LETTER TO THE EDITOR

The Editor,
Medical Journal of Malaysia

Dear Sir,

ACUTE APPENDICITIS PRESENTING AS MELAENA

Most doctors would agree that diagnosing acute appendicitis in children is no easy task. Recently, a 9 year old Malay boy presented to us with melaena, pallor and right hypochondrial pain for two days following fever for five days. Clinically he was toxic, pale and dehydrated with a temperature of 39.5°C. The abdomen was tender with guarding and rebound over the right hypochondrial area. Liver dullness was diminished but the spleen was not palpable. Fresh melaena was obtained per rectally. Haemoglobin was 4.0 gm and total white cell count 32.0 x $^{109}/_{L}$ (polymorphs 85%). Abdominal Xray revealed gas under diaphragm.

We made a provisional diagnosis of typhoid fever with perforation and differential diagnosis of a perforated Meckel's or appendix. After resuscitation, surgery was performed and 600 ml of pus was obtained from the peritoneal cavity. The 5 cm long appendix was found to have perforated. The omentum covering it was gangrenous and thrombosed. Marked typhlitis was also noted with a small necrotic patch. Appendicectomy was performed and the necrotic caecal patch invaginated into the caecum itself, covering it with omentum. Intravenous metronidazole and cefoperazone were given. He recovered uneventfully. Blood and pus cultures were negative.

In the last forty years, only one case of acute appendicitis with considerable melaena was reported in 1977.[1] Typhoid fever was listed as the leading cause here in view of its endemicity and incidence although they usually perforate in the 2nd or 3rd week. Crohn's disease is another possibility but its occurrence in an Asian community is very rare. Bleeding in our case was probably from the infected and inflammed caecum. Another possible cause was from an eroded vessel. Fistulation of the caecum to the iliac artery has been reported. Intraoperatively, fatal bleeding may occur if care is not taken in mobilizing the appendix that might be adherent to the underlying iliac vessels. Post-operative per rectal bleeding is apparently more common in the pre-antibiotic era. Interestingly enough, pneumoperitoneum in perforated appendix is less well documented but may be more common than expected since appendicectomy is usually performed without an abdominal X-ray.

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REFERENCE

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