Mucinous Tumor of Appendix: An Uncommon Disease with Rare Presentations

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Mini Review

Recently in our hospital 54-year-old Indian female patient presented with pain right hypochondrium, underwent cholecystectomy 3 years back for the same pain, now presented in emergency with severe persistent pain right side of abdomen and fullness abdomen for 2 days. On examination there was tenderness and guarding of the right lumbar, right hypochondrium region, post surgery scar was normal, no hepatosplenomegaly. A laparotomy was performed, during which a large amount of mucinous material seen in subhepatic region along with bulky gelatinous appendiceal retrocecal tumor not infiltrating the omentum were found. All mucinous substance aspirated and appendicectomy done. Colon and cecum was inspected and palpated with no recognition of infiltration and separate appendix. Pathologist confirmed mucinous tumor of appendix progressing to of pseudomyxomaperitonei, opinion of oncologist is being taken while writing the short review.

Etiological factors are mostly inflammatory and also neoplastic. Treatment is directed as per the underlying pathology. Proper management of neoplastic mucoceles is essential to prevent rupture of the mucocel and progression to mucinous intraperitoneal dissemination, resulting in a syndrome called pseudomyxomaperitonei which is called “jelly belly” [4] and constitutes around 1% of all colorectal cancers in the Western countries [5].

Discussion

There are different reports of patients with mucinous neoplasms of the appendix presenting with clinically varied spectrum of pathologic processes and presentations. Mostly incidental diagnosis as described in our experience [6]. While, pseudomyxomaperitonei, though clinically more severe, commonly has a mild course with non-specific abdominal symptoms; therefore, a high level of suspicion is essential, especially if the medical history is suggestive of Appendiceal pathology [7]. The mucinous neoplasms of the appendix are classified into 4 pathological entities as per the characteristics of the epithelium [2,3,6]:

I. Simple or retention mucoceles result from non-tumoral obstruction of the appendiceal outflow, usually by a fecalith or inflammatory stricture, and they are characterized by normal epithelium and mild luminal dilatation up to 1 cm.

II. Mucoceles with local or diffuse villous hyperplastic epithelium. The luminal dilatation is also mild and they constitute 5-25% of mucoceles.

Abbreviations: EPIC: Early Postoperative Intraperitoneal Chemotherapy; WHO: World Health Organization; PMP: Pseudomyxomaperitonei; DPAM: Disseminated Peritoneal Adenomucinosis; PMCA: Peritoneal Mucinous Carcinomatosis; HIPEC: Hyperthermic Intraoperative Peritoneal Chemotherapy
The pouch of Douglas/rectovesical pouch, right and left dislodged by peristaltic movement and adhere at sites of relative pseudomyxomaperitonei are poorly adhesive, they are easily is a diagnostic sign on CT. As the mucin producing cells in and a higher perforation rate (20%) [12,13]. Visceral scalloping usually associated with cystadenoma or cyst-adenocarcinoma suggests of cystadenocarcinoma [11]. Mucoceles less than 2 cases [10], while enhancing nodules in the mucocele wall are round, thin-walled cystic mass. Calcification is seen in 50% of an appendicealmucocele, CT scan shows a well-encapsulated, of pseudomyxomaperitonei. The diagnosis is established in most cases of appendicealmucoceles or even in the presence of pseudomyxomaperitonei. Pseudomyxomaperitonei (PMP) is a broad term including a wide spectrum of tumors, ranging from benign to the frankly malignant lesion. Ovary was considered as the commonest primary site in the past, now with immunohistochemical analysis and molecular biology, it is confirmed that ovary is a rare source of pseudomyxoma, and most of the lesions diagnosed as “borderline mucinous tumors of the ovary” are typically metastatic from the appendix [7]. Ronnett classification explained “disseminated peritoneal adenomucinosis” (DPAM) from “peritoneal mucinous carcinomatosis” (PMCA) [8]. DPAM represents the classic PMP with paucicellular mucinous ascites with mild clinical course, while MCA has a higher percentage of overtly malignant cells and a poor prognosis [9].

The clinical symptoms are usually absent or non-specific in most cases of appendicealmucoceles or even in the presence of pseudomyxomaperitonei. The diagnosis is established mostly by abdominal CT scan now a day. In the presence of an appendicealmucocele, CT scan shows a well-encapsulated, round, thin-walled cystic mass. Calcification is seen in 50% of cases [10], while enhancing nodules in the mucocele wall are suggestive of cystadenocarcinoma [11]. Mucoceles less than 2 cm are rarely malignant but larger mucocoeles (6 cm or more) are usually associated with cystadenoma or cyst-adenocarcinoma and a higher perforation rate (20%) [12,13]. Visceral scalloping is a diagnostic sign on CT. As the mucin producing cells in pseudomyxomaperitonei are poorly adhesive, they are easily dislodged by peristaltic movement and adhere at sites of relative stasis. The pouch of Douglas/rectovesical pouch, right and left subphrenic spaces, and surface of the liver and spleen are the commonest sites involved [14,15].

Although right hemicolecotomy has been traditionally the standard treatment for mucinous appendiceal malignancies, recent papers shows that an intact mucocele represents benign process and does not progression. [16]. Gonzalez-Moreno et al. [17] reported no survival advantage with right hemicolecotomy versus appendectomy after reviewing 501 patients diagnosed with appendiceal epithelial neoplasms. They suggested need of right hemicolecotomy:

i. total removal of the primary tumor or complete cytoreduction,

ii. lymph node involvement and

iii. A non-mucinous neoplasm identified by histopathology. Few authors suggest that laparoscopic appendectomy is a safe option for mucocele of the appendix [18].

Possible rupture and dispersion of mucus or epithelial cells into the peritoneal cavity is associated with a poorer prognosis. Grasping of the appendix specimen should be minimal, pneumoperitoneum levels should be low, and a retrievable bag should always be used when the laparoscopic approach is favored [18]. Any mucinous fluid within the abdomen should be carefully examined and if epithelial cells are identified, a diagnosis of pseudomyxomaperitonei syndrome or mucinous peritoneal carcinomatosis of appendiceal origin should be established. It is probably safer to convert to an open procedure if such mucoceles are visualized during a laparoscopic approach [19].

Treatment of pseudomyxomaperitonei is variable, both due to the rarity of the disease and to its frequently slow-growing nature [20]. Current treatment strategies range from watchful waiting to extensive cytoreductive surgery alone or with hyperthermic intraoperative peritoneal chemotherapy (HIPEC) or early postoperative intraperitoneal chemotherapy (EPIC) [21]. Recent study showed that cytoreductive surgery with intraperitoneal hyperthermic perfusion permitted complete tumor removal, confirmed efficacy of combined treatment in terms of improved long-term survival and better regional control of the disease [22]. Other studies reported fluorouracil-based adjuvant systemic chemotherapy better for patients with PMP of appendiceal origin [23]. In situations where surgery is not immediately required, patients can be monitored via CT scans, tumor marker laboratory tests, and physical symptoms, to determine when and why surgery is warranted. Risk of adenocarcinoma of the colon is 6 times greater in patients with a mucocele than in the general population, colonic surveillance is warranted in these cases [24].

Conclusion

Patients with appendicealmucoceles can present with varied sign and symptoms. Preoperative diagnosis, although challenging, helps in planning right management and avoiding both intra-operative and post-operative complications.
Pseudomyxomaperitoneiis a complex medical situation that is best dealt with in a specialized center, where doctors should focus on the prevention of loco-regional recurrence.

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