In the literature there are several reports of primary teratomas of the rectum [1]; however, the incidence of ovarian teratoma with secondary rectal involvement is extremely rare (10 cases in the literature in the past 100 years) [2]. Ovarian teratoma is usually a benign lesion, containing a diversity of tissues including hair, teeth, bone, and thyroid [3]. It is mostly detected in the childbearing years, and up to 15% of women have bilateral lesions. The prevalence of complications is < 5%, and the complications include torsion, rupture, infection, and malignant transformation [4,5].

We present a case of a 31-year-old woman who was referred to our gastrointestinal unit because of constipation, lower abdominal pain, tenesmus, and a positive fecal occult blood test. She also reported having dysmenorrhea in the past 3 months. Blood and biochemistry data showed only a slight increase in alpha1-fetoprotein (13.3 ng/mL, normal values < 6 ng/mL). Colonoscopy revealed a finger-like polypoid lesion on the anterior wall of the rectum, at about 15 cm from anal verge. The lesion was approximately 2 cm in size, translucent, firm in consistency when held with the biopsy forceps, with hair growth on the surface (Fig. 1).

In addition, pulling on the lesion elicited pain. Histological examination of the endoscopic biopsy specimens from the lesion showed squamous epithelium (data not shown). A computed tomographic (CT) scan of the abdomen and pelvis revealed a bilateral ovarian mass adhering to the anterior wall of the rectum, with an intraluminal, protruding mass of approximately 2 cm (Fig. 2).

The patient was therefore referred to the department of surgery for resection of the ovarian mass along with anterior rectal resection and colorectal anastomosis. Histological examination of the resected colonic segment showed the features of a benign mature cystic teratoma (Fig. 3).

**Competing interests:** None
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