

Peritoneal Pseudomyxoma about a Case and Review of the Literature

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ARTICLE INFO

Article history:

Received: 23 November 2020;

Received in revised form:

13 January 2021;

Accepted: 23 January 2021;

Keywords

Pseudomyxoma,
 Mucinous Tumor,
 Suspected Appendicitis.

ABSTRACT

Peritoneal pseudomyxoma, sometimes called a gelatinous disease of the peritoneum or gelatinous ascites of the peritoneum, is a rare disease. Peritoneal pseudomyxoma is defined by the presence of extracellular mucin in the peritoneal cavity. The objective of our work is to study, through a case of pseudomyxomeperitoneal and a review of the literature, the semiological, diagnostic and therapeutic features of this pathology.

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Introduction

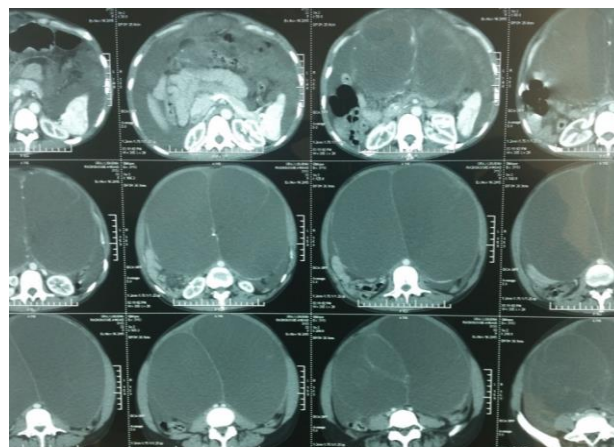
Peritoneal pseudomyxoma is defined by the presence of extracellular mucin in the peritoneal cavity. It is due in the majority of cases to the intraperitoneal rupture of a mucinous tumor of appendicular origin with ovarian secondary extension.

Observation

32-year-old female patient, unmarried, null and void, with no significant pathological history, who has had a progressive increase in isolated abdominal volume without accompanying signs over the last 11 months, with an enormous abdominal examination of the abdominal mass of the polylobea reaching the xiphoid and the costal margins at TR: uterus of normal size, CDS crown of douglas and left lateral uterine.

Pelvic ultrasound: a huge heterogeneous multi-locus image.

CT TAP: a huge suspect ovarian tumor with ascites. The patient had left adnexectomy, right ovary biopsy, omentectomy, appendectomy and peritoneal cytology.



The anatomo-pathological result: left adnexectomy: mucinous tumor, peritoneal pseudo-myxoma, disrupted appendicular mucocele.

Peritoneal cytology rich in non-atypical mucinous epithelial cells, Immunohistochemistry: inconclusive.

Re-reading evoking a low-grade, low-grade appendicular mucinous tumor with diffuse peritoneal and bilateral ovarian adenomucinoses at high risk of recurrence.



Discussion

The clinical presentations described were 27% suspected appendicitis, 23% progressive abdominal distension and 14% revealing hernia, mostly inguinal. In women, 39% of patients presented for evaluation of ovarian mass [1]. Thanks to immunohistochemistry, it is now accepted that its origin is mainly appendiceal and not ovarian [2]. It is a malignant pathology "border line" because of its inevitable persistence and progression in the absence of appropriate therapeutic management.

The surgical management of the PMP consists of: multiple surgical debulking [3] and cytoreduction surgery (CCR) with perioperative intraperitoneal chemotherapy: hyperthermic intraperitoneal chemotherapy (CHIP) with or without postoperative intraperitoneal chemotherapy Immediate (CIPPI) [4,5]

The prognostic factors are dominated by the importance of the surgical past, the radicality of the cytoreduction and especially by the histopathological grade.

Conflicts of interest

The authors do not declare any conflict of interest.

Conclusion

PGM remains mysterious and difficult to diagnose but significant progress has been made in recent years in its understanding. CCR with CHIP appears to be the recommended and preferred treatment for most experienced centers.

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