

PICTURES IN DIGESTIVE PATHOLOGY

Abdominal pain for 9 days

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CASE REPORT

We report the case of a 22-year-old male patient who was admitted at the ER because of abdominal pain for 9 days. His personal record did not reveal any significant findings, operations, toxic habits, or regular medications.

The patient reported abdominal pain in the right lower quadrant for 9 days. He did not relate the pain to any specific event, and he described it as of moderately severe, constant pain irradiating to the left thigh, unaltered when moving, resting or sleeping. The patient did not present nausea or vomiting, and his intestinal habit was normal. He had no fever or feelings of dysthermia.

Physical exploration revealed: BP: 117/82, HR: 92 bpm, T: 37.1 °C. Abdominal exploration revealed normal abdominal noises, and no masses or enlargement of the abdominal organs were observed. Surface palpation was normal, but deep palpation triggered a moderately severe pain in the right lower quadrant (RIF) with no peritoneal response.

Emergency blood testing revealed: biochemistry: glucose 109 mg/dl, urea 23 mg/dl, Cr 0,86 mg/dl, Na 138 mmol, K⁺ 5,3 mmol, C-reactive protein (CRP) 6,0 mg/dl, osmolarity 266 msom/kg; the urinalysis showed no disorders. Hemogram: hemoglobin 15.6 g/dl, hematocrit 45.4%, mean corpuscular volume (MCV) 87 fl, leukocytes 11900/ml, neutrophils 74.1%, platelets 220,000/ml. Coagulation: prothrombin time (PT): 98%, activated partial thromboplastin time (APTT): 32.7 s.

An abdominal X-ray reveals a well-defined oval mass of 4 cm in the right hemipelvis (we include the picture with the surgical specimen).

Afterwards, an ultrasonogram was performed, which was compatible with appendicitis, although other patholo-



Fig. 1.

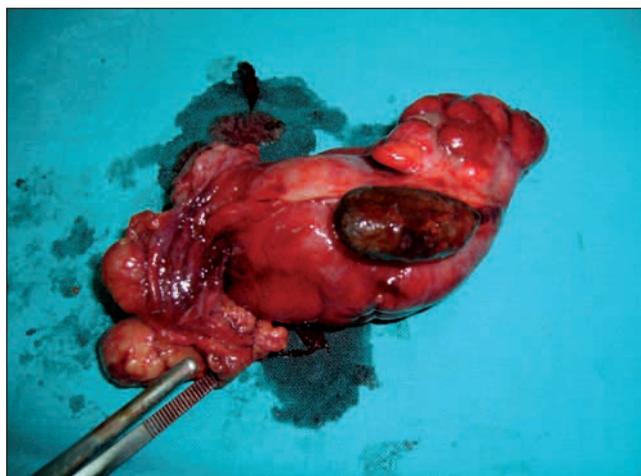


Fig. 2.

gies could not be ruled out. The test also showed free periappendicular fluid, a big appendicolith, and big, 8-9-cm adenopathies in the RIF.

A McBurney's incision was performed, and the appendix was removed, showing a great inflammatory reaction that reached the mesoileum and cecum. The report from the Pathology Department on the surgical specimen suggested acute appendicitis, intra-appendicular fecalith, and reactive lymphadenitis.

DISCUSSION

The slow progression of symptoms, absence of common symptoms (1) (such as abdominal pain with acute-subacute onset, located mainly in the RIF, fever or peritoneal reaction, which are common in acute appendicitis), poor lab expression with low leukocyte count, and absence of other atypical symptoms (2), together with the presentation of a big surgical specimen and inflammatory reaction, prompted a differential diagnosis with appendicular tumors (3).

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