Mature cystic teratomas of the fallopian tube are unusual, being almost incidentally identified. Here we describe a case of mature cystic teratoma arising in the fallopian tube, in a 44-year-old female. The mass was found during a regular checkup without complication. Microscopically, components from each germ layer were identified.

CASE REPORT

A 44-year-old female, gravida 4, para 1, presented with a right adnexal mass discovered at a pelvic ultrasonography performed during a regular checkup; at ultrasonography, a 3.5 cm sized markedly heterogeneous mass was presented (Fig. 1). At that time, this mass was considered as a right ovarian mass. A laparoscopy demonstrated a cystic mass located at the ampullary portion in the right fallopian tube. Consequently, a laparoscopic right salpingectomy was performed. Grossly, a 3.3 cm sized cystic mass was present within the ampulla, which was filled with whitish gelatinous and yellowish greasy material with hairs. The outer surface was smooth (Fig. 2). A microscopic examination revealed squamous epithelium with sebaceous glands and hair follicles, pseudostratified ciliated respiratory epithelium with cartilage and mucous glands, and thyroid gland tissue (Fig. 3).

DISCUSSION

Tumors of the fallopian tube are uncommon. Approximately 60 cases of mature teratoma of the fallopian tube have been reported in the literature. Most cases of tubal mature cystic teratomas have been diagnosed during the reproductive years and most of them are found incidentally via image study or during pelvic surgery. At examinations prior to surgery, tubal teratomas are often misdiagnosed as ovarian teratomas. These tumors are usually asymptomatic but are sometimes associated with reduced parity, menstrual irregularity, leukorrhea, postmenopausal bleeding, and abdominal pain. They are usually attached by the pedicle to the tubal mucosa and commonly located in the ampulla or the isthmus. The tumor diameters have been reported to range between 0.7 and 20.0 cm. The pathogenesis of tu-
Tubal teratomas is not clearly understood, but it is believed to arise from germ cells migrating from the yolk sac to the primitive gonadal bud. Tubal teratomas might result from the failure of these germ cells to reach the ovary. Most of them are cystic, but in rare examples are solid and three cases of immature tubal teratomas have been reported. Although the inci-

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**Fig. 1.** Presence of a 3.5 cm sized heterogeneous echoic mass in the right adnexa at ultrasonography.

**Fig. 2.** The appearance of the fallopian tube is dilated, while the inner cystic space is filled with hair and yellowish greasy material.

**Fig. 3.** A microscopic examination demonstrates squamous epithelium with skin appendages (A), respiratory epithelium, cartilage, and mucous glands (B) and thyroid tissue (C) and a transitional site of squamous epithelium and tubal epithelium (inset) (D).
dence of tubal teratomas is low, awareness of its occurrence is necessary. Especially pathologists must consider the possibility of a tubal teratoma when the origin of the adnexal mass is ambiguous grossly, because tubal teratomas are often misdiagnosed as ovarian teratomas in radiologic studies.

REFERENCES