the diagnosis of enterobiasis, which presented itself mimicking Crohn's disease.

References

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Acute appendicitis presenting as acute hemorrhocrotum in a boy
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A 5-year-old boy presented with diffuse abdominal pain, nausea and vomiting followed by features of acute scrotum. Laboratory and radiological investigations suggested presence of infective pathology in the inguinoscrotal region. Surgical exploration revealed patent right processus vaginalis with purulent collection resulting from the presence of perforated tip of appendix in the hernial sac. Appendectomy with drainage of scrotal collection and ligation of hernial sac resulted in satisfactory recovery. [Indian J Gastroenterol 2004;23(3):150-151]

Key words: Acute scrotum

Acute appendicitis in children sometimes manifests with rare clinical features owing to its unusual anatomic locations. Scrotal symptoms as manifestation of acute appendicitis are