GOOD MORNING!

Case Presentation and Discussion on Intraabdominal Mass

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OMMC

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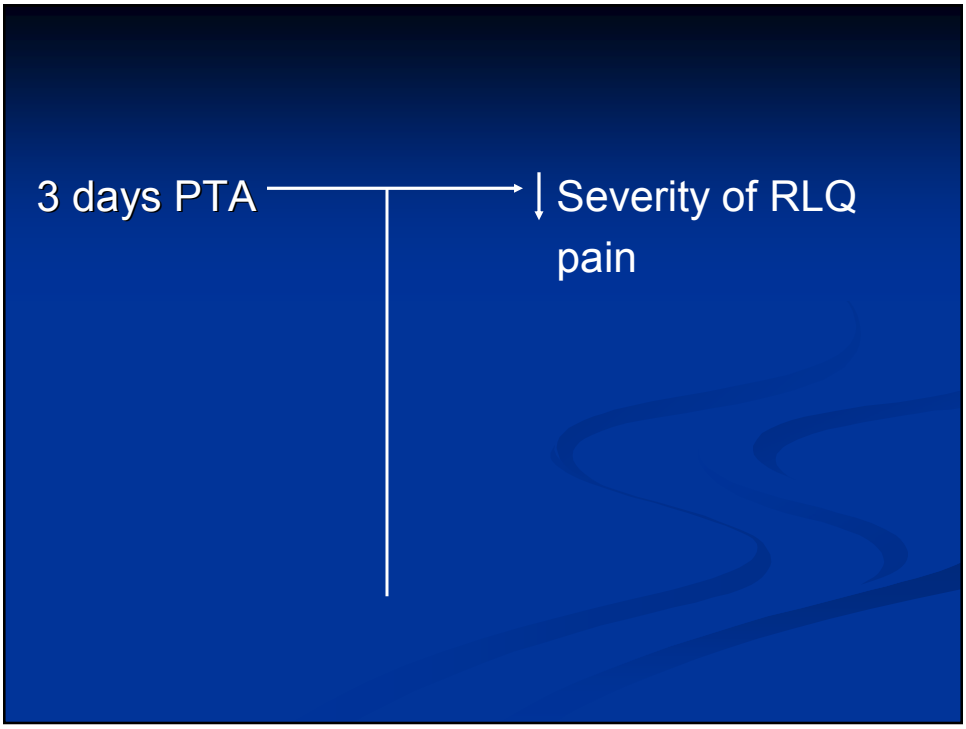
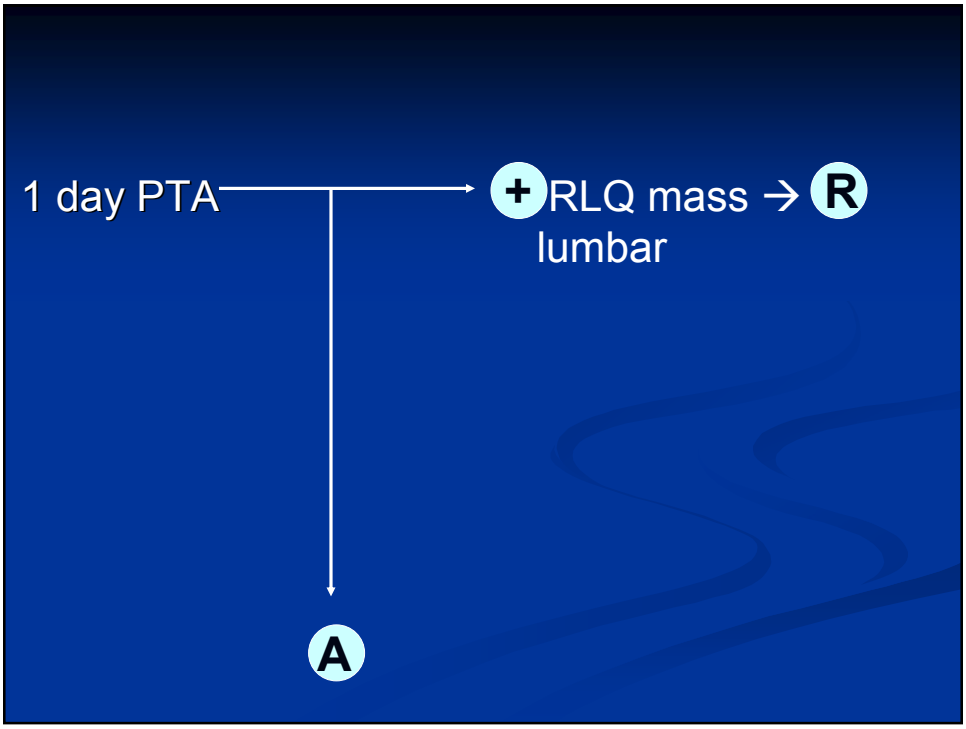
Chief Complaint:
Abdominal Mass

