

Congenital Cervical Teratoma

A 26-years second gravida woman delivered a term male newborn weighing 2490 grams by caesarean section for fetal distress. Ultrasonography performed just prior to delivery had revealed tumor arising from the neck. There was no history of consanguinity and the first sibling was alive and well. The infant was severely asphyxiated necessitating endotracheal intubation which was performed with difficulty. The infant had a huge cervical mass measuring 14×12 cm (*Fig. 1*). The tumor was lobulated with a thin capsule and had partial cystic and solid consistency on palpation. Transillumination of the mass was



Fig. 1. Giant cervical teratoma.

negative and there was no bruit. The rest of the examination was non contributory. Postnatal ultrasonography was strongly suggestive of congenital cervical teratoma. The infant expired at 2 hours of age. The autopsy revealed a mature teratoma arising from the anterolateral aspect of neck.

Cervical teratomas account for approximately 3% of neonatal teratomas. The histologic appearance of these masses is varied because all three germinal layers are represented. Often immature neural elements are identified, especially in the solid portion of the tumor, suggesting neuroectodermal origin. Airway compromise is the most serious postnatal complication of giant cervical teratoma, and prenatal diagnosis is crucial, allowing for early recognition of neck masses that obstruct the airway. A prenatal ultrasound can identify the characteristic appearance of multiloculated cystic mass originating most commonly from the anterolateral aspect of the fetal neck. Polyhydramnios and rarely non-immune hydrops are associated with this condition. The other conditions that need to be considered for a mass at this site include cystic hygroma (usually transilluminant), cervical goiter, cervical sarcomas and neuroblastoma.

Management strategies for giant cervical teratomas include in-utero resection, resection on placental support during an ex-utero intrapartum treatment (EXIT) procedure, intubation or tracheostomy during EXIT, and postnatal resection.

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