Secondary peritoneal malignancy

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Peritoneal carcinomatosis Peritoneal carcinomatosis is common and refers to malignant nodules on the surface of the peritoneum. It normally arises in conjunction with ovarian malignancy or malignancy in an organ of the mesenteric domain. It can be localised or di ff use. Any peritoneal surface can be involved. Sometimes the omen Paul H Sugerbaker , b. 1941, Director of Surgical Oncology , Washington Cancer Institute, Washington, DC, USA. tum is di ff usely involved, forming a mass termed an omental cake. The symptoms and signs are mainly related to the primary pathology . If the tumour burden is considerable, a mass may be palpable and the accompanying ascites substantial. Radio - logical cross-sectional imaging with CT or magnetic resonance imaging (MRI) is usually diagnostic; however, histological or cytological confirmation is essential to distinguish it from peri - toneal TB. The visceral origin of peritoneal carcinomatosis is important as this can guide chemotherapy and cytoreductive or extirpative surgery . The visceral origin of peritoneal car cinomatosis is import - ant because if curative resection of the primary tumour is deemed feasible and the peritoneal disease considered resect - able, resection with peritonectomy and HIPEC should be con - sidered. HIPEC is a highly concentrated, hea ted (41–42°C) chemotherapy delivered directly into the abdomen for 90 min - utes after cytoreductive surgery . HIPEC is particularly valu - able in trea tment of pseudomyxoma peritonei and has become the standard of care in carefully selected patients assessed in specialist centres (Sugerbaker) (see Chapter 76). -

Figure 65.8 (a) Plain chest radiograph from a 55-year-old man showing miliary tuberculosis (TB); (b, c) representative computed tomography images from the same patient showing gross ascites, nodular stranding in the omentum and mesentery, as well as nodular enhancement of the peritoneum – TB peritonitis (courtesy of Dr S Burke, Homerton University Foundation Trust, London, UK).

treatment is palliative. Subacute intestinal obstruction may require intestinal bypass or a defunctioning stoma (see Chapter 78). Malignant ascites may be drained externally or via a peritoneovenous shunt (LeV een).

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