

# A rare presentation of a retroperitoneal cystic teratoma in an adult.

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## Abstract

Being of embryonal tissue origin, the teratomas are rare in adults, typically occurring either in the gonads or in the sacrococcygeal region in infancy and childhood. We present a case of a teratoma in the lesser sac of an adult female managed by en-bloc resection with the infiltrating stomach segment.

## Clinical Image

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## Abstract:

Being of embryonal tissue origin, the teratomas are rare in adults, typically occurring either in the gonads or in the sacrococcygeal region in infancy and childhood. We present a case of a teratoma in the lesser sac of an adult female managed by en-bloc resection with the infiltrating stomach segment.

## Clinical message :

Retroperitoneal teratomas are rare in adults and, present challenging surgical management as they usually infiltrate into adjacent retroperitoneal organs. Most are benign but the malignant mature cystic teratomas have the potential to metastasize to retroperitoneal lymph nodes and lung parenchyma. The definitive treatment of these neoplasms is surgical resection.

## Case:

A 27-yr-old African woman presented with a 2 year history of an abdominal mass that waned in size. It was associated with abdominal bloatedness, postprandial vomiting, lethargy and difficulty in performing her daily activities. On examination she was clinically well but exhausted from the weight of the abdominal mass. Physical examination revealed a large circumscribed mobile abdominal mass of ~ 20cm d, extending across the upper abdomen that did not move with respiration. There were no hepatosplenomegaly nor ascites. Ultrasonography suggested a retroperitoneal mesenteric mass with no lymphadenopathy. Blood tests were within the normal range. Laparotomy revealed a circumscribed retroperitoneal mass in the

stomach 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 mobilization of the mass allowed entry into the lesser sac. There was no cleavage plane between the posterior stomach wall and thus the posterior stomach wall was excised en bloc with the mass (figure 1). The stomach defect was closed and the mesenteric defect closed to prevent an internal hernia. Postoperative recovery was unremarkable. Histology confirmed a benign cystic teratoma (figure 2).

## References

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## Figures

Figure 1. Cystic teratoma (15kg, 15cmx 10cmx 6cm) Figure 2: Cystic teratoma composed of somatic cell types from two or more embryonic germ layers ( ectoderm, mesoderm or endoderm)