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Pseudo-pseudo Meigs' syndrome in Rheumatology

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Dear Editor,

The Meigs' Syndrome (MS) described in 1937 by Meigs and Cass was characterized by benign ovarian fibroma, ascites and hydrothorax that resolve after the tumor removal. Peritoneal and pleural fluids of the patients originally with MS were transudates [1]. In pseudo-MS similar features are due to other benign or malignant tumors; Pseudo Pseudo-MS (PPMS) occurs in Systemic Lupus Erythematosus (SLE) alone or SLE plus scleroderma [2-6]. The term PPMS was first utilized in 2005 by Schmitt et al., in the case report of a 33-year-old woman with the classical characteristics of the syndrome and enlarged cystic ovaries [2]. However, the abnormal cystic ovarian changes in this patient could indicate coexistent MS or PMS with active course of SLE in a young female with the tendency to multi-organ serositis. In fact, PPMS may be due to lupus phenotype characterized primarily by polyserositis [4]. The differential diagnosis of PPMS constitutes a challenging task mainly for non-specialists. A major concern is about the interpretation of elevated levels of CA 125 described in patients with PPMS [2-6], because this tumor marker is considered indicative of ovarian malignancy. High levels of CA125 may be also due to pelvic tuberculosis and nephrotic syndrome [3,4]. This tumor is the fifth cause of death by cancer and the most lethal malignancy in women. Therefore, accurate clinical evaluation with adequate laboratory determinations, imaging and pathology studies is mandatory in order to establish the correct diagnosis as early as possible. The mechanisms of elevated levels of CA 125 as well as the origin peritoneal exudate in active SLE have been associated with uncontrolled action of pro-inflammatory cytokines, local vasculitis, aggregation of plasma cells, immune complexes, elevated serum levels of ferritin, and the expression of the tumor marker by cells of the omentum and mesovarium [6]. Pleural effusion is due to ascites passive transfer to pleural cavity or by lymphatic route, mechanisms that explain the difference with the pleural transudate of the classical MS. Paracentesis and therapeutic control of the SLE flare up will improve the pleural effusion [1].

PPMS is an exceeding uncommon condition diagnosed in rheumatologic patients, and the scarcely reported cases were associated with SLE, or SLE and scleroderma (MCTD) [2-6]. Taking in account that MS exclusively affects women and SLE more often occurs in females, the hypothesis of a casual concomitance between these conditions might be also considered. As benign and malignant ovarian tumors are more frequent than PPMS, one must rule out the typical MS and the PMS caused by ovarian malignancy that are more prevalent entities [1-6].

Key words: Mixed connective tissue disease, Pseudo-pseudo Meigs' syndrome, Systemic lupus erythematosus

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