

Absence of fetal movement with severe flexion deformities of all the 4 limbs with associated poly hydromnios sometimes, which is a poor prognostic sign. Other associated findings are cleft palate, meningocele, congenital heart disease, klippel feil syndrome⁶. Arthrogyposis is seen more frequently in mothers suffering from Insulin Independent Diabetes Mellitus⁷. In Arthrogyposis with genetic defect there is increased nuchal translucency⁸.

Differential diagnosis include Trisomy 18 where there will be only involvement of upper limbs.

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Sacroccocygeal Teratoma: A Case Report

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Abstract: Sacroccocygeal Teratoma (SCT) is common congenital tumour that develop early in foetal life. Foetuses with this malformation are at risk for significant perinatal morbidity and mortality. This report demonstrates the role of foetal sonography in diagnosis of Sacroccocygeal Teratoma.

INTRODUCTION

Sacroccocygeal Teratoma (SCT) are relatively common congenital tumours that develop early in foetal life¹. It can be diagnosed by prenatal sonography in second or early third trimester of pregnancy². This report demonstrates the role of foetal sonography in the diagnosis of SCT.

CASE REPORT

A 28 year old women .gravida 1 was referred to our hospital at 30 week gestation. There was no family history of birth defects. The sonographic examination revealed a single inrauterine pregnancy with an estimated gestational age of 30 weeks. The study revealed a mixed echogenic mass arising from sacroccocygeal region (figure 1). There were cystic areas within the mass. The spine appeared intact and the lower limbs appeared normal. The foetal kidneys and bladder appeared normal. There was no evidence of possible invasion of foetal pelvis and abdomen. Liquor was increased. Based on above findings a diagnosis of external variety (type I) of SCT was made. The patient decided to continue the pregnancy and was scheduled for follow up ultrasound 2 weeks later. She presented at 34 weeks gestation with rapid increase in the size of the uterus, premature rupture of membranes, and spontaneous labour pains. She delivered a dead foetus. At local examination, however, there was no evidence of foetal hydrops. Placental size was within normal limits.

DISCUSSION

Sacroccocygeal Teratoma is a common neoplasm with a reported incidence of 1-2 per 40,000 deliveries⁸. It contains derivatives of more than one of the three primary germ cell layers. Embryologically SCT are thought to derive from multipotential cells in hensen's nodes that migrate caudally and come to lie within the coccyx. SCT can be benign or malignant. Cystic lesion are more likely benign. Malignant SCT are extremely rare in foetus and uncommon in new born infant. The likelihood of malignancy greatly increases in tumours diagnosed after the infant is 2 to 4 months old. Congenital anomalies may be present in association with SCT including genitourinary, anorectal and lower vertebral malformation and need to be ruled out during prenatal sonography^{2,3,5}. Large benign tumour are associated with significant morbidity and mortality. In such foetuses complication result from massive intratumoral hemorrhage and dystocia^{6,7}.

Altman's classification: They are classified accordingly to the degree of exterior component or intrapelvic extension. Type I tumour (46.7%): Predominantly lie external to the foetus. TYPE II tumour (34.1%): Present externally but have

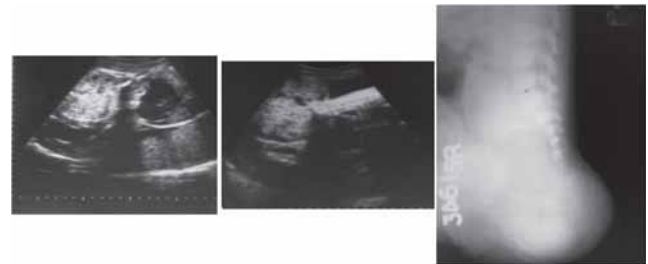


Fig 1: Longitudinal ultrasound scan of tumour showing solid and cystic components arising from caudal part of spine
Fig 2: Sagittal section scan of tumour showing solid and cystic components arising from caudal part of spine
Fig 3: X-Ray Of Foetus Showing Soft Tissue Mass In Sacroccocygeal Region.

significant intrapelvic extension. TYPE III tumour (8.8%): They are apparent externally but predominantly lie within the pelvis and abdomen. TYPE IV tumour (9.8%): They are entirely presacral with no external presentation^{3,4}.

CONCLUSION

SCT are common congenital tumour that develop early in foetal life. Foetuses with this malformation are at risk for significant perinatal morbidity and mortality. The diagnostic technique of choice is ultrasonography. Early diagnosis influences clinical decision and management, which produces better outcome.

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