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Letter to the Editor

ACUTE GANGRENE PERFORATED APPENDICITIS WITH COMPLICATED ISCHIO-RECTAL ABSCESS AND SPONTANEOUS DRAINAGE THROUGH THE RECTUM

Apendicite aguda gangrenosa perfurada complicada com abscesso ísquio-retal e drenagem espontânea pelo reto

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INTRODUCTION

The term "appendicitis" is attributed to the surgeon-anatomist Reginald Fitz in 1861[3]. Het was also the first to propose immediate surgical treatment, consisting of complete removal of the inflamed appendix as early as possible[1]. Date of the 16th century the first mention of an appendix bordered by a blackish pus which was called "perityphlitis"[2].

Acute infection is the most frequent disease of the vermiform appendix and it is the main cause of emergency abdominal surgery. It was responsible for high levels of mortality in the past, killing more people than many other diseases combined. At present, despite all the progress of medicine and surgery in particular, still has a mortality rate of 2% when not treated[3].

CASE REPORT

Adolescent of 12 years, student, black, looked for medical attention complaining of abdominal pain started about 12 days. Reported episodes of diarrhea, nausea, pain and vomits. Physical examination showed signs of dehydration and fever (38° C). Abdominal examination had weak peristalsis, tense, painful on superficial and deep palpation with signs of diffuse peritonitis and presence of a palpable mass in right iliac fossa. No other changes. Laboratory tests showed a hematocrit of 30%, 10 hemoglobin, red cell count of 3.64, a leukocyte count of 20,300 (neutrophils: 85, rods 6, eosinophils: 0, lymphocytes: 4, monocytes, 5). Radiological examination showed air-fluid levels in small intestine and colon and infalmation of preperitoneal fat (Figure 1).

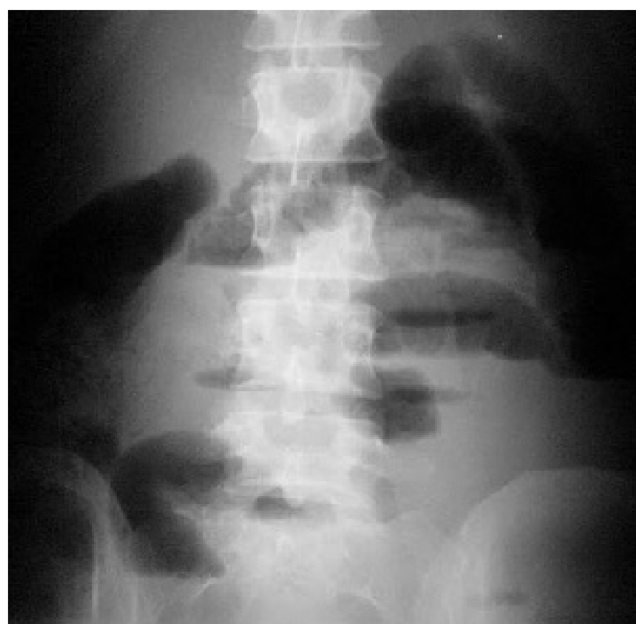

FIGURE 1 - Abdominal radiograph showing peritonitis

He was conducted to laparotomy through median infraumbilical incision. The examination of the cavity showed the presence of a large pelvic abscess associated with free pus and an ischio-rectal abscess. The vermiform appendix showed areas of gangrene and perforation associated with a serous injury in the terminal jejunum suggesting ischemia. A classical appendectomy was done associated to copious irrigation of the peritoneal cavity with warm saline solution and also at the topography were was found the ischio-rectal abscess. During the operation was observed a spontaneous leakage of pus through the anus. It was then realized a proctologic examination that showed a possible fistula between the ischio-rectal abscess and rectum

being responsible for the drainage of purulent material. Was chosen to handle the case making sigmoidostomy. The patient had good clinical outcome and colostomy was functioning from day 3 after surgery with no signs of wound infection, good diet acceptance on day 2. Antibiotic therapy was based on gentamicin and metronidazole for six days. He was discharged in good clinical condition.

On fifth day post-discharge, the patient returned to the emergency room with abdominal pain and bloating associated with persistent. Computed tomography of the abdomen and pelvis revealed reformation of pelvic abscess. It was then submitted to spinal anesthesia and placed in the lithotomy position. Was done a new digital rectal examination at the previously identified fistulous orifice, quickly draining large amounts of pus. He remained hospitalized for nine days without complications, using ampicillin, metronidazole and gentamicin suspended on the 7th day of hospitalization. After eight months the loop colostomy was returned to normal transit without further complications.

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