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Case Study

Bladder invasion by a right ovarian teratoma discovered incidentally during acystocele treatment

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Mature teratoma is the most common ovarian tumors. It can be for all ages with a predominance in the period of genital activity. Symptomatology is highly polymorphic. We report a case of right ovarian teratoma invasive bladder discovered during acystocele treatment of grade III in a 65 patient aged.

Key words: ovarian teratoma, mature teratoma, cystocele

INTRODUCTION

Dermoid cyst or Benin or dysembryome mature ovarian teratoma is a benign tumor, congenital and composed of well-differentiated adult tissues from the three germinal lines (ectoderm, endoderm and mesoderm). This is the most common benign ovarian tumor, accounting for about 5 to 25% of all ovarian tumors (Peterson *et al*., 1995). It may occur at any age, but with a clear predominance during the reproductive years (Huc *et al*., 1996). The clinical diagnosis is not easy being polymorphic clinical symptomatology. It can be discovered incidentally during a clinical or radiological examination or at laparotomy performed for another disease (O'Neill and Cooper, 2011). Pelvic ultrasound may suggest the diagnosis but only histological examination after surgery will confirm the diagnosis. We report a case of ovarian teratoma right invasive bladder discovery during a grade III cystocele treatment in a 65 years old patient.

OBSERVATION

Mrs. AB, native of Guinea Conakry, age 62, house wife and resident in Rufisque (Dakar). She was admitted to our department for the perception of vulvar mass discomfort. She also complained of burning on urination, intermittent dysuria and nocturia with 5 sunrisess nighton average.

The beginning goes back there 7 years by the occurrence of dysuria accompanied burning micturition who received several unsuccessful treatments. These symptoms would accentuated especially with the third pregnancy during which a cystocele was detected. Surgical treatment was indicated but not performed due to the refusal of the patient.

Background: married; gestity7; parity7; five living and two dead children. Hypertensive known and followed on amlodipin tablet 10mg1 per day.

The patient was in good general condition and had to review the urogenital cystocele grade III, signs of vaginal atrophy without loss of urine with coughing and maneuvering Bonney. The abdomen was soft with nopalpable mass. Urinalysis found a urinary tract infection by *Escherichia coli s*ensitive to chloramphenicol.

Surgery was indicated for management of the cystocele. Promonto fixation was laid. During surgery, we discover a tissue mass, irregular ovarian cyst with a big right partner. Ovarian mass was contiguous with the right horn bladder with intravesical continuity. We carry a right associated with omentectomy right oophorectomy carrying a portion of the bladder mucosa. The mass developed a close relationship with the hornipsilateral bladder and found the presence of hair joined to the wall. We then proceed to the promonto-fixing after washing the

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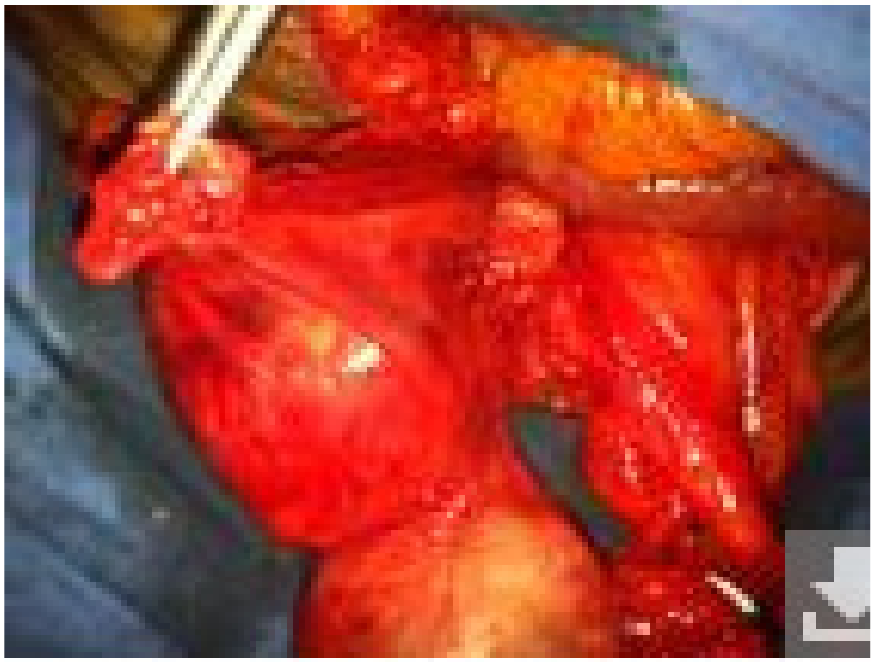

