CERVICAL TERATOMA CAUSING DYSPNEA.

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INTRODUCTION

■From the Greek word "tératos" meaning monster, teratomas are malformative tumors arising from the transformation of germ cells. Cervical localization is rare and requires a multidisciplinary approach. Prenatal diagnosis is crucial due to the risk of respiratory distress. However, it is still rarely performed in our context in Algeria, which delays the management of these cases.

OBJECTIVES

- Management of rare cases of embryonic tumors.
- Challenges in the surgical management of respiratory distress in infants with compressive teratomas.
- Role of prenatal diagnosis in embryonic tumors.

Materials and Results:

This case concerns a newborn male, whose birth was very difficult (via cesarean section), and who was subsequently hospitalized in the intensive care unit. On the 9th day after birth, the ENT team was consulted due to laryngeal dyspnea caused by a large cervical mass.Examination revealed a newborn in respiratory distress with slight cyanosis and a resilient mass approximately 25 cm in size, completely displacing the neck backward. A cervical CT scan showed a large mass compressing the larynx and trachea, without involvement of the vessels or the trachea.After consultation with the intensive care team, surgical intervention was proposed. An emergency total surgical excision of the mass was performed. Pathological examination indicated an immature multi-tissue teratoma.Unfortunately, the postoperative course was marked by hemodynamic instability, and the infant passed away due to cardiovascular arrest.

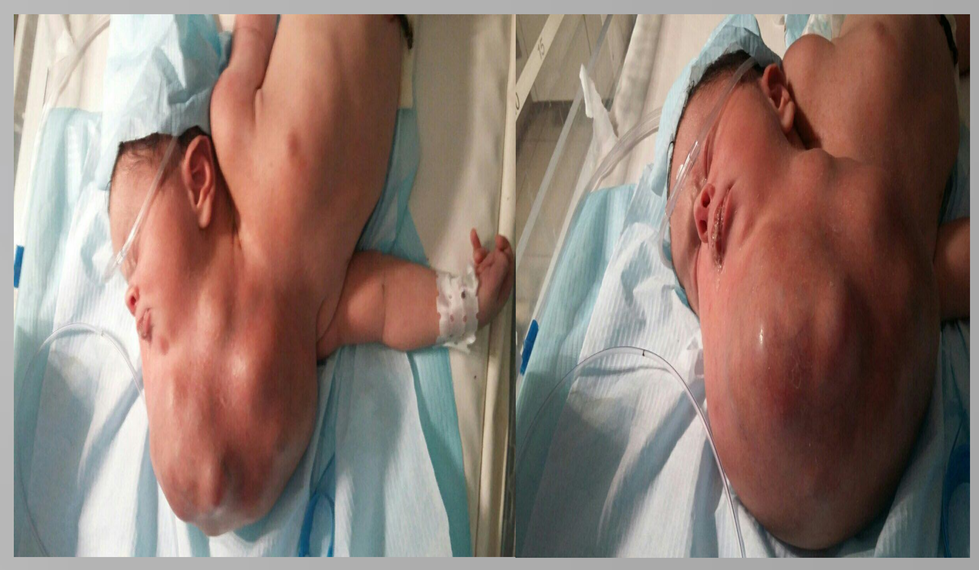
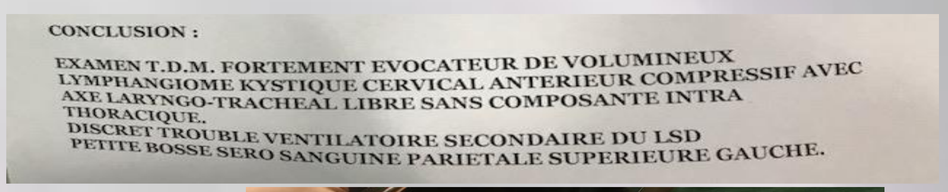


FIG 1: Cervial tumor



CONCLUSION :

