Maternal Complications Following Intrauterine Fetal Demise from Sacrococcygeal Teratoma: A Case Report

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Background

Fetal sacrococcygeal teratoma (SCT) occurs in approximately 1 in 40,000 live births and is the most common congenital tumour identified in neonates. Large, vascular SCTs can act as an arteriovenous shunt, leading to high-output cardiac failure, hydrops fetalis, and intrauterine fetal demise (IUFD). While fetal and neonatal outcomes of SCT are well described, maternal complications following IUFD secondary to fetal SCT are rarely reported in the literature.

Aims

To present a case of severe maternal morbidity following IUFD secondary to a large fetal SCT, highlighting the complexity of postpartum management in this clinical scenario.

Case

A 35-year-old G6P4+1 woman presented at 23 weeks gestation with abdominal pain. Ultrasound revealed a 15.8cm highly vascular fetal sacral mass with polyhydramnios. Maternal-fetal medicine assessment confirmed a Type I SCT (144×140×100mm) (image 1)with fetal cardiomegaly and a hyperdynamic circulation. Counselling covered three options: expectant management, experimental fetal intervention, or termination of pregnancy. Six days later, at 24 weeks, a repeat scan confirmed intrauterine fetal demise. She underwent an emergency (third) Caesarean section, complicated by severe postoperative abdominal pain requiring intensive analgesia, including a ketamine infusion, with CT imaging unremarkable at that stage and USS Pelvis was organised. USS pelvis identified a R ovarian cyst measuring ~133cc (Image 2) and the decision was made for a diagnostic laparoscopy. While awaiting surgery she also developed a fever (38.5°C) and surgery was expedited.

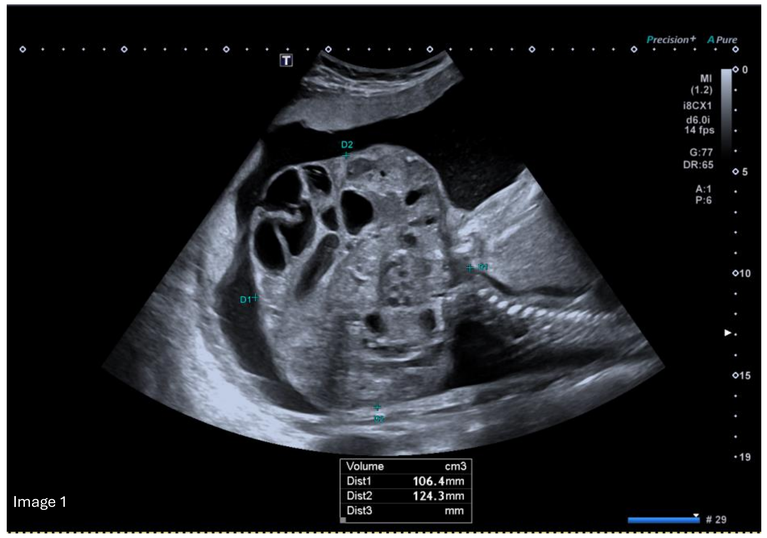

Image 1

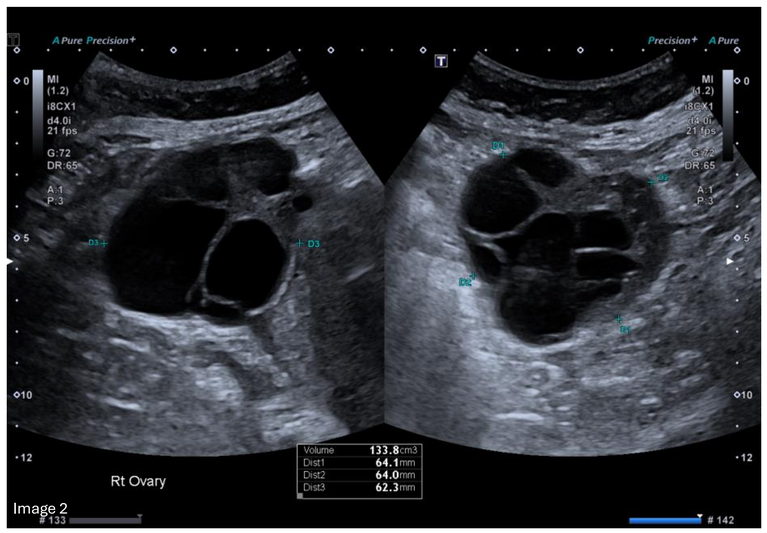

Image 2

Results

Diagnostic laparoscopy identified bilateral enlarged polycystic ovaries (right 134cc), consistent with theca lutein cysts secondary to SCT-driven beta-hCG elevation, alongside Fitz-Hugh-Curtis adhesions suggesting previous pelvic infection. Right ovarian cystectomy achieved a 75% reduction in ovarian volume. Postoperatively, she developed ileus with marked faecal loading, requiring conservative management with electrolyte correction, enemas, and gradual diet advancement over a seven-day admission. A history of Ogilvie syndrome following her second Caesarean section in 2021 suggested a predisposition to pseudo-obstruction.

Discussion

This case demonstrates significant maternal morbidity associated with fetal SCT and IUFD, including theca lutein cyst formation and postoperative ileus. The enlarged ovaries likely resulted from elevated beta-hCG driven by the large tumour. Clinicians should anticipate these complications and maintain heightened awareness for ovarian pathology and bowel dysfunction in similar cases, with a low threshold for imaging and multidisciplinary review.

References

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- Kim JW, et al. (2021) – Recent case report on theca lutein cysts with maternal virilization.
- Hughes DL, et al. (2019) – Review on Ogilvie's syndrome/acute colonic pseudo-obstruction after Caesarean section.