Figure 1. Lobed mass of the right ovary attached to the bladder.

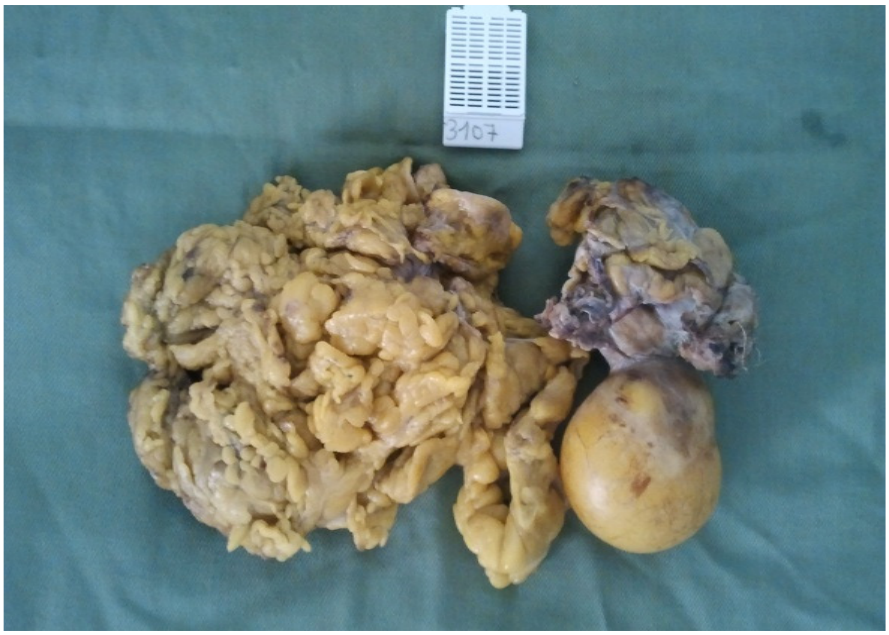

Figure 2. Macroscopic examination of the room with the attached omentun

abdominal cavity. The patient was put on antibiotics and the specimen sent for histological examination. The immediate postoperative and short-term were simple.

Histological examination of the play was performed. Macroscopy noted an auxiliary weighing 143grams and measuring 5.5 × 10 × 5 cm lobed appearance, consistency with a well limited heterokystique nodular surface and emission of some hair on one side. The second nodule attached to the previous yellowish smooth outer surface (Figure 1).

On section there is a greyish sébomateux content accompanied by hair of the first nodule and softened (Figure 2). There are a few homes and cartilaginous part calcifiés. laOmentectomy includes an appendix fragment

