Case	(162) An infrecuent cause of abdominal pain and distension in emergency room: pseudomyxoma peritonei.
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CASE PRESENTATION

We report the case of a 48-year-old woman who came to emergency department with 5 days of nausea and vomiting, right lower quadrant pain and abdominal distension. Sonograms of the abdomen showed a 15 cm complex cystic pelvic mass, another in the spleen and also hypoechoic ascitis with septa and non mobile echoes. The woman was admitted for surgery.

CT described a possible ovarian origin of the pelvic mass, a cystic lesion with mass effect on the spleen surface and the presence of ascites and peritoneal nodes, being informed of ovary cistoadenocarcinoma with carcinomatosis.

The ovarian mass and the appendix were removed conteining gelatinous material. Histologic results were ovarian cystic metastasis of mucinous adenocarcinoma of apendicular origin.

DISCUSSION

The Pseudomyxoma peritonei (PP) is a rare entity characterized by presence of intraperitoneal accumulation of a gelatinous ascites secondary to rupture of a mucinous tumor. The reported incidence is one case per million population per year. Patients typically complain of progresive abdominal pain, sometimes, predominant right side pain similar to those of appendicitis when PP is located in the right lower quadrant like in our case.

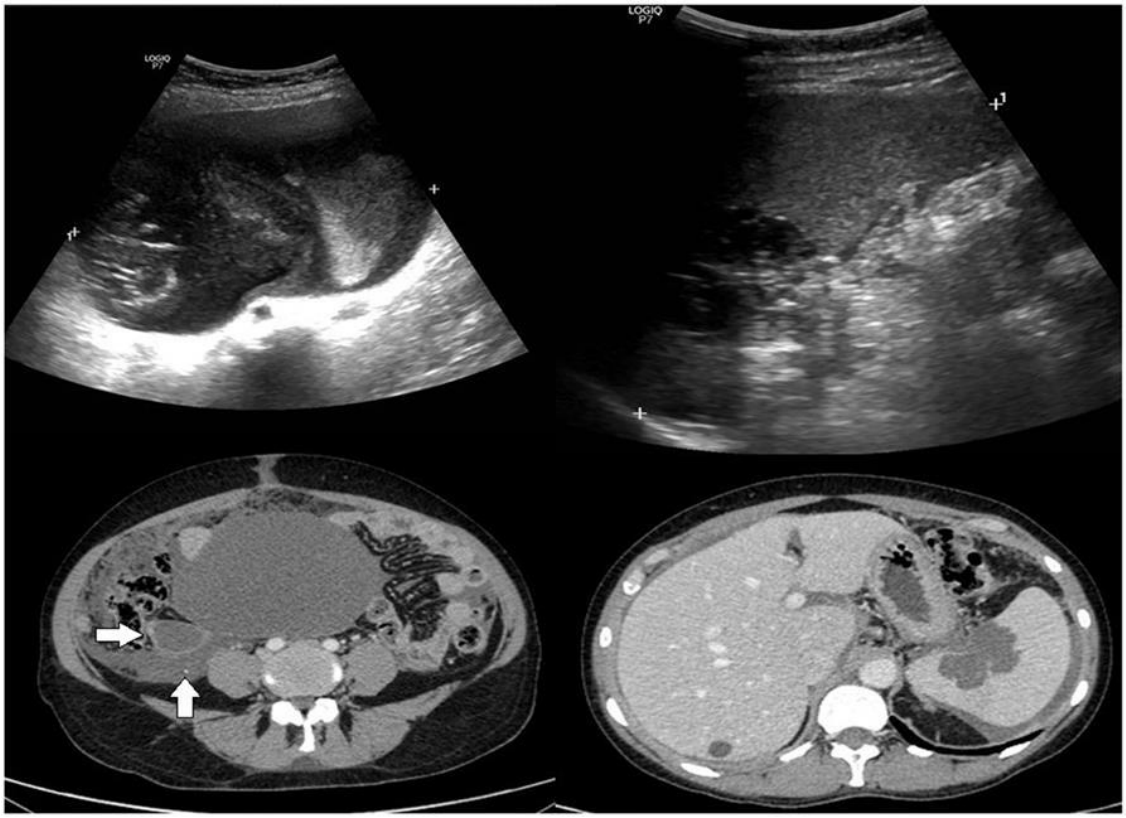
Radiografic feature are typically characterized by loculated collections of fluid throughout the peritoneum causing scalloping of visceral surface, displaced small bowel loops and scattered punctate or curvilinear calcifications (1,2).

Scalloping of the visceral surfaces of the intraperitoneal organs is an important diagnostic finding that helps differentiate pseudomyxoma from simple ascites.That occur from the extrinsic pressure of the intraperitoneal mucinous implants, most commonly observed along the margins of the liver and spleen. At sonography, PP might be suspected when ascitic fluid is echogenic. In contrast to echoes that may be secondary to proteinaceus, bloody or fibrinous exudates or infection, the echoes within PP are not mobile(1,3).

The imaging differential considerations include peritoneal carcinomatosis with mucinous ascites, peritoneal sarcomatosis and peritonitis.

CONCLUSION

We present a curious case given the place of the primary tumor (the appendix is more frequent in men) and the existence of a big ovarian metastasis that was misinterpreted as the primary tumor. The appendix was not recognized (in the CT imagen is the cystic dilatated mass between cecum and the main cystic pelvic mass)but mis-interpreted like part of the primary mass. And the typical findings weren´t recognized as importante clues like the scalloping of spleen, or the non mobile echoes in sonography.



Upper left image: hypoechoic heterogeneus mass in a central pelvic location that contains nonmobile echoes that corresponds to a secondary involvement from the ruptured appendiceal mucinous "cystoadenoma".
Down left image: at the level of the pelvic mass, there is a cystic mass that corresponds to a distended and enlarged appendix (arrow). Mass also displaces bowel and mesentery, and contains a punctate calcification (arrow). There is also a nodular peritoneal thickening.
Upper right image: cystic septated mass in splenic hilium.
Down right image: cystic septated mass in splenic hilium and peri-splenic ascitis that scallops the margins of the spleen.

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