Caecal diverticulitis mimicking acute appendicitis

Akut apandisit benzeri çekal divertikülit

To the Editor

Solitary caecal diverticulitis is a rare cause of abdominal pain in Western patients and is more common in the Oriental population (1). In this paper, we describe a patient who was thought to have acute appendicitis or pelvic inflammatory disease preoperatively. At operation, inflamed solitary caecal diverticulum was detected.

A 56-year-old man was admitted to our hospital with two-day history of abdominal pain in the right lower quadrant. He had no nausea or vomiting. His past medical history was unremarkable. Physical examination revealed a temperature of 37.8°C, heart rate - 80 beats/min, and blood pressure of 128/75 mmHg. Physical examination was unremarkable other than right iliac fossa tenderness and rebound. Rectal digital examination was normal. Apart from the increase in WBC to 12.9 and CRP to 42, laboratory investigations including urinalysis were within normal limits. Computed tomography (CT) scan showed a tumor in the cecum surrounded by inflammatory plate (Figure 1). At operation, there was a small amount of clear free fluid. The appendix was normal, as was the terminal ileum. There was a solitary diverticulum projecting from the medial aspect of the caecum and forming an inflammatory mass with the omentum (Figure 2). Diverticulectomy and incidental appendectomy were performed. His postoperative course was uneventful, and he was discharged home after a week of admission.

The true prevalence of colonic diverticulosis is difficult to ascertain, however, it appears that about 8.5% of people in Western countries are afflicted (2). In Western countries, 85% of all diverticula occur in the descending and sigmoid colon. The reported frequency of caecal diverticulum in the literature has been estimated to be 1 in 300 appendicectomies (3). Nausea and vomiting are less frequent, abdominal pain typically starts and remains in the right iliac fossa rather than beginning in the central abdomen and shifting to the right iliac fossa. Right iliac fossa tenderness is not usually as marked as in acute appendicitis. Intravenous contrast-enhanced CT scanning can accurately demonstrate the features of acute right-sided diverticulitis (4). The features of caecal diverticulum include colonic wall thickening, pericolic fat infiltration, associated abscess formation, and extraluminal air denoting perforation. In our case, CT indicated diverticulum without abscess formation in the caecal wall. In patients with preoperative di-

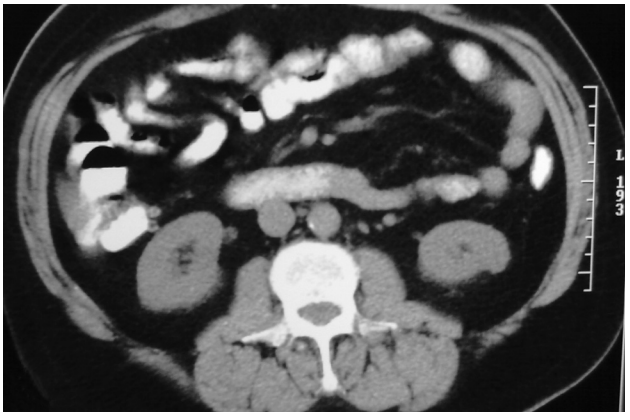

Figure 1. 2-cm long inflamed caecal diverticulitis resembling acute appendicitis on CT images

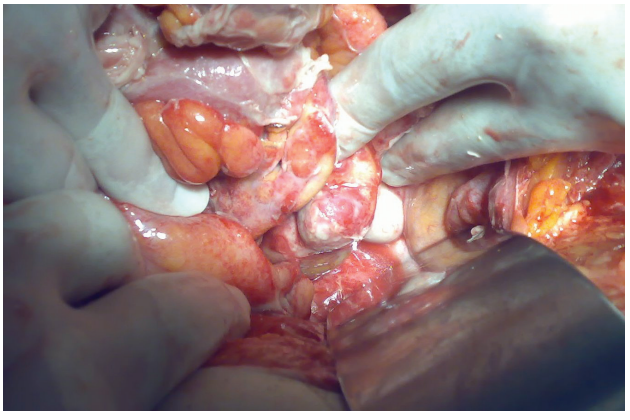

Figure 2. Intraoperative macroscopic view of the inflamed caecal diverticulum

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agnosis of cecal diverticulitis without signs of peritonitis, medical treatment with antibiotics may be sufficient (4). There is no standard surgical procedure for the treatment of inflamed solitary caecal diverticulum. Surgical treatment varies from diverticulectomy, ileocaecal resection, and standard right hemicolectomy (3).

In conclusion, caecal diverticulitis may mimic appendicitis, hence, it should be considered in the differential diagnosis of right iliac fossa pain.

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An unexpected cause of acute colonic obstruction: globe vesicale

Akut kolon obstrüksiyonunun beklenmedik bir nedeni: globe vesicale

To the Editor

The most common causes of colonic obstruction in adults are malign tumors, diverticular disease, and volvulus (1). Acute colonic obstruction due to bladder distention (globe vesicale) is highly rare. To the best of our knowledge, just few cases have been reported in the literature (2, 3). Here, we present a case of acute colonic obstruction associated with globe vesicale and its treatment with a urinary catheter in a simple and timely fashion.

A 75-year-old male patient was hospitalized in the neurology clinic with a diagnosis of cerebrovascular disease as a sequel. He was consulted in our clinic for the complaints of abdominal distention, nausea, inability to pass intestinal gas and constipation, as well as severe abdominal pain for 3 days. The physical examination revealed abdominal sensitivity with palpation, distention, dullness with a downward opening, and tenderness. The rectal examination was normal. A plain X-ray image showed widespread air-fluid levels in the colon and small intestines (Figure 1). The laboratory findings were within normal limits. Based on

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