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Letter to the Editor

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Managing sacrococcygeal teratoma in a resource constrained setting

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Dear Sir

Sacrococcygeal teratoma (SCT) is a rare condition, occurring in 1/35000 to 40000 live births. [1] Unlike high-income countries (HICs), its diagnosis and management are still challenging in low-and-middle-income countries (LMICs), such as in the Eastern Democratic Republic of the Congo.

A female patient was born to a 26 years-old mother whose pregnancy was not medically followed-up. The vaginal birth occurred at the 39th gestational age, as the newborn extraction needed maneuvers due to the sacrococcygeal mass identified during labor. The patient weighed 3250 grams, and the parents were not consanguineous.

A sacrococcygeal soft mass was noted on physical examination with a greater diameter of 31 cm and an ulcerated area (Fig. 1A).

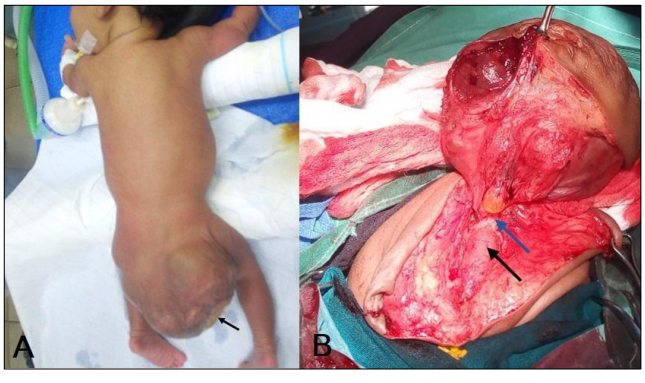

Figure 1: A) Clinical view of the sacrococcygeal mass. Note an ulcerated zone (black arrow) due to maneuvers during labor. B) Intraoperative view. Aspect after dissection of the mass, with intact posterior rectal wall, with its fascia (black arrow) and the coccyx (blue arrow), prior to its resection, along with the mass.

Due to parental financial constraints, serum alpha-fetoprotein (AFP) could not be realized. Abdominopelvic ultrasound concluded the absence of an intrapelvic extension. However, medical resonance imaging (MRI) was unavailable, and the parents could not afford computed tomography (CT) scans. The abdominopelvic x-ray did not identify any sacral anomaly. We considered the tumor to be an Altman Type 1.

On day ten, surgical excision was done (Fig. 1B), and the tumor weighed 950 grams. The discharge occurred on day three. Two weeks later, partial wound dehiscence occurred and was treated with daily honey dressing till complete healing 13 days later. Microscopy revealed immature grade 3 teratoma. The patient was clinically healthy eight months later, without any recurrence signs. However, AFP dosage could still not be obtained.

In HICs, prenatal diagnosis is made from 47 to 88% of cases [1], while from nil to 45% in LMICs. [2–5] This contrast is mainly due to the lack of pregnancy supervision, reported in as high as 66% of cases. [4] This was the case with our patient. Prenatal diagnosis allows to plan for a special follow-up, with additional fetal monitoring and planned birth in a tertiary center. The C-section is preferable in a fetus whose tumor exceeds 5 cm to reduce rupture risk. [2] In our patient, the giant tumor has led to dystocia. In LMICs, vaginal birth ranges from 79 to 97%, with the remaining patients being born through a C-section, which is indicated due to dystocia. [4,5] Some African reviews reported preoperative AFP testing from nil to 79% of patients. [4,5] However, reasons were not evoked. In our settings, these may include unavailability of the dosage in local laboratories and high cost, as was in our case. In LMICs, MRI is rarely available, leading to its substitution for lateral sacral x-rays [4,5] and pelvic CT. [3]

In LMICs, significant challenges make SCT's antenatal diagnosis and management difficult, as shown in our patient, mainly due to parental financial constraints. Lower cost or governmental subvention of health care and better parental education would help overcome these challenges.

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