Figure 1 Contrast-enhanced abdominal computed tomography, showing cecal wall thickening and an ill-defined pericecal mass lesion with marginal enhancement (arrow).

Figure 2 Colonoscopic image showing mucosal bulging, edema, and hyperemia at the appendiceal orifice, with a spontaneous discharge of pus.

A 65-year-old woman presented with intermittent right lower quadrant pain that had persisted for more than 2 weeks. The pain was described as cramping, and was unrelated to food intake or defecation. Five days before admission, a tender mass had become palpable over the right lower quadrant. There had been no fever episodes before she came to the hospital. The physical examination was unremarkable except for a palpable, tender mass over the ileocecal area. The laboratory data were within reference ranges, except for a white blood cell count of $11\,700/\text{mm}^3$ (normal: $4\,500\text{--}10\,000/\text{mm}^3$). Tumor markers, including carcinoembryonic antigen, CA199, and CA125, were normal. Abdominal ultrasonography revealed a heterogeneous mass lesion over the right lower quadrant. Contrast-enhanced computed tomography (CT) showed cecal wall thickening and an ill-defined pericecal mass lesion with marginal enhancement (Figure 1). Because a cecal tumor could not be excluded, colonoscopy was performed, demonstrating mucosal bulging, edema, and hyperemia, with a spontaneous discharge of pus at the appendiceal orifice (Figure 2). A diagnosis of appendicitis with abscess formation was made. Conservative treatment with intravenous antibiotics was administered, and the abdominal mass was not palpable 2 weeks later. The clinical course was uneventful, and the patient remained asymptomatic during the ensuing 3-month follow-up period.

Acute appendicitis is the clinical diagnosis of an inflammatory reaction in the appendix, relying on a detailed history and physical examination. However, up to one-third of patients suspected of having acute appendicitis may present with atypical clinical findings [1]. In addition, 2–6% of the patients may present with a palpable mass [2]. With a concern about possible cecal malignancy, surgeons may be faced with a dilemma when deciding on the appropriate form of management. CT and transabdominal ultrasonography have been reported to demonstrate excellent accuracy in the diagnosis of suspected appendicitis [3]; however, cecal carcinoma may present as a pericecal inflammatory mass, due to a perforation [4]. Colonoscopy therefore appears to be helpful for diagnosing appendicitis when imaging studies are nondiagnostic. With regard to the treatment of appendicitis with abscess formation, a conservative approach with routine follow-up has been recommended [5]. Appendectomy is suggested only when symptoms recur.

Endoscopy_UCTN_Code_CCL_1AD_2AG
Endoscopy_UCTN_Code_CCL_1AD_2AD

S. L. Yan¹, Y. T. Liu¹, D. A. Chou²

¹ Division of Gastroenterology, Dept. of Internal Medicine, Show Chwan Memorial Hospital, Changhua, Taiwan

² Division of General Surgery, Dept. of Surgery, Show Chwan Memorial Hospital, Changhua, Taiwan.

References

- Berry JJ, Malt RA. Appendicitis near its centenary. *Ann Surg* 1984; 200: 567–575
- Hoffmann J. Contemporary management of appendiceal mass. *Br J Surg* 1993; 80: 1350
- Horton MD, Counter SF, Florence MG, Hart MJ. A prospective trial of computed tomography and ultrasonography for diagnosing appendicitis in the atypical patient. *Am J Surg* 2000; 179: 379–381
- Poon RT, Chu KW. Inflammatory cecal masses in patients presenting with appendicitis. *World J Surg* 1999; 23: 713–716
- Tingstedt B, Bexe-Lindskog E, Ekelund M, Andersson R. Management of appendiceal masses. *Eur J Surg* 2002; 168: 579–582

Corresponding author

D. A. Chou, M. D.

Division of General Surgery,
Dept. of Surgery
Show Chwan Memorial Hospital
542 Chung-Shan Road, Section 1
Changhua 500
Taiwan

Fax: +886-4-7233190

Email: yslscmc@hotmail.com

DOI: 10.1055/s-2006-944919