Letter to Editor

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A Case of Meigs' Syndrome in Rheumatology: Pseudo-Pseudo

Witorino Sodesto

Department of Armed Forces Hospital, Brasília-DF, Brazil

***Corresponding Author :** Witorino Sodesto, Department of Armed Forces Hospital, Brasília-DF, Brazil

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Meigs and Cass (1937) identified three symptoms of Meigs' Syndrome (MS): benign ovarian fibroma, ascites, and hydrothorax that resolve following tumour excision. Transudates were found in the pleural and peritoneal fluids of MS patients [1]. Similar features in pseudo-MS can be attributed to other benign or malignant tumours; Pseudo Pseudo-MS (PPMS) is associated with either SLE alone or SLE in conjunction with scleroderma [2–6]. Schmitt et al. initially used the term PPMS in 2005 when they reported on a 33-year-old woman who had enlarged cystic ovaries and the classical symptoms of the syndrome [2]. Yet, the patient's aberrant cystic ovarian alterations may point to the presence of PMS or MS alongside an active course of SLE in a young woman who has a propensity for multi-organ serositis. As a matter of fact, polyserositis, the primary feature of the lupus phenotype, may be the cause of PPMS [4]. PPMS differential diagnosis is a difficult task, especially for non-specialists. The interpretation of elevated levels of CA 125, which have been reported in patients with PPMS [2–6], is a significant cause for concern because this tumour marker is thought to be suggestive of ovarian cancer. Nephrotic syndrome and pelvic tuberculosis may also be the cause of high CA125 levels [3, 4]. This tumour is the most deadly cancer in women and the fifth leading cause of death from cancer. In order to establish the correct diagnosis as soon as possible, accurate clinical evaluation along with sufficient laboratory determinations, imaging, and pathology studies is therefore required. The uncontrolled action of pro-inflammatory cytokines, local vasculitis, plasma cell aggregation, immune complexes, elevated serum ferritin levels, and tumour marker expression by omentum and mesovarium cells have all been linked to the mechanisms of elevated levels of CA 125 and the origin of peritoneal exudate in active SLE [6]. The causes of pleural effusion, which differ from the pleural transudate in classical MS, are either lymphatic or ascites passive transfer to the pleural cavity. Pleural effusion will be improved by paracentesis and therapeutic management of the SLE flare up [1]. SLE or SLE and scleroderma (MCTD) have been linked to PPMS, an extremely rare disorder that is diagnosed in rheumatologic patients [2–6]. Given that SLE is more common in women and MS only affects women, it is possible to explore the possibility of a coincidental relationship between these two disorders. One must rule out the more common entities of typical MS and PMS caused by ovarian malignancy, as benign and malignant ovarian tumours are more common than PPMS [1-6].Key words: Systemic lupus erythematosus, pseudo-pseudo Meigs' syndrome, mixed connective tissue disease.

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