignant clinical course, careful follow-up is necessary for such cases.\(^8\)

REFERENCES


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