Review Article

Benign Sacrococcygeal Teratoma in Adult: Rare Case

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1. Abstract

The benign sacrococcygeal teratoma is exceptionally discovered in adulthood, incidentally because it is asymptomatic.

We present the observation of a young woman of 30 years whose discovery of the teratoma was fortuitous, aided by pelvic computed tomography, the diagnosis of benign teratoma is confirmed by the anatomopathological study of the operative part. The puncture and the biopsy are contraindicated due to infectious risk, fistula, and neoplastic dissemination.

The degree of malignancy of a teratoma is generally in inverse function of the degree of tissue differentiation. The diagnosis is mostly fortuitous and has largely benefited from advances in medical imaging. Blood levels of ACE and alpha-foetoprotein are increased in 82% of cases, including 53% of benign teratomas. Very high rates would be in favor of a malignant transformation and their postoperative monitoring makes it possible to diagnose recurrences. A benign teratoma if it is operated and if it recurs, it is most often malignant, hence the need for rigorous monitoring. Once the diagnosis is made, complete surgical excision is necessary allowing the histological analysis of the entire specimen and the reduction of the rate of recurrence.

The sacro-coccygeal teratoma of the adult is very rare, once the diagnosis has been made the complete surgical excision is necessary and this by adapting the way of approach. In case of recurrence, the risk of degeneration is important.

2. Keywords: Teratoma; Benign's sacrococcygeal tumors; Retrorectals tumors

3. Introduction

The benign sacrococcygeal teratoma is part of the retro-rectal vestigial formations. It is rare, the diagnosis is usually neonatal. Exceptionally, it is discovered in adulthood and this fortuitously because asymptomatic. Also called dysembryoma or dysembryoplastic tumor.

4. Materials and methods

We report the observation of a 30-year-old woman who has discovered a fortuitous mass at the intergluteal fold, three years later, gradually increasing in volume. On clinical examination, it is a presacral mass 12 cm long, with no sign of inflammation, no signs of infection, renitent and painless. At the rectal examination there is a slight bulging of the posterior wall of the rectum. The biological tests were normal, she has benefited from a computed tomography of the pelvis returned in favor of a very limited impure fluid formation, measuring 11/8/7 cm, not elevated, sitting at the upper part of the intergluteal fold, taking the corps of S5 and the coccyx. Forward, it gets a contact with the lifting muscles of the anus without sign of invasion. (Figure 1) Coronal pelvic scans of our patient showing the teratoma; (Figure2) Sagittal pelvic scans of our patient showing the teratoma

The patient was operated and a complete resection was performed, the postoperative follow-up was simple and the patient left three days later.

The anatomopathological study of the specimen returned in favor of a mature cystic teratoma with absence of histological sign of malignant. The patient is regularly reviewed in consultation. (Figure 3) Image of the teratoma before the intervention; (Figure 4) Image of teratoma after excision.

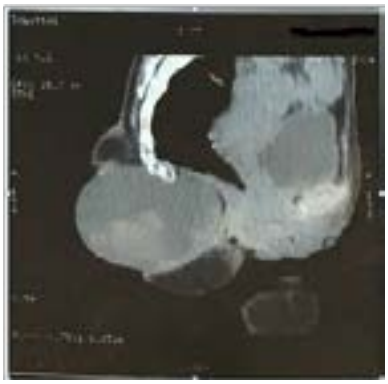

Figure 1: Coronal pelvic scan of our patient showing the teratoma.

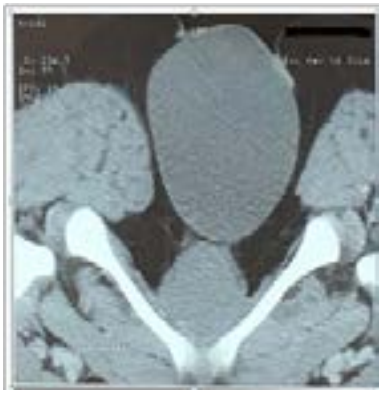

Figure 2: Sagittal pelvic scan of our patient showing the teratoma.

