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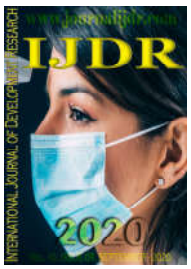

RESEARCH ARTICLE OPEN ACCESS

MEIGS SYNDROME AND ONCOLOGY: SIMULATION OF MALIGNANCY

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ABSTRACT

Meigs syndrome (MS) is a rare pathological condition, characterized by the presence of benign ovarian tumor, ascites and pleural effusion that resolve after tumor resection. The present study aims to report a clinical case of a female patient, 33 years old, with a history of localized pain in the pelvic region. The tomographic study revealed ascites, pleural effusion and ovarian mass. She had been submitted to cancer surgery, showing a fibrotecoma. It evolved satisfactorily, with resolution of the clinical picture and without the need for adjuvant treatment.

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INTRODUCTION

Meigs Syndrome (MS) is dated to the 19th century, rare, consisting of a triad of benign ovarian tumor, ascites and pleural effusion, resolving after tumor resection (Gonçalves & Blanco, 2019). The clinical manifestations of MS generally consist of symptoms related to ascites and pleural effusion, such as dyspnea, fatigue, dry cough and heartburn (Calvo, et al, 2010). Although it simulates a malignant condition, MS has an excellent prognosis, to the detriment of other ovarian neoplasms, which can spread at the peritoneal and pleural levels (Blanco, 2019). This article aims to report a case of a 33-year-old patient, without previous comorbidities, with benign ovarian tumor, ascites and pleural effusion, with resolution after tumor resection.

Case Report

VFS, female, teacher, 33 years old, catholic, attended at a public emergency service, reported that, in December 2019, she had opened a clinical condition of pain located in the pelvic region, without irradiation, of moderate intensity, looking for medical assistance, where chosen for conservative clinical conduct.

If there was no improvement in clinical status after 72 hours, she again sought medical assistance, where computed tomography (CT) of the total abdomen was requested, showing a lesion with suspicion of ovarian neoplasia, in addition to moderate ascites. On physical examination, she had altered pulmonary auscultation with decreased breath sounds (MV) in the right lung base; mobile dullness with abdominal percussion, as well as positive flickering signal and pain on superficial and deep palpation of the lower quadrant of the abdomen. She denied fever and weight loss.

An emergency physician referred the patient to a specialized hospital. She underwent an exploratory laparotomy with ovarian mass resection and iliaco-pelvic lymphadenectomy, omentectomy and peritoneal biopsies. The patient did not have elevated tumor markers (CA-125, CEA, CA 19-9 or protein alfalfeto). After 10 days, the patient was in an improved clinical condition and was discharged from the hospital. The result of immunohistochemistry showed the histological diagnosis of fibrotecoma. The patient had been referred to the gynecological oncology outpatient clinic and had no need for adjuvant treatment. He is undergoing cancer follow-up.

DISCUSSION

Meigs syndrome has been known since the 19th century and consists of the triad of benign ovarian tumor, ascites and pleural effusion that resolve after tumor resection (Gonçalves & Blanco, 2019). The terminology of SM is due to Joe Vincent Meigs (1892-1963), however, other authors, such as Albert Demons, had already described SM, justifying the fact that other publications mention SM as Demons-Meigs Syndrome (Vázquez, et al, 2016). Although simulating a malignant condition, MS has an excellent prognosis, unlike other ovarian neoplasms (Gonçalves & Blanco, 2019). The pathophysiology of MS is not clear; ascites can be explained by the elevated pressure exerted by the tumor on blood and lymph vessels, in addition to irritation of peritoneal surfaces, which could stimulate the production of peritoneal fluid (Rodriguez, 2017). Another theory would be the increase in capillary permeability by hormonal stimulation or release of tumor mediators (Turan, et al, 1993). Pleural effusion is common on the right and would be secondary to the diffusion of ascitic fluid into the pleural space through lymphatic vessels of the diaphragm (Gonzalez et al, 2011). The ovarian tumors most associated with the syndrome are ovarian fibroids, which are characterized by hypoechoic and homogeneous images on ultrasound and are more frequent in middle-aged women (Neto et al, 2011). Other tumors related to Meigs Syndrome are cystadenomas and tecomas (Rodriguez, 2017). The clinical manifestations of the syndrome basically consist of symptoms related to ascites and pleural effusion, such as dyspnea, fatigue, non-productive cough, heartburn (Calvo, et al, 2010). Menstrual pain and irregularity are also described in fibroids (Rodriguez, 2017). Peritoneal tuberculosis is one of the main differential diagnoses of MS, since it can develop with ovarian mass, abdominal pain and ascites, with intraoperative lesion biopsy being the method of choice for diagnostic confirmation (Ramírez-Cornelio, 2018). Another differential diagnosis is pseudo-Meigs syndrome (PMS), which includes pleural effusion and ascites associated with other benign or malignant pelvic tumors (Santos et al, 2017). Serum CA-125 levels are not able to distinguish MS from PMS, that is, they do not discriminate between benign and malignant abdominal conditions (Santos, et al, 2017). This is because high levels of this serum marker are nonspecific, and may be present and sometimes altered in pregnancy, menstruation, endometriosis, peritonitis, liver cirrhosis (Park, 2015). Therefore, the combination of pelvic mass, ascites, pleural effusion and elevated serum CA125 does not always predict a dismal prognosis (Liou et al, 2011). The elevation of CA 125 in MS may be related to its expression by the mesothelium and not by the neoplasm itself (Benjapibal et al, 2009).

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