Case Report

Pseudo Meig's syndrome- a case report

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Introduction: Pseudo-Meig is a condition where other type of tumor as a variant to ovarian fibroma associated with hydrothorax and ascites containing no malignant cells, which resolve after removal of tumor.
Case Report: This case concerns Pseudo-Meigs' in a 34year old lady with 3 months history of abdominal pain and distension due to ascites and pelvic mass along with massive right pleural effusion who underwent thoracocentesis and total abdominal hysterectomy with bilateral salphingooophorectomy and total omentectomy for ovarian malignancy histologically proven to be papillary adenocarcinoma with negative cytology of ascitic and pleural fluid, that resolved following tumour removal.

Case report

Thirty four year old lady presented to the emergency room with complaints of pain abdomen and distension of the lower abdomen along with shortness of breath and cough with sputum for three months.There was no alterations in bladder or bowel habits. She is a regularly menstruating lady, a para one who had a normal delivery at home.
Clinical examination revealed a distended abdomen with a well defined, non tender mass, freely mobile occupying the lower abdomen extending to the umbilical region measuring 10×10 cm. Cervical lymph nodes were palpable on the right side. On examination of chest, exposed decreased breath sounds over the right lung. Ultrasound showed a 11.2× 10.5× 11.5 cm size mass in the pelvic region extending to the upper abdomen. The mass contained hyperechoic area with not well defined cystic foci. Presence of pleural effusion. CA 125 was 411.2U \ ml. She was taken for surgery and because of poor lung field and massive pleural effusion on the right side depicted by the X Ray*;* chest tube drain was inserted prior to laparotomy draining 1750 ml of clear pleural fluid *(Fig. 1).*

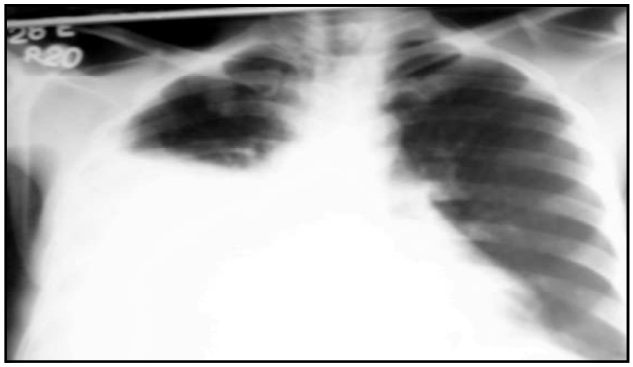

Fig. 1. Hydrothorax (right sided)

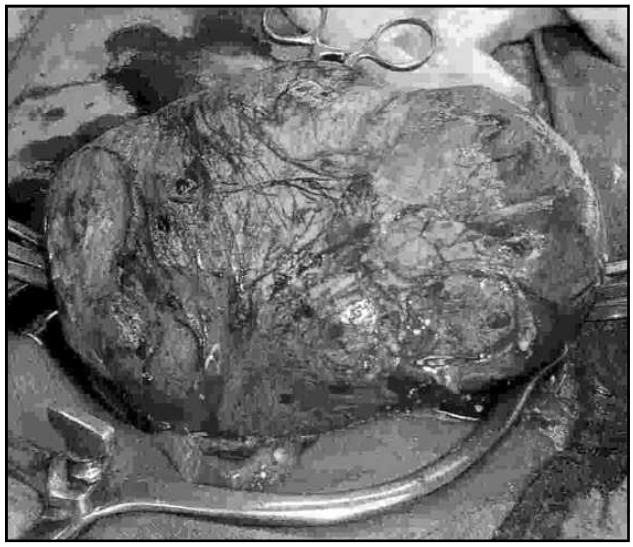

Fig. 2. Intraoperative ovarian malignancy.

On opening the abdomen 2 litres of clear ascitic fluid was drained and a left ovarian mass measuring 20× 15 cm, bilobed with irregular surface but intact capsule containing haemorrhagic areas was seen. Uterus, right ovary and tube were found to be normal *(Fig. 2)*. The under surface of the diaphragm and liver were free of deposits. The mass along with the uterus and right ovary and tube were removed along with omentum *(Fig. 3).* In the postoperative period, there was nither development of ascitis, nor the collection of pleural fluid *(Fig. 4).* Cytology of the peritoneal fluid and ascitic fluid was free for malignant cells
She was discharged on the 6th postoperative day. Histopathology showed , moderately differentiated, papilary adenocarcinoma.

