

A Rare Case Report of Asymptomatic Tumor Mass as Incidental Finding during Cesarean Section

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Abstract: *Teratoma is the most common germ cell tumor among pediatric and female patients which originates from germ layers and can be located everywhere in the body. They are diagnosed by ultrasonography which is characterized by calcification and cystic anechoic view [1]. Here we present a case of cystic teratoma in pregnant women which was an incidental finding during lower segment caesarean section. 33-year gravida 3 para 1 live 1 abortion 1 at term was posted for emergency lower segment caesarean section in view of previous caesarean section with cephalopelvic disproportion in labour. Intraoperatively large lobulated cystic masses were observed in right parametrium surrounded by omental adhesions, largest measuring approximately 10cmx8cm. After extensive blunt and sharp dissection, the cyst wall could be separated from the surrounding structures and excised in toto. [2] Histopathology was suggestive of cystic teratoma.*

Keywords: cesarean section, asymptomatic tumor

1. Introduction

Teratoma is a type of germ cell tumor comprising of well differentiated tissue and three germ cell layers: ectoderm, mesoderm and endoderm with peak incidence in females aged 20-40 years, these tumours comprise 10-20% of all ovarian neoplasms.[3] These tumors are characterized as generally slow growing and unilateral, with a reported bilateral incidence of 10%.[3] Generally, teratomas are asymptomatic, however, the most common symptom is abdominal pain.[1] They rarely cause ovarian rupture or torsion. [1] Teratomas can be located anywhere in the body, but usually in gonads. The treatment is conservative surgery but radical surgery is performed when it is required. [1] Here we present a case of asymptomatic incidentally discovered benign cystic teratoma during lower segment caesarean section, which clinically looked to be right chronic parametrial cold abscess.

2. Case Report

My patient, 33 years old female, gravida 3 para 1 live 1 abortion 1, who conceived the index pregnancy spontaneously and came at 40 weeks with pain in abdomen for 4 hours. Past obstetric history: para 1 live 1- male 6 years old, underwent lower segment caesarean section in view of fetal distress. She had an induced abortion 1 year back in view of unwanted pregnancy, and dilatation and curettage was done. Patient had history of copper T insertion after the induced abortion which was removed in 4 months, in view of excessive menstrual bleeding with dysmenorrhea and intermenstrual per vaginal white discharge. Gravida 3-present pregnancy, registered at D.Y. Patil Hospital Kolhapur. Patient's antenatal ultrasonography did not mention any cystic lesion. Patient also had a history of

laparoscopic cystectomy done at the age of 14 years of which documentation was not available. Patient was posted for lower segment caesarean section for cephalopelvic disproportion with previous caesarean section at D.Y. Patil Hospital Kolhapur. Intraoperatively large lobulated cystic mass was observed in right parametrium that appeared to be inflamed, surrounded by omental adhesions and adherent to the anterior wall of the uterus (figure 1), the largest measuring approximately 10cmx8cm. A band like structure extending from the cystic mass to the left ovarian ligament was also observed (figure 3). On careful examination both the ovaries were normal. Both tubal ends and fimbriae were normal. A normal saline wash was given to the pouch of Douglas and abdominal cavity before dissection and piece of omentum that was adhered to the mass was taken and sent for histopathological examination. After extensive blunt and sharp dissection, the mass was separated from the surrounding structure and removed completely (figure 4). Accidental rupture of one of the small cyst occurred that brought out flakes. Precautions were taken with mops beneath. Hence no spillage occurred in the abdominal cavity (figure 2). Later the cyst was dissected and frank pus discharge was seen which clinically was suggestive of chronic right parametrial abscess (figure 5). Specimen was sent for histopathological examination. Immediately post operatively CA 125 was sent which was normal. Post operative was uneventful. Patient was discharged with healthy suture line on post operative day 7.

Histopathologically, multiloculated cysts with different germ cell linings like urothelial, intestinal and endometrial lining was seen. All linings show mild proliferation but without any atypia. The endometrial tissue shows diffuse decidual change. The lumina contains keratin, serous or mucinous contents. Remaining areas show loose fibrous and

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edematous tissue. Final diagnosis of germ cell tumor? Cystic teratoma adherent to anterior wall of uterus was made.

Teratoma are universal and can be found anywhere in the body. However, being in pelvic cavity, possibility of ovarian cystic teratoma was expected. No malignancy was detected.



Figure 1



Figure 3



Figure 2



Figure 4

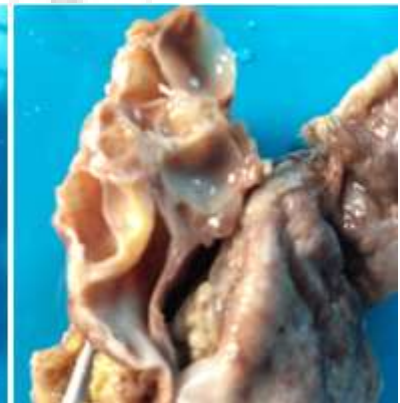
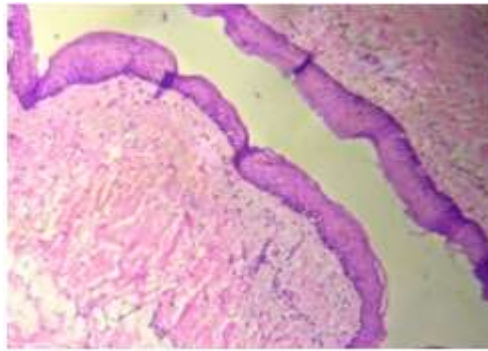


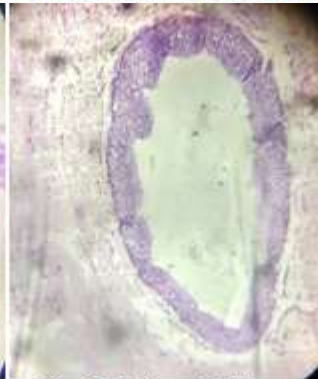
Figure 5



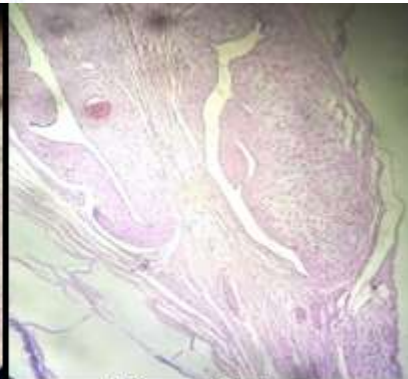
Ectoderm-squamous epithelium



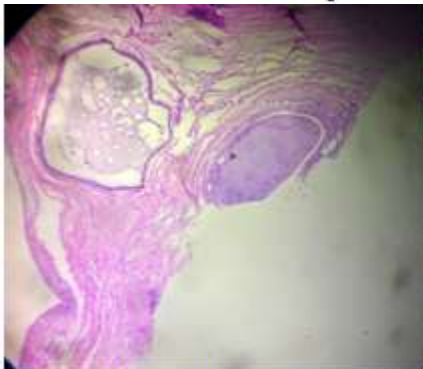
Endoderm-intestinal epithelium



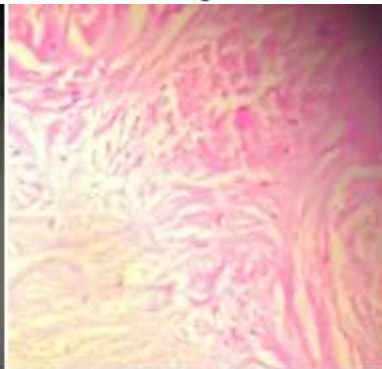
Urothelial epithelium



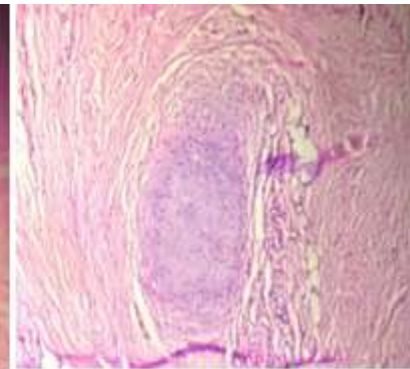
Endometrial tissue



Mesoderm- cartilage



Smooth muscles



Bronchial muscles

3. Discussion

For gynecologist, a teratoma is primarily associated with a cystic tumor of the female ovary. A teratoma is a rare tumor that most often occurs in females of 15-40 years of age. A teratoma contains thick leather like capsule that covers amorphous fatty masses and poorly to fully differentiated structures derived from the ectoderm. Most ovarian cystic teratomas contains skin and skin adnexa, including prominent sebaceous glands, hairs and nails but also teeth or eyes. Teratoma of the ovary is usually benign and easy to remove. Malignant transformation in a teratoma is a complication and mainly occurs in older age group.

The main importance of presenting this case was, diagnosis of tumor at pregnancy is rare event. The band stretching around raises a suspicion of ectopic ovary with teratoma. But since both ovaries being normal, the mass could be independent from ovary. Though this teratoma was huge of approximately 10cmx8cm, still the patient was asymptomatic which might be due to the reason that these cysts are usually slow growing and was even undiagnosed during pregnancy only to be found as incidental finding in

caesarean section. Also the decision of removal of such big undiagnosed asymptomatic cyst during cesarean section or during pregnancy is controversial as increased vascularity during pregnancy might add to increased bleeding during dissection and can add to complication in an already major surgery like caesarean section.

Intraoperatively a strong suspicion of chronic parametrial cold abscess was raised and the fluid was even sent for culture and sensitivity and for Ziehl-Neelsen(ZN) staining to rule out infective and tuberculous origin, both of which were negative.

The decision to remove the mass was taken because it appeared dissectable, and to avoid post operative complications like torsion or rupture, presenting as acute abdomen and to avoid repeat laprotomy.

Our possible differential diagnoses were chronic parametrial cold abscess, ectopic ovary, teratoma, corpus luteal cyst, cyst of Morgagni, wandering fibroid.

The histopathological report of benign cystic teratoma was the most unexpected report for all of us involved in this case and so the decision to share this rare case was taken.

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