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Torsion of a Giant Ovarian Teratoma during Pregnancy in a Patient with a Uterine Malformation: a Case Report

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Abstract

Background: Adnexal masses complicate 0.3–5.4% of pregnancies, with mature cystic teratomas (dermoid cysts) being the most common benign germ cell tumor. Though usually asymptomatic, they can cause torsion, rupture, or labor obstruction, making management during pregnancy challenging. Case: We report a 25-year-old woman, gravida 2 (one prior cesarean), followed for a uterine malformation at 22 weeks of gestation, with an arrested pregnancy in a rudimentary uterine horn. Obstetric ultrasound confirmed a viable singleton pregnancy (estimated fetal weight 1268 g, cephalic presentation). Abdominal MRI revealed a uterine malformation with an additional gestation in a rudimentary left horn, at high risk of rupture. After multidisciplinary discussion, exploratory laparoscopy was performed and converted to laparotomy, revealing a 10 cm left ovarian mass with three turns of pedicle torsion. Detorsion and resection confirmed a mature teratoma.

Discussion: Mature teratomas are generally managed expectantly when small and asymptomatic, but larger or symptomatic masses require surgical intervention tailored to gestational age, ideally with fertility preservation. This contrasts with immature teratomas, which are malignant and require aggressive multidisciplinary management, and fetal teratomas (e.g., sacrococcygeal), which carry substantial risk of hydrops and fetal demise. Early detection through imaging and tumor markers, combined with individualized multidisciplinary care, is essential to balance maternal and fetal outcomes.

Conclusion: Ovarian teratomas in pregnancy, though rare, require prompt diagnosis and individualized management. This case highlights successful surgical management of a torsed mature teratoma in a complex pregnancy with uterine malformation, achieving favorable maternal and fetal outcomes.

Keywords: Ovarian teratoma, Pregnancy, Adnexal torsion, Uterine malformation, Rudimentary horn pregnancy, Laparoscopy, Case report

Introduction

Adnexal masses are occasionally encountered during pregnancy, with a reported incidence of 0.3–5.4% **[1]**.

Among them, mature cystic teratomas, also known as dermoid cysts, represent the most common benign germ cell tumors. Although usually asymptomatic, they may lead to complications such as torsion, rupture, or obstruction during labor. The management of ovarian teratomas in pregnancy remains challenging, balancing maternal and fetal risks.

Ovarian tumors during pregnancy represent a diagnostic and therapeutic challenge. We report the case of a pregnant patient in whom an ovarian teratoma was diagnosed and treated dur-

ing pregnancy.

Case Report

A 25-year-old patient, second pregnancy (one living child by cesarean section), without any significant medical history, is being followed for a uterine malformation during a pregnancy of 22 weeks of amenorrhea, with an aborted pregnancy located in a uterine horn.

On admission, the patient was afebrile, conscious, hemodynamically and respiratorily stable, with a blood pressure of 130/90 mmHg and a heart rate of 82 bpm. Obstetric examination revealed a relaxed uterus without contractions. Vaginal examination showed a closed cervix, with an intact amniotic sac and no signs of membrane rupture.

Obstetric ultrasound revealed a viable singleton pregnancy with positive cardiac activity, cephalic presentation, biometry corresponding to 22 weeks of gestation, and an estimated fetal weight of 1268 g.

Abdominal MRI showed a uterine malformation with a triplet gestation in the larger horn and two in a rudimentary left horn, likely arrested, with a high risk of rupture **(Figure 1 and 2)**.

After multidisciplinary discussion, the patient underwent exploratory laparoscopy, which was secondarily converted to laparotomy. Intraoperative findings included a 10 cm left ovarian mass with three turns of the pedicle, and detorsion with resection of the mass (teratoma) was performed **(Figure 3 and 4)**.

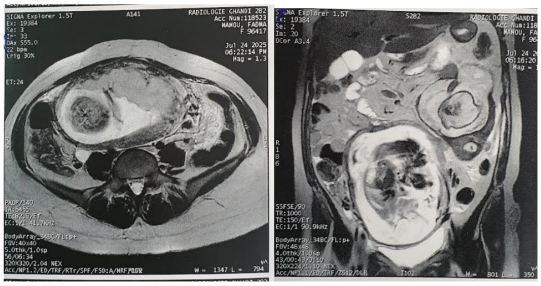

Figure 1 and 2: Abdominal MRI showed a uterine malformation with a triplet gestation in the larger horn and two in a rudimentary left horn, likely arrested, with a high risk of rupture.

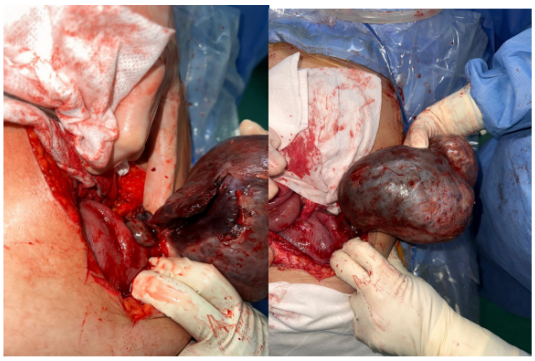

Figure 3A

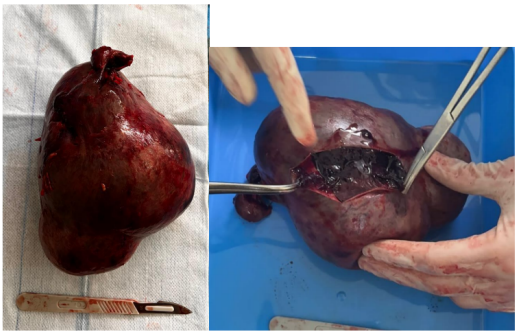

Figure 3B: 10 Cm left ovarian mass with three turns of the pedicle.

