CASE REPORT

A differential for right iliac fossa pain and the importance of consenting properly

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SUMMARY

A 39-year-old man presented with a 2-day history of central abdominal pain which had subsequently localised to the right iliac fossa, with clinical signs of tenderness with guarding in the right iliac fossa. With these classical signs, he was diagnosed with probable appendicitis and a laparoscopy with a view to appendicectomy was arranged. At laparoscopy, a tortured, dusky-looking ischaemic greater omentum was found and resected. When performing laparoscopy for suspected appendicitis, it is important to look for other unexpected pathology and treat it as the situation requires, if the appendix is normal at the time of laparoscopy. The possibility of other pathologies to account for the patient's symptoms must not be overlooked.

BACKGROUND

We felt that this case serves as an important reminder that no matter how classical the presentation, there could be an unusual pathology causing the patient's symptoms, and therefore this should always be discussed with the patient when gaining their consent for a laparoscopy with a view to appendicectomy.

CASE PRESENTATION

A normally healthy 39-year-old man presented with a 2-day history of central abdominal pain which had subsequently localised to the right iliac fossa. On examination, he was tender in the right iliac fossa with rebound and guarding locally.

DIFFERENTIAL DIAGNOSIS

The top differential diagnosis was appendicitis.

TREATMENT

The patient gave consent for a laparoscopy with a view to appendicectomy for a clinical diagnosis of appendicitis. Informed consent was obtained and the risk of possible conversion to open procedure, and a possible bowel resection, if required, was discussed. Our routine explanations of the rare outcomes possible include stoma formation, and in women, removal of ovarian cyst, oophorectomy and salpingectomy.

The patient underwent laparoscopy, which revealed a normal appendix but a tortured, ischaemic greater omentum. This was successfully removed laparoscopically (figure 1).

OUTCOME AND FOLLOW-UP

The patient's pain and tenderness settled and he was discharged 2 days postoperatively. However, he

continued vomiting and was readmitted the day after discharge. He underwent further laparoscopy and washout at 1 week after the original operation; no intra-abdominal complications were found. He made an excellent recovery after this operation and returned to work 2 weeks later.

DISCUSSION

There have been previous case reports describing the diagnosis of tortured omentum on CT imaging, and subsequent laparoscopic removal of the infarcted omentum.¹ In many of these reports, the abdominal pain which the patient presented with was non-specific. However, in many cases of suspected appendicitis presenting with classical symptoms and signs, the patient will not have a preoperative CT to confirm the diagnosis, rather proceeding directly to laparoscopy. Primary omental torsion accounts for 0.1% of laparotomies performed for acute appendicitis in children,² and it is likely that the figure is similar in adults, making it a rare pathology. In our patient, while CT would have confirmed the diagnosis, he would still have required an operation to treat the problem.

It could be considered whether to perform any imaging, CT or ultrasound being the most common modalities, prior to laparoscopy. This would potentially remove or reduce uncertainty regarding the diagnosis. The patient would need to be counselled as to radiation risks (for CT) and the possibility that waiting for imaging could delay any surgical procedure that may eventually be required. It would need to be explained that imaging has no therapeutic value, and patients may therefore prefer to proceed straight to surgery. The efficiency of the combined diagnostic and therapeutic value

Figure 1 The resected omentum. The pedicle, about which it had torted, is on the right of the picture.

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Learning points

- ▶ When a patient gives consent for laparoscopic appendectomy, always mention the possibility that the appendix is not the problem; counsel the patient as to some of the possible surgical outcomes, and warn the patient that any other suitable procedure (with their permission) could be carried out.
- ▶ Consider the risks and benefits of imaging in order to narrow the differential diagnosis before surgery. Patients may equally prefer to have a single procedure that is both diagnostic and therapeutic.

of laparoscopy may outweigh the potential benefits of preoperative imaging, especially in cases such as ours, where the presentation matched the classical symptoms and signs of appendicitis.

In female patients, where the probability of the pathology underlying right iliac fossa pain not being appendicitis is proportionally higher than in male patients, ultrasound is often used as a radiation-free method of imaging. Equally, when signs and symptoms are very strongly suggestive of appendicitis, a patient may still elect to undergo a procedure which is simultaneously diagnostic and therapeutic.

Contributors SYWG and PK were directly involved in the patient's care. SYWG wrote the article; PK gave advice and edited the manuscript before submission.

Competing interests None.

Patient consent Obtained.

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