

Retroperitoneal Perforation of the Appendix Presenting as Right Thigh Abscess, A Case Report.

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Abstract

A case of retroperitoneal perforation of the appendix presenting with a thigh abscess is described.

Keywords: Complicated acute appendicitis, retroperitoneal perforation, retroperitoneal abscess, Thigh abscess

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Case Report

A 45-year man presented with a 7-day history of right loin pain and a 5-day history on the lateral aspect of right thigh pain. He was pyrexial at 38°C, with a pulse of 100 beats per minute and blood pressure of 110/70 mmHg, with slight tenderness in the right loin and normal examination findings of the right lower limb¹. Plain X-ray showed gas in the soft tissue of the gluteal region and lateral aspect of the right thigh. There was a collection of fluid in the right side of the abdomen and pelvis with inflammatory changes. Laparotomy revealed no free intraperitoneal pus. A loop of distal ileum was adherent to right side wall of the pelvis with complete obstruction at this point. This was relieved and there was a retroperitoneal abscess extending from above the upper pole of the right kidney down to the presacral space and to the right side of the pelvis at the site where the loop of the ileum was adherent¹⁻². The right side of the colon was mobilized to drain the pus. The appendix was found amputated spontaneously about 1 cm from its base and was secured by a tie.

Discussion

The position of the appendix is influenced by the changes in position and shape of the cecum undergoes during development. The ascending colon is normally retroperitoneal in position and the cecum is usually intraperitoneal.³ If the cecum does not fully descend, the appendix lies retroperitoneally behind the cecum in front of the right kidney. In the latter cases, the appendix may be intraperitoneal, or retroperitoneal with or without a paracecal fossa formed by peritoneum⁴⁻⁵. The clinical diagnosis of retroperitoneal abscess is often delayed or missed because of the insidious onset of symptoms and the paucity of localizing signs⁶⁻⁷. The route of spread can be broadly separated into two groups. Direct soft tissue extension of infection down the thigh almost always originates from the rectum below the peritoneal reflection. The second route of extension of infection into the thigh is through naturally occurring defects in the abdominal wall⁸⁻⁹. The diagnosis of a thigh abscess as such is not difficult, because it usually presents with the typical signs and symptoms of inflammation and gas that are reliably noted on X-ray of the soft tissue¹⁰⁻¹¹. Both the intra-abdominal process and the thigh abscess must be treated. In literature, when cases of thigh abscesses, secondary to intra-abdominal sepsis, were managed without attention to the underlying

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etiologic process, such as by local thigh drainage plus antibiotics, the mortality was 93%. If some form of definitive therapy was added to the local management of the thigh abscess, such as appendectomy, stoma, or debridement, the mortality was 34%. However, the overall mortality rate was 53%.¹²⁻¹³ A thigh incision is mandatory to allow direct drainage of the pus and examination of the

viability of the fascia and muscle. The location of the thigh incision is best determined by clinical examination assisted by CT scan findings that can accurately localize the collection and the gas distribution in the soft tissue. Pott's disease should be excluded and gluteal abscess in thigh below the inguinal ligament¹⁴.

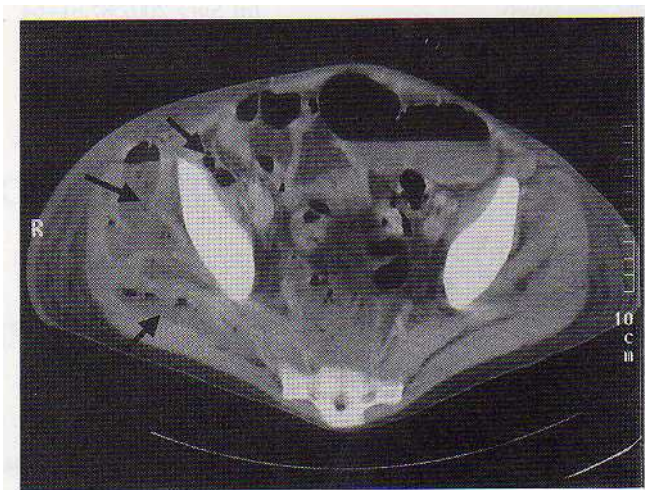


Fig. 1 CT scan showing free gas and collections on either side of the right iliac bone (arrows) and distended small bowel loops.



Fig. 2 CT scan showing gas and collection on the lateral aspect of the right thigh (arrow).

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