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Case Report

Endoscopic Appendectomy in a Case of Retroverted Appendix

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Case

A 65-year old woman presented with dull abdominal pain localized in right lower quadrant, the moderate intensity irradiated to the right leg, for 4 years old duration that had gradually worsened in the past 4 months. She denies fever, weight loss, hematochezia, melena with any alterations of the intestinal habits. She had surgical history of appendectomy 9 years ago during right Oophorectomy. Physical examination revealed a soft, non-distended abdomen with mild right lower quadrant tenderness with normal bowel sounds, no abdominal mass was palpable. The routine blood test was normal. Under colonoscopy showed a 3 cm long, polypoid lesion projecting from the orifice of the appendix (APP), the surface of the lesion was smooth (Figure 1),



Figure 1. Polypoid lesion projecting from the orifice of the appendix.

we could not evidence any alterations of the mucosa besides the use of chromoendoscopy with Indigo carmine, we took several biopsies in order to reveal any underlying condition, which showed inflammation. After discussions with the patient and a consulting surgeon, we decided to practice endoscopic appendectomy under laparoscopy surveillance. An endoloop was placed around the base of the polypoid lesion and it was transected by using polypectomy snare above endoloop with only cut setting (Figures 2,3).



Figure 2. An endoloop was placed around the base of the polypoid lesion and it was transected by using polypectomy snare above endoloop with only cut setting.

Then we used methylene blue and no leak was revealed. The length of the lesion was 3 cm. Histopathologic evaluation confirmed that it was an inverted appendiceal with slight inflammation. The patient was relieved of any abdominal

nal pain and 10 months later, colonoscopy revealed a normal appendiceal orifice (Figure 4).



Figure 3. Look the remnant after appendectomy.

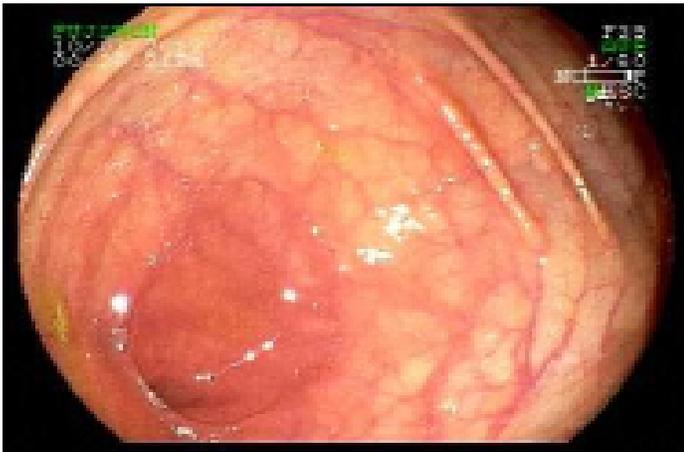


Figure 4. Appearance of the orifice of the appendix, after 10 months of endoscopic appendectomy.

Discussion

Intussusception of the appendix (APP) is a rare condition with an estimated incidence of 0.01% [1]. There are 4 categories of intussusception according to its location : 1. Enteroenteric, confined to the small bowel only; 2. Colocolic, involving the large bowel only ; 3. Ileocolic, when the terminal ileum prolapses itself within the ascending colon, and 4. Ileocecal, where the ileocecal valve is the lead point of the intussusception [2]. Pathologic lesions within the lumen of the appendix that may lead to intussusception have been reported as calcified fecalith, mucosa associated lymphoma, juvenile polyp, villous adenoma, mucocele, adenocarcinoma, carcinoid tumor, endometriosis and inflammatory polyp in Crohn's disease. In some case no underlying abnormality is identified and abnormal peristalsis caused by local irritation seems to be the essential mechanism [3]. In our case the colonoscopic appearance

was similar to that of an appendiceal polyp but the surgical past history was the clue; total inversion of the appendix is an old method of treating a noninflamed APP. The APP was expected to necrose after inversion, especially when the vascular supply was interrupted by suturing; remnants of appendix nonetheless could survive. However few cases as ours the APP remains it can produce symptoms such as abdominal pain. Rarely, appendiceal stumps can harbor malignancies and even bleed years after appendectomy [4]. Our decision was based in the clinical scenario of our patient. With the development of endoloops and endoclips we are now able to remove organs such as appendix in a safe way. We recommend take in consideration, colonoscopic appendectomy as a new technique in cases of appendix intussusception type colocolic, with or without under laparoscopic supervision. Finally our case contributes to resolve rare cases where APP remains after surgical total inversion.

References

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