Valentino’s Syndrome: Perforated Peptic Ulcer Mimicking Acute Appendicitis Managed Through Rutherford Morrison Incision

Sir,

Right lower abdomen pain is a common surgical emergency and the most common cause is acute appendicitis. Other common causes in children include acute non-specific mesenteric lymphadenitis, pyelonephritis, acute gastroenteritis and urinary tract infection.1 Perforation of duodenal ulcer is rare in children and presentation as acute appendicitis is even rarer in a child with no history of peptic ulcer disease, intake of steroids or non-steroidal anti-inflammatory drugs.2

A 7-year boy was admitted in the children ward with one-day history of pain in the epigastrium and paraumbilical region. He was being managed conservatively. On second day of admission, he also felt pain in the right iliac fossa for which surgical consultation was taken. On clinical examination, he had pulse of 84 bpm, and was afebrile. Abdomen was soft with tenderness and rebound tenderness in the right iliac fossa. Total Leucocyte Count (TLC) was 12.7x10⁹ with 86% neutrophils. Keeping in view the classical clinical symptoms and signs as well as raised inflammatory markers, clinical diagnosis of acute appendicitis was made. X-ray of chest was not done as patient was clinically diagnosed as a case of acute appendicitis and was not having any cardiac or pulmonary disease. A plan for open appendicectomy was made after informed consent. Patient was kept Nil Per Oral (NPO), and intravenous fluids and antibiotics were given. Abdomen was opened through Grid iron incision. On opening the peritoneum, lot of brownish-green fluid was seen. Fluid was aspirated and appendix was found normal. Keeping in view the suspicion of perforated duodenal ulcer, incision was converted into Rutherford Morrison to explore the duodenum. A perforation was seen in the anterior wall of duodenum in the first part (Figure 1 and 2). Omental patch repair of perforation was done along with appendicectomy to prevent confusion of appendicectomy scar in case an attack of appendicitis occurs in future. Abdominal cavity was washed and drain was placed. Patient had uneventful recovery. Drain was removed on third postoperative day and patient was discharged on fourth postoperative day. Histopathology of the appendix showed benign reactive lymphoid hyperplasia. Postoperative samples were sent for screening of Zollinger-Ellison syndrome and H. pylori, which were negative and upper gastrointestinal endoscopy at 6 weeks showed complete healing of the ulcer.

The syndrome carries its name after Rodulph Valentino, a famous American film actor who died in 1926 due to complication related to the perforated peptic ulcer. He presented with pain in right lower abdomen and was diagnosed and treated as a case of acute appendicitis and later on autopsy, he was found to have perforated peptic ulcer.3 There are three peculiarities in this case. First is the unusual presentation of perforated duodenal ulcer, second is the age of the patient without any previous history or predisposing factors for duodenal ulcer, and third is the incision with which he was managed. The patient had initially presented with upper abdominal pain which later subsided and shifted to the right iliac fossa, like pain of acute appendicitis. As the patient was 7 years old and had no history of previous episodes of upper abdominal pain or its association with meals, the possibility of perforated duodenal ulcer or peptic ulcer disease was not considered. Usually, when such findings of suspected perforated duodenal ulcer are found in an adult during appendicectomy, the

Figure 1: Perforation in first part of duodenum.

Figure 2: Rutherford Morrison incision.
previous incision is closed and the abdomen is opened by upper midline incision, or the appendicectomy incision is closed and the laparoscopy is done, known as “reverse conversion”.4,5 But, as in this patient the muscle bulk was less and we were able to visualize and access the duodenum and perforated part by converting the incision into Rutherford Morrison. The upper midline laparotomy was not done and the perforation was repaired by omental patch. If the pathology is missed and only appendicectomy is done and abdomen closed, patient would not recover and deteriorate in the postoperative period with a need of formal laparotomy and a lot of morbidity and mortality.3,6 The purpose of reporting this case is that one should keep in mind a broad, common, and rare differential diagnosis when assessing a case of pain in right iliac fossa. Moreover, other pathologies should be looked into when faced with unusual situation while doing appendicectomy. Laparoscopy is the optimal treatment for acute appendicitis, as it can look for other intraabdominal pathologies apart from appendicitis.

REFERENCES


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