HPI

6 days PTA → RLQ pain,
Low grade fever
Anorexia, vomiting
Dysuria
diclofenac

5 days PTA → Persistence of RLQ pain→flank area,R
(+) chills


3 days PTA
Severity of RLQ pain

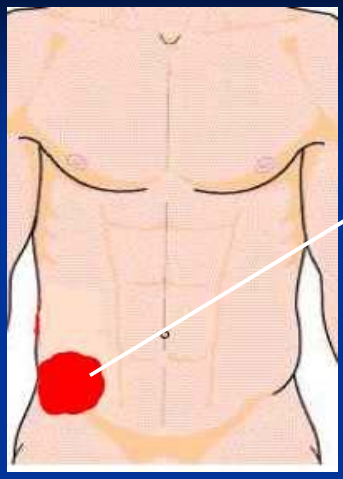

1 day PTA
+
RLQ mass → lumbar
R
A

PE: conscious, coherent, NICRD

BP 110/80 CR 96 RR 23

T 38.8º C

Abdomen: flat, NABS, mass 10 x 8cm, movable, w/ irregular margin, RLQ extending to the R flank, direct tenderness, RLQ, Kidney punch, R; Psoas sign



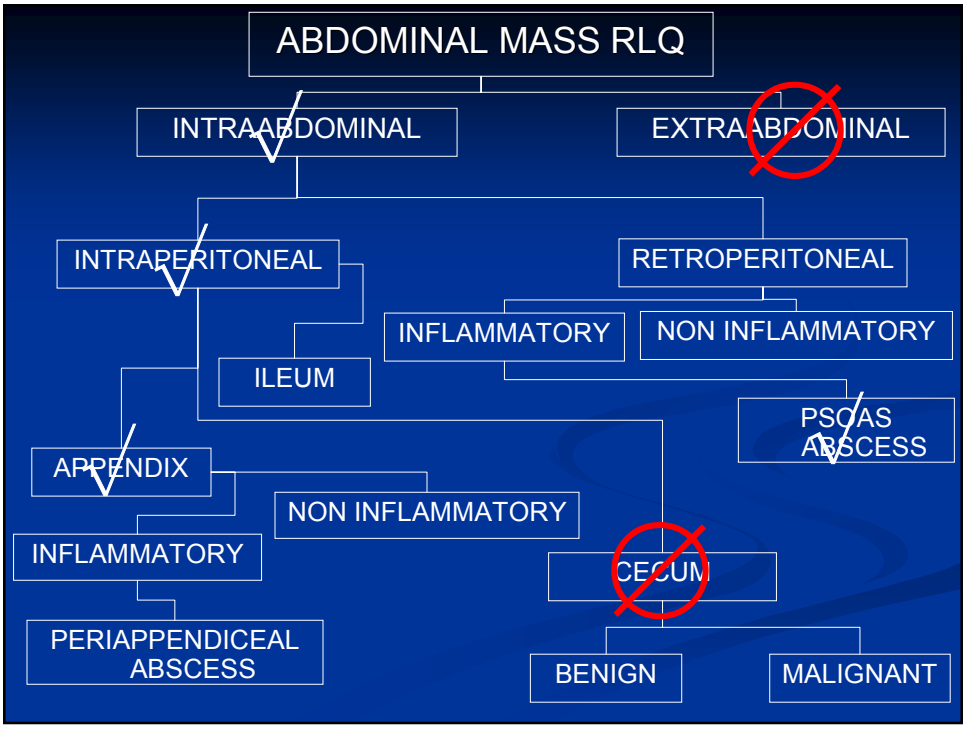
10 X 8 cm mass with irregular margin RLQ extending to the R lumbar

