

**Research Article**

## Case Report of a Mega Appendix

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### ABSTRACT

Surgeons maintain continuous interest about the appendix due to its multiple presentation types and potential pathologies and functional aspects. The acute appendicitis condition represents one of the main reasons for sudden abdominal pain. Open appendectomy remains the preferred treatment and is a commonly performed emergency surgery, especially among trainees. The appearance of the appendix during surgery can be misleading, even for experienced surgeons. The standard surgical practice takes each appendicitis situation as an individual expulsion that requires specific treatment. Each person possesses an appendix of different sizes which generally measure between 6-9 cm in length with 7-8 mm in diameter. Previously, the longest appendix recorded in India was 17.5 cm, and the global record was a perforated appendix measuring 55 cm. This report highlights a rare case of non perforated inflamed appendix measuring 9.8 cm in length and 5.5 cm in diameter at its widest point, which appeared as a sealed off perforated appendicular mass on USG AND CECT, was removed. Highlighting the fact that diagnosing acute appendicitis remains clinically challenging despite medical advances.

### CASE REPORT

A female patient aged 47 years visited the hospital because she experienced severe abdominal pain coupled with high-grade fever that developed within one day. She showed symptoms of nausea along with multiple bouts of vomiting. The patient was found to have a fever with normal vital signs. The starting location of pain was the periumbilical area but the area became restricted to the right iliac fossa. The pain occurred sporadically yet short-lived periods between doses of medication. The patient has never reported such symptoms before. Right iliac fossa exhibited tenderness plus guarding as well as it maintained its color and shape during physical examination. The hernial orifices were normal. Medical testing confirmed bowel

sounds while bladder control along with bowel movements remained normal. The abdominal ultrasonography showed evidence of a sealed off ruptured appendix which resulted in an abdominal abscess formation. A large peripherally enhancing area of size 4.6×7.5×6.1 mm originated from the base of cecum in CECT scans but an independent appendix was not visible.

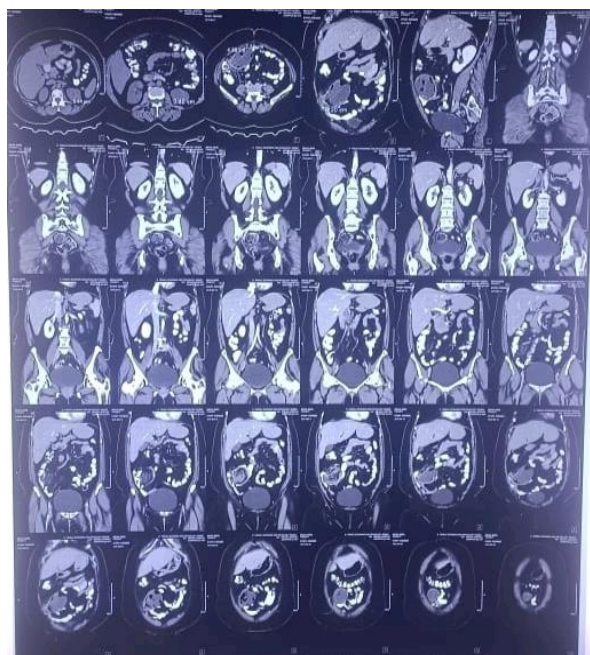
Following informed consent, an emergency open appendectomy was performed. Intraoperatively, a non-perforated, inflamed appendix measured 9.8 cm in length and 5.5 cm in diameter at its widest point was found. Histopathological examination confirmed the diagnosis.



Fig. 1 Operative View, Showing the Appendix Removed in our Case.



Fig. 2 the Appendicectomy Specimen.



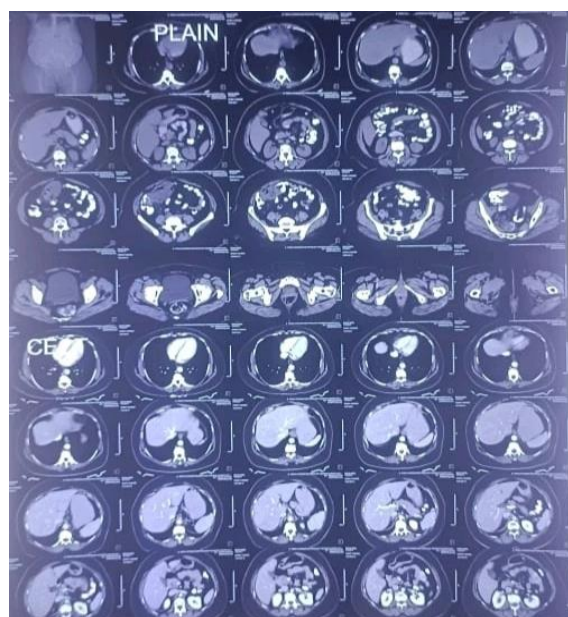


Fig. 3 Cect Whole Abdomen

## DISCUSSION

The initial identification of acute appendicitis as a clinical condition can be attributed to Reginald Fitz, who introduced the term "Perforating inflammation of the vermiform Appendix" in 1886 [1]. Charles McBurney later expanded upon this by describing characteristic symptoms, including the well-known point of maximum tenderness [2]. Although the frequency of appendectomies rose significantly in the early 20th century, recent decades have seen a notable decline [3]. The risk of undergoing appendectomy during life span stands at 8.6% for men alongside 6.7% for women. The risk is particularly elevated during childhood and early life. Prior to puberty, the incidence is nearly equal among both sexes, but after puberty, males become more susceptible, with a male-to-female ratio of approximately 3:2 [4]. Multiple theories attempt to describe acute appendicitis pathogenesis as well as the pattern of its occurrence in modern times. One such theory emphasizes the role of dietary habits, particularly the consumption of refined carbohydrates, which has been linked to conditions like colonic diverticulosis [5]. Epidemiological data support the observation that appendicitis rates are lower in populations with high-fiber diets, especially in developing countries. In contrast, developed nations with 'refined western diets' have historically experienced higher incidence rates. However, in the past 30 years, these rates have been steadily declining in the West, likely due to

improved hygiene and reduced childhood infections, aided by widespread antibiotic use [6]. From an anatomical perspective, the appendix is lined with multiple mucosal folds and may contain argentaffin (Kulchitsky) cells. The cancerous cells that cause carcinoid tumors normally affect the appendix leading to obstructed appendiceal lumen which presents as acute appendicitis [7]. Other causes of obstruction include fecaliths and structural abnormalities[8]. In terms of size, the appendix from the present case measured 9.8 cm in length and 5.5 cm in diameter at its widest point.

## CONCLUSION

Despite medical advances, diagnosing acute appendicitis remains clinically challenging. Its presentation during surgery can sometimes be deceptive. Therefore, histopathological analysis remains essential to confirm the diagnosis and rule out alternative underlying pathologies.

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