Recurrent immature teratoma of the ovary: case report

Fondazione IRCCS

Policlinico Cà Granda

II Clinica Ostetrico Ginecologica

Università di Milano

Dr Villa Antonella

Malignant germ cell tumor

- 27 years old woman
- Regular menses
- Nullipara

Presenting symptoms (jan 1995):

- Abdominal pain
- Right pelvic mass
- Silent tumor markers
- Transvaginal ultrasound: 8 cm mixed solid and cystic right ovarian mass (confirmed at CT scan)

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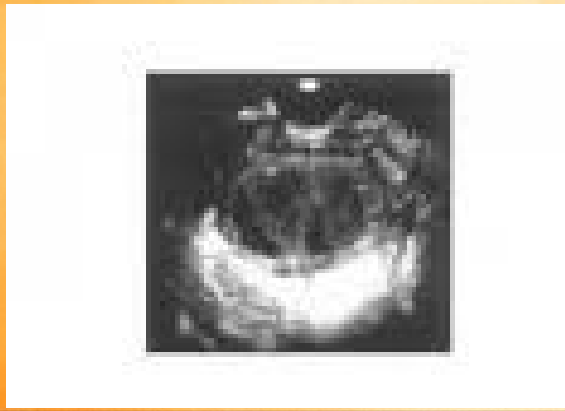
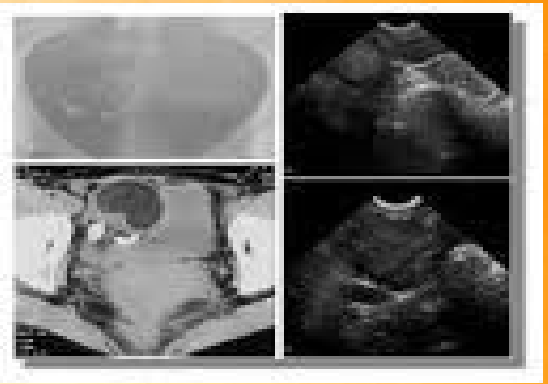
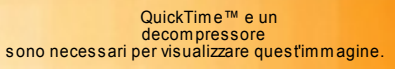




First Surgery (feb 1995):

- Laparoscopic right salpingo-oophorectomy
- Random peritoneal biopsy
- Left ovarian biopsy

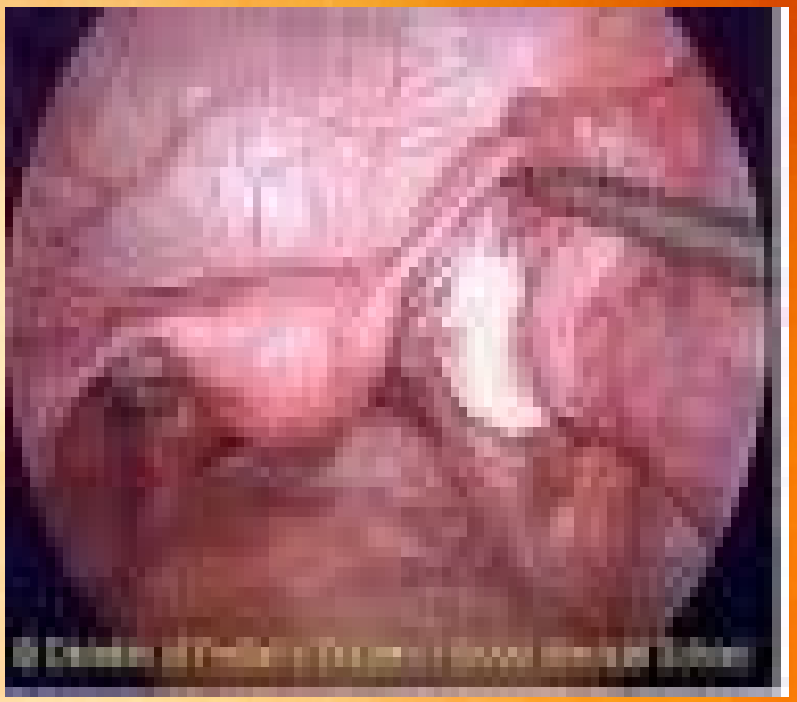


Histology:

