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Squamous cell carcinoma for mature cystic teratoma

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Case description: A 28 year old nulligravida with married life of 2 years, homemaker by occupation came to our gynecology out patient with complain of pain abdomen since 1 month which was insidious in onset, gradual and progressive in nature. No history of loss of weight and appetite. No bowel and bladder abnormalities. On examination, per abdomen revealed mass palpable up to 20 weeks, right side and smooth surface, firm consistency, restricted mobility, no tenderness. Bimanual examination confirmed our finding right sided mass 7*8 cms, firm, cystic, no transmitted mobility.

Keywords: Chemotherapy, dermoid cyst, mature cystic teratoma, squamous cell carcinoma of ovary, tumor markers.

INTRODUCTION: Mature cystic teratoma are a part of subclass of ovarian germ cell tumors believed to arise from the primordial germ cells. Ovarian germ cell tumors account for around 20-25% of ovarian neoplasms and 5 % of ovarian cancers. Presence of pure squamous cell carcinoma is very rare findings which is attributable to malignant transformation into a preexisting desmoids cyst. It is mainly seen in postmenopausal women. As there are no specific signs and symptoms to suggest malignancy in dermoid cyst therefore it's difficult to predict and in most cases are diagnosed postoperatively. More than 80 % of malignant transformation of teratoma to squamous cell carcinoma arises from ectoderm. Mature cystic teratomas are made of mature tissue originating from all three gem cell layers (ectoderm, mesoderm and endoderm). They might arise from germ cells by failure of meiosis II or from a premeiotic cell in which meiosis I has failed.

CASE DESCRPTION: A 28 year old nulligravida with married life of 2 years, homemaker by occupation came to our gynecology out patient with complain of pain abdomen since 1 month which was insidious in onset, gradual and progressive in nature. No history of loss of weight and appetite. No bowel and bladder abnormalities.

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On admission relevant investigations were sent. CA 125 – 139.8, AFP, Beta HCG, LDH were within normal limits. Ultrasonography revealed a well-defined, rounded, hyper echoic lesion, 7.8*5.4 cm in right adnexal region, and 4.3*3.4 cm in the left adnexal region, surrounded by free fluid in the pelvis.

Contrast enhanced CT scan revealed a large lobulated cystic lesion, from the right adnexa, 8.7*10.7*10.9 cms, showing calcification – 9mm and floating fatty component. A similar predominantly fatty lesion with few solid areas and thin septations with minimal enhancement noted likely arising from left adnexa measuring 6.6*5.3*8 cms. The lesion abutting the caecum, anterior abdominal wall, bladder and opposite side lesion. Minimal free fluid in the right paracolic gutter. Few enlarged Para-aortic lymph node, largest measuring 17*11mm. F/S/O bilateral desmoids cyst. Minimal fluid and fat stranding the right paracolic gutter, so possibility of rupture to be considered.

Explatory laparotomy was done on her. Bilateral ovarian cyst noted, adhesion released between the right ovary and omentum by cautry and omental ends clamped and ligated. Right sided mass 16*14 cms, right sided cystectomy attempted, failed in view of solid areas invading the capsule, hence right oophorectomy done. Left ovary 8*10 cms, left cystectomy done. Lymphadenectomy not done and fluid cytology not sent. Gross – 8*6*4 cm, left side irregular cystic mass, cut surface, shows multiloculated cyst, with yellow pultaceous material along with haemorrhage and tuft. Right sided dermoid cyst, cut section, is solid cystic, with foci of hair tuft. The cystic measures 8*6.5*3 cm. Rokitansky protruberance not identified. Histopathology picture was fibrocollagenous cyst wall, lined by stratififed squamous epithelium, infiltrated by tumour cells, arranged in nest sheaths and trabecular pattern with desmoplastic stroma, keratin pearls and necrosis. Cyst wall shows fibrocollagenous tissue, with hyalinization infiltrated by chronic inflammatory cells, histiocytes. The tumor is seen upto the surface of the ovary without breach.

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