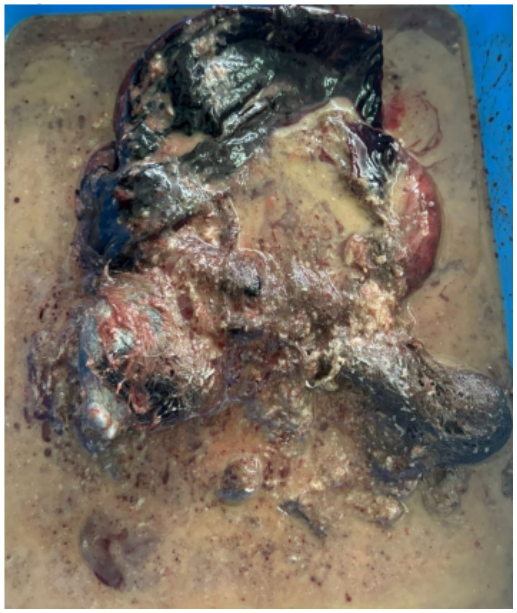

Figure 4: Ovarian teratoma.

Discussion

Teratomas encountered during pregnancy pose unique diagnostic and therapeutic challenges due to their rarity and overlapping presentation with common obstetric conditions. Among these, mature ovarian teratomas—also known as dermoid cysts— are benign but may become symptomatic or complicated during gestation. In one recent case report, a 30-year-old pregnant woman presented with acute pelvic pain and a large abdomino-pelvic mass. Imaging revealed a 15 × 15 cm lesion, leading to surgical management via cystectomy. Histopathology confirmed a mature teratoma, and fertility was preserved through a conservative approach **[2]**.

Mature teratomas are often asymptomatic, and many cases are identified incidentally during routine prenatal ultrasound. Expectant management is feasible for small (< 6 cm), asymptomatic lesions, as they generally exhibit a favorable prognosis. However, symptomatic or larger masses necessitate surgical intervention, with timing and approach tailored to gestational age and maternal–fetal risk **[2]**.

In contrast, immature ovarian teratomas, though rare, present greater concern. These malignant germ cell tumors require prompt diagnosis and aggressive management. One report describes a pregnant patient diagnosed at 19 weeks with a left adnexal mass. The patient underwent salpingo-oophorectomy and omental biopsy, revealing a Stage IA, Grade 2 immature teratoma. Despite surveillance, metastatic disease emerged by 30 weeks. An early multidisciplinary intervention, including timely chemotherapy, could potentially have mitigated progression. Ultimately, a cesarean section and oncologic resection were performed, followed by postoperative chemotherapy using a BEP (bleomycin, etoposide, cisplatin) protocol. This highlights both the aggressive behavior of high-grade immature teratomas and the importance of personalized, multidisciplinary care during pregnancy **[3] [4]**.

Beyond ovarian presentations, fetal teratomas—such as sacrococcygeal teratomas (SCT)—carry significant fetal risk. Large or malignant SCTs may lead to hydrops fetalis, high-output cardiac failure, and fetal demise. One reported case involved a fetal SCT detected at 16 weeks that expanded rapidly; the fetus unfortunately died in utero by 20 weeks, underscoring the potential severity of such tumors and the importance of early detection and monitoring **[5]**.

Overall, several key principles emerge:

• Early detection and accurate classification (mature vs. immature; maternal vs. fetal) are vital. Imaging modalities like ultrasound and MRI, paired with tumor markers such as AFP and LDH, can assist diagnosis, though interpretation must consider pregnancy-related physiological changes **[3]**.

• Individualized, multidisciplinary management is essential. For mature teratomas that are large or symptomatic, surgical management—ideally with fertility preservation—is preferred. In contrast, high-grade immature teratomas may re-

quire early surgery combined with chemotherapy, even during pregnancy, to improve outcomes **[3,4]**.

• Maternal and fetal safety must be balanced. In cases such as fetal SCTs, maternal monitoring, obstetric coordination, and planning for immediate neonatal intervention are crucial if viable outcomes are possible **[5]**.

• Finally, prognosis varies widely: mature ovarian teratomas generally have excellent outcomes, while immature or fetal teratomas—with complications like metastatic spread, hydrops, or mass effect—require closer surveillance and may carry higher perinatal risk **[2,3,5]**.

Conclusion

Teratomas in pregnancy are rare tumors that require timely diagnosis and individualized management.

While mature ovarian teratomas generally have favorable outcomes with conservative or surgical treatment, immature and fetal forms carry significant risks and demand multidisciplinary care.

Early detection and close surveillance remain key to optimizing both maternal and fetal prognosis **[2]**.

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