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International Journal of Current Research
Vol. 6, Issue, 11, pp.9719-9720, November, 2014

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

ISSN: 0975-833X

CASE STUDY

MESENTERIC TERATOMA IN A CHILD, A RARE CASE REPORT

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ARTICLE INFO

Article History:
Received 19th August, 2014
Received in revised form
04th September, 2014
Accepted 10th October, 2014
Published online 18th November, 2014

Key words:

Teratomas, Mediastinum
Retroperitonium, Cranial cavity,
Nasopharynx and Upper jaw.

ABSTRACT

Mesenteric teratomas are very rare tumors arising from totipotent primordial cells which displays a mixture of tissues of tridermal or bidermal origin. Teratomas are usually found in saccrococcygeal area (47.2%), in the gonads (31.6), and less frequently in other sites like neck, mediastinum, retroperitonium, cranial cavity, nasopharynx and upper jaw.[1]Teratomas in GIT and associated organs like stomach and pancreas are very rare and there are only occasional case report on mesenteric teratoma.

INTRODUCTION

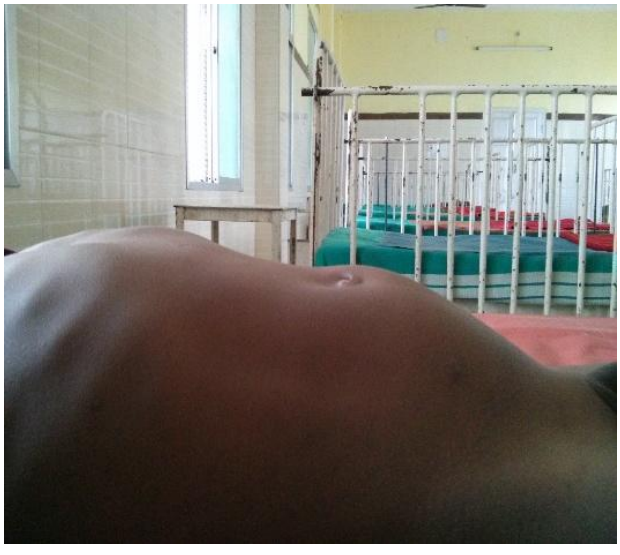
A cystic mature teratoma develops from pleuripotent cells of embryologic remnants of the ectodermal lines and usually contains a combination of both cystic and solid elements including hair, teeth, cartilage, and dermal appendages. A plain x-ray abdomen shows teeth and bone. On CT, it shows characteristic sign called 'Rokitanskyprotruberence' (dermoid plug).

Case report

A 7 year old male child presented with lump over the lower abdomen noticed 1 week back, which remained same size. Child doesn't have pain in the lump and also no gastro intestinal and genitourinary complaints. On examination, there was lump of size around 12*8 cm in the hypogastric region. Borders are well made out. Lump is mobile in both vertical and horizontal direction. On leg raising lump becomes less prominent. On knee elbow position lump falls forward. All above examination findings suggest the lump is 12 *8 cm in the hypogastric region. Borders are well made out. Lump is mobile in both vertical and horizontal direction. On leg raising, lump becomes less prominent. On knee elbow position lump falls forward. All above examination findings suggest the lump is intraperitoneal. On investigations, ultrasound abdomen showed heterogenous lesion with hyper echoic and mass of 11.5*8.5 cm noted in the umbilical and hypogastric region.

CT abdomen showed large well defined heterogeneously enhancing hypodence predominantly solid mass lesion with intralesional fat componentin the lower abdomen s/o teratoma.

Child's abdomen was explored with mid midline incision. There was well circumscribed cystic mass of size about 12*10 cm attached to mesentery of small bowel at jejunoileal junction. The mass contained haemorrhagic fluid with pultaceous material.