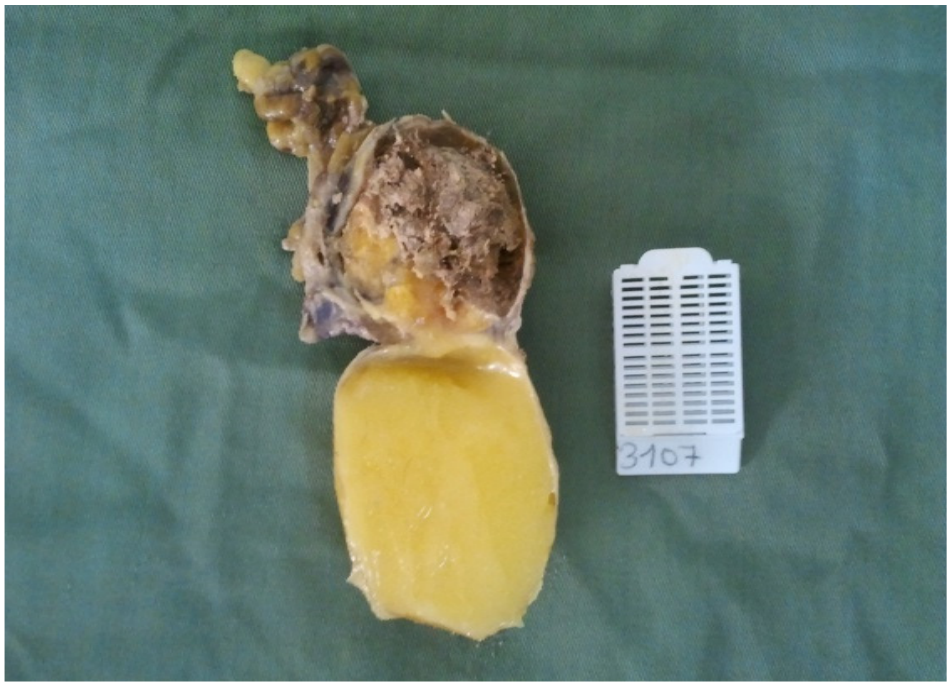

Figure 3. Macroscopic examination after cutting room.

cystic appearance.

Histology revealed at the right ovary a thickened cyst wall lined with a regular squamou stopped with a thin layer of keratin with underlying fibro fatty connective tissue (Figure 3). The omentum is made of adipocytes associated with some fibrous tissue.

DISCUSSION

Dermoidcystis the most common benign tumors of the ovary; it can be for all ages but with a predominance in the period of infancy and childbearing. The screening age benign teratoma of the ovary varies from 3 months to 86 years. The average age is 34 years. The diagnosis is made between 15 and 50 years for 77-90% of cases [6]. Our case was found incidentally inpost menopausal period. Dermoidcystsin 50-60% are asymptomatic and discovered incidentally on clinical examination or during aroutine ultrasound (Huc *et al*., 1996 ; Comerci *et al*., 1994; Morgante *et al*., 1998). The diagnosis can also be established in the course of chronic pelvic pain, menstrual irregularities or complications (Huc *et al*., 1996; Morgante *et al*., 1998). Dysuria and especially the pro-lapse of the anterior wall of the bladder probably favored by the compression of adjacent organs was the cause of surgery in our patient. In some cases they are identified by a systematic review, alaparotomy for banal cyst ovary or rupture of the bladder and rectum (Philippe and Charpin, 1992). The treatment of ovarian dermoidcysts is surgical. Cystectomy is the usual response in young women. Ovarian conservation may not be possible in case of a large tumor and is not justified in post menopausal women or peri-menopause (Milad and Olson, 1999). In our case oophorectomy was performed immediately because of the terrain of our patient and of advanced age, and also because of the invasion bladder. We distinguish between single dermal teratomas formed from a single mature tissue as Strumaovarii (ovarian goiter) (Carrefour pathologique, 2005), carcinoid tumor, nerve tumors differentiation (Bamarey *et al*., 2010) and teratomas pluritissulaires which are by far the most common (Carrefour pathologique, 2005).

