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PSEUDOMYXOMA PERITONIE- A CASE REPORT WITH REVIEW ON LITERATURE

General Surgery

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ABSTRACT

Pseudomyxoma peritonie is a rare clinical condition occuring due to mucinous tumour of appendix..Incidence of pseudomyxoma peritonie is one to two million per yer[1].It is a rare entity which is often asymptomatic and often patient presents with vague symptoms such as chronic abdominal pain.*We present a case of a 60 year old female patient with pseudomyxoma peritonie and review its literature regarding its management* .

KEYWORDS

INTRODUCTION

Pseudomyxoma peritonei (PMP) being a rare clinical condition, having an incidence of 1-2 cases per million[(1)] shows dissemination of mucinous implants on the peritoneal surface and subsequent progressing ascites with distribution on omentum[(2)].Many cases present usually at laparotomy/laparoscopy and there is always uncertainity regarding its treatment.PMP ranges from mucinous ascites, with cystadenoma of the appendix , to frank mucinous adenocarcinoma.

CASE REPORT

Patient presented with complaints of abdomen distension with pain in lower abdomen since last 2 months not radiating to back associated with complaints of nausea.There was no aggravating or relieving factor of pain. Patient also had complaint of difficulty in micturition since last 10 days. Bowel habits were normal. Patient had past history of left ovarian mass? Mucinous adenocarcinoma of ovary for which she was operated one month back in some other hospital and biopsy was sent which revealed features of Pseudomyxoma peritonei.

ON Examination: there was generalised tenderness present in lower abdomen with no guarding and rigidity and Distension of abdomen ,with ill defined intra abdominal mass occupying almost all quadrants of abdomen, irregular borders, lower border cannot be felt, soft in consistency, with bilateral flank fullness, with presence of free fluid . Bowel sounds were sluggish. Per vaginal the cervix was drawn up with left fornix fullness..

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Investigations:

USG : abdominopelvis shows a large approx 170x60mm thin walled cystic lesion with a small solid mural nodule on posterior wall and thin septations, however with no significant colour flow. It is compressing the uterus and urinary bladder anteriorly. Bilateral ovaries not separately visualised. No bowel loop dilatation. Another similar looking 70x60 mm lesion seen in right lumbar region.

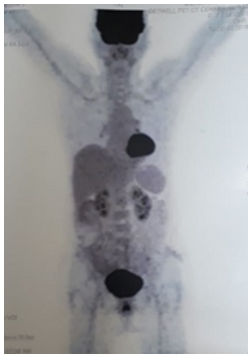
Routine investigations were within normal limits.

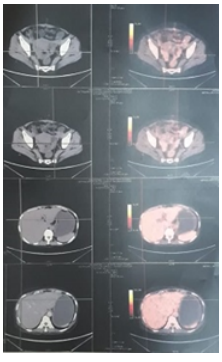
CA125-59

CECT Abdomen And Pelvis-Abdomino-pelvic cystic ;esion with mild ascites and omental thickening suggestive of neoplastic ovarian etiology.

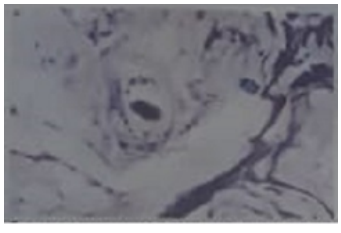
Whole Body PETCT Scan-Abnormally FDG avid variable density lesion involving bilateral adnexal regions and the pouch of Douglas appears strongly suspicious to represent a neoplastic etiology involving bilateral ovaries.

Mildly FDG avid fluid in perihepatic and gastrohepatic peritoneal recesses alongwith extensive omental nodularity all over the abdomen likely represents metastasis.



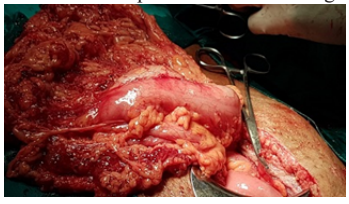


PETCT SCAN **PETCT SCAN**



Section show abundant mucin pools with viable but with low cellularity, bland cytology and nonstratified simple cuboidal epithelium, also hyperaemic vessels and chronic inflammatory cells.

Exploratory Laparotomy was planned on 9th October and during surgery , Transabdominal hysterectomy with bilateral salpingo-oophorectomy with appendicectomy with omentectomy done alongwith the removal of all deposits in Pouch of Douglas



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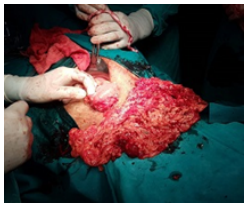

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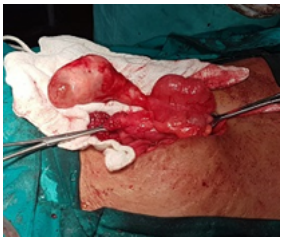
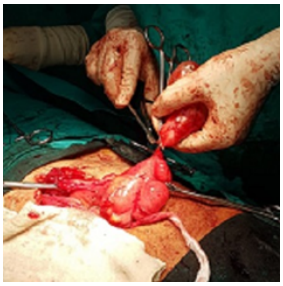


SWOLLEN APPENDIX



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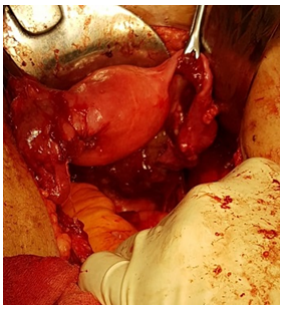
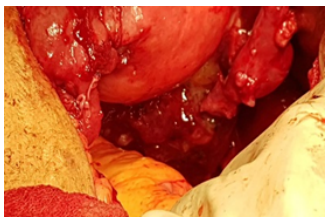


UTERUS WITH BILATERAL SALPINX AND OVARIES



DEPOSITS IN POUCH OF DOUGLAS

BIOPSY REPORT –Specimen of Appendix with omentum with uterus alongwith both salpinx and ovaries and deposits of Pouch of Douglas suugestive of features of **Pseudomyxoma Peritonei.**

Further patient was advised for regular follow up and chemotherapy for the same.

RESULT

The post operative recovery was uneventful and patient was discharged on 5th post operative day and resumed her routine activities within 2 weeks with chemotherapy started after 1 month.

DISCUSSION

Werth in 1884 coined the term PMP, describing it in association with a mucinous tumour of the ovary[3] In 1901, Frankel[4] described a case associated with a cyst of the appendix.

PMP originates predominantly in the appendix in men and evidence suggests a similar site of origin in females with more prevalence[5,6].Immuno-histochemistry and molecular genetics support the hypothesis that in the majority of women, the ovarian tumour is metastatic from a perforated appendiceal mucinous tumour[7-10]

Undoubtedly a proportion of cases arise from other organs(11,12)

In our case the findings were features of large bowel obstruction warranting the need of immediate exploratory laparotomy. Intraoperatively, a loop of bowel was found twisted around adhesions between liver & anterior abdominal wall with no signs of perforation.

The optimal treatment involves a combination of surgery and heated intra peritoneal chemotherapy HIPEC.

Recent updates by Glehen et al[54] reported a median survival of 156 mo, with 5 and 10 year survival of 72% and 55% respectively in 501 PMP patients. The majority (approx. 70%) had complete cytoreduction.

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