- Thirumalai
- 13 year old boy
- studying 7th std
- coming from Ponneri,
- belonging to socio economic class IV came to the OP

CHIEF COMPLAINTS

- Pain in the right lower abdomen for past 4 days

PRESENTING ILLNESS

- The patient was apparently normal 4 days back after which he developed
- **pain** : in right lower abdomen
  for 4 days,acute in onset
  colicky in character
  intermittent in nature with symptomless interval,started in the umbilical region and progressed towards right iliac fossa
  moderate to severe intensity
  aggravated by coughing and relieved by rest.

- **H/O Vomiting:** for 3 days

3-4 episodes/day-immediately after eating

contains food particles

non projectile,not bile stained,not blood stained,not foul smelling

relieved by antiemetics

- **H/O FEVER:** for past 3 days,
  sudden in onset,
  low grade fever,continuous,
  not associated with chills and rigors,
  no h/o evening rise of temperature,
  not associated with night sweats,convulsions,altered sensorium,
  relieved by medication.
- He is currently afebrile

- **H/O loss of appetite for past 3 days**
- No H/O cough with expectoration
- No H/O Loss of weight
- No H/O Abdominal distension
- No H/O Constipation, Diarrhoea
- No H/O Bleeding per rectum, blood in stools
- No H/O Painful, increased frequency of urination, hematuria
- No H/O Jaundice, bone pain
- No H/O headache,blurring of vision

PAST HISTORY

- No H/O similar complaints in the past
- No H/O Diabetes mellitus, Hypertension, Bronchial asthma, Epilepsy,jaundice
- NO H/O previous surgery and hospitalisation
- No H/O Blood transfusion

PERSONAL HISTORY

- Consumes non vegetarian diet
- Non smoker,not an alcoholic
- Normal bowel and bladder habits

- **ALLERGIC HISTORY**:
  No H/O Allergy to drugs or food.

- **FAMILY HISTORY**:
  No significant family history

GENERAL EXAMINATION

- Patient is conscious, oriented,
- Moderately built and nourished
- No Pallor
- No icterus
- No cyanosis
- No Clubbing
- No pedal edema
- No generalized lymphadenopathy
- Hydration:fair
- Afebrile

VITALS

- **Pulse rate**: 86/min, regular in rhythm, normal in volume, no specific character, no radio-radial or radio-femoral delay, felt in all palpable peripheral vessels
- **Respiratory rate**: 18/min,abdomino thoracic
- **Blood pressure**: 110/70 mm Hg, in right upper arm in sitting posture

LOCAL EXAMINATION OF ABDOMEN

- After getting consent from patient and explaining procedure to patient,he is exposed from nipples to mid thigh,and examined on both sides under bright light in **supine position** with male attender by the side.

ABDOMEN EXAMINATION

- **INSPECTION:**
- Abdomen – Normal in shape, umbilicus in midline and inverted
- All quadrants move equally with respiration
- No scar, sinus, dilated veins, visible pulsation
- No fullness, visible gastric/intestinal peristalsis
- Flanks free, hernial orifices free, external genitalia normal
- Renal angle free
- Left supraclavicular fossa– normal

PALPATION

- **Patient in supine position with hips and knees semi flexed**
- Not warm, tenderness at ***McBurney's point, guarding present***
- A mass is felt in the *right iliac* fossa of size 3*3 cm, **hemispherical** in shape
- Extends-medially 2cm from **umbilicus**
  laterally 3cm from **anterior superior iliac spine**
  superiorly 5cm from **right costal margin at midclavicular line**
  inferiorly 4cm from **pubic symphysis**
- **Firm** in consistency, with irregular surface,with ill defined borders,**immobile,**no pulsation,normal skin

- No organomegaly
- Left supraclavicular region –no nodes palpable
- Hernial orifices– free
- External genitalia–normal
- **Carnett's test–negative**
- Renal angle –no tenderness
- Per rectal examination to be done

- **PERCUSSION:**

  Impaired resonance over the mass
  other quadrants–tympanic resonance

  Liver span – normal

- **AUSCULTATION:**

  Normal bowel sounds heard

OTHER SYSTEM EXAMINATION

- **CVS**- S1, S2 heard, no murmur
- **RS**- Normal vesicular breath sounds heard
- **CNS**- No focal neurological deficit
- SPINE and CRANIUM-normal

DIAGNOSIS

- A case of Right iliac fossa mass probably **Appendicular mass.**

INVESTIGATIONS

- **Baseline :**
- Blood inv- Hemoglobin, Total count, Differential count, ESR, Blood grouping and typing

  Blood sugar, Urea, Serum creatinine, Electrolytes
- Urine- albumin, sugar, deposits
- Stool- occult blood
- Xray Chest, ECG

SPECIFIC INVESTIGATIONS

- Ultrasound abdomen
- Xray abdomen erect
- CT scan abdomen
- Mantoux, Sputum for acid fast bacilli
- Tumour markers- CEA, Alpha fetoprotein
- Colonoscopy

TREATMENT

APPENDICULAR MASS:

1. **Ochsner and Sherren regimen**
   - A-aspiration with ryles tube
   - B-bowel care(do not give purgatives)
   - C-charts
   - D-drugs
   - E-exploratory laparotomy not to be done
   - F-fluids(nil oral for few days)

2. **interval appendicectomy after 6 weeks**