DRE

(-) mass, good sphincteric tone, palpable tender mass, Right anterior position, feces on tactating finger

SALIENT FEATURES

1. 35M
2. RLQ pain → RUQ → R flank
3. fever, chills
4. RLQ mass, extending to R flank
5. palpable tender extraluminal mass Right anterior position



PRETREATMENT DIAGNOSIS

1 o	PERIAPPENDICIAL ABCESS	80%	Surgical
2 o	PSOAS ABCESS	20%	Surgical

PARACLINICAL PROCEDURE

YES

1.) I am not certain of my primary diagnosis.

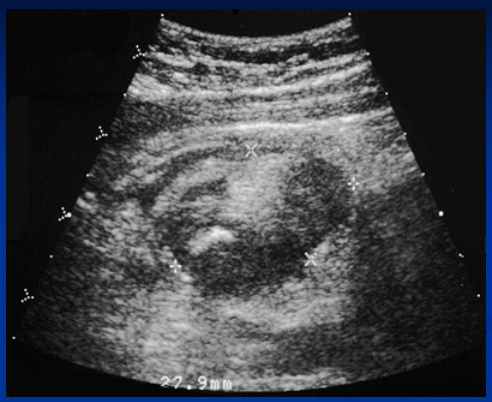
Paraclinical Procedures

	BENEFITS	RISK	COST	AVAILABILITY
	certainty	Radiation		
1.) PFA	Sen:40% Spc: 60%	+	P 150	+++
2.) UTZ	Sen:90% Spc: 95%	-	P 300	+++
3.) CT SCAN	Sen:95% Spc: 98%	++	P 4000	+

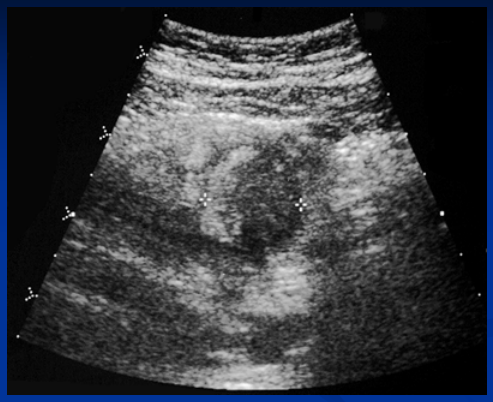
UTZ RESULT

GB Stone, N Liver, N R Kidney

\+ COMPLEX MASS 10 X 8cm RLQ



Transverse abdominal US demonstrates a noncompressible mixed echotexture mass in the RLQ consistent with appendiceal abscess



Longitudinal abdomen US demonstrates a noncompressible, mixed echotexture mass in the RLQ consistent with appendiceal abscess

PRETREATMENT DIAGNOSIS

1º	PERIAPPENDICIAL ABCESS	90%	SURGICAL
2º	Ruptured Diverticulitis	10%	MEDICAL/ SURGICAL

TREATMENT GOALS

1. Complete resolution of the appendiceal Abscess
2. Resolution of infection
3. Prevention of Complication

TREATMENT OPTIONS

	BENEFITS			RISK		COST	AVAILABILITY
	AP	Drainage	Recurrence	Wound Infection	Hospitalization		
Immediate Appendectomy and Drainage	√	√	None	31%[5] 3-7%[4]	8-9 days[5] (once)	P 7,000	+++
Interval Appendectomy	√	√	46%[1]	10%[5]	20-30 days[1] (twice)	P 15,000	+++
Percutaneous Drainage	-	-	37%	18%	7-8 Days (once)	P20,000	++

Preoperative preparation

- Psychological support
- Optimize patient's condition
- NPO for 6 hours
- Adequate antibiotic coverage
- Consent
- Preparation of OR materials

TREATMENT: OPERATIVE TECHNIQUE

- Patient supine under GA
- Asepsis/Anti-sepsis
- RLQ transverse incision carried down from skin to subcutaneous, fascial and peritoneal layers
- Formal exploration done
- Intraoperative findings noted

Upon opening up omentum was noted to be plastered to the right paracolic gutter. A 9 x 8 cm mass at the cecal area was noted. Adhesiolysis done which revealed a pocket of localized abcess walled of f by the peritoneum.