EXAMEN T.D.M. FORTEMENT EVOCATEUR DE VOLUMINEUX LYMPHANGIOME KYSTIQUE CERVICAL ANTERIEUR COMPRESSIF AVEC AXE LARYNGO-TRACHEAL LIBRE SANS COMPOSANTE INTRA THORACIQUE.
DISCRET TROUBLE VENTILATOIRE SECONDAIRE DU LSD
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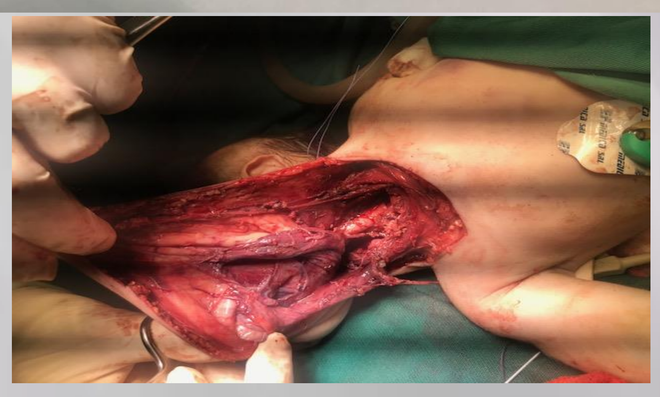
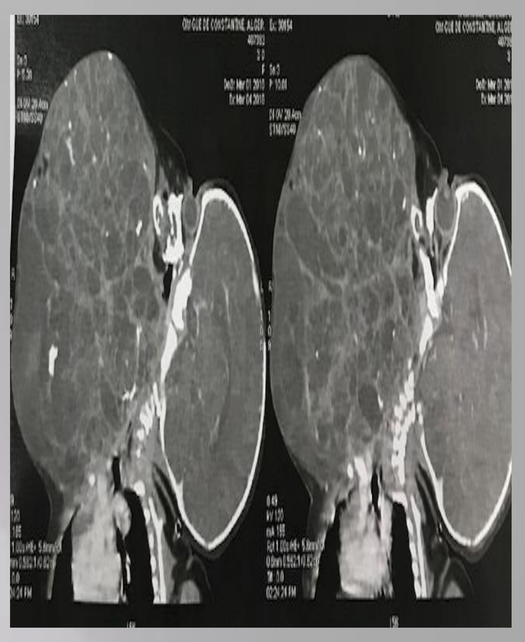
FIG%. Tu;or for qnqto;opqthology



FIG$. Surgery procedure



FTG2: CT SCAN

FIG3:Intensive care and difficulties in intubation

DISCUSSION:

From the Greek word "tératos" (monster), teratomas are malformative tumors arising from the transformation of multipotent germ cells. They are composed of ectodermal, endodermal, and mesodermal tissues in varying proportions, hence the term embryonic tumor [1, 2].
This is a rare tumor, occurring in 1/40,000 births. Cervical localization accounts for 1.5 to 5% of all locations [3]. There is a clear female predominance (3/4 of cases). Its volume can impede normal fetal growth, potentially causing hypotrophy or prematurity. During the first weeks of intrauterine life, primary germ cells or gonocytes migrate from the yolk sac, colonizing the sex cords to form undifferentiated primitive gonads. These cells may halt their migration and transform into benign or malignant germ cell tumors, which can thus be located anywhere from the child's head to the coccyx [3, 4].Teratomas are highly heterogeneous tumors, cystic with solid parts. They may contain hair, bone fragments, cartilage, and sometimes organoid structures. Complete tumor excision and multiple biopsies are necessary to avoid missing any undifferentiated, malignant areas, the presence of which can alter the prognosis [3, 5].
Prenatal diagnosis via ultrasound is possible from the second trimester, indicated by polyhydramnios, but particularly if a mass with calcifications is visualized. A fetal MRI can then be performed to assess the degree of upper airway compression. Prenatal diagnosis allows for the preparation of a multidisciplinary team to manage the newborn, given the risk of respiratory distress, and to prevent dystocia during delivery or tumor rupture. Unfortunately, in our context, this is still rarely performed, and diagnosis is often made at birth [3, 5]. Respiratory distress caused by the tumor can be fatal for the newborn, as was the case for our patient.
The prognosis is primarily respiratory when the mass is large and compresses the airways. Therefore, prenatal diagnosis allows for appropriate management. Two techniques of artificial ventilation at birth before clamping the umbilical cord are described, performed via scheduled cesarean section: EXIT (ex-utero intrapartum treatment), where the fetus's head is delivered to allow airway exploration and, if necessary, intubation or tracheostomy; and OOPS (operation on placental support), where the newborn is fully delivered and placed on a surgical table for airway examination. These techniques require maximal uterine relaxation, which can cause severe uterine hemorrhage and complications for the newborn, such as thrombocytopenia, ascites, or pleurisy [2, 6, 7]. Surgery should be performed once the newborn is stabilized unless there is a deterioration in the general condition. Complete tumor excision is often straightforward due to its separation from surrounding tissues and organs [6, 7]. This was the case for our patient. The prognosis depends on the severity of respiratory symptoms and signs of malignancy. It is generally benign in newborns.

CONCLUSION

Cervical teratoma is a rare localization. Treatment is surgical. Prenatal diagnosis allows for better management of these patients due to the risk of respiratory distress at birth from compression. The prognosis primarily depends on the severity of respiratory symptoms and whether the tumor is malignant.

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