

Case	(652) Fishbone simulating acute appendicitis
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CASE PRESENTATION

A 58-year-old female was admitted to the emergency department due to abdominal pain, primarily in the right iliac fossa.

On the physical exploration Blumberg's sign was positive and laboratory tests revealed leukocytosis and high C-reactive protein.

The clinical suspicion was acute appendicitis and an ultrasound was performed in the first place. Despite not seeing anything pathological during the ultrasound the patient was very sore and we decided to perform a CT.

Abdominal computed tomography scan showed 2 cm linear density (fishbone) in the distal ileum, which was slightly thickened, with adjacent fat stranding and extraluminal air bubbles that suggested pneumoperitoneum.

DISCUSSION

The vast majority of ingested foreign bodies pass through the gastrointestinal tract uneventfully and in less than 1% of cases the ingestion of foreign bodies cause a perforation. This usually occurs in regions of acute angulations, such as the ileocecal and rectosigmoid junction.

Foreign body ingestion diagnosis involves different challenges. Firstly, it can be a long time, even months, since the ingestion of the foreign body until it produces symptoms. Secondly, a perforation caused by a foreign body can have very variable clinical manifestations, as in our case even simulate acute appendicitis. Finally, the plain radiography is unreliable in the diagnosis of various types of foreign body ingestion, such as the fishbone and in addition if pneumoperitoneum is present, usually is too small to identify through this technique.

CT is considered the gold standard because it allows the radiologist to identify the presence, location and cause of intestinal perforation. It has some problems because if we use oral and/or intravenous contrast during CT it can cause difficulties in identifying fishbones or fishbones can be mistaken for opacified blood vessels.

CONCLUSION

Fishbones and other foreign bodies can produce an acute abdomen and simulate other pathologies (an acute appendicitis in our case). Usually it will not be the first diagnostic suspicion, but the radiologist should keep this option in mind.

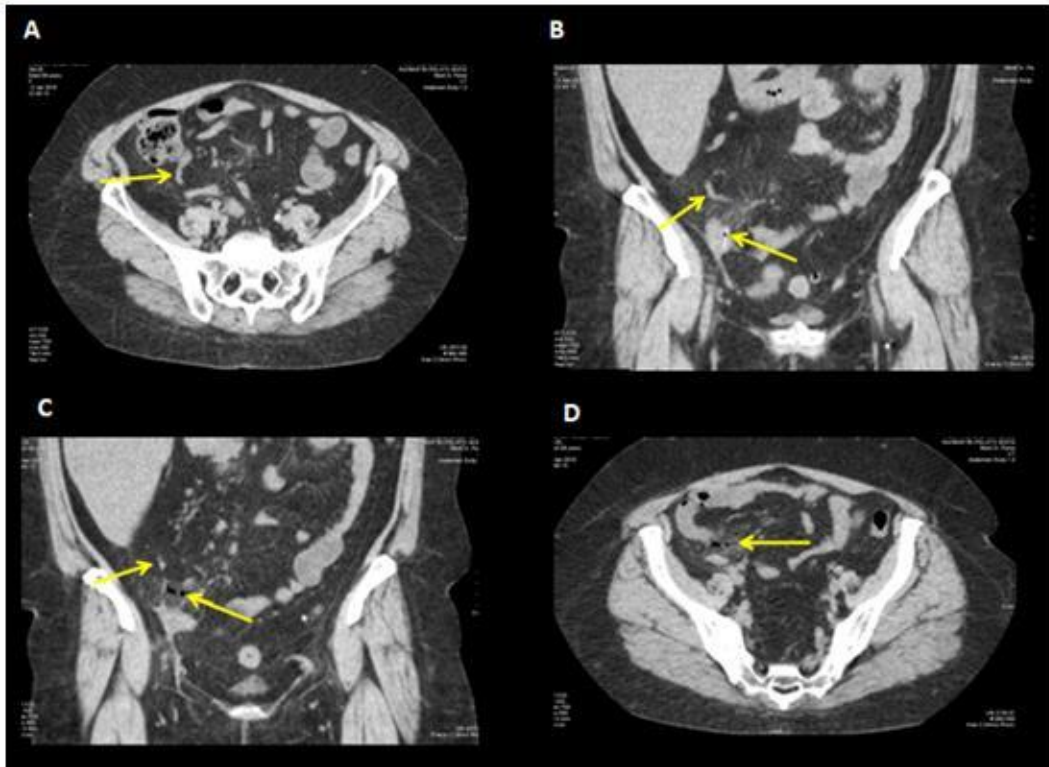


Fig. 1. Normal appendix with thin walls and a 5 mm wall-to-wall diameter. There was not fat stranding around the appendix. Fig. 2. Coronal reconstruction that shows the normal appendix and a linear density in the distal ileum, the fishbone. Fig 3. And 4. Show air bubbles located anterosuperior to the distal ileum compatible with neumoperitoneum and fat stranding.

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