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RESEARCH ARTICLE

APPENDICULAR LUMP PRESENTING AS A PELVIC MASS-AN INTERESTING CASE REPORT

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ABSTRACT

Introduction: There can be many differential diagnosis of abdomino pelvic mass in young girls. Germ cell ovarian tumors which are the common ovarian malignancy of young age, which may present as acute abdomen. Likewise other surgical conditions may also present as large pelvic masses. **Case:** We herewith report a case of 20 year old unmarried female who presented with acute abdomen and a large abdominopelvic mass. Ovarian torsion was ruled out by doppler but high suspicion of ovarian malignancy was there as CA-125 was raised (371.4IU/ml). CECT findings were suggested of a large mass with undefined ovary margin. She developed jaundice and repeat MRI was done which showed large mass with bowel perforation with gas under diaphragm. Exploratory laprotomy was done by surgeons and to everyone's surprise, patient turned out to be a case of appendicular lump which had perforated. Patient improved in postoperative period. **Conclusion:** In cases of large abdominopelvic masses, surgical causes should always be kept as differential as even advanced imaging modalities may not be diagnostic. Multidisciplinary approach may be beneficial.

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INTRODUCTION

An adnexal mass is a common gynecologic problem. Pathology in this area may also arise from the uterus, bowel, retroperitoneum, or metastatic disease from another site, such as the gastrointestinal tract or breast. We report a case of a patient who presented with acute pain lower abdomen, which was initially attributed to a pelvic tumor. However, operative findings revealed an appendiceal mass.

Case Report: A 20-year old unmarried female presented to the causality with acute pain abdomen and vomiting since 2 days. There was history of fever one week back and widal was positive. The pain had started at umbilicus and was more towards right side. Pain was stabbing in nature and moderate to severe intensity. Her last menstrual period was 7 days back. There was no history of menstrual problems in the past. No history of previous medical or surgical problem either. On examination there was a mass corresponding to 24 weeks uterine size with margins not well defined. There was guarding and tenderness all over and the abdomen felt warm all over. On local examination, no abnormality was detected. Per rectal examination was refused by the patient. Her laboratory findings were HB 6.2, TLC 44800 and platelets 3.38 lac with normal liver and kidney function test. A USG doppler was done which ruled out ovarian torsion. Tumor markers were within normal limit except CA 125 which was raised (374.5). Ultrasound findings were suggestive of large pelvic mass with origin not defined. CECT abdomen was suggestive of large heterogeneously enhancing mass of 14x10x13 cms in peritoneal cavity with high vascularity at periphery. Mass was causing displacement of small and large bowel with planes of ovary not well defined. Raised CA 125 and CT abdomen raised suspicion of mass being ovarian cancer. On second day of admission, patient deteriorated clinically and metabolically. She became severely icteric. Her laboratory findings were TLC 74,000, T.bil 20.7, D.bil 11.1, blood urea 146 and S.creat 2.3, hematocrit showing falling trend and deranged coagulation profile (APTT 52.3, FDP 1800). MRCP was done which was normal and MRI was done which revealed gas under diaphragm with suspected perforation peritonitis. Hence, the patient was taken for emergency laparotomy. To everyone's surprise, it revealed a burst appendicular mass with tubes and ovaries buried in inflamed mass. Appendicectomy was done. Patient made an unremarkable recovery.

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DISCUSSION

There has been no recent discussion in gynaecologic literature of appendicular mass in a young woman presenting as gynaecological disease like this. It is possible for appendicitis to perforate into ovary and producing a presentation indistinguishable from other causes. Marked inflammatory changes of the surrounding mesentery or omentum and abnormal fluid collection or even an abscess formation in the right lower abdomen or pelvic cavity may be clues to the diagnosis of perforated appendicitis in children (Park, 2011). Jinxing Yu *et al*. in a comprehensive CT scan essay described uncommon mimics of appendicitis which can present as gynaecologic diseases like ovarian vein thrombosis, dermoid, necrotic uterine leiomyoma, ovarian torsion, endometriosis and ruptured ectopic pregnancy (Rafi, Junaid, 2009). Gastrointestinal processes such as diverticulitis and appendicial abscesses can present as pelvic mass but presentation as suprapubic mass is unusual (Yu *et al*., 2005). This rare presentation of appendicular mass alerts gynaecologists and surgeons for the need of lateral thinking and multidisciplinary input.

Conclusion

In females, pelvic mass and pain is considered as gynaecologic symptom and emphasis is to rule out common causes like ovarian torsion and ovarian masses.

Appendicitis although being an important differential diagnosis is often missed. In this case, it was an unusual presentation for an appendicular mass, highlighting the importance for gynaecologists for lateral thinking when seeing pelvic mass patients, especially in young females with low chances of malignancy. Our case presentation highlights the fact that pelvic mass presentation can be misleading, not always gynaecologic therefore multidisciplinary approach must be inevitable.

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