Figure 3: Image of the teratoma before the intervention.

Figure 4: Image of the teratoma after excision.

5. Results and Discussion

Retro-rectal vestigial tumors are the most common congenital tumors (three times out of four) [1]. They predominate in women with a sex ratio of 3/1 to 15/1. The average age is in the third decade [2]. Teratomas are usually found in children, especially in the neonatal period. The incidence is estimated between 1/30 000 and 1/43 000 [3,4]. They sit willingly in the gonads, retro-rectal space, mediastinum and retroperitoneum [4]; Less than one hundred cases of teratoma in adults [5,6] have been described in the literature. Sacro-coccygeal teratoma is the most common germline extra-gonadal tumor [7]. Malignant teratomas have an incidence ranging from 10 to 50% in children, with an average age of 2 years, and then decreases after the second decade to become rare in adults [8,9].

The degree of malignancy of a teratoma is generally in inverse function of the degree of tissue differentiation. We thus distinguish [1]: Mature benign teratomas: They are presented in cystic form and are of mixed epithelial and mesothelial origin [10], constituted of well differentiated tissues developed from the three primordial embryonic layers: the ectodermic tissues form the keratinized squamous epithelium, associated with pilosebaceous annexes ; The endodermal tissues constitute the respiratory or gastrointestinal epithelium; The mesodermic tissues make it possible to constitute the connective tissue, the smooth muscles, the cartilaginous and osseous tissue. Immature teratomas with intermediate malignancy: Still called "border line" require extensive histological analysis. Complete surgical excision is sufficient. The malignant teratomas: They produce embryonic tissues, more or less identifiable, most often able to develop α-fetoprotein. Tumor immaturity or regression can go as far as the production of placental tissue (choriocarcinoma) or vitelline tissue (vitelline tumor characterized by the production of hyaline globules, PAS and α-foetoprotein positive). The presence of calcifications is not an element of poor prognosis and is not synonymous with malignancy.

The diagnosis is mostly fortuitous and has benefited greatly from advances in medical imaging: ultrasound, computed tomography and magnetic resonance imaging and prenatal diagnosis, which sometimes makes it possible to detect them in utero. In our case, A pelvic computed tomography.

The blood levels of ACE and alpha-foetoprotein are increased in 82% and 53% of benign teratomas [11] it has not been assayed in our patient. Very high rates would be in favor of malignant transformation. In all cases, their postoperative monitoring allows us to diagnose recurrences [5], a benign teratoma if operated and if it recurs, it is most often malignant and hence the need for rigorous surveillance.

Puncture and biopsy are contraindicated due to infectious risk, fistu-

la, and neoplastic dissemination.

Once the diagnosis is made, a treatment is necessary which is nothing other than a complete surgical excision whose aim is on the one hand the excision of the tumor in total which allows the histological analysis of any The operative part and on the other hand to reduce the recidivism rate estimated at 33% [5].

Four ways are first described in the literature:

The perineal way of Kraske with coccygeal resection: It allows a complete excision but exposes the risks of osteitis, painful sequelae, and perineal events;

The trans-anal way: for cysts less than 4 cm. But the exposure is bad;

The retro-anorectal perineal way: This is the one we used and which is described in more than 80% of the publications, because simple, and exposes to fewer complications;

The anterior abdominal way: It indicates if the upper pole rises above S2. The risk being incomplete excision, some authors use combined anterior and posterior approaches. In all cases, the resection must be complete, in healthy margin, the risk of recurrence increases if not. If pathologic analysis reveals a malignant tumor, abdomino-perineal amputation may be necessary to achieve healthy carcinological margins.

The surgical management of malignant teratomas often involves a combined anterior and posterior approach followed by adjuvant chemotherapy to improve survival.

6. Conclusion

The sacro-coccygeal teratoma of the adult is very rare, once the diagnosis has been made the complete surgical excision is necessary and this by adapting the way of approach. In case of recurrence, the risk of degeneration is important.

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