Case report

Intrapulmonary teratoma*

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Abstract
Case report of a 49-year-old man, presenting chest pain and bloody sputum for six months. Chest X-ray and computed tomography scan showed opacification in the left upper lobe. The bronchoscopy showed bronchial hemorrhage in the lingular bronchial segment. Due to diagnostic and therapeutic needs, this patient underwent a left inframamillary thoracotomy. The anatomopathological analysis of the surgical sample revealed an intrapulmonary teratoma. The patient presented favorable evolution and is now under outpatient follow-up treatment.

Keywords: Teratoma; Lung; Neoplasms.

Introduction
Teratoma can be found in various organs. In decreasing order of location, it is seen in the ovaries, testicles, sacrococcygeal region, mediastinum, and other sites.1-4 In the international literature, 43 cases of intrapulmonary teratoma have been described, the first in 1939.3

Intrapulmonary teratoma originates from totipotent cells of one or more of the three germinative layers, which can differentiate themselves into any type of tissue.2,3 There are no specific clinical or radiological characteristics, and the anatomopathological study is the definitive diagnostic method.1,3,4 Curative treatment consists of complete resection of the tumor.3,4

Case report
We report the case of a 49-year-old male Caucasian who was a businessman from Italy and a resident of São Paulo. The patient sought emergency treatment, presenting with bloody sputum and chest pain in the left anterolateral region for six months. The epidemiology was negative for tuberculosis. He was a 20-pack-year smoker. He presented good general health status. The physical examination revealed discrete wheezing in the middle third of the left hemithorax, with no other alterations. The body mass index was 36.3 kg/m².

A chest X-ray revealed nodular opacities in the middle third of the left hemithorax, in lingular projection, meas-

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Discussion

Teratomas present slow growth and are typically benign. When in the lung, they are most often found in the upper left lobe, as in the case reported. Symptomatology varies according to the location and size of the tumor, as well as to the histological components. In this case, the patient reported bloody sputum and thoracic pain which, together with cough, are the most commonly reported symptoms. Other symptoms reported in the literature are trichoptysis, bronchiectasis, fever, abscess, repeated pneumonia, signs of compression of thoracic structures, and fistulas, with or without infection of the tumor.

Teratoma is an extremely rare disease that affects both genders and all age brackets equally. The size of the tumor has no relationship with malignancy. On chest X-rays, teratoma can present as lobulated upper lung lobe tumors or intraparenchymal opacities, corresponding to the exam shown above. On tomography scans of the chest, homogeneous or heterogeneous tumors can be observed.

In anatomopathology, these tumors present endodermic components (pancreatic acinar tissue, with or without islets of Langerhans and respiratory epithelium), thus differing those found at extrathoracic sites. Intrapulmonary teratoma originates in cells that can differentiate into any tissue type. In the case reported, microscopy of the resected surgical sample revealed pancreatic tissue, carti-
lage, bone, epidermis and sebaceous glands. It has been suggested that intrapulmonary teratoma derives from the thymic tissue of the third branchial arch. However, mediastinal teratoma results from the dislocation and early separation of the thymic tissue, during embryogenesis, with capture and migration of thymic primordia during the development of the respiratory system.

The classification system used in order to categorize teratomas as benign or malignant is that proposed by Gonzales-Crussi in 1982, which has proven practical to date.

1) Benign teratomas:
   a) Mature teratoma
      Grade 0 - all components are well differentiated
      Grade 1 - non-undifferentiated components do not exceed 10%
   b) Immature teratoma
      Grade 2 - immature tissues among 10 to 50% of components
      Grade 3 - undifferentiated components over 50% and probable metastatic potential.
      Benign evolution is still possible.

2) Malignant teratomas:
   a) With germ cell tumor areas
      Germinoma (seminoma - dysgerminoma)
      Embryonal carcinoma - Coriocarcinoma
      Yolk sac tumor
   b) With non-germ cell tumor areas
      Carcinoma - Sarcoma - Malignant embryonal tumor
      Mixed cell type
   c) Malignant immature teratoma

The prognosis of malignant teratoma is poor. In a study comprising eleven patients with malignant teratoma, seven patients (63.6%) died after a six-month follow-up period. None of these patients underwent surgery, or the tumor was nonresectable by thoracotomy. Metastases were reported in three of these patients.

In patients with benign teratoma, the recommended procedure is complete resection of the tumor, upon which the patient is considered totally cured. Patients who did not undergo surgery can present massive hemoptysis or increased tumor growth and can die. In the case reported, the patient evolved without complications and did not require any further therapeutic measures, as has been reported in the literature, and, after two years of outpatient follow-up treatment, presented no signs of relapse.

In conclusion, intrapulmonary teratoma is a rare tumor, and surgery is the definitive treatment. Definitive confirmation of the diagnosis is made through anatomopathological examination, and prognosis is good when the condition is properly treated.
References