Benign Cystic Teratoma of the Fallopian Tube: An Incidental Finding at the Time of Laparoscopic Hysterectomy?

Abstract

This case report is on an incidental discovery of a benign cystic teratoma of the fallopian tube. This mass was noted at the time of a total laparascopic hysterectomy for dysmenorrhea and menorrhagia. Since teratoma of the fallopian tube are very rare, with approximately 60 case reports worldwide, several authors have advised reporting each case for statistical purposes for tracking worldwide, to expand the database for study of this most unusual occurrence. Though benign, these teratomas are not always asymptomatic and can be a causative factor for torsion or ectopic pregnancies. There is reasonable evidence that in this case the dermoid caused an ectopic pregnancy.

Keywords: Laparoscopy; Dysmenorrhea; Teratomas; Dermoid; Cyst

Case Report

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Introduction

The least common tumors of the female reproductive system occur as neoplasm's of the fallopian tube. Approximately 60 cases of cystic teratomas of the fallopian tube have been reported to date; worldwide [1].

Tubal teratomas are usually found incidentally; either by radiologic or physical findings, or at the time or surgery. Not all of these masses are asymptomatic as several have been causative for ectopic pregnancies, as reported in Kuttech's review [2].

In this case report, I discovered a benign cystic teratoma of the fallopian tube as an incidental finding at the time of laparascopy.

Case Report

A 26 year old female G4P3 was seen for gynecologic care for chronic dysmenorrhea, menorrhagia, and accompanying dyspaurenia. Pelvic examination revealed cervical motion tenderness and a tender uterus. An ultrasound of the pelvis revealed a complex mass measuring 2.59x1.49x1.72 cm on the right ovary. I suspected this may be a corpus hemorrhagic cyst or endometrioma due to the fact that she had pain upon palpation of the mass. Her Gonorrhea and Chlamydia cultures were negative. Treatment with antibiotics and pain medicine were not successful in resolving her cervical motion tenderness or her pain. Her past surgical history included a laparascopic tubal ligation and a previous laparascopic salpingostomy with removal of an ectopic pregnancy.

Preoperatively, I considered that these findings represented chronic pelvic inflammatory disease, post-tubal ligation syndrome, endometriosis, and/or adenomyosis; coupled with a probable benign ovarian corpus hemorrhagic cyst or endometrioma.

A total laparascopic hysterectomy with preservation of the adnexa was planned as the patient refused further conservative therapy for her chronic dysmenorrhea, menorrhagia, and dyspaurenia. At laparascopy, the uterus appeared normal. Evidence of a prior tubal by falope rings was noted. The right fallopian tube was dialted in the ampulla, just distal to the prior tubal ligation. No abnormality was seen visually of the right ovary. The left fallopian tube had evidence of a falope ring and the ovary appeared normal. The decision was made to remove the right fallopian tube with the uterus. Her post-operative recovery was uneventful except that she developed a vaginal cuff abcess three weeks later that had to be opened and drained. No further problems were encountered.

The fallopian tube was opened in the operating room. A solid mass made up of a waxy, yellow substance and hair appeared to be consistent with dermoid cyst of the fallopian tube.

Pathology describes a fallopian tube that measured 3.5 cm in length by 1.5 cm in diameter. Located 2.5 cm from the distal end of the tube and 0.8 cm from the proximal tube was a disrupted partially cystic mass. The mass measured 2x1.5x1.5cm. The surface of the mass had a pale yellow, tan, semi-solid material with several hair shafts. These findings were consistent with a mature cysticteratoma within the fallopian tube, with no immature or malignant constituents identified.

Comment

Mature cystic teratomas of the fallopian tube are a very uncommon finding, as only approximately 60 cases have been reported to date. Most dermoids arise in the ovary. The pathogenesis of the tubal terartomas is not yet known, but it is thought to arise from germ cells migrating from the yolk sac to the primitive gonadal bud [3].

Two prior laparascopies failed to describe or prompt removal of this mass that was clearly seen with my laparascopy. And it seems reasonable to conclude that the prior ectopic

pregnancy occurred because of blockage from this mass. A careful and thorough evaluation of all pelvic structures should be accomplished at every laparascopy with findings described in detail. Video imaging and still pictures are readily available and are an important adjunct at the time of laparascopy. Imaging should be included with a description of the findings, especially if biopsy or removal of abnormal findings are not done, as not all tubal masses are benign.

References

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