Coincidental Acute Appendicitis with Retrograde Menstruation Diagnostic Miscorrelations 'Case Report'

AKUT APENDİSİT İLE BİRLİKTE RASTLANTISAL RETROGRAD MENSTURASYON TANI UYUMSUZLUKLARI

Ercüment Hayrı TEKİN*, Fent TANERİ*, Emin ERSOY*, Reha YAVUZER*

* Dr.Gazi Üniversitesi Tıp Fakültesi Genel Cerrahi AD, ANKARA

Summary

Objective: *To present a case of a acute surgical condition of the ahdo/nen, clinical diagnosis of acute appendicitis which does not correlate the operative diagnosis of the surgeon as well as the diagnosis of the surgeon does not con-elate the histopathologic diagnosis of the pathologist.*

Instituée: *Gazi University Medical School Department of General Surgery*

Material and Method: *A patient with acute abdomen who was operated with a clinical diagnosis of acute appendicitis.*

Results: *The patient was operated with a clinical diagnosis of acute appendicitis but operative diagnosis was retrograde menstruation and even though the appendix seemed normal, appendectomy was performed and the histopathological diagnosis was found to be acute appendicitis.*

Conclusion: *Patient who are operated for the diagnosis of acute appendicitis and found to have, another pathology that can explain the signs and symptoms, appendectomy should he performed, because sometimes it can not be possible to differentiate normal from inflamed appendices in a considerable percent of patients or if other pathologic finding has a risk of relapse.*

Key Words: Acute appendicitis, Retrograde mensturation, Appendectomy

T Klin J Gynecol Obst 1997, 7:251-253

Özet

Amaç: *Klinik tanısı akut apendisilis olan fakat cerrahın ameliyat esnası tanısının ve cerrahın tanısı ile patologun histopatolojik tanısının korelasyon göstermediği bir olgunun sunumu.*

Çalışmanın Yapıldığı Yer: *Gazi Üniversitesi Tıp Fakültesi Genel Cerrahi Anabilim Dalı*

Materyal and Metod: *Akut apendisitis klinik tanısı ile öpere edilen bir akut karın vakası.*

Bulgular: *Hasta akut apendisilis klinik tanısı ile ameliyat edilmiştir ancak ameliyat esnası tam retrograd mensturasyon olarak bulunmuştur ve apendiks normal görülmesine rağmen apendektomi yapılmış ve histopatolojik lanı akut apendisitis olarak saptanmıştır.*

Sonuç: *Akut apendisit tanısı ile öpere edilen hastalarda semptom ve bulguları açıklayan başka patoloji bulunduğunda normal apendiks ile enflame apendiks bazen ayırt edilemediğinden veya eğer diğer patolojinin yüksek tekrarlama riski var ise apendektomi yapılmalıdır.*

Anahtar Kelimeler: Akut apendisitis, Retrograd mensturasyon, Apendektomi

T Klin Jinekol Obst 1997, 7:251-253

Appendicitis is the most comman acute surgical condition of the abdomen requiring emergency surgical intervention with a life time risk of 6% (1,2). Clinical manifestations and laboratory findings are not spesific for acute appendicitis and identical clinical pictures can result from a wide variety of acute processes within or near the peritoneal cavity that produce the same alterations of function as acute appendicitis. The rate of normal appendectomy is within the 15% to 25% range (3-5) and the majority of these patients were female,

Geliş Tarihi: 18.08.1997

Yazışma Adresi: Dr.Ercüment TEKİN
Turan Güneş Blv. 41.Sok
Aktürk Sit 2. Kısım A/6
Oran, ANKARA

possibly due to an expanded differential diagnosis that includes ovarian cysts, pelvic inilamatory disease and ectopic pregnancy (3). The operative diagnosis of the surgeon is based upon the gross infection signs of the appendix. Therefore, misdiagnosis are inevitable as 19% of the patients having a peroperative diagnosis of normal appendices grossly were found to have acute appendicitis and 7.7% of them who were diagnosed as acute appendicitis, were intact normal.

Case

A 20 year old female patient was admitted to the Department of General Surgery of Gazi University, Medical Faculty Hospital on August 8, 1994 with complaints of abdominal pain, anorexia during that particular menstruation period. Her menstruation was started three days ago with her usual complaint of dysmenorrhea. Eighteen hours ago a more severe pelvic pain was superimposed accompanying with anorexia and nausea without vomitting.

