



Case Report

Local Foreign Body Reaction of Peritoneum After Rupture of Cystic Partially Immature Teratoma

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ABSTRACT This is a pictorial report of rare sequelae after an unintended intraoperative rupture of a cystic teratoma. A 30-year-old woman was operated on for a mature cystic teratoma of the right ovary with an unintended intraoperative rupture of the ovarian tumor during the procedure. Postoperatively, the final immune histologic report showed partial neuroendocrine differentiation of an immature origin. At relaparoscopy for staging 7 weeks later, several suspicious peritoneal lesions of up to a 2.5-cm diameter were discovered and excised for which malignancy could not be excluded macroscopically. However, the final histologic report revealed a foreign body reaction related to spilling of the content of the mature teratoma. It is important to distinguish local peritoneal reaction from chemical peritonitis. The postoperative follow-up regarding symptomatic recurrence was uneventful. *Journal of Minimally Invasive Gynecology* (2014) ■, ■–■ © 2014 AAGL. All rights reserved.

Keywords: Teratoma; Cystic rupture; Spilling; Peritoneal reaction; Complication; Foreign body

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A benign cystic teratoma is a common ovarian lesion (15%–20% of all cystic ovarian tumors) [1,2], and the incidence of malignant transformation (immature differentiation) is very low (<0.2%) [3]. Treatment of a suspected teratoma is complete surgical removal, preferably without rupture and spilling. However, depending on the risk factors, intraoperative rupture of the cyst and spilling of the content can occur. This is a report of an unintended rupture and spilling of cyst content followed by an unusual complication.

Case History

A 30-year-old woman presented with a negative medical history of pregnancies and no previous surgeries. Laparoscopic evaluation was performed because of a persisting adnexal tumor. Ultrasound result showed a solid lesion of

5 cm, most likely corresponding to a dermoid cyst without signs for malignancy (tumor markers on Doppler imaging). The patient underwent surgery after unsuspecting preoperative evaluation. During surgery, an evenly confined cystic ovarian tumor without further abnormalities became apparent in the pelvis, originating from the right ovary. After obtaining washing cytology, the cystic tumor was enucleated, conserving the ovary. At the end of the procedure, the cyst ruptured, draining fat and hair, which macroscopically corresponded to the classic signs of a mature teratoma. After laparoscopic removal of the cyst, it was retrieved using an endobag. Subsequently, the cavity was irrigated thoroughly until no remains of the teratoma were visible.

After additional immunohistochemical examinations, the histologic report showed a mature teratoma including partially solid parts of a poorly differentiated neuroendocrine tumor (G3). After re-evaluation by the pathologists and the tumor board, preoperative staging and subsequent fertility-conserving relaparoscopy were indicated.

Preoperative staging using magnetic resonance imaging showed a normal result for the abdomen and pelvis without indication of a residual tumor and no abnormal lymph nodes. The tumor markers were normal with the exception of

The authors declare no conflicts of interest.

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Submitted January 31, 2014. Accepted for publication March 1, 2014.

Available at www.sciencedirect.com and www.jmig.org

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<http://dx.doi.org/10.1016/j.jmig.2014.03.001>

carcinoembryonic antigen of 4.6 $\mu\text{g/mL}$ (normal range, 0.5–3.5). Relaparoscopy with fertility-sparing surgery was scheduled for 7 weeks after the primary surgery without a definite indication of any residual tumor. The patient was subjectively free of complaints.

At laparoscopic staging, the peritoneum showed highly suspect peritoneal lesions; small yellowish implants of 2 to 3 mm in size (Fig. 1) and an oval yellowish protrusion of approximately 2 cm with an obvious vascular marking (Fig. 2A–C) cranial of the residual right ovary were visible on the bladder peritoneum. Smaller peritoneal lesions were visible on the right side in the fossa ovarica up to the pouch of Douglas. Furthermore, similar lesions in the peritoneum were manifest in the puncture site of the right trocar. These were assumed to be port-site implants (Fig. 3). The left ovary was normal. Because of these results, a straying tumor of the immature teratoma part was suspected macroscopically. After obtaining a washing cytology, the right ovary, the fallopian tube, and the suspicious peritoneal implants were removed. This corresponds to a complete deperitonealization (Fig. 4) on the right pelvic wall. Additionally, the infracolic omentum was resected. Because of the early stage and the normal lymph node status and according to local and international guidelines, lymphadenectomy was not planned [4].

