

CASE REPORT

A RARE AND UNUSUAL CASE OF DERMOID CYST OF FALLOPIAN TUBE

Lalitha Shivanna¹, Pradeep M.R², Shwetha³

HOW TO CITE THIS ARTICLE:

Lalitha Shivanna, Pradeep M.R, Shwetha. "A Rare and Unusual case of Dermoid Cyst of Fallopian Tube". Journal of Evolution of Medical and Dental Sciences 2014; Vol. 3, Issue 12, March 24; Page: 3154-3156, DOI: 10.14260/jemds/2014/2259

ABSTRACT: Benign solid teratomas within the fallopian tubes are very rare. They are found incidentally on laparotomy/by laparoscopy or mistaken for ovarian tumors or paraovarian cysts. Only 3 cases of teratomas have been reported. So this rare entity has been reported.

KEYWORDS: Benign solid teratomas, laparotomy.

INTRODUCTION: Benign solid teratoma within the fallopian tube is very rare, though most of cystic teratomas are located in the isthmus or ampullary region. 58 cases have been reported all over the world and are found incidentally either on laparotomy or by laparoscopy¹. Out of which 30% were neoplastic in origin², more common were cystadenomas, cystadenofibromas and papillary borderline tumors. Hence a rare case of dermoid cyst attached to fimbrial end of the fallopian tube, found incidentally on laparotomy has been reported.

CASE REPORT: A 40yr old patient married since 25yrs with parity P₄ L₄ and last delivery 14 years back and tubectomised 13 yrs. back was admitted to gynecology ward in the Department of OBG,MIMS with history of white discharge and pain abdomen, on and off since 3 years. Her past history was positive for having treated for PID. Her past cycles were regular. Her past, family, present history was insignificant.

Physical examination; patient was anemic & vital parameters were within normal limits. Cardiorespiratory system was normal. B.P- 110/70 mm of Hg, pulse -70beats / min. On pelvic examination cervix was hypertrophied, cervical erosion was present. Uterus 12-14 week size, firm, irregular in contour, fornix free.

INVESTIGATIONS: Hb%-8.1gm%, O⁺ve group. HIV, HB_sAg Non-reactive, VDRL negative, blood urea, serum creatinine, ECG, Chest X-Ray with in normal limits.

PAP SMEAR: Inflammatory smear

CERVICAL BIOPSY: Suggestive of endocervical glandular polyp.

A provisional diagnosis of fibroid uterus was made and posted for Hysterectomy. 2 units of blood were transfused preoperatively.

Patient underwent TAH with BSO under sub arachnoid block.

PER OPERATIVE FINDINGS: (1) uterus was 12-14 week size. Both ovaries were normal and both fallopian tubes were adherent to ovaries. Right fallopian tube had a twist & a cyst of 3×4 cm was attached to fimbrial end with a pedicle. It was solid in consistency & showed hair strands. On cut section it was gritty & partially cystic. Cut surface showed hairs, pultaceous material & yellow area. On microscopy, it was lined by keratinized stratified squamous epithelium. Fibrocollagenous strands

CASE REPORT

showed foci of mature adipose tissue, thyroid tissue & space filled with mucoid material and lined by cuboidal cells & diagnosis of dermoid was confirmed. Post-operative period was uneventful and discharged on 7th post-operative day.

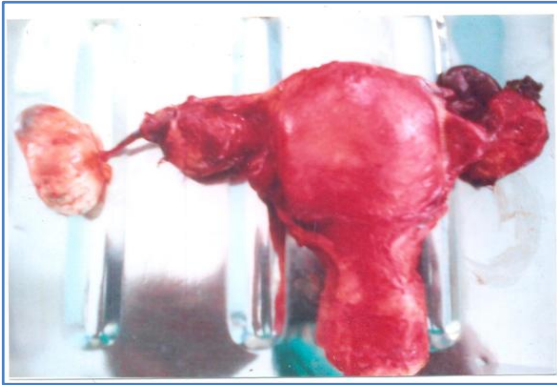
DISCUSSION: Mature solid and cystic teratomas are known to occur most commonly in the gonads. Extragonadal occurrence is observed primarily in the sacrococcygeal region, mediastinum, retroperitoneal cavity, cranial cavity or in the neck area^{3,4}, Paraovarian cysts are presumed to come in the remnants of mullerian duct³. Pathogenesis of benign teratomas is still unclear and may develop from totipotent stem cells & reflects different biological potentials of various stem cells including meiotic germ cells & pluripotent embryonic cells & karyotype is 46XX^{4,5}. Neoplastic paraovarian cysts originate from a neoplastic transformation of a paraovarian simple cyst or from adjacent ovary⁵. Study by Genadry et al^{6,7} 5% of the malignant cystadenocarcinoma & according to Stein et al⁸ incidence of malignancy in paraovarian tumors was 2%.