Although her vital signs were all in normal range, physical examination revealed tenderness of entire abdominal wall but especially the lower quadrants. Muscular resistance was found during the palpation of the lower abdominal wall mostly in the right side. Direct and indirect rebound tenderness were present significantly in the right lower quadrant. Rousing's sign was positive. She had a leukocyte count of 11.600/mm3 and her urinalysis revealed microscopic hematuria due to her menstruation. Two distended small bowel loops in the right lower quadrant were the only findings in the plain abdominal x-rays. Ultrasonography showed minimal pelvic and right paracolic fluid collection.

Patient was taken to operating room with a preoperative diagnosis of acute appendicitis two hours after the admission. After having an access to the abdominal cavity with a Rockey-Davis incision, abdominal exploration revealed 50 cc of pelvic blood collection and appendix seemed to be normal. Intraabdominal blood was evacuated and there was no evidence of endometriosis. Operative diagnosis was concluded as retrograde menstruation as the blood was escaping from fallopian tubes. Keeping in mind that retrograde menstruation is a pathology that can repeat, an appendectomy was performed even the appendix was thought to be normal. During the recovery period and early postoperative days her pelvic pain complaints continued and required analgesia. Contraversory to the operative diagnosis histopathologic examination result was acute appendicitis. Patient was discharced without any complication.

Discussion

Acute appendicitis is the most common acute surgical condition of the abdomen. The differential diagnosis of acute appendicitis is essentially the diagnosis of the 'acute abdomen'. Accuracy of preoperative diagnosis is about 75% to 85% (3-5). The disease processes confused with appendicitis are also surgical problems or if not, are not made worse by operations. Rarely acute appendicitis is found histopathologically after a peroperative diagnosis of another condition. Most common erroneous preoperative diagnosis in descending order of frequency are lymphoid hyperplasia, no organic pathologic condition, acute pelvic inflammatory disease, twisted ovarian cyst, graafian follicle and gastroenteritis (3,6,7). Endometriosis and retrograde menstruation are very rarely encountered for the differential diagnosis of acute appendicitis (3). Retrograde menstruation that can have related symptoms such as dysmenorrhoea and infertility (8), is a comman and physiological event in menstruating women with patent tubes. Diagnosis of retrograde menstruation is based on the observation of blood escaping from the fallopian tubes during the operation of menstruating women (8).

In this case the retrograde menstruation diagnosis was based on the finding of blood escaping from the fallopian tubes as mentioned above. Although the appendix was appeared normal and there was another pathology that could explain the symptoms and signs, appendectomy has to be performed as the retrograde menstruation is a relapsing condition. As in this particular case, appendectomy should be performed even though there is another pathology found during the operation which appendectomy does not increase the mortality or morbidity of the patient. In the light of this case it could be possible to conclude that for eliminating

the operative diagnosis of acute appendicitis, the surgeon can rely on solely to the classical signs of infection in the appendix even though there is an abdominal pathology that can explain the present condition (6).

Patient who are operated for the diagnosis of acute appendicitis and found to have another pathology that can explain the signs and symptoms, appendectomy should be performed for two reasons; First, if other pathologic finding has a risk of relapse, to eliminate the possible problems in differential diagnosis of acute appendicitis in the future. Secondly, it can not be possible to differentiate normal from inflamed appendices in a considerable percent of patients so, acute appendicitis could be present coincidentally even though the surgeon's gross operative diagnose was normal appendix as in this case (3).

REFERENCES

1. Editorial. A sound approach to the diagnosis of acute appendicitis. Lancet 1987; 198-200.
2. Samelson S, Reyes H. Management of the perforated appendicitis in children - revisited. Arch Surg 1987; 122: 691-5.
3. Blair NP, Bupis SP, Turner LJ, et al. Review of the pathologic diagnosis of 2,216 appendectomy specimens. Am J Surg 1993; 165:618-20.
4. Blind J, Dahlpren S. The continuing chalange of the negative appendix. Acta Chir Scand 1986; 152:623-7.
5. Puyleart J, Rutgers P, Lalisang R, et al. A prospective study of ultrasonography in the diagnosis of appendicitis. N Engl J Med 1987; 317: 666-9.
6. Lewis FR, Holcroft JW. Appendicitis. A critical review of diagnosis and treatment in 1,000 cases. Arch Surg 1975; 110: 677.
7. Seal A. Appendicitis: A historical review. Can J Surg 1981; 24:427.
8. Kruitwagen RFPM. Menstruation as the pelvic aggressor. Bailliere's Clin Obstet Gynaacol 1993; 7:687-99.