

**Silent recurrence in pseudomyxoma peritonei:
A call for standardised Post-CRS/HIPEC surveillance**

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Dear Editor, Pseudomyxoma peritonei (PMP) is a rare peritoneal malignancy arising most commonly from a perforated mucinous appendiceal tumour, characterised by progressive mucinous accumulation within the abdominal cavity.¹ Cytoreductive surgery combined with hyperthermic intraperitoneal chemotherapy (CRS/HIPEC) remains the standard of care, achieving 10-year overall survival rates exceeding 60% in high-volume centres.² Yet recurrence remains a defining challenge, occurring in approximately 20–30% of patients after curative CRS/HIPEC, almost exclusively within the peritoneal cavity rather than at the primary appendiceal site.³

The principal concern is not merely the incidence or frequency of recurrence, but rather the insidious manner in which recurrent disease manifests clinically. The clinical presentation of PMP is non-specific, with many patients being asymptomatic, with recurrence detected only through imaging or at the time of surgery.¹ Recurrent disease causes abdominal distention, bloating, and vague abdominal pain, and is indistinguishable from the expected post-CRS baseline.¹ Consequently, there is no reliable clinical distinction between early disease progression and surgical sequelae. By the time the recurrence becomes clinically evident, the Peritoneal Cancer Index (PCI) is likely to be high enough to compromise resectability at the re-do CRS, the only consistent factor associated with longer survival.⁴

This issue remains inadequately addressed in the literature. The first study that directly examined adherence to postoperative follow-up in PMP patients undergoing CRS/HIPEC treatment showed that noncompliance had a trend toward poorer survival.⁵ However, there is no consensus surveillance protocol; imaging modality, frequency, and duration of follow-up are widely variable among centres, and there is no validated risk-stratified framework to guide practice.⁵

Surveillance post-CRS/HIPEC should therefore be

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Submission completed: 30-05-2026 **1st Revision received:** 06-06-2026

Acceptance: 22-07-2026

2nd Revision received: 21-07-2026

protocolised, risk-stratified (by histological grade and index PCI), and should be cross-sectional imaging-based rather than symptom or tumour marker-driven review alone. For instance, patients with high-grade histology and high PCI may require 3-monthly imaging, while those with low-grade disease could be followed at 6-monthly intervals. No consensus currently exists on optimal management of recurrent disease,⁴ but that discussion cannot begin if recurrence is being detected too late to act upon. More patients will be arriving at re-do surgery with the disease that has quietly progressed beyond surgical salvage. Given the limited number of high-volume CRS/HIPEC centres in Pakistan, establishing standardised surveillance protocols is particularly crucial to optimise outcomes in our setting. Multicentre collaborative efforts are essential to establish evidence-based surveillance guidelines post CRS/HIPEC.

Disclaimer: None.

Conflict of Interest: None.

Funding Disclosure: None.

DOI: <https://doi.org/10.47391/JPMA.41788>

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