- Immature teratoma at right ovary
- Grade 2 (according Norris' definition)
- Stage I C (FIGO)

2nd Surgery (MITO group Center): feb 1995

- Laparoscopic re-staging
- Multiple peritoneal biopsies
- Peritoneal washing



Histology

- All histologic samples were negative
- Negative peritoneal cytology

Follow-up

2007JOURNAL OF CLINICAL ONCOLOGY
REVIEW ARTICLE: Management of Ovarian Germ Cell Tumors David M. Gershenson

Trend Toward Surveillance:

Historically, the only patients thought to be appropriate candidates for treatment with surgery alone were those with stage IA dysgerminoma and stage IA, grade 1 immature teratoma. However, there is a **strong trend toward exploring the feasibility of surgery followed by close surveillance** in a much broader group of patients, although further study is warranted

Bonazzi C, Peccatori F, Colombo N, et al: Pure ovarian immature teratoma, a unique and curable disease: 10 years experience of 32 prospectively treated patients. Obstet Gynecol 84:598-604, 1994

Dark GG, Bower M, Newlands ES, et al: Surveillance policy for stage I ovarian germ cell tumors. J Clin Oncol 15:620-624, 1997

Surgical resection alone is effective treatment for ovarian immature teratoma in children and adolescents: A report of the Pediatric Oncology Group and the Children's Cancer Group

Barbara Cushing, MD,[a] Roger Giller, MD,[b] Arthur Ablin, MD,[d] Lewis Cohen, MD,[c] John Cullen, MD,[c] Edith Hawkins, MD,[f] Stephen A. Heifetz, MD,[g†] Mark Krailo, PhD,[h] Stephen J. Lauer, MD,[i] Neyssa Marina, MD,[j] P.V. Rao, PhD,[k] Frederick Rescorla, MD,[g] Charles D. Vinocur, MD,[l] Robert M. Weetman, MD,[g] and Robert P. Castleberry, MD[m]

Detroit, Michigan, Denver, Colorado, San Francisco and Arcadia, California, Portland, Maine, Houston, Texas, Indianapolis, Indiana, Atlanta, Georgia, Memphis, Tennessee, Gainesville, Florida, Philadelphia, Pennsylvania, and Birmingham, Alabama

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Follow -up

- From feb 1995 to sep 1995 patient had negative follow -up
- At sep 1995 she underwent laparoscopic second-look: multiple peritoneal,peritoneal washing, omental biopsy, left ovarian biopsy

Histology:

- **Immature glial implants at right utero sacral ligament**
- Mature glial implants at: Douglas, right pelvic peritoneum, and omentum

Chemotherapy

- From oct 1995 to nov 1995 patient underwent 3 cycles of chemotherapy with BEP scheme

- At the end of the treatment a third- look was planning but patient refused because of psycological problems

Follow up

- Within 1 year patient resumed normal menstrual cycles
- **Seven years after the completation of chemotherapy treatment she termed a pregnancy**
- Patient is free from disease after 15 years of follow up

Key-points

- Conservative surgery followed by platinum-based chemotherapy is considered the standard approach for stage I immature ovarian teratoma stage more than IA G1
- The use of chemotherapy in stage I A G2-3 and IB-IC is still debated
- **Role of adjuvant chemotherapy compared with surveillance**
- **Role of salvage chemotherapy**

Is adjuvant chemotherapy indicated in stage I pure immature ovarian teratoma (IT)? A multicentre italian trial in ovarian cancer (MITO-9) retrospective study

Coordintors: Dr Giorgia Mangili
Dipartimento di Ginecologia e Ostetricia
IRCCS Ospedale San Raffaele
Milano

Conclusions

- Several studies reported severe long term complications from chemotherapy after BEP for malignant germ cell tumor
- The side effects of chemotherapy and the ability to successfully salvage relapsed patients with surgery and chemotherapy suggests to consider surveillance alone in a boarder subgroups of patients
- **Surveillance policy could be safe in stage I G2 G3 ovarian immature teratoma**
- **Salvage chemotherapy colud be reserved in case of recurrance with excellent chences of therapeutic success**

Grazie per l’attenzione!