SACROCOCCYGEAL TERATOMA, CASE REPORT

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ABSTRACT
Sacrococcygeal teratoma (SCT) is the most common tumor presenting at birth. Commonly seen in female fetuses; this case presented, more or less with the whole feature of typical sacrococcygeal teratoma.

Keywords: sacrococcygeal teratomta, polyhydramnios, ante natal care

INTRODUCTION
Teratomas are tumors that are derived from the totipotent cells and include embryonic ectodermal, endodermal, and mesodermal tissue derivatives. Sacrococcygeal Teratomas (SCT) are the most common tumors presenting at birth[1]. Forty – seven percent of the tumors are external, 34% are external with significant pre-sacral component and 19% are predominantly, or completely, presacral (1)
The fetus is also at risk of high output cardiac failure, placentomegally and hydrops (2, 3).
Fetuses with SCT detected at antenatal period have three times mortality rate compared with postnatal diagnosed neonates. Neonatal death may result from maternal obstetric complications of tumor rupture, preterm labour, or dystocia (2).

EDITORIAL

CASE REPORT

A 33- year- old Sudanese women G4 P3 +0 all were alive and well, spontaneous normal vaginal delivery last delivery was 3 years. She presented to the casualty. Distressed, she had been referred from rural health center; as a case of polyhydramnios. After admission, the initial medical and obstetrical evaluation was done. A part from dypsnoea no any other medical symptoms. Obstetrical history, she was 26 weeks gestational age, unfortunately no any ante- natal care follow up. Nothing of significant regarding her history. This condition had been noticed few weeks back (approximately three weeks), the dypsnoea progressed even at rest. ***On examination***, she was orthopenic. RR 39 /min, P.R 106 bpm. BP. 100/70 mmHg. NO thyroid swelling, no lymph nodes enlargement. Cardiopulmonary system's examination revealed tachycardia and bilateral fine crepitations. The abdomen was fully distended due to polyhydramnios, with fundal level of 36 weeks gestation age. No clear fetal poles and there was distant faint fetal heart sounds, within the normal range.

Blood grouping (is A Rh positive). Electrocardiogram (ECG) showed the acceptable pregnancy changes. Chest X-ray with bilateral basal haziness. All others investigations (renal functions test, liver functions test and complete blood count) were within the normal ranges.

Ultrasound scanning (USS) Showed massive polyhydramnios, alive active fetus, with moderate hydrops. There was mass from the caudal end outwards with different echogenicities All measures were compatible with that gestational age.

Amniocentesis guided by USS was done slowly and smoothly to relieve the mother's distress, two litters were drained; she improved, over that night. Revaluation was done by USS next day, confirmed the findings (polyhydramnios- in spite of drained fluid.-and the fetal mass). Termination of pregnancy was decided based on mother's distressful condition.

Caesarian section was performed. A female fetus was delivered alive, attended by neonatologist. No intraoperative or postoperative complications.

The neonate died after 20 min figure (1). Then X-ray was done showed absence of the fetal caudal part figure (2).

The histopathology result showed cells of endodermal, mesodermal, and ectodermal origin which is confirming the diagnosis.

DISCUSSION

The Sacrococcygeal teratoma incidence is 1:40000 and has 3:1 female to male ratio. Teratomas occur most often in a para- axial area, gonadal, or midline location from the brain to sacral area **(1)**. Primary sites in infants and children include sacrococcyx (60%), gonads (20%), and chest and abdomen (15%) **(1)**.

Even though the occurrence of a majority of malformation can be traced to a defect in embryogenesis at a specific period of development, detection by ultrasound may not be possible at that period. The optimal time to perform a screening scans from 16-28 weeks in various studies. Meticulous ante natal care will detect this anomaly at suitable time to be managed accordingly. Variable options of managements are of discussion; vary from termination of pregnancy, intrauterine surgery and early neonatal surgery, complete surgical excision remains the mainstay of treatment **(4)**.

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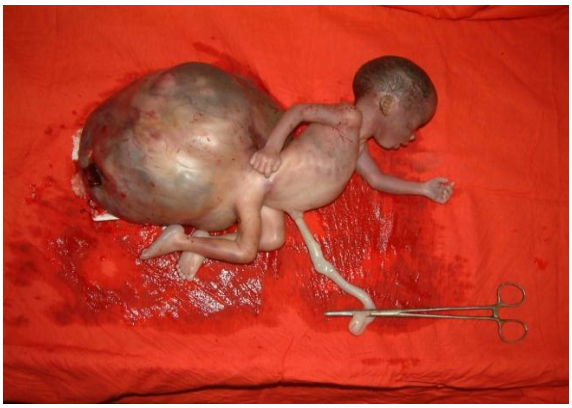

Figure (1) : The died neonate with the mass arising from the caudal part.

Figure (2): The Lateral body X- Ray

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