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Visual Diagnosis Pearl

Foreign Body Appendicitis (Nailed the Diagnosis)

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CLINICAL PRESENTATION

A 25-year-old male without any significant past medical history presented to the emergency department (ED) with abdominal pain. He reported that the pain had started one week prior and was in the right lower quadrant. The pain had initially resolved but recured four days prior to presentation. He described the pain as sharp and worse with movement. He developed non- bloody diarrhea followed by constipation. He had a no appetite but was forcing himself to take in liquids. He denied fevers, chills, nausea or vomiting. His presenting vital signs in the ED were within normal limits. Initial laboratory testing included a complete blood count (CBC) and basic metabolic panel (BMP) which were all normal. His physical exam revealed a non-distended abdomen with decreased bowel sounds. He had point tenderness in the right lower quadrant with associated guarding and a normal rectal exam. He underwent a computed tomography (CT) scan of his abdomen and pelvis which showed an abnormal metallic foreign body within the retrocecal appendix with associated inflammatory reaction and likely causing appendicitis (Figure 1 A, B, C). The patient was treated with antibiotics and referred to a general surgeon. He underwent a laparoscopic appendectomy. Intraoperatively a perforated appendicitis with retrocecal abscess and acute on chronic inflammation was seen. The foreign body appeared to be a nail and was removed. Five years after patient's initial operative management he returned to the ED with recurrent right lower quadrant pain. A CT scan demonstrated a right retroperitoneal fluid collection concerning for an abscess. An CT guided drainage was attempted but no fluid was able to be aspirated, and an open ileocolic resection of the mass was performed. Pathology revealed mixed acute on chronic inflammation. Five months later patient was again hospitalized and found to have an iliopsoas abscess which was drained under CT guidance. He had another similar episode 10 months later which required similar management. Another 5 months would pass before the patient would again be hospitalized with fevers and abdominal pain. This time magnetic resonance image (MRI) of the abdomen showed a large multiloculated abscess in the right iliacus muscle extending into the abdominal wall musculature. Another laparotomy was required and ongoing inflammation found in the right lower quadrant but without an abscess. A partial bowel resection was performed, and he was treated with a course of antibiotics.

DISCUSSION

Appendicitis is a common condition affecting all age groups and the most common abdominal surgical emergency.[1] It is thought to be due to obstruction of the appendiceal outlet which could be from an appendicolith, calculi, lymphoid hyperplasia, infection or tumors.[1] Foreign body appendicitis is however a rare and infrequently reported as a cause of appendicitis as most pass through the gastrointestinal tract without complication.[2] Foreign body ingestion itself tends to present in younger patients however foreign bodies occasionally remain in the digestive track for months or years and can lead to complications later in life.[3] The patient presented here had no recollection of ingesting the foreign body so it is unclear how long it may have been in his bowel. However, based on the surgical findings we suspect it may have been present for an extended period given the degree of acute and chronic inflammation. Complications, as in our patient with perforation and abscess tend to be more common with foreign bodies as they present a nidus for infection.[2] The presented case also highlights the possible long-term complications of foreign body appendicitis as being unique from more common cases of acute appendicitis. The patient presented here required multiple repeat surgeries due to ongoing inflammatory response and recurrent abscesses. This may suggest the need for closer and longer follow up in patients diagnosed with foreign body associated appendicitis.

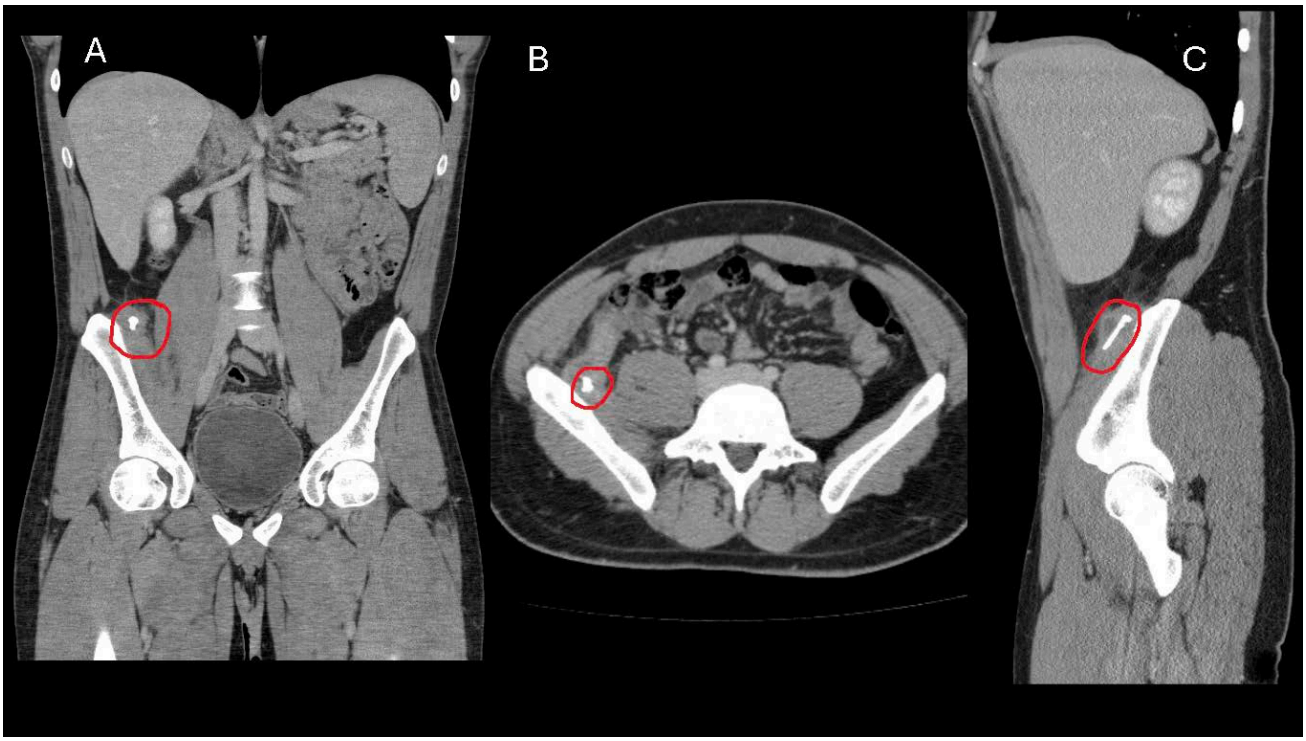

Figure 1. A, B, C: A non-contrast CT scan of the abdomen/pelvis in coronal view (A), transverse view (B) and right lateral view (C) demonstrating a linear metallic density within the right lower quadrant (outlined in red).

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