

# Pseudomyxoma Peritonei- A surgeon's Nightmare – A case report

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**ABSTRACT :** Pseudomyxoma peritonei is a clinical term used to describe the finding of abundant mucoid or gelatinous material in the pelvis and abdominal cavity surrounded by fibrous tissue. It is most commonly secondary to a well-differentiated appendiceal mucinous neoplasm or other gastrointestinal primary; rarely, mucinous tumors arising in an ovarian mature teratoma are associated with pseudomyxoma peritonei. 30 years old female, P2L2, with H/O previous 2 LSCS presented with complaint of abdominal distention since 2 months which was gradual in onset, increased in the last one month, associated with abdominal fullness and breathing difficulties, no aggravating or relieving factors. Patient was taken for Exploratory Laprotomy.

## INTRODUCTION-

Pseudomyxoma peritonei is a clinical term used to describe the finding of abundant mucoid or gelatinous material in the pelvis and abdominal cavity surrounded by fibrous tissue. It is most commonly secondary to a well-differentiated appendiceal mucinous neoplasm or other gastrointestinal primary and rarely, mucinous tumors arising from ovary.

The overall incidence is 0.5 to 1 cases per 100,000 people per year.

It is slightly more common in women than men. The median age at presentation is typically about 50 years with a range of 20-25 years.

- **CASE REPORT-** 30 year old female, P2L2, with history of previous 2 LSCS and ovarian cystectomy five months back came with complaint of abdominal distention since 2 months.
- The distention was gradual in onset, painless increased in the last one month, associated with abdominal fullness and breathing difficulties, no aggravating or relieving factors.

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- **On Examination-** Patient was conscious, oriented and vitally stable.
- **P/A-**

- abdominal contour abdomen upto umbilicus was normal
- umbilicus shape and size- normal
- scars of 2 Pfannenstiel incisions seen.
- Non tender, globular swelling in the lower approximately 10x10 cms in the left lumbar region, cystic to firm in consistency, with regular margins, horizontal mobility restricted whereas vertical mobility free. No fluid thrill or shifting dullness present.

## Per speculum-

Cervix deviated to the right side. Thread of copper T seen. On p/v: Left sided mass 10x12 cms, globular, firm to cystic in consistency, non-tender, and felt separate from uterus with restricted mobility.

## INVESTIGATIONS-

USG- Large pelvic abdominal mass with thin septations measuring 13x10x9 cm with internal vascularity (venous) within it suggestive of possibly ovarian mass.

Tumour Markers- CA 125, LDH, AFP, Beta hCG within normal limits

## MANAGEMENT-

Exploratory Laparotomy done under GA. Intra-op findings were left ovarian mass 15x10x6 cm was present engulfing the left fallopian tube and mesosalpinx. The mass was tense, cystic, multiloculated, adherent to left uterine wall completely, posterior to loop of sigmoid colon, anterior to parietal peritoneum with rectus muscle and bladder completely adherent. Patient underwent sub-total abdominal hysterectomy with bilateral salpingo-oophorectomy with resection anastomosis of sigmoid colon with end colostomy with appendicectomy. On histopathology examination mucinous cyst was seen.

**DISCUSSION-** Treatment ranges from debulking and hyperthermic intraperitoneal chemotherapy with cytoreductive surgery.

In debulking, the surgeon attempts to remove as much tumor as possible. Cytoreductive surgery involves surgical removal of the peritoneum and any adjacent organs which appear to have tumor seeding. Since the mucus tends to pool at the bottom of the abdominal cavity, it is common to remove the ovaries, fallopian tubes, uterus, and parts of the large intestine. Depending upon the spread of the tumor, other organs might be removed, including but not limited to the gallbladder, spleen, and portions of the small intestine and/or stomach.

Chemotherapy (typically the agent Mitomycin C) may be infused directly into the abdominal cavity after cytoreductive surgery to kill remaining microscopic cancerous tumors and free floating cells. The heated chemotherapy (HIPEC) is perfused throughout the abdominal cavity for an hour or two as the last step in the surgery, or ports are installed to allow circulation and/or drainage of the chemicals for one to five days after surgery, known as early postoperative intraperitoneal chemotherapy (EPIC).

**CONCLUSION-** Oophorectomy in cases of mucinous ovarian cyst prevents dreaded complication of pseudomyxomateritonei

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