The postoperative course was uncomplicated, and the patient was discharged on the second postoperative day. The final histologic result showed a peritoneal foreign body reaction to parts of the known mature teratoma, which did not correspond to the immature teratoma parts. The omentum and the washing cytology showed no pathologic mutations. In conclusion, a tumor dissemination of the immature teratoma could be histologically excluded. In the removed ovary, no immature neuroendocrine elements were present. The patient's final stage because of the intraoperative rupture of the cyst was G3pT1cNx.

After intensified multidisciplinary discussions of our tumor board regarding the performance of adjuvant therapy with all aspects of fertility (e.g., downregulation and cryo-

Fig. 1

Intraoperative image of relaparoscopic staging: 2- to 3-mm yellow implants in the peritoneum of the bladder.

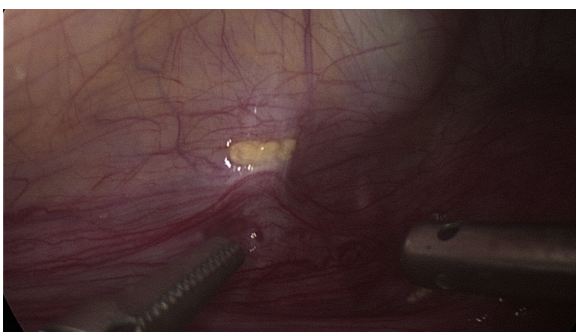
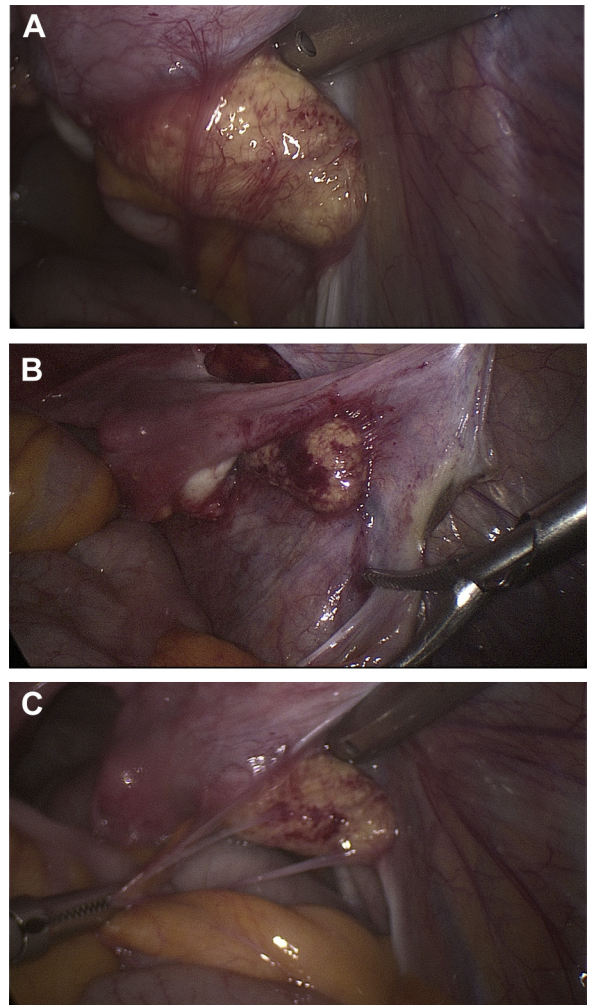


Fig. 2

(A–C) Intraoperative images of the major tumor beside the right ovary.



conservation), postoperative treatment was started with monthly downregulation with 3.8 mg goserelin subcutaneously. Although observation was a theoretic and possible option, it was not offered to the patient. Three weeks after downregulation, 2 cycles of adjuvant chemotherapy were started according to the BEP regimen (bleomycin/etoposide/cisplatin). On day 9 of cycle 2 of chemotherapy, after admission the patient was unconscious for 10 minutes showing neurologic symptoms and presenting with hemiplegia. Unfortunately, the evaluation of the symptoms showed a massive cerebral infarction of the blood flow region of the right arteria cerebri media. The cause was dissection of the arteria carotis interna (sequela of an old sports traumatic lesion of the intima). Magnetic resonance imaging excluded cerebral metastases. A stent was placed in the carotis interna, and the patient was completely free of symptoms after neurorehabilitation. The completion of chemotherapy was abandoned. Three monthly oncologic follow-ups were scheduled with the patient. Further oncologic follow-up was uneventful up to 14 months postoperatively.

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