Macroscopically, mature teratoma is a cystic tumor in 88% of cases, rarely solid (Bamarey *et al*., 2010). This is most often have bulky grey cysts (10-15 centimeters) (O'Neill and Cooper, 2011; Comerci et al., 1994). The size is between 0.5 cm and 40 cm. Most tumors (60%) have a size of 5 and 10 cm long axis. Its wall is coated with asquamouse pithelium derived from ectoderm and the limited outside by ovarian stroma packed periphery of the cyst. Its content is mostly liquid type sebaceous, more rarely serious. We can also restore your hair within the cyst. Quite frequently a solid noduleis affixed to the inner face of the cyst wall, Rokitansky called nodule or protrusion. It is in this projection that met derivatives of the 3 layers of stem cells: nerve tissue, hair and nails, adipose tissue, gastro-intestinal, bronchial ...Visible in the cyst hair from the nodule (Bamarey *et al*., 2010).

A histologically benign cystic teratomas, ovarian mature normally comprise three germ layers derivatives. The skin and its annexes are almost always present in teratomas, single component (30% of cases) orin varying amounts relative to other tissues. Carcinoma. The coating

is generally not keratinized and non-parakeratotic, stroma and contains a variable number of hair follicles, sebaceous glands and sweat glands. Sometimes, the coating maybe squamous cell hyperplastic. Instead, it may be atrophic and often then continuous with a cylindrical coating respiratory type, or intestinal flattened (Philippe and Charpin, 1992). It was a right ovary with a thickened cyst wall lined with a regular squamous topped with a layer of keratin with underlying fibro fatty connective tissue confirming the nature of the tumor Benin fine.

Conclusion

Benin teratoma of the ovary is the most common ovarian tumor. Symptomatology is polymorphic especially in the elderly or the discovery may be coincidental with the waning of surgical exploration. The diagnosis remains histology of the specimen which will affirm the mature or immature nature of the tumor.

REFERENCES

Bamarey, B., Farine, M.O., Vinatier, D., Collinet, P., Lucot, J.P., Kerdraon, O., Poncelet, E. (2010). Tératomes ovariens matures et immatures: caractéristiques en échographie, TDM et IRM. *J. Radiologie* 91(1-C1) : 27-36.

Cartault, A., Ponsar, C., Menendez, M., Pienkowski, C. (2008). Kystes et tumeurs ovariennes de l'enfant prépubère : aspects hormonaux. *Arch. Pédiatrie* 15 : 778- 780.

Comerci, J.T., Licciardi, F., Bergh, P.A., Gregori, C., Breen, J.L. (1994). Mature cystic teratoma: a clinico pathologic evaluation of 517 cases and review of the literature *Obstet. Gynecol.,* 84 : 22–28.

Huc, M., Lafay-Pillet, M.C., Lecuru, F., Ruscillo, M.M., Chevalier, J.M., Vildé, F. (1996). Peritonite granulomate use après traitement cœliochirurgical d'un kyste dermoïde de l'ovaire : diagnostic, prise en charge, prévention à propos d'un cas. *J. Gynecol. Obstet. Biol. Reprod.* (Paris), 25 : 365–372.

Milad, M.P., Olson, E. (1999). Factors that increase the risk of leakage during surgical removal of benign cystic teratomas. *Hum. Reprod.*, 14 : 2264–2267.

Morgante, G., Ditto, A., La Marca, A., Trotta, V., De Leo, V. (1998). Surgical treatment of ovarian dermoid cysts. *Eur. J. Obstet. Gynecol. Reprod. Biol.,* 81 : 47–50.

O'Neill, K.E. and Cooper, A.R. (2011). The approach to ovarian Dermoids in adolescents and youngwomen. *J. Pediatr. Adolesc. Gynecol.* 24(3): 176-180.

Peterson, W.F., Prevost, E.C., Edmunds, F.T., Mason Hundley, J., Morris, F.K. (1995). Benign cystic teratomas of the ovary. A clinico statistical study of 1007 cases with review of the literature. *Am. J. Obstet. Gynecol.,* 70 : 368–382.

Philippe, E., Charpin, C. (1999). "Pathologie gynécologique et obstétriclae ". Pages 191-193. Masson.

Symposium organisé par M. Devouassoux-Shisheboran (Lyon) Tumeurs germinales. Société Françaises de pathologie (SFP). Carrefour pathologique 2005.