CONCLUSION: Though fallopian tube tumors are very rare, still many are found on laparotomy or mistaken for ovarian tumors. They develop from totipotent stem cell & reflect different biological potentials of various stem cells including pluripotent embryonic cells. About 5-10 % undergoes malignant transformation of any one of the components like choriocarcinoma, adenocarcinoma, thyroid carcinoma, melanoma, squamous cell carcinoma^{6,7, and 8}. Hence the importance of expectancy & to prevent spillage and preoperative diagnosis by ultrasonography which demonstrates papillary excrescences on the internal cyst walls in malignancy and may cause intraperitoneal dissemination.

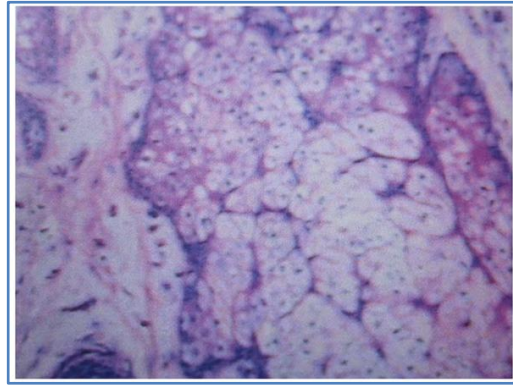
REFERENCES:

1. Mozzarella P, OksggkiT. Teratoma of uterine tube, a case report and review of literature. *Obs & Gynaec* 1971; 39381-8.
2. Osmers RG, Osmers M, von Maydell B, Wagner B, Kuhn W. Preoperative evaluation of ovarian tumors in the premenopause by transvaginasonography, *Am J Obstet Gynecol*. 1996 Aug;175:428-34.
3. Muller's GL. Teratoma Genetics and stem cell review. *Obstetrics and Gynecology survey* 1987 42; 661-70.
4. Samaha M, Woodruff J D. Paratubal cysts: frequency, histogenesis, and associated clinical features. *Obstetrics & Gynecology* 1985; 65:691-694. [PubMed].
5. Honore l h, o' harai K E. Serous papillary neoplasms arising in paramesonephric paraovarian cysts. *Acte Obstetrics & Gynaecology Scand* 1980;59:525-528(pub med).
6. Genadry R, Parmley T, Woodruff T D. The origin and clinical behaviour of paraovarian tumours, *Am J obstetrics & gynaecology* 1927:129:873-880(pub med).
7. Savelli L, Ghi T, De Iaco P, et al. Paraovarian/paratubal cysts: comparison of transvaginal sonographic and pathological findings to establish diagnostic criteria. *Ultrasound Obstet Gynecol*. 2006; 28:330-334. [PubMed].
8. Stein AL, Koonings PP, Schlaerth JB, et al. Relative Frequency of Malignant Paraovarian Tumors: Should Paraovarian Tumors be Aspirated? *Obstet Gynecol* 1990. 75:1029-1031. [PubMed].

CASE REPORT



Dermoid cyst in the fimbrial end of right Fallopian tube



HPE of dermoid showing keratinized squamous epithelium, adipose tissue and thyroid tissue.

AUTHORS:

1. Lalitha Shivanna
2. Pradeep M.R.
3. Shwetha

PARTICULARS OF CONTRIBUTORS:

1. Professor and HOD, Department of Obstetrics and Gynaecology, Mandya Institute of Medical Sciences, Mandya.
2. Assistant Professor, Department of Obstetrics and Gynaecology, Mandya Institute of Medical Sciences, Mandya.
3. Junior Resident, Department of Obstetrics and Gynaecology, Mandya Institute of Medical Sciences, Mandya.

NAME ADDRESS EMAIL ID OF THE CORRESPONDING AUTHOR:

Dr. Lalitha Shivanna,
Department of Obstetrics and Gynaecology,
Mandya Institute of Medical Sciences,
Mandya, Karnataka.
E-mail: drlalithashivanna@gmail.com

Date of Submission: 17/02/2014.
Date of Peer Review: 18/02/2014.
Date of Acceptance: 26/02/2014.
Date of Publishing: 22/03/2014.