Loculations were broken which revealed 150 cc of foul-smelling yellowish green purulent with fecal material. No appendix was identified nor palpated. Posterior peritoneum necrotic. Cecum and terminal ileum were both intact.

Periappendiceal Abscess

- Adhesiolysis done
- Abscess evacuated
- Peritoneal Lavage
- Peritoneal Toilette
- Hemostasis
- Drain placed at the RLQ

- Correct instrument and sponge count
- Layer by layer closure
- Fascia with vicryl 0
- Partial wound closure done with silk 3-0

FINAL DIAGNOSIS:

Periappendiceal Abscess
S/P Open Drainage

Post Operative Care

- Analgesia
- Adequate IV antibiotics coverage
- Progression of Diet as needed
- Early ambulation
- Monitor drain output
- Daily wound care

Prevention and Health

- Anticipate complications
  - Adequate hemostasis
  - Avoid Recurrence
  - Avoid infection
  - Avoid dehiscence

Prevention and Health

- Alive patient
- Patient's health problem resolved
- No complaint
- No disability
- No medical suit
- Satisfied patient

Discussion on Acute Appendicitis and Periappendiceal Abscess

- **Etiology**
  Appendicitis is most common in late childhood and early 20s, but may occur in any age group. While more common in males in the teenage years, the sex incidence equalizes by the mid 30s.

- Appendicitis is caused by obstruction of the appendiceal lumen.
- The causes of the obstruction include
  - lymphoid hyperplasia (IBD or infections)
  - fecal stasis and fecaliths (more common in elderly patients),
  - parasites foreign bodies and neoplasms

- **Pathology:**
  - Following obstruction of the lumen, mucus accumulates causing distention of the mucosa. This predisposes to bacterial infection due to compromised vascularity and stasis.

- A vicious cycle begins where increasing pressure causes further occlusion leading to still more distention. Eventually the poor blood supply leads to necrosis and eventually perforation.

- Perforation occurs in roughly 20% of cases and may lead to a focal walled-off abscess or generalized peritonitis.

- **Clinical Details:** A diagnosis of appendicitis usually can be made on the basis of history and physical examination.
- Symptoms of appendicitis may take 4-48 hours to develop.
- lack of appetite and periumbilical pain followed by nausea, RLQ pain, and vomiting occurs in 50-60% of patients.

- **Staging:** Appendicitis usually has 3 stages.
  - Edematous stage
    - Appendicitis may have spontaneous regression or may evolve to the second stage.

  - Purulent (phlegmonous) stage
    - Spontaneous regression rarely occurs.
    - Appendicitis usually evolves beyond perforation and rupture.
    - Peritonitis may be possible.

- Gangrenous stage
  - Spontaneous regression never occurs.
  - Peritonitis is present.

- Phlegmonous appendicitis or abscess: An inflamed or perforated appendix can be walled off by the adjacent greater omentum or small bowel loops and phlegmonous appendicitis or focal abscess occurs.

Periappendiceal Abscess

- Frequent complication of neglected AP
- 2-12%
- Management remains to be a point of controversy and evoked debate among surgeons

Management of Periappendiceal Abscess

- Immediate Appendectomy
  - Premise: if not drained sooner may cause generalized peritonitis
  - SSI:15-35% or as low as 3-7%
  - Hospital stay: 9 days
  - Low cost
  - No risk of Recurrence
  - No need for follow up

- Interval Appendectomy
  - Premise: abscess formation- defense mechanism, infection may disseminate during manipulation, trauma and damage(fistula)
  - RR: 46% - 70%
  - SSI: 10%
  - Hospital stay: 20-30 days
  - Cost: high
  - Poor follow up: 25%

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THANK YOU!