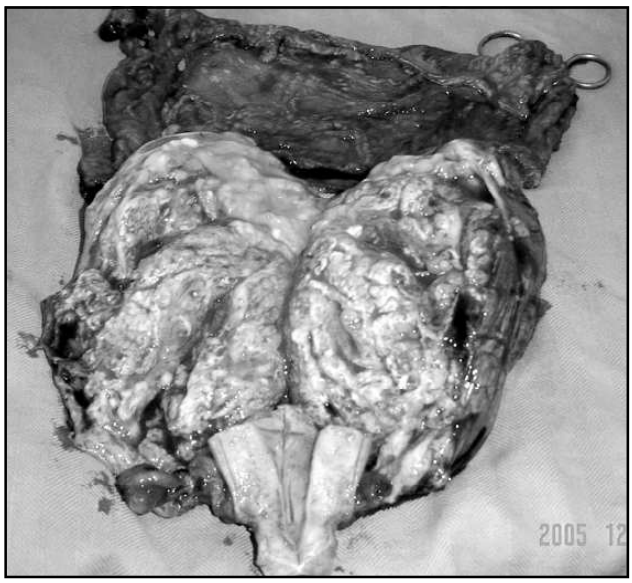

Fig. 3. Ovarian tumour superior to uterus, overlying is the resected omental mass.

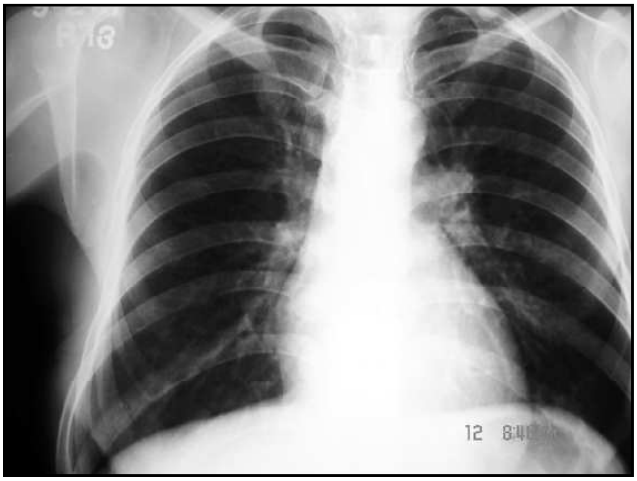

Fig. 4. Post operative X ray chest showing complete resolution of hydrothorax.

She received her 3rd course of cisplatin and cyclophophamide. there has been no recurrence of ascites or pleural effusion.

Discussion

Meigs' syndrome is a condition when hydrothorax and ascites resolve after the removal of coexisting ovarian fibroma associated with it.

Pseudo-Meigs' is a term when there are other types of tumour as a variant to ovarian fibroma, asscociated with hydrothorax and ascites containing no malignant cells which resolves after removal of tumour.

These are classified under PseudoMeig's Syndrome even when they are found to be malignant like dysgerminoma., Dysgerminoma should be considered in the differential diagnosis in a young patient with a pelvic mass, ascites, and pleural effusion . In addition, dysgerminomas may be accompanied by ovarian stromal luteinization and steroid hormone production, which occasionally result in chemical or clinical hyperandrogenism. There have been reports where Psuedo Meig's is associated with germ cell tumours ,andenocarcinoma of the fallopian tube Malignant struma ovarii is a rare tumor, consisting of a struma ovarii with malignant transformation. The association of a malignant struma ovarii with pseudo-Meigs' syndrome has also been reported.

Meigs, in 1937; from his early report of 7 cases of ovarian fibroma with ascites and hydrothorax that were completely cured upon removal of the tumor, introduced the triad of benign ovarian fibroma with ascites and effusion with negative malignant cell cytology; which was named under him as Meig's Syndrome.

Pseudo Meigs, similarly is a condition which describes resolution of pleural differing in the nature of the ovarian tumour which has been documented to range from benign to malignancy. In simple words, Psuedo-Meig's or atypical Meig's syndrome in contrast, occurs with the clinical triad of ascites, hydrothorax, and a pelvic mass other than an ovarian fibroma. Meigs and psuedo-Meigs syndromes are uncommon diseases, with Meigs syndrome being, more commonly reported variant. The benign tumors in Meigs syndrome are usually fibromas or fibrothecomas and constitute 4% of all ovarian neoplasms.

Seldom uterine leiomyomas have also been associated with, pseudo-Meigs syndrome although the cause of ascites are not well known which has been proposed to be due to leakage of intratumoral fluid as a result of hydropic degeneration of subserosal leiomyomas and peritoneal inflammation. Hydrothorax in this setting is hypothesized to be due to transdiaphragmatic transport of the ascitic fluid being more common on the right side as Diaphragmatic openings and lymphatic drainage are known to be more prominent within the right hemithorax, which probably accounts for the right-sided predominance.

Conclusion

The surgical therapy has a very important role for the complete remission of the disease in the Meigs' syndrome and for the remission of ascites and pleural effusion in the Meigs' pseudosyndrom. Although being a rare clinical entity, the identification of such syndrome can result in an

accurate diagnosis, leading to an efficient surgical treatment, without morbidity for the patient.

References

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