Appendicitis with a palpable mass

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

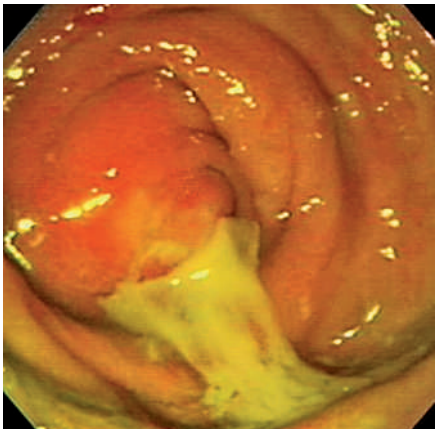

Figure **2** Colonoscopic image showing mucosal bulging, edema, and hyperemia at the appendiceal orifice, with a spontaneous discharge of pus.

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 11700/mm^3 (normal: 4500 – 10000/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.

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