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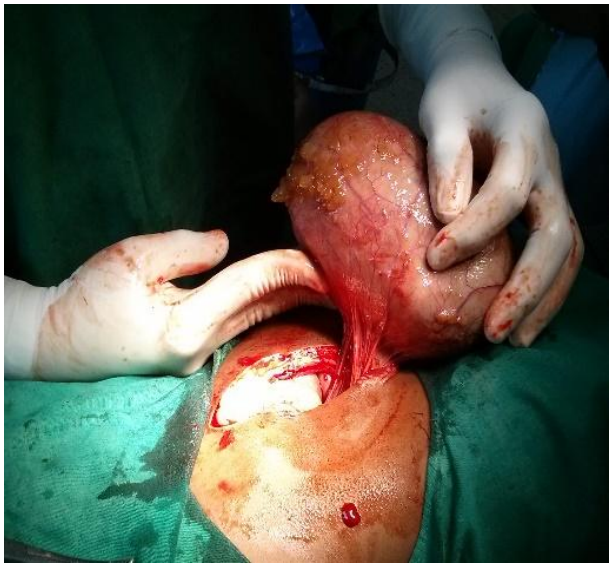

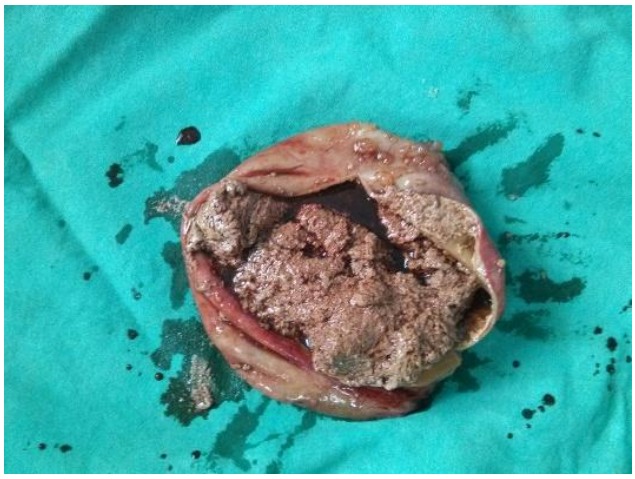

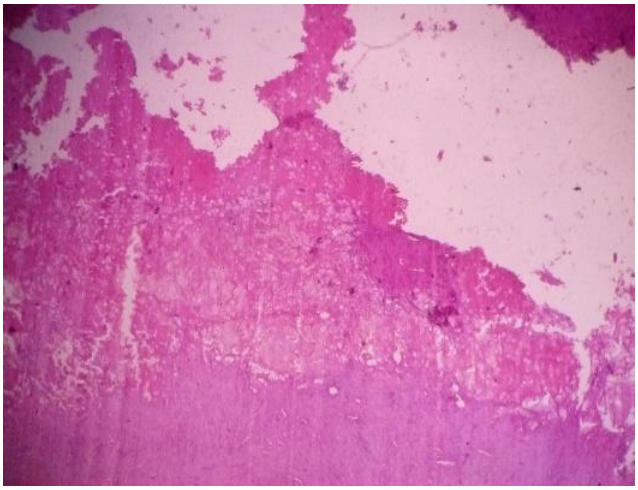

DISCUSSION

Teratomas have no pathognomonic signs or symptoms and their clinical manifestations depend greatly on size and location of growth. The anatomy of mesentery usually offers sufficient space considerable growth before symptoms can appear, particularly when lesion is located near root. The symptoms may develop early if the lesion is located at more periphery of mesentery. They presentfrequently as mass per abdomen, as in our case. Nausea, vomiting or constipation is the result of intestinal compression by mass. An intractable chronic diarrhoea as a manifestation has also been described (Upadhyaya *et al.,* 2010; Ratten *et al.,* 2007).

Plain abdominal radiograph commonly demonstrates soft tissue mass with calcification noted in nearly 60% of cases. USG shows in between predominantly cystic to predominantly solid mass with cysts. CT is considered as more suited for diagnosis. Complete surgical excision is the mainstay of treatment of intra-abdominal teratoma. Complete tumor resection is sufficient for benign teratoma. Most of the abdominal teratomas are benign in nature. The presence of immature elements in the histology needs chemotherapyand regular follow up. Serum AFP levels and USG abdomen are reliable methods of detecting recurrence.

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