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A Rare Presentation of A Retroperitoneal Cystic Teratoma in an Adult

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Abstract

Teratomas are derived from embryonal tissue and typically found in gonadal and sacrococygeal regions of adults. Retroperitoneal teratomas are rare in adults and, present challenging surgical management as they usually infiltrate into adjacent retroperitoneal organs. We present herein a rare case of a giant mucinous retroperitoneal teratoma infiltrating the posterior stomach of a 27-year- old adult female. This was successfully managed by a difficult and tedious surgical resection along with excision of the infiltrating section of the stomach. A review of the literature supports our management of this case.

Introduction

A teratoma is considered to be a non-seminomatous germ cell tumor composed of somatic cell types from two or more germ layers (ectoderm, mesoderm or endoderm). It is typically located in either the sacrococcygeal region or in the gonads [1]. Being of embryonal tissue origin, the retroperitoneal teratomas are rare in adults, typically occurring in this location only in infancy and childhood [3]. Teratomas are the most common type of germ cell tumor in humans, and most teratomas are benign. The malignant mature cystic teratomas (0.2 to 2% of cases) [2] have the potential to metastasize to sites such as the retroperitoneal lymph nodes and lung parenchyma [1]. The definitive treatment of these neoplasms is surgical resection. We present a case of a giant retroperitoneal (lesser sac) teratoma in a 27 yr-old African female which was successfully managed by surgical resection.

Case Report

A 27-yr-old African woman with no significant past medical history presented with a 2-year history of an abdominal mass that wanes in size following mucinous discharge. It was gradually associated with abdominal fullness, postpandrial vomiting, tiredness and difficulty in carrying her daily activities. On examination she was clinically well but exhausted from the weight of this abdominal mass. Physical examination revealed a large abdominal mass mobile but did not move with respiration. It measured about 20 cm in diameter with smooth regular edges extending across the upper abdomen. There were no signs of hepatosplenomegaly or ascites. An ultrasound (US) scan confirmed a retroperitoneal mesenteric mass and no lymphadenopathy. A full blood count and serum biochemistry tests were within the normal range. Laparotomy revealed a large retroperitoneal mass (20cm in d) in the stmach bed protruding into the lesser sac and adherent to the transverse colon, mesocolon and posterior surface of stomach with dilated gastroepiploic veins. There was mucinous exudate from the cystic mass but no evidence of metastases. A difficult and tedious mobilization of the mass from the transverse colon, mesocolon and greater omentum allowed entry into the lesser sac. There was

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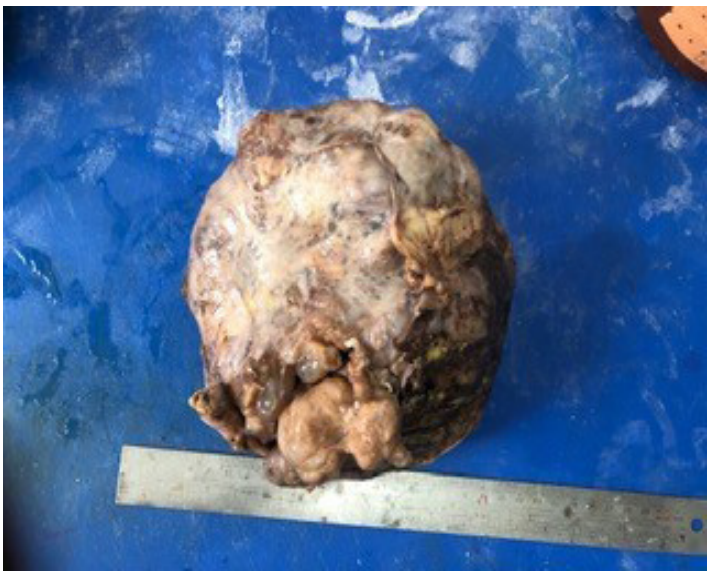

Figure 1: Cystic teratoma (15kg, 15cmx 10cmx 6cm).

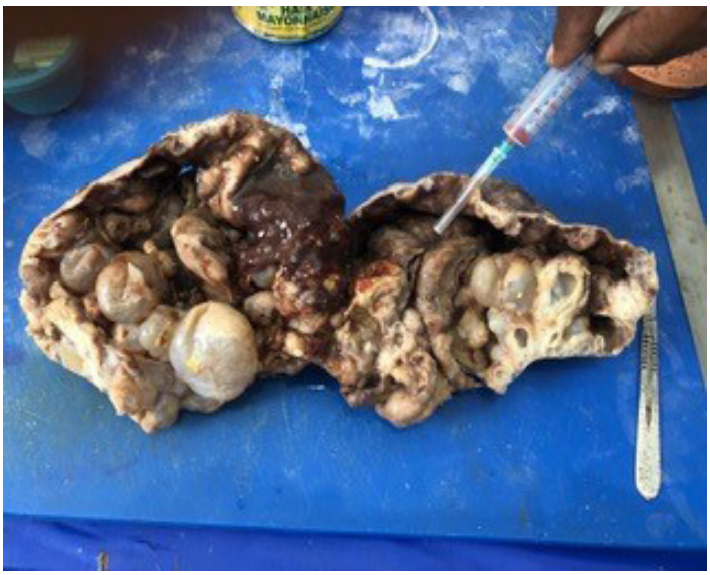

Figure 2: Cystic teratoma composed of somatic cell types from two or more embroyonic germ layers (ectoderm, mesoderm or endoderm).

no cleavage plane between the posterior stomach wall from the mass and thus the posterior stomach wall was excised enbloc with the mass. The posterior wall of the cyst did not affect the retroperitoneal pancreas or other stomach bed viscera and was safely dissected out. The stomach defect was closed in 2 layers with continuous 2.0 vicyl. The defect in the lesser omentum was closed to prevent an internal hernia. There was less than 500mls of blood loss and postoperative recovery was unremarkable (Figures 1&2).

Discussion

The case of a giant retroperitoneal (lesser sac) teratoma in a 27 yr-old African female which was successfully managed by surgical resection was prresented. Retroperitoneal teratomas are rare in adults and, present challenging surgical management as they usually infiltrate into adjacent retroperitoneal organs. In this case the posterior aspect of the stomach was locally infiltrated as it lay in the stomach bed of the lesser sac. Most teratomas are benign but the malignant mature cystic teratomas have the potential to metastasize to retroperitoneal lymph nodes and lung parenchyma [1-3]. The definitive treatment of these neoplasms is surgical resection [1-4]. Follow-up at 1 year showed no evidence of local recurrence.

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