Case study

Case report on: Appendicitis

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Abstract

Introduction: It is an acute inflammation of the appendix. It occurs in all age-groups, most common between the ages of 10 to 30 years and male and females are equally affected. The incidence of appendicitis is much lower in underdeveloped countries, especially some parts of Africa and in lower socio-economic groups. 24 year old male was admitted in AVBRH with the complaint of Pain in right iliac fossa, nausea, vomiting after the diagnosis he has case of appendicitis. Examination findings were consistent with acute appendicitis.He remained systemically well; investigations including blood tests, urine sample and abdominal ultrasound were inconclusive.

Keywords: Appendicitis,subhepatic appendix, malrotatedcaecal pole, adhesions

Introduction

Acute appendicitis (AA) is a widespread disease requiring emergency care. AA may progress rapidly if not treated early. The complications of appendicitis such as perforation peritonitis are common in the extremes of age group. [1]Appendicitis is the swelling (inflammation) of the appendix. The appendix is a small, tube like organ attached to the large intestine. The condition is due to blockage inside the appendix.[2]the blockage leads to increased pressure and inflammation.Symptoms include right iliac fossa (RIF) pain, anorexia, nausea, constipation, and vomiting; however, these classical presentations only occur in 50% of people.The pain originated in the umbilical region, radiating diffusely across the lower abdomen and subsequently localized to the RLQ.[3, 4] the pain was of sudden onset, sharp and colicky with progressing intensity.The hallmark of pathogenesis is luminal obstruction.[5] Obstruction is commonly caused by a faecolith which result from accumulation and inspissation of faecal matter around vegetable fiber. Enlarged lymphoid follicles associated with viral infection, insipissated barium, worms and tumours also may occlude the lumen. Serection of mucus distends the lumen, raises intraluminal pressure leading to appendicitis.[6]

If the process evolves slowely, an inflammatory mass involving the terminal ileum, caecum and omentum is formed leading to formation of appendicular abscess.Subsequent rupture of abscess may produce fistula between appendix and bladder,small intestine,sigmoid colon or caecum.[7]

Case Presentation

Present medical history:24yr old male was admitted in AVBRH on 11th march 2021 by his wife with the chief complaint of Pain in right iliac fossa,nausea,vomiting. He was admitted in surgery ward.He feels discomfort becauseof pain and dull expression on the time of admission.

Past medical history: 24yr old male had no any illness found such as diabetes mallitus, hypertension, asthma, and any allergy.

Examination

On examination, there was moderate tenderness on deep palpation of the RIF and the physiological parameters including heart rate, respiratory rate, temperature and blood pressure were all within normal limits.

Investigations

Diagnostic Assessment: Blood test: Hb -14.5 gm%, Total RBC count -4.5millions/cu mm,Total WBC count -8000/cu mm,Total Platelet count -2.5 lacs/cu mm,Albumin -4.1 gm%,Bilirubin(conjugated)-0.4gm%,Bilirubin(unconjugated)-1.1gm%.

CT scan of abdomen and pelvis: Abnormal appendix (diameter >6 mm) identified or calcified appendicolith seen in association with periappendiceal inflammation, fat stranding

Therapeutic Intervention: Inj.Amoxicillin 500mg x OD,Tab.Emset 4mg x TDS,Inj.Tramadol 100mg x TDS,Tab.Limcee 500mg x OD,Tab.pantaprozol 40mg x OD.

Discussion

It is rare for the caecum and appendix to be located subhepatically since subhepatic appendicitis makes up an annual incidence of 0.09 per 100,000 populations. [8] In this patient, malrotation of the caecal pole resulted in the caecum being located at the hepatic flexure and appendix base posteroinferior to the inferior border of the liver. The cause, in this case, was attributed to congenital adhesions which tend to arise during physiological organogenesis or as a result of an abnormality in the embryonal development of the abdominal cavity.[9]

The most reliable examination findings for acute appendicitis have been noted as tenderness on percussion, guarding, and rebound tenderness at the RIF. When considering the anatomically higher appendix, it is noteworthy that examination findings are consistent with an appendix lying in the standard RIF location. Similar cases of subhepatic appendicitis accounted by Hafiz et al. (2017) and Ball et al. (2013) both report predominant RUQ pain as opposed to RLQ pain prompting an inaccurate consideration of biliary pathology [10]. In the case observed by Hafiz, a positive Murphy's sign was also elicited despite previous cholecystectomy [11].

Conclusion

To conclude, this was a 24-year-old male who presented with RLQ pain and was diagnosed with acute appendicitis. The patient had an appendix located poster inferior to the inferior border of the liver.Chronic appendicitis does not manifest with classical clinical symptoms and signs ofacute appendicitis. In the evolution of the chronicand recurrent abdominal pain, the chronic appendicitis must always be considered as one of the probablepathological conditions.

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