Case Report

I may be a centimeter, but I'm still an appendix: a rare case report

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Abstract

Acute appendicitis is the most common general surgical emergency, and early surgical intervention improves outcome. Length of appendix varies from 2 to 20 cm and the average length is 9cm in adults, diameter ranges from 7 to 8 mm. The longest appendix ever removed measured 26 cm from a patient in Zagreb, Croatia[3]. This case report is about 13 year old boy who presented with signs and symptoms of acute appendicitis and underwent emergency open appendectomy, in which appendix size was 1cm, which was confused with Epiploicappendagitis. Finally diagnosis was confirmed by histo-pathology.

Key Word: acute appendix, Epiploicappendagitis.

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INTRODUCTION

The appendix, ileum and ascending colon are all derived from the midgut. Appendix first appears at the eighth week of gestation as an out pouching of the cecum and gradually rotates to a more medial location as gut rotates and cecum becomes fixed in the right lower quadrant. Base of appendix is located at the convergence of taeniae, which facilitates its identification during surgery. The tip of appendix may lie in various positions, the most common being retrocecal[4]. On microscopic view, lumen is irregular, encroached by multiple longitudinal folds of mucous membrane lined by columnar cell intestinal mucosa of colonic type. Kulchitsky cells lie at the base of crypts, submucosa contains numerous lymphatic follicles. Mucosa is bounded by a relatively thin muscularis mucosa[5]. Acute appendicitis is the most common cause of acute abdomen in young adults and should be considered in differential diagnosis. Early diagnosis remains the most important clinical goal in patients with suspected appendicitis and can be made primarily on basis of history, physical examination and Alvardo scoring system.

CASE PRESENTATION

A 13 year old boy presented at the emergency department of AIMS, Bellur, with abdominal pain that started first in peri-umbilical region 24 hrs ago and progressed to the right lower quadrant pain, accompanied by nausea, mild fever. On physical examination patient was febrile (38°C) with tenderness at McBurneys point, no rebound tenderness, with normal bowel sounds and per-rectal examination was normal. Laboratory tests showed leukocytosis(13000 cells/cmm) with normal PMNS and blood biochemistry levels.

Alvardo scoring was 8/10. USG abdomen was normal except for probe tenderness at McBurneys point and appendix was difficult to locate. Erect X-ray abdomen was normal. Patient was taken to emergency open appendectomy on clinical basis and Alvardo scoring system. McBurney incision was taken with muscle splitting, and found a ONE CM blind ending tube,

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inflammed which was confused with Epiploicappendagitis because of its small size and meckels diverticulm was absent. Appendectomy was done and specimen was sent for histo-pathology. Patient recovered uneventfully and was discharged 4 days later. Histo-pathological examination revealed single round tissue measuring 1× 0.5cm, mucosa shows focal ulceration with inflammatory exudate in lumen and transmural inflammatory cell infiltrate, with congested blood vessels in serosa.

DISCUSSION

The differential diagnosis of acute appendicitis is essentially the diagnosis of the acute abdomen.[6]

Children	Adults	Adult female	Elderly
Gastroenteritis	Regional enteritis	Mittelschmerz	Diverticulosis
Mesenteric adenitis	Ureteric colic	Pelvic inflammatory disease	Intestinal obstruction
Meckel's diverticulitis	Perforated peptic ulcer	Pyelonephritis	Colonic carcinoma
Intussusception	Torsion of testes	Ectopic pregnancy	Torsion appendix epiploicae
Henoch-schonleinpurpura	Pancreatitis	Torsion or rupture of ovarian cyst	Mesenteric infarction
Lobar pneumonia	Rectus sheath hematoma	Endometriosis	Leaking aortic aneurysm

Epiploicappendagitis was considered in our diagnosis because of its small size and leukocytosis. Appendices epiploicae are fatty appendages that arise from taenia coli in large bowel.their role in bowel is uncertain. They occur in rectosigmoidjunction(57%), ileocecal region (26%), ascending colon (9%), transverse colon (6%) and descending colon (2%)[7-8]. In case of torsion the blood supply is interrupted and results in infarction. This can present with right or left lower quadrant pain and can mimic appendicitis, diverticulitis or abscess depending on site of inflammation[6]. In our case blind ending tube had lumen and appendicitis was confirmed nyhisto-pathology.

CONSENT: Written informed consent obtained from patient.

CONFLICT OF INTEREST: All the authors have read and approved the manuscript.

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