PSEUDOMYXOMA PERITONI WITH PSEUDOMEIGS SYNDROME

by

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and

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Introduction

Association of pseudomeig's syndrome with pseudomyxoma peritoni is a rare entity. An interesting case with atypical features of the syndrome is presented.

Case Report

A 37 year old woman who presented with complaints of amenorrhoea 9 months, with the loss of foetal movements of 2 days duration. She had regular antenatal check up in a private nursing home.

She was para 1, last child birth was 5 years back. Routine check up as an outpatient gave an impression of either, an extrauterine pregnancy, or an ovarian tumour. Further examination on admission revealed right massive pleural effusion and normal cardiovascular system.

On abdominal examination, there was a multinodular mass arising from pelvis, which was extending upto xiphisternum. This mass was freely mobile. She had moderate ascitis. On bimanual pelvic examination, uterus was found to be retroverted, normal size, separate from the nodular mass. Small nodules were palpable on posterior surface of the uterus, and in the pouch of Douglas. The uterus and cervix was not moving with the mass.

Liver function tests and renal function tests were normal. X-ray chest (Fig. 1) showed mass pleural effusion on right side of the chest. X-ray abdomen (Fig. 2) showed soft tissue shadow. IVP revealed bilateral hydroureters. Pleural tap was done on two successive days, around 900 ccs. of straw coloured fluid was drained.

On laparotomy around 2000 ccs. of straw coloured gelatious type of fluid was drained. A right ovarian tumour, partly cystic and partly solid, multinodular lined by a thin layer of gelatinous sheath was found. Right ovariotomy, total abdominal hysterectomy, left salpingo-oophorectomy and partial omentectomy was done.

The tumour was 3,500 gms. and 40 x 40 cms. outer surface was irregularly bosselated, which showed many dilated veins. The tumour showed no evidence of rupture, and was covered with thin gelatious sheath. The cut section showed small and large cysts filled with mucoid material. Half of the cysts were having haemorrhagic fluid. There was papillary type of growth in certain areas.

Histopathology showed a benign mucinous cystadenoma of right ovary.

Post operative period was uneventful, X-ray chest (Fig. 3) on 10th day showed no evidence of pleural effusion.

Patient for following up was seen after 6 weeks, 3 months and 6 months interval. She has been found clinically normal. X-ray chest was also normal. The patient is still being followed up.

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Accepted for publication on 7-4-83.

See Figs. on Art Paper VIII