

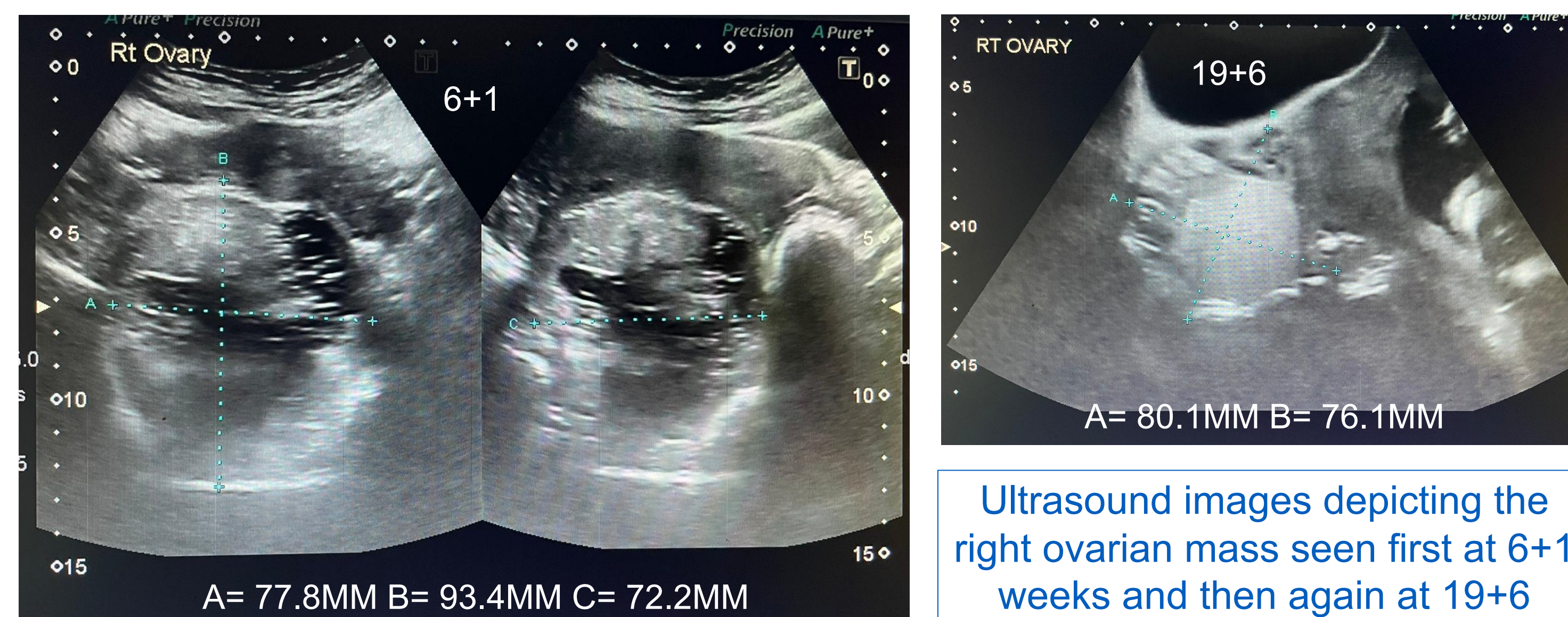
Case Report: Ruptured Teratoma Causing an Acute Abdomen in the Second Trimester.

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Background

A 37 year-old G2 P1 (previous uncomplicated normal vaginal delivery at term) was brought in by ambulance out of hours with severe abdominal pain. She was 25+0 weeks gestation and noted to have a 9cm right sided suspected dermoid cyst seen on both dating and anomaly scans. Otherwise, the pregnancy was uncomplicated.



Presentation

The patient presented to Delivery Suite with severe abdominal pain and mild tightening. On examination she had an acute abdomen with signs of frank peritonitis. On speculum the cervix was long and closed.

Investigations

Her observations were all within normal limits. CRP115, lactate normal and other bloods test unremarkable. The fetal heart rate was detected on US and normal.

Management

Given the patient's haemodynamic stability and an appreciation of the risks of extreme preterm delivery that might be precipitated by emergency exploratory surgery; a decision was made to postpone surgical management of her acute abdomen to optimise the foetus for potential preterm delivery. The first dose of antenatal steroid was administered and magnesium sulphate for neuroprotection commenced. The patient was taken to theatre ~3 hours later. A midline incision below the umbilicus revealed a ruptured right ovarian cyst with cyst content spilled in all four quadrants. Histology confirmed ruptured mature cystic teratoma with evidence of torsion. Recovery from the operation was uncomplicated and patient went on to have normal Foetal Wellbeing scans at 27 and 35 weeks.

Outcome of Pregnancy

The patient continued to spontaneously rupture membranes at 40+0 weeks gestation and was induced with oxytocin only at 40+1. She had an uncomplicated normal vaginal delivery.

Discussion

This case report highlights some of the considerations in managing acute presentations at a gestation of foetal viability where the risks of prematurity are still very significant.

Learning Points

In this case:

- Stable maternal condition allowed for an attempt at foetal optimisation to be considered and performed.
- Laparotomy was selected over laparoscopy based on the clinically acute peritonitis and impact of the gravid uterus on effective access to the affected adnexa.
- We note that the second trimester gravid uterus is not so space occupying as to prevent a 9cm solid adnexal mass from torting and rupturing.
- Exploratory laparotomy has a role in the management of second trimester acute abdomen and need not result in preterm delivery.