

General Data

- Name: 蘇xx, 73 y/o, male
- Date of admission: 93/01/11
- Chief complaint:
 - Progressive abdominal distention for 20 days

Present illness

- Poor appetite
 - Decrease food intake
 - Diffuse mild abdominal pain
 - PE:
 - Distended abdomen
 - Hypoactive bowel sound
- Lower abdominal tenderness
 - A firm, smooth, fixed mass, 15x8 cm, over right abdomen,
- Lab: Hb: 7.7

Hospital Course

- 93/1/11: Abdominal CT→ encapsulated hypodense mass
- 93/1/12: CT-guided drainage
- 93/1/15: Exploratory laparotomy and abscess debridement and drainage
 - Frozen: Inflammatory change
 - Pathologic report: Pseudomyxoma peritonei
 - Well-differentiated mucinous columnar cells of intestinal type

Image on 1/11

- Multiple renal and liver cyst



- A huge size encapsulated hypodense structure, measuring about 20x12cm in largest dimension, extend from upper pelvic cavity extend upward and overlap with hepatic hilar



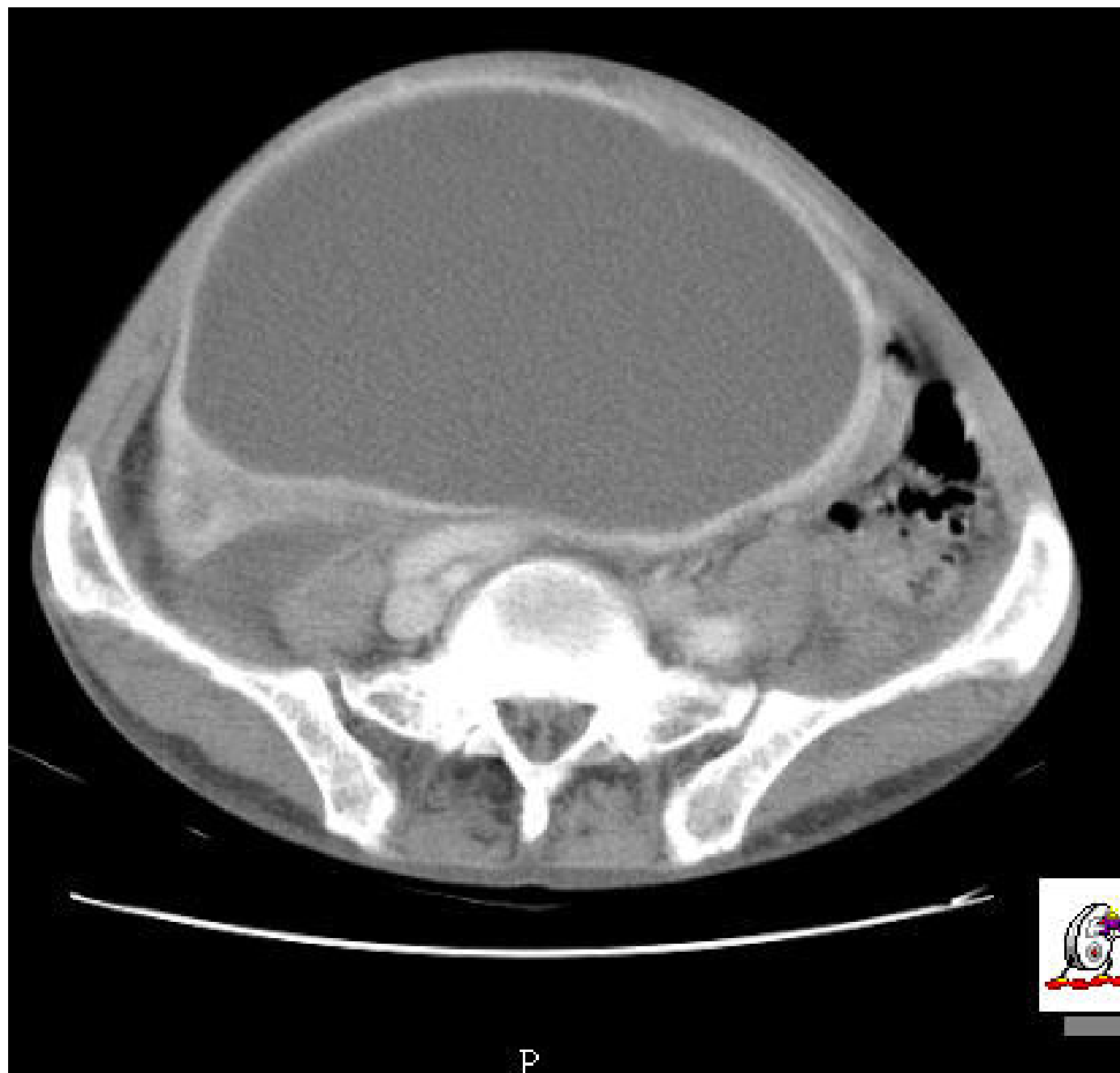




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Hospital course

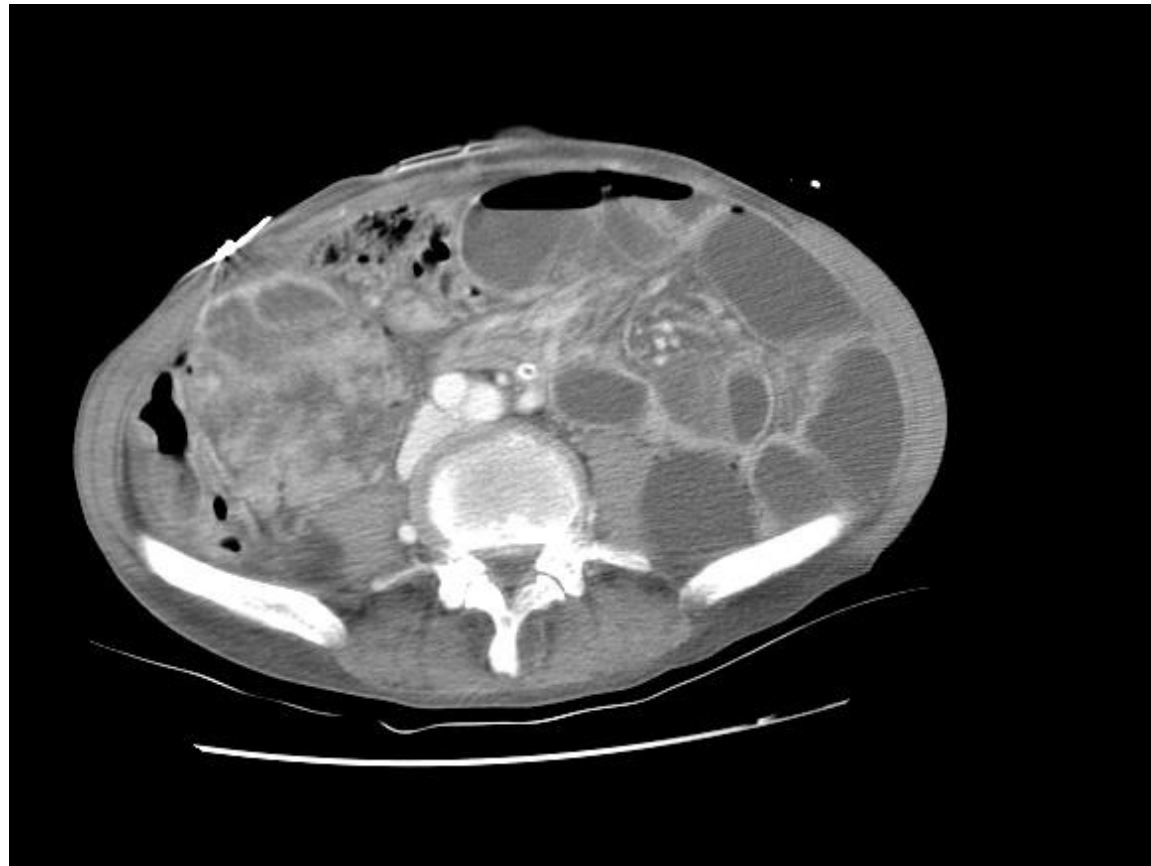
- 93/1/21: Abdominal fullness and vomiting
- 93/2/02: Abdominal CT→Intraperitoneal infiltration at Rt lower quadrant abdomen
- 93/2/03: right hemicolectomy
- Pathology:
 - Mucinous adenocarcinoma 2.5 cm distal to the ileocecal valve
 - Invasion to serosa, 1/ 15 lymph nodes (+)
 - Dukes C2

KUB on 1/27



2/02

heterogenous
enhanced infiltrative
peritoneum at Rt
lower quadrant
abdomen, include Rt
anterior pararenal
region.



- Dilated bowel loop

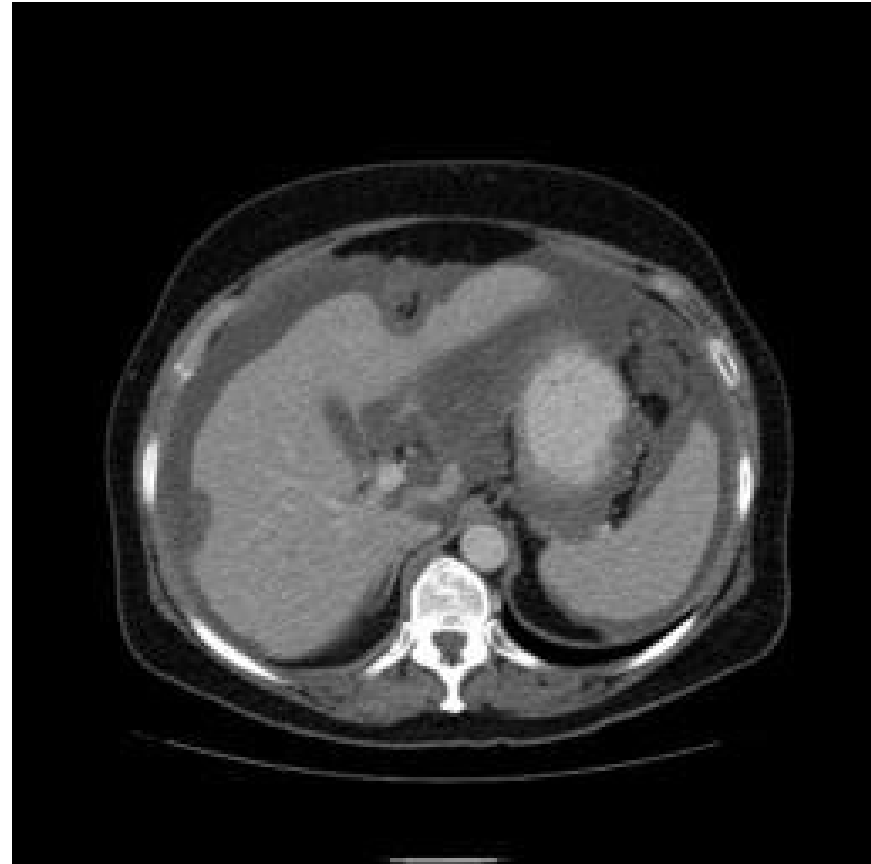


Differential Diagnosis

- Pseudomyxoma peritonei
- Intraabdominal abscess
- Mesothelioma
- Hydatid cyst
- Ascites

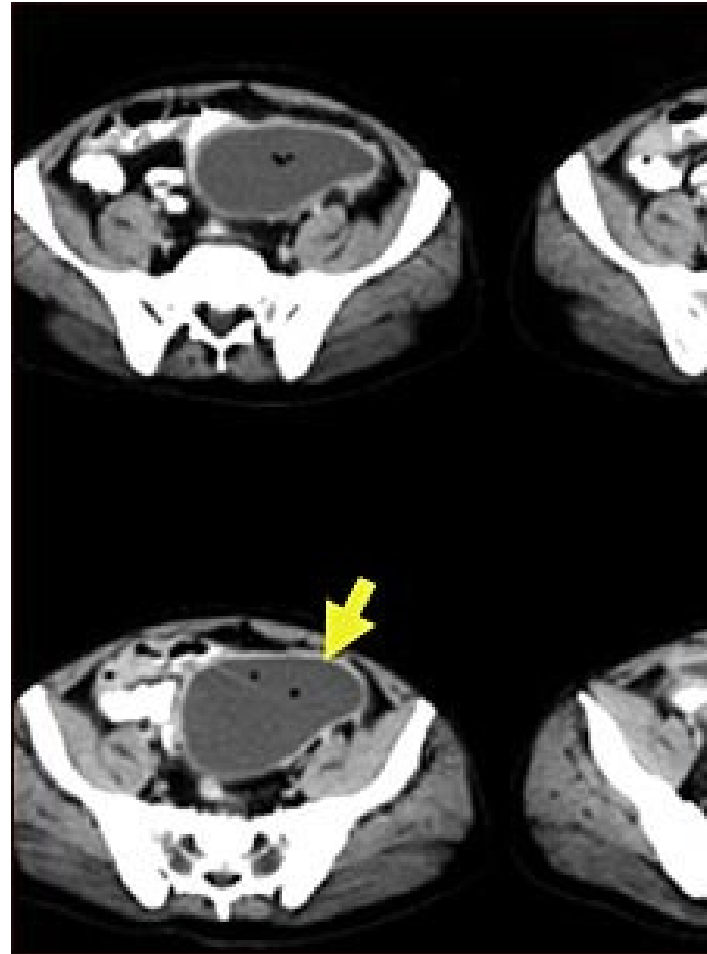
Pseudomyxoma peritonei

- Mucinous ascites with the density of fat
- Omental thickenings
- Multiseptated lesions
- Scalloping of organs
- Curvilinear calcifications



Intraabdominal abscess

- Mass with soft tissue density
- A definite wall with water attenuation center
- Gas within loculated fluid collection



Mesothelioma

- Diffuse thickening or nodularity of the peritoneum
- Omental and mesenteric thickening
- Peritoneal and omental mass with little ascites

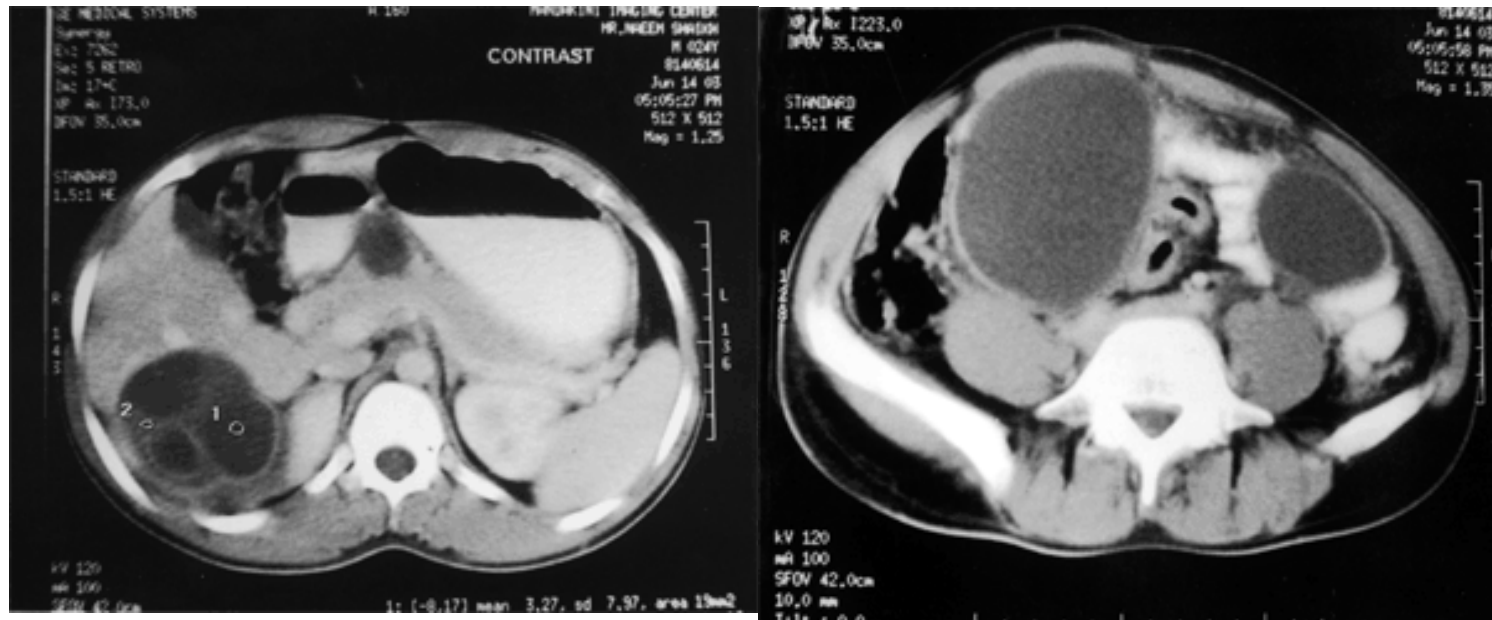


Ascities

- Fluid localize in the right perihepatic space, the posterior subhepatic space (Morison pouch), and the Douglas pouch



Hydatid cyst



- Taenia echinococcosis

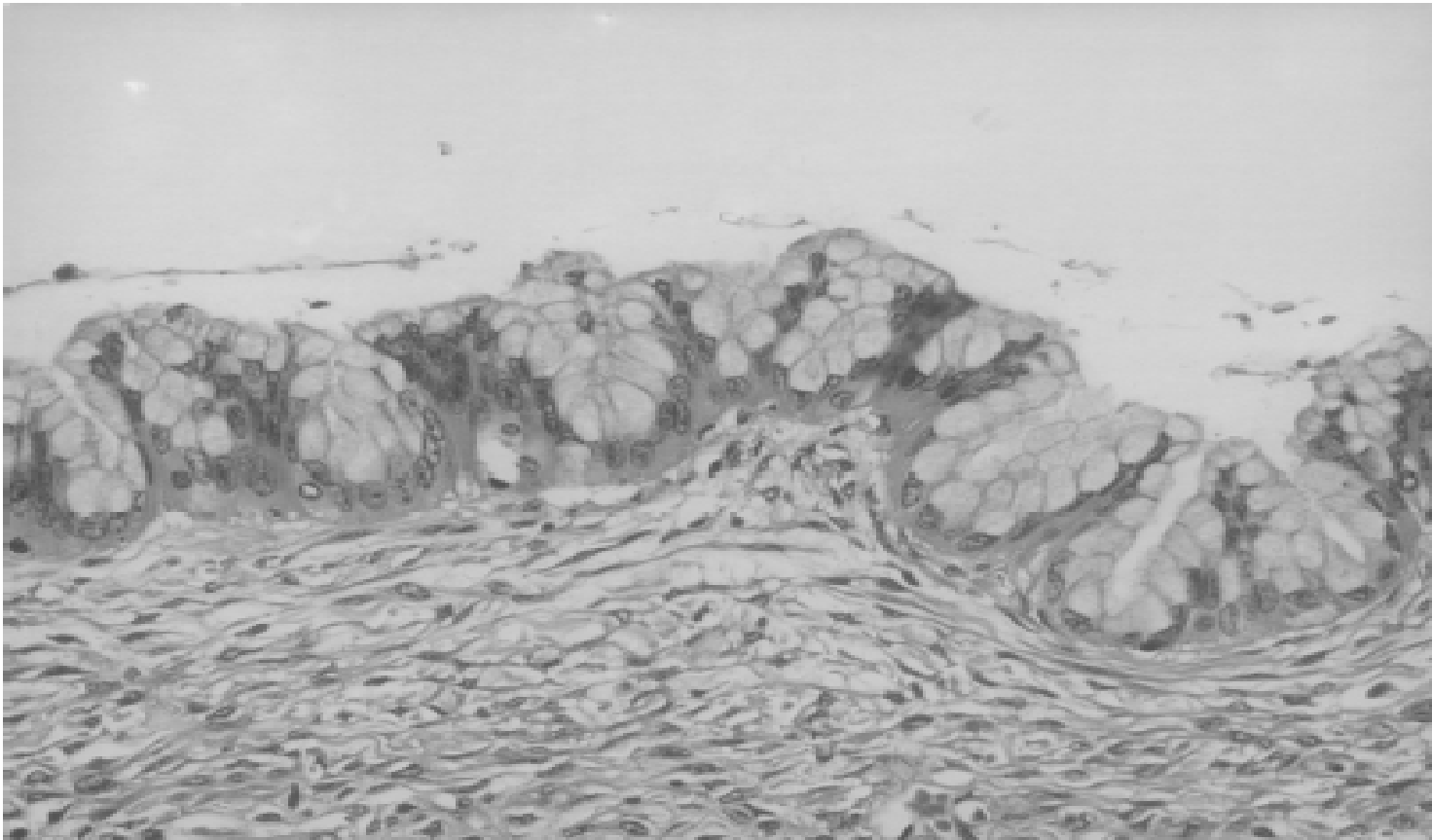
Pseudomyxoma peritonei: the "controversial" disease

- Massive amounts of mucinous ascites and peritoneal and omental implants
- Seventy-five percent of patients with PMP are female.
- The median age is 53 years.

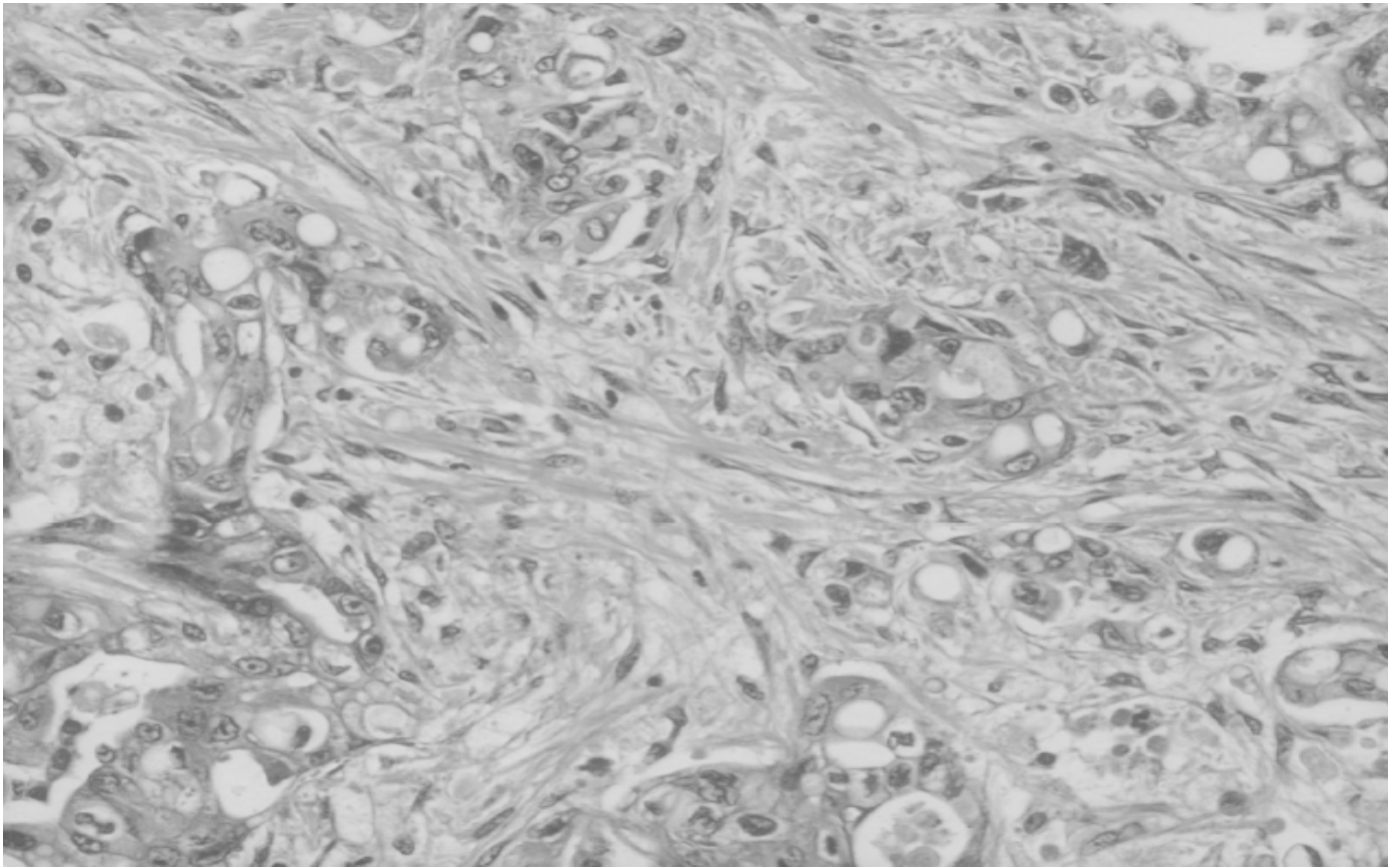
Histology

- Disseminated peritoneal adenomucinosis (DPAM)
- Peritoneal mucinous carcinomatosis (PMCA)
- Peritoneal mucinous carcinomatosis with intermediate or discordant features (PMCA-I/D)

Disseminated peritoneal adenomucinosi (DPAM)



Peritoneal mucinous carcinomatosis (PMCA)



Origin

- Mucinous tumors of the appendix or the ovary.
- Mucinous carcinomas of other organs, including the bile ducts, stomach, pancreas, colon, fallopian tube, uterine corpus, urachus, urinary bladder, breast, and lung

Clinical presentation

- Abdominal distention and abdominal pain.
- Abdominal masses or palpable ovarian masses and hernias
- Nausea, vomiting, fatigue, and urinary tract symptoms

Diagnosis

- Ultrasonography:
 - Nonmobile echogenic ascites with multiple semisolid masses
 - Scalloping of the hepatic and splenic margins
 - CT findings :
 - Mucinous ascites with the density of fat
 - Omental thickenings
 - Multiseptated lesions
 - Scalloping of organs
 - Curvilinear calcifications
- *Histology remains the golden standard

Treatment

1. Surgical debulking ,Peritonectomy
2. Intraperitoneal intraoperative heated chemotherapy
3. Postoperative intraperitoneal chemotherapy.
 - Mucolytic agents
 - Intraperitoneal radioisotopes and external radiotherapy

Prognosis

- Complete cytoreduction and adenomucinoses : 86%
- Intermediate histologic features : 50%.
- Incomplete cytoreduction : 20%
- Peritoneal carcinomatosis of colorectal origin: 27%