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was carried out with preservation of adequate normal ovarian tissue. e cytology report of peritoneal uid was negative for malignant cells. Histopathology con rmed bilateral mature cystic teratoma (Figure 2).

: Mature cystic teratoma; Huge; Bilateral; Adolescence

e incidence of mature cystic teratoma is 10-20% of all ovarian tumor [1,2]. It is usually unilateral, and bilateral in 10-15% of cases [3], commonly seen in patients between 20 and 40 of age. Size of this tumor rarely exceeds 10 cm [4]. An unusual presentation of bilateral mature cystic teratoma in a young adolescent patient is described.

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A 13 years old, single female, presented to our emergency room complaining of generalized abdominal pain for two weeks. It was colicky in nature, progressive in intensity over time, with no history of fever, nausea, vomiting, or changes in bowel habits. She did not notice any abdominal distension or changes in weight, but, complained of dysuria for two weeks. Her menarche was two years ago and regular menstruation for the past elven months. e vital signs were within normal. A palpable pelvic-abdominal mass reaching up to the umbilicus, non-tender, mobile with no skin changes was found on abdominal examination. Ultrasound of the abdomen and pelvis revealed a normal, retroverted uterus, three multiple, right sided ovarian cyst, largest measuring 6.3 × 7.3 cm and 5.6 × 6.3 cm, and Le hyper-echogenic ovarian cyst measuring 12.5 × 7.8 cm with some projections inside the cavity. ere was no uid in pouch of Douglas ilar characteristics lesions were noted in higher cuts measuring, approximately 10.5 × 5.6 × 12 cm in size, corresponding to L5 vertebral body and extending superiorly to level of the renal hilum, occupying the right side of the abdomen and pushing the ascending colon posteriorly. No obvious in ltration to adjacent structures was noted. No lymphadenopathy or ascites was noted. Chest x-ray and tumor markers were within normal limits. e guardian of the patient were advised to consent for laparotomy, a er full explanation if the possible operative procedures on entering the abdomen, which they agreed and signed. A midline sub-umbilical incision was made to enter the peritoneal cavity. Minimal serous uid in peritoneal cavity was aspirated and sent for cytology. Bilateral, lobulated, ovarian cysts were found; right one measured 15 × 10 cm, le measured 12 × 9 cm. e uterus and fallopian tubes were normal. Bilateral ovarian cystectomy