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Vaginal Teratoma: A Fistulized or Parasitic Recurrent Ovarian Teratoma? A Case Report

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A 39-year-old nullipara female presented with a 4 cm symptomatic vaginal mass, suspected of being a teratoma because hair and fat tissue were directly visible through the surface (Fig. 1). The patient had a history of a 5 cm left ovarian mature teratoma removed by laparoscopy in 2005, with extraction by colpotomy and concurrent excision of an endometriotic lesion involving the rectovaginal septum.

The initial hypothesis in the current case was that the vaginal teratoma might be a fistulised ovarian teratoma, resulting from the previous colpotomy, inflammation, and adhesions caused by endometriosis facilitating the formation of an ovarian-vaginal fistula. The second consideration was that of a parasitic vaginal teratoma. The magnetic resonance image (MRI) confirmed the teratoma nature of the vaginal mass and identified an associated left ovarian teratoma (Fig. 2). The patient underwent transvaginal excision of the vaginal mass and a concomitant laparoscopy with removal of a left pelvic adhesia mass (Figs. 3 and 4). Histopathological analysis confirmed a mature vaginal teratoma containing cartilage and neural tissue (Fig. 5) and a left ovarian mature teratoma associated with endometriosis. At a second look of the MRI images, the ovarian-vaginal fistula was noted as well.

Vaginal teratomas are very rare, with only twelve cases presented previously [1–4]. The coexistence of mature teratomas and endometriomas has been reported [5]. Recurrent abdominal cavity teratomas caused by cyst spillage during ovarian teratoma removal, although very rare, have been described [6,7] and led to our speculation that surgical contamination during the previous uncontained transvaginal extraction of the ovarian teratoma may have occurred. This resulted in the decision to perform the systematic extraction of the suspected teratomas in a bag to avoid cyst spillage and cell implantation.
References


Figure legends
Fig. 1 Colposcopy revealing the vaginal mass and typical appearance of a teratoma (hair).
Fig. 2 Magnetic resonance image revealing an ovarian-vaginal fistula (arrow) and two sharply defined, heterogeneous lesions originating from the left ovary with cystic components on T2 sequence.
Fig. 3 Intraoperative image of the left adnexa with adhesions and signs of endometriosis.
Fig. 4 Intraoperative image of colpotomy (←), oophorectomy (⋆), and endometriotic lesions (♯).

Fig. 5. Microscopic anatomopathological findings (mature cartilage and neural tissue).