

LETTER TO THE EDITOR

Gastric Mature Teratoma in Newborn

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DEAR SIR

A seven-day old male infant (weight 3.5 kg) presented with abdominal distension and a mass in the abdomen since birth. There was no history of exposure to any drugs or radiation to the mother in the antenatal period. All the laboratory investigations including beta-human chorionic gonadotropin (hCG) and alpha-fetoprotein (AFP) were normal. X-ray abdomen showed a mass effect in the abdomen with calcifications in the left hypochondrium (Fig.1A).

Ultrasound showed a huge complex cystic mass with multiple septations and solid components, both the kidneys were normal. There was no free fluid in the peritoneal cavity. MRI scan (Fig.1B) showed expansive, multilocular and mostly cystic mass with compressive effect on surrounding structures. Exploratory laparotomy through a bilateral supra-umbilical transverse incision revealed a large multicystic mass arising from postero-superior wall of the stomach along its greater curvature (Fig.1C). Greater part of the mass was lying outside the stomach while a small part was extending into the lumen of the stomach. The mass was excised in toto with a small fringe of the gastric wall from which the lesion originated. The stomach was repaired in layers.

Cut surface revealed large cystic areas with solid areas. Solid tissue was composed of greyish white areas with foci of cartilage and bone (Fig.1D). Postoperative course was uneventful. The histopathology was reported as mature gastric teratoma, There has been no evidence of recurrence during the follow-up period of six months.

Gastric teratoma is usually large size tumor and may cause respiratory difficulty [1]. The site of gastric teratoma is variable most commonly from greater curvature and posterior wall of the stomach [2]. In our case, it was also a huge tumor arising from greater curvature.

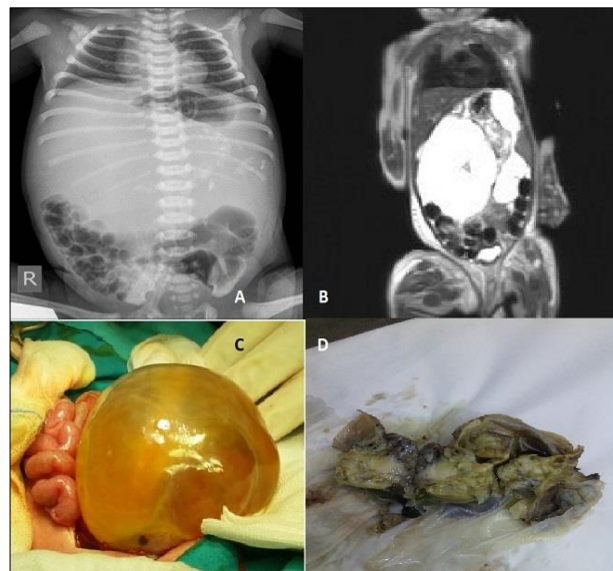


Figure 1: A) X-ray abdomen showing mass effect and calcifications. B) MRI abdomen showing huge mass mostly cystic with displacement of surrounding structures. C) peroperative picture. D) Gross specimen showing cartilagenous structures.

Majority of tumours are exogastric, but sometimes a small endogastric component or mixed variety may be present. Our case was also mixed variety with major component lying outside the gastric lumen and a small endogastric component. In case of intramural extension the patients may present with hematemesis or melena; but this presentation was not observed in our case. The investigating

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modalities include abdominal radiograph, ultrasonography, and CT/MRI scan.

The monitoring of AFP and beta hCG reflect the treatment response after excision and may be of significant value where chemotherapy is recommended in immature teratomas. The treatment is complete excision of tumour and long term follow-up [3] as we are doing in our case.

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