

## CASE REPORT

# Anesthetic management of a neonate with an intrapericardial teratoma: a case report

Ying E. Lu-Boettcher<sup>1</sup>  | Prabhat Koppera<sup>2</sup> | Lori Q. Riegger<sup>2</sup>

<sup>1</sup>Department of Pediatric Anesthesiology, University of Wisconsin, Madison, Wisconsin

<sup>2</sup>Department of Pediatric Anesthesiology, University of Michigan, Ann Arbor, Michigan

**Correspondence**

Ying E. Lu-Boettcher, University of Wisconsin Hospital and Clinics, 600 Highland Ave, B6/319, Madison 53792-3272, Wisconsin.  
Email: YingLu2010@gmail.com

**Abstract**

Intrapericardial teratomas can exert mass effect on the cardiovascular and respiratory system. Adequate volume resuscitation and anticipation of cardiopulmonary collapse is paramount in the management of these patients in the operating room.

**KEYWORDS**

Intrapericardial Teratoma, Neonatal Teratoma

## 1 | INTRODUCTION

We describe the anesthetic management of a 4-day-old premature infant presenting for urgent resection of a massive posterior intrapericardial teratoma. Anesthetic challenges include anticipating cardiopulmonary collapse upon induction and hemodynamic instability associated with blood loss or tumor manipulation. Premature infants present unique challenges due to patient-to-tumor size discrepancy.

Intrapericardial teratomas are rare primary cardiac tumors with a reported incidence of 0.003%-0.14% in published literature, accounting for 15%-19% of pediatric cardiac tumors. These tumors can arise from the inner lining, cardiac muscle layer, or the pericardium, and the majority in infants and children are benign.<sup>1-4</sup>

During fetal life, manifestations of a cardiac tumor can include congestive heart failure, hydrops, arrhythmias, and possible stillbirth. In postnatal life, cardiac tumors may exert mass effect on adjacent structures leading to inflow or outflow tract obstruction, myocardial dysfunction, respiratory distress, arrhythmias, and sudden death.<sup>3,5</sup> Surgical resection is the treatment of choice as it can definitively alleviate mass effect exerted by the tumor. Our current anesthetic experience

is predominately based on case reports. Thus, the aim of this report was to address perioperative concerns unique to neonatal intrapericardial teratomas and aid in future anesthetic planning.

## 2 | CASE DESCRIPTION

We present a 2 kg preterm female with a large prenatally diagnosed posterior intrapericardial mass concerning for teratoma, without signs of hydrops on prenatal ultrasound which confers lower morbidity and mortality.<sup>6</sup>

The infant was born via spontaneous vaginal delivery at 33 weeks and 6 days of gestation in the setting of preterm labor and was successfully intubated at minute 3-4 of life. Apgars at 1 and 5 minutes of life were 3 and 7, respectively. UVC and UAC were placed, labs obtained, prostaglandins started while awaiting formal echocardiography, and patient transferred to pediatric cardiac ICU for further management. Postnatal echo, MRA/MRI confirmed findings of a 4.3 × 3.6 × 3.5 cm mass displacing the heart within in a massive pericardial effusion. The mass was intimately related to the roof of bilateral atria, the ascending aorta,

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main and right pulmonary artery, and right coronary artery. There was mass effect causing compression of the superior vena cava, leftward displacement of the left pulmonary artery, anterior leftward displacement of the aorta, and mild narrowing in the distal trachea, all without evidence of tamponade (Figures 1-2). Preoperative alpha-fetoprotein level was >145 000 ng/mL.

On DOL2, hypotension in the cardiac ICU prompted initiation of dopamine infusion, bedside drainage of 60 mL of pericardial effusion with placement of a pericardial drain.

### 3 | PERIOPERATIVE COURSE

On the 4th day of life, the patient was brought to OR for tumor resection. The patient had a preexisting 3.5 uncuffed ETT, and all inpatient infusions were maintained, including TPN, dexmedetomidine 0.3 mcg/kg/h, morphine 20 mcg/kg/h, and dopamine 2.5 mcg/kg/h. Patient was given additional 0.4 mg of midazolam and 5 mg of rocuronium prior to transport. In addition to existing UAC and UVC, two 22 g IV's were established in OR for access. ETT was exchanged to 3.0 cuffed ETT uneventfully under direct laryngoscopy due to leak.

General anesthesia was maintained with oxygen/air, sevoflurane, 5 mcg increments of fentanyl, and 2 mg of rocuronium intermittently. In addition to arterial waveform and CVP, near-infrared spectroscopy (NIRS), capnography, temperature, and pulse oximetry monitoring were utilized. Via median sternotomy, with cardiopulmonary bypass on standby, the pericardium was opened and a multiloculated hemorrhagic-appearing mass measuring approximately 5 cm in length was revealed, densely adherent along the entire lateral aspect of the ascending aorta as well as the medial aspect of the SVC. There were multiple bouts of hemodynamic instability while the mass was being resected due to the proximity of the mass to the systemic venous connections. As a result, the patient remained on dopamine throughout the case and received liberal fluid resuscitation (25 mL/kg of crystalloid) as well as 40 mL/kg of pRBCs. Permissive hypotension was

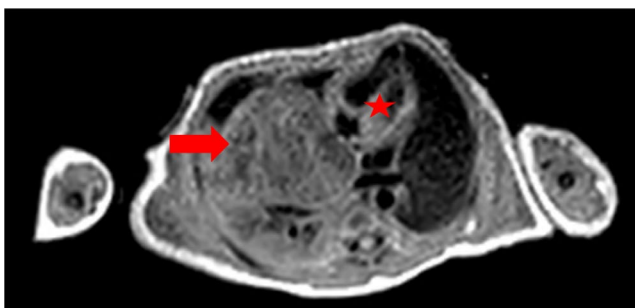
allowed to facilitate resection. The case did not require cardiopulmonary bypass, and the chest was closed uneventfully after resection (Figure 3). She was brought to cardiac ICU intubated postoperatively, and required inotropic support until postoperative day 1. She was extubated in the intensive care unit on postoperative day 2. The patient was discharged home on postoperative day 4.

### 4 | DISCUSSION

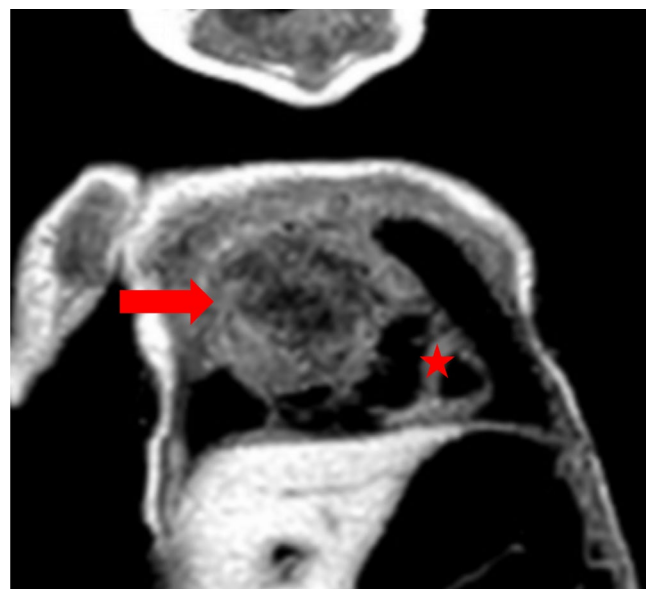
Anesthetic management of an intrapericardial tumor can present a serious challenge for the anesthesiologist. Our current anesthetic experience is predominately based on case reports. Teratomas can be associated with mass effect and pericardial effusions resulting in cardiac compression and respiratory distress after birth. After diagnosis, the typical treatment of choice is surgical resection.

For preoperative planning, it is important to obtain two-dimensional echocardiography as well as magnetic resonance imaging for larger tumors to elucidate the tumor's involvement with adjacent structures. Determining the ability to separate the mass from vital structures, such as the great vessels and airway, is essential for anesthetic and surgical planning. In our patient's case, MRI/MRA and 2-dimensional echo were all obtained during preoperative planning.

In patients with mass effect on the respiratory tree, the goal of preventing respiratory collapse is achieved by performing intubation while the patient is ventilating spontaneously. Depending on location of tumor, airway obstruction and hemodynamic collapse may still occur, which may need to be

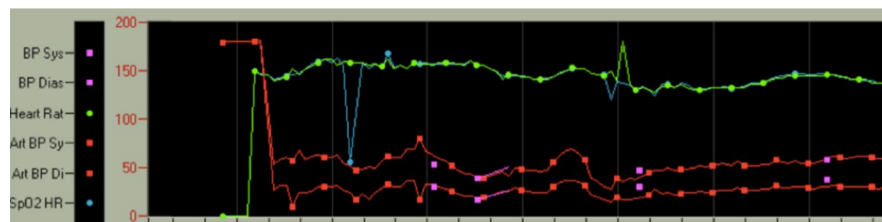


**FIGURE 1** Axial Plane. Star indicates cardiac tissue, and arrow indicates tumor



**FIGURE 2** Coronal Plane. Star indicates cardiac tissue, and arrow indicates tumor

FIGURE 3 Intraoperative Course



alleviated by immediate removal/lifting up of tumor by the surgeon after sternotomy. Cardiopulmonary bypass is often on standby, either as a rescue measure or to facilitate resection. In patients with critical positional symptoms of cardiopulmonary compression, induction of anesthesia with maintenance of spontaneous ventilation may still be unsafe. Alternatives such as extracorporeal membrane oxygenation may need to be established prior to surgical resection.<sup>7,8</sup> In our patient's case, mass effect on the cardiorespiratory system was somewhat mitigated after drainage of pericardial effusion. There was only a mild compression of distal trachea, and we had the knowledge that she was previously uneventfully intubated during neonatal resuscitation. In our patient's case, tumor resection occurred > 34 weeks' gestational age and weight > 2000 g to allow for cardiopulmonary bypass rescue or ECMO,<sup>9,10</sup> which may be precluded in smaller patients.

Intraoperatively, hemodynamic disturbances should be anticipated with tumor manipulation and surgical blood loss. Adequate IV access is essential as hemodynamic instability is expected and significant blood loss, while rare, can occur. In our patient, an infusion of dopamine and liberal fluid resuscitation including blood products were required to maintain hemodynamic stability. In addition, epinephrine and vasopressin infusions were immediately available. Despite these precautions, permissive hypotension was still required to facilitate surgical resection.

Postoperatively, most patients experience smooth recovery. Our patient was uneventfully discharged on POD 4. Histological examination showed a predominately mature teratoma with immature components, with elements from all three primitive germ cell layers. Patient returned on POD 36 for a repeat cardiac MRI, which showed no residual tumor.

## 5 | CONCLUSION

Surgical resection remains the treatment of choice for intrapericardial teratomas. During anesthetic management, one should anticipate cardiopulmonary collapse upon induction, particularly with nonintubated patient with severe mass effect, as well as hemodynamic instability associated with blood loss and tumor manipulation. Understanding the potential complications associated with intrapericardial teratomas

was paramount in the successful anesthetic management of our patient.

## ACKNOWLEDGMENTS

None.

## CONFLICT OF INTEREST

None of the authors of this article have any conflict of interest to disclose.

## AUTHOR CONTRIBUTIONS

YELB: was clinically involved, wrote the manuscript, and obtained consent. PK: was clinically involved with the case and edited the manuscript. LQR: helped with the writing, editing, and obtaining consent for the manuscript.

## ETHICAL APPROVAL

A written patient consent and HIPAA authorization have been obtained from the patient's mother to disclose protected health information. No IRB or further ethical approval was required for this case report.

## ORCID

Ying E. Lu-Boettcher  <https://orcid.org/0000-0002-1844-8263>

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