

BENIGN TERATOMA OF THE FALLOPIAN TUBE

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ABSTRACT

Primary neoplasms of fallopian tube are relatively uncommon. Even less common are the benign tumours of fallopian tube. The benign teratoma of fallopian tube is very rare and its extreme rarity is documented with approximately less than 50 cases reported in world literature since 1865. This is a case of an unmarried girl of 18 years presented with acute lower abdominal pain since 3 days. Her last menstrual period was 5 days back. Her menstrual cycles were regular with dysmenorrhoea. Physical examination was unremarkable. Ultrasonography revealed a left adnexal mass of 6x 5 cm with an impression of endometriotic cyst of left ovary. On laparotomy she had a 6x6 cm cystic mass arising from the fimbrial end of left fallopian tube and other pelvic organs were normal. Resection of the mass with part of fimbriae was carried out. Histopathology concluded the tumour to be mature teratoma of fallopian tube.

Keywords: Teratoma, Benign Fallopian neoplasia, Pelvic mass

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INTRODUCTION

Primary neoplasms of fallopian tube are relatively uncommon. Among the malignant neoplasm adenocarcinoma is the commonest fallopian tube neoplasm representing less than 1% of all genital malignancies in females. Even less common are the benign tumors of fallopian tube¹. The benign teratoma of fallopian tube is very uncommon and its extreme rarity is documented with approximately less than 50 cases reported in world literature since 1865². This is the second reported case of benign teratoma of fallopian tube in India.

CASE REPORT

The patient an unmarried girl of 18 years was admitted to hospital with history of acute abdominal pain since 3 days. Pain was confined to lower abdomen on left side. Her menstrual cycles were regular cyclical & spontaneous with dysmenorrhoea. Her last menstrual period was 5 days before she presented to the hospital. Her menstrual flow was within normal limits. She had no medical or surgical illness in the past. Physical examination was unremarkable except a vague tenderness in left flank. Ultrasonography was sought which revealed a left adnexal mass of 6x 5 cm with an impression of endometriotic cyst of left ovary.

In view of a presumptive diagnosis of endometriotic cyst she was planned for diagnostic laparoscopy & ovarian cystectomy. But because of

her low socioeconomic strata and non-affordability she refused laparoscopy and was decided for laparotomy.

Laparotomy was performed. Intraoperatively she had a brownish black solid to cystic mass measuring 6X6 cm arising from the fimbrial end of left fallopian tube.(Figure 1) Resection of the mass with part of fimbriae was carried out. The uterus, tubes & both ovaries appeared normal. The mass was sent for histopathological examination. Her post operative period was uneventful and recovery was satisfactory.



Figure 1: Left fallopian tube teratoma (Intra operative figure)

Pathological Findings

Gross appearance

Gross specimen showed a single nodular dark brown to black mass with attached part of fallopian tube measuring 6x4x2.5 cms. (Figures 2 & 3) Outer surface partly showed protruberant nodules. Cut section shows a unilocular cyst containing dark brown thick sauce like material. Inside of cyst wall is smooth and glistening.

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Figure 2 & 3: Gross specimen of tubal teratoma

Microscopic appearance

Section from the tumour made up of cystic spaces lined by layers of squamous epithelium. Tumour composed of skin, islands of cartilage, adipose tissue, mucous glands and sebaceous glands & smooth muscle bundles. The tumour is splaying the muscular layers of the tube. (Figure 4)

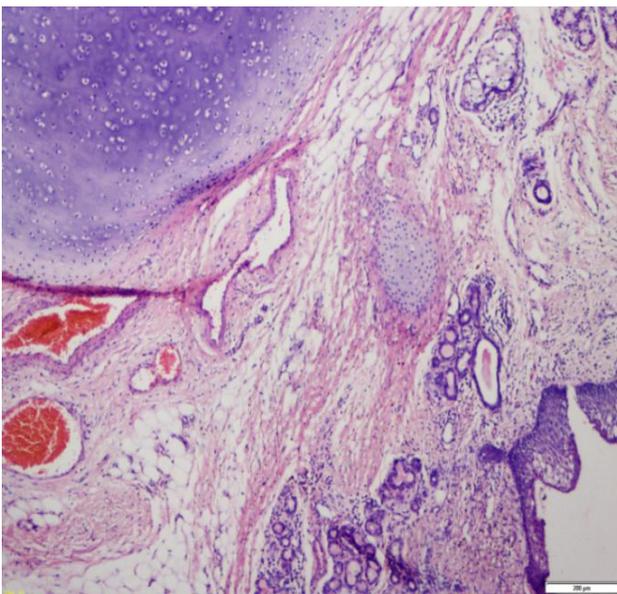


Figure 4: Histopathological appearance of tubal teratoma

DISCUSSION

Benign teratoma of fallopian tube is extremely rare. Literature review proved its rarity with less than 50 cases reported worldwide. Mazzarella reviewed the literature of first 43 cases³. This enabled some features of benign teratoma of fallopian tube to be defined. The reported age group of these patients ranged from 21-60 years with most of them occurring in the fourth decade⁴. But in our case patient was 18 years old. Majority of the patients were nulliparous or have parity less than two⁴ in contrast to our

case who is unmarried and nulliparous. The clinical manifestations are usually the colicky abdominal pain⁵ dysmenorrhoea or menstrual irregularity⁶ & postmenopausal bleeding. There is no set clinical pattern. The size of the tumour is widely variable ranging between 0.4 – 2 cm. The smallest size reported is 0.4 cm by Walter⁷. Tubal teratomas are commonly located in the ampulla or the isthmus⁷. It was arising from the fimbrial end of the tube in our case.

Unusual presentations of some teratomas of fallopian tube may be i) a free floating pelvic mass⁸ as was in our case ii) rupture into rectum⁹ iii) coexistence with tubal pregnancy¹⁰. Only four cases of malignant tubal teratoma has been recorded in the world literature.

Diagnosis is usually done intra operatively with no cases till now diagnosed preoperatively. Histogenesis of tubal teratoma is still unclear. It is believed that these teratomas arise from cells that were migrating from the yolk sac to primitive gonads but failed to reach their destination. One theory suggested the parthenogenetic fertilization of germ cells insitu because teratomas are found along the known pathways of migration of germ cells during fetal development. Another theory suggested the process of blastomere isolation in which some cells of the blastula which was sequestered and later developed into teratoma because they still retained their pluripotent character. High index of clinical suspicion may help in preoperative diagnosis of this condition.

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