CASE REPORT

RETROCECAL APPENDECTOMY: A CHALLENGE

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ABSTRACT

A case of 25 years old Saudi male underwent appendectomy two years ago at Mecca. He was admitted with complaint of sever painful swelling in right iliac fossa which aggravated with change of posture and was associated with anorexia .The diagnosis was made on clinical assessment and was supported by blood investigations, ultrasound of abdomen and CT scan showed a retrocecal abscess 6 cm × 7 cm layer underneath scar. The patient underwent emergency laparotomy, which revealed retrocecal abscess with old perforated appendix with a fecolith. Drainage of abscess and appendectomy was performed and emphasized the importance of early treatment of appendicitis.

Keywords: Post appendectomy mass right iliac fossa, perforated retrocecal appendix and fecolith.

1. INTRODUCTION

Retrocecal appendix followed an atypical course.[1] Usually perforated retrocecal appendix imply delay in presentation with more tolerable symptoms. The commonest site of appendix is retrocaecal.[2] The incidence of retrocecal appendix is 26% to 65% with a risk of perforation up to 65%.[3] It is very difficult to diagnose a perforated appendix in a patient who underwent appendectomy two years ago, especially when the previous record is not available.[4]

2. CASE REPORT

A twenty five years old Saudi male presented with H/O appendectomy performed two years ago with a scar mark, severe painful swelling in right iliac fossa, anorexia and fever for two days. The pain was localized in right iliac fossa and aggravated with the change of position. On general physical examination the patient showed fever (100°F), pulse 95/min, blood pressure 120/80 mmHg. Abdominal examination showed a mass in right iliac fossa about 6×7 cm underneath grid iron scar, tenderness, guarding and rigidity in right iliac fossa and right groin. Rectal examination revealed tenderness. Examination of chest, CVS and CNS revealed no abnormality. His white blood cells count was 18000, hemoglobin was 14 gm, serum electrolytes, blood urea, creatinine and blood sugar were normal. Ultrasound abdomen revealed fluid collection in right iliac fossa. Plain X-ray of abdomen showed air filled small bowel loops. CT scan of abdomen demonstrated fluid collection beneath the cecum extending up to the anterior abdominal wall and thickening of post wall of cecum.

On mid line abdominal exploration, there was an abscess behind the cecum containing thick pus above 30 ml, appendicolith. The appendix was adherent with the posterior wall of cecum which was 5 cm in length, perforated with fibrotic base. Abscess drainage, removal of fecolith and appendectomy was performed. Pus was sent for culture, sensitivity test and for histopathological examination, which revealed appendicitis. The lower abdomen and pelvis was irrigated with normal saline and close suction drain placed in residual cavity. Abdominal wall closed with prolene in layers. Post operatively patient developed hypomagnesaemia which was corrected. On fifth post operative day the patient discharged without post operative complication.

3. DISCUSSION

Anatomically most common location of appendix is intraperitoneal retrocecal, where as it is retroperitoneal in 7% of the population.[5] Approximately, 7% of all the population undergoes

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appendicectomy.[6]

The presentation of patient with mass/abscess in right iliac fossa with spontaneous origin, goes in favors of perforated or complicated appendicitis.[7] The dilemma is more difficult with the history of appendectomy performed two years ago.[8] The development of abscess was due to presence of feacolith and old perforation of appendix.[9] Patients with large appendicial abscess greater than 4-6 cm in size benefit from a drainage through laparotomy.[10]

The appendectomy in this situation is difficult and may be associated with iatrogenic injury on account of fibrotic adhesions.[11] In the patient the appendix was of full size, perforated, adhered with the positive wall of cecum and the base was fibrotic.[12] In this situation carcinoma of colon can be suspected in about 5% of cases, a recurrent appendicitis may be considered in about 15-20% of cases whereas stump appendicitis is also a well known entity.[13]

4. CONCLUSION

The retrocecal appendix can lead to difficult surgery. Due to recurrent appendicitis the elective appendectomy should be employed within three months. The reports of such cases are discussed in literature. Recognition of this important entity is emphasized when the previous record is not available for the patient.

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