

DOI: 10.5455/2320-1770.ijrcog20140931

Case Report

Torsion of huge cystic teratoma of ovary with multiple fibroids uterus: a case report and review of literature

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Received: 18 June 2014

Accepted: 5 July 2014

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ABSTRACT

Ovarian teratomas and leiomyomas are tumours of reproductive age group. But simultaneous occurrence of these tumours is rare. Here we present a rare case of benign cystic teratoma which underwent torsion along with multiple uterine fibroids.

Keywords: Teratoma, Torsion, Leiomyoma

INTRODUCTION

Leiomyoma is the most common tumor of reproductive age group occurring in 20-40% of women in reproductive age group. Leiomyomas are more common in nulliparous, infertile women. Another pathology common in these women are ovarian cysts. Hence the two pathologies may co-exist in a woman adding up to pose a twin diagnostic dilemma and operative challenge to the gynaecologist. More than 80% of benign cystic teratomas occur during the reproductive years. The risk of torsion with dermoid cysts is approximately 15% and it occurs more frequently in dermoid cysts than with other ovarian tumors, perhaps because of their high fat content allowing them to float in the pelvic and abdominal cavity.

CASE REPORT

A 48 year old multiparous female, married since 26 years, came to us with complaint of pain in abdomen since 4 months, distension of abdomen since 1 month and generalized weakness. Her past menstrual cycles were regular, moderate, painless. She had 2 full term normal deliveries, no significant medical / surgical illness in past.

On examination, her general condition was fair, vitals were stable. On per abdomen examination, mass arising from pelvis, 30 weeks size, firm, tense, minimal tenderness was present with no guarding / rigidity, margins were ill defined. On per speculum white discharge was present. On per vaginal examination uterus was 12-14 weeks size, a similar 28wk size mass was felt which was separate from the uterus. Her Pap smear was suggestive of inflammatory smear with no malignant cells. Her tumour markers were CA 125 - 44.40 (0-30.2 units/ml), CEA - 0.5 (0.21-2.5), alpha feto protein - 2.73 IU, beta HCG - 16.54 mIU.

Her USG pelvic Doppler was suggestive of enlarged Uterus of size 14 cm x 11 cm x 12 cm with multiple well-defined hypoechoic lesions on posterior wall, largest 6.3 cm x 5.3 cm x 4 cm. A large cystic lesion arising from pelvis, upto supraumbilical region of size 20 cm x 18 cm x 12 cm was present with right ovary not seen separately from lesion, the lesion showed central vascularity with low resistance flow RI = 0.5, PI = 1.2

Her CT scan was suggestive of soft tissue density lesion probably arising from ovary of size 14 cm x 10 cm x 7.6

cm with calcification within, mostly dermoid, multiple uterine fibroids were also noted.

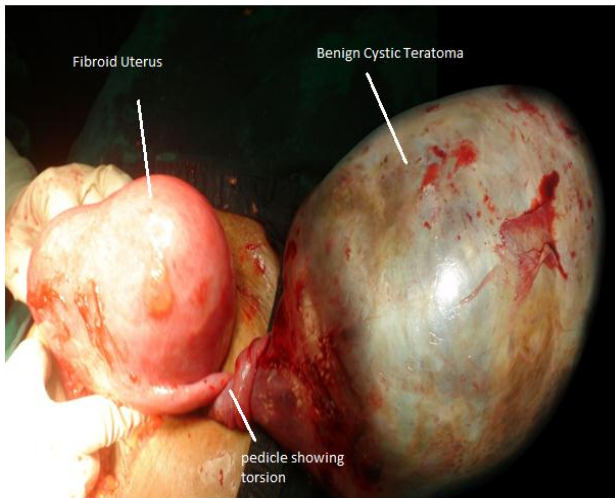


Figure 1: Fibroid uterus, benign cystic teratoma and pedicle showing torsion.



Figure 2: Benign cystic teratoma weighing 2.6 kg.

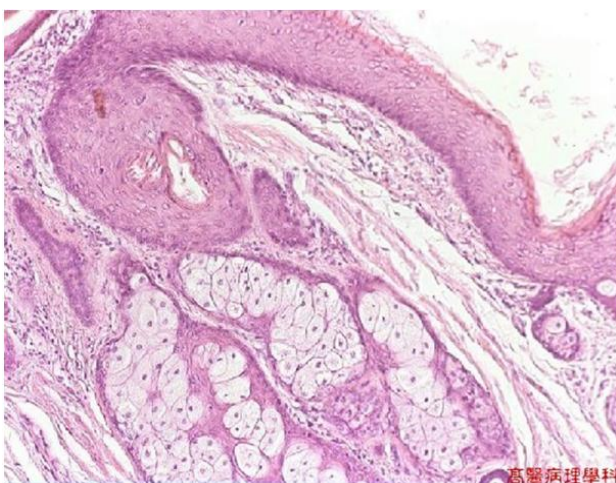


Figure 3: Photomicrograph showing multiple uterine fibroids.

DISCUSSION

A teratoma is an encapsulated tumour with tissue or organ components resembling normal derivatives of more than one germ layer. The tissues of a teratoma, although normal in themselves, may be quite different from surrounding tissues and may be highly disparate; teratomas have been reported to contain hair, teeth, bone and, very rarely, more complex organs or processes such as eyes, hands, feet, or other limbs.¹

Teratomas are usually benign; although they can be malignant rarely in 2% of cases. Benign teratomas are mostly in the form of large fluid filled cysts. A mature teratoma; also called as dermoid cyst is typically benign and found more commonly in women, while an immature teratoma is typically malignant and is more often found in men. Mature cystic teratomas account for 10-20% of all ovarian neoplasms. They tend to be identified in young women, typically around the age of 30 years² and are also the most common ovarian neoplasm in patients younger than 20 years. They can rarely undergo torsion, rupture or infection.

These cysts are usually asymptomatic and are identified incidentally during either physical or radiological examination of the abdomen.³ Our patient had presented with pain in abdomen.

The incidence of torsion in a case of ovarian teratoma is approximately 15%. The reason may be the high fat content of teratomas, causing them to float in the peritoneal cavity, promoting twisting or torsion of the adnexa with trunkal movement or physical activity. Torsion produces tissue ischemia leading to pain; as had occurred in our case. Adnexectomy is usually required in such cases.⁴

CONCLUSION

Our case was a rare combination of a huge benign mature cystic teratoma with multiple fibroid uterus presenting as a twin pathology. Below the age of 20 years, 60% of the tumours are of germ cell origin but at the age of 48 years such huge teratomas are rare. A huge teratoma with a long pedicle in a state of torsion in the limited peritoneal space was a surprise on the operating table.

Torsion of ovarian cyst usually presents with acute symptoms and requires emergency surgical intervention or can usually be diagnosed on Doppler. In this case however though the patient had such a huge ovarian cyst torsion she had no symptoms suggestive of torsion. Sheer neglect towards personal health and lack of awareness on the part of the patient added to the magnitude of her problems and delay in seeking medical attention. This is thus an interesting complicated case of dual pathology which needed expert surgical skills and clinical expertise in order to be dealt with.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: Not required

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DOI: 10.5455/2320-1770.ijrcog20140931

Cite this article as: Katke RD. Torsion of huge cystic teratoma of ovary with multiple fibroids uterus: a case report and review of literature. *Int J Reprod Contracept Obstet Gynecol* 2014;3:793-5.