

Sacrococcygeal teratoma

Neonatal surgery

Patient information

What is a sacrococcygeal teratoma?

A sacrococcygeal teratoma (SCT) is usually a benign tumour that develops at the base of your baby's coccyx (tailbone).

SCT is rarely malignant (i.e. cancerous). This happens in only about 1% of cases.

The incidence of SCT is one in 35,000 live births.

There are four grades:

- Type I - Nearly all the tumour is on the outside.
- Type II - The tumour is mostly outside but some is in the pelvis.
- Type III - Some tumour is outside but the biggest part is on the inside around the hips and tummy area.
- Type IV - tumours are totally inside the tummy.

SCT are diagnosed on antenatal scans.

During pregnancy

Most SCTs are not associated with other problems but in one in five pregnancies there can be other problems as well. A detailed ultrasound scan will be performed to check for this.

Sometimes, an SCT can be a very serious problem and there is a risk of losing the baby during pregnancy. These issues will be discussed with you in detail.

SCT is more serious when:

- the tumour is very large before 24 weeks.
- the tumour grows quickly during pregnancy
- when the scan shows that the tumour has a large blood supply

- when heart failure develops as a result of the tumour's large blood supply.

The outcome for babies with these features is sadly very poor and often the baby will die. This happens in about 15% of babies with SCT.

For this reason you will need regular ultrasound scans to measure the growth of the baby and the SCT. These scans will be at least every four weeks (and sometimes may need to be more frequent).

The birth of your baby

Your delivery will be planned at 38 weeks (approx) but in some cases may have to be earlier. Where the SCT is very large, it may be necessary to deliver your baby by caesarean section but this will be discussed in detail with you in the later stage of your pregnancy.

Following the birth, your baby will need to go to the neonatal unit (NNU) and will need to be assessed by the neonatologists (doctors specialising in the care of newborn babies). Your baby will need to have a drip (a cannula) put into a vein to receive intravenous fluids as it may not be possible to feed your baby straight away.

If you cannot feed your baby and you wish to breast feed, the nursing staff will teach you how to express and store your milk to feed to your baby when they are ready.

How is it treated?

The tumour is removed by surgery. Your baby will be seen by a Paediatric Surgeon. Your baby may need further radiological examinations (X-rays, ultrasound and possibly MRI) before surgery. The operation to remove the tumour might be complicated. As the tumour is very vascular (has a good blood supply), it is possible that the operation itself can cause blood loss and carries a small risk of the baby not surviving the operation. Also because of the position of the tumour the operation to remove it may cause some damage to the nerves to the bowel or bladder. This is more common when a tumour is mostly intra-abdominal (Types III and IV).

Your baby will come back to the NNU and will be ventilated (attached to a machine to help them breathe) and connected to monitors to check their breathing, heart rate and oxygen levels. They will be given pain relief if needed, so they feel comfortable. You will be able to visit as soon as your baby is settled back on the ward. Your baby will be closely monitored after their operation.

As your baby recovers and wakes up, within a few days they will be able to have some milk feeds. Once they are feeding and gaining weight they can be discharged home.

Long term and follow-up

Following discharge from the ward there will be regular check-ups in order to monitor your baby's progress. Your baby will be seen in the outpatient's department. It may be possible for this follow up to take place in your local hospital.

Following an operation there is always a small risk of a future obstruction occurring. If your baby has a bilious (green) vomit or a distended (swollen) tummy, medical advice should be sought.

If St George's Hospital is not your local hospital

Once your baby has had surgery and made a good recovery, i.e. when their specialist medical and nursing requirements are less, the baby will be transferred back to the care of your local hospital. This transfer is a sign of progress and will not occur until the baby is ready. It will allow you to be closer to home and become familiar with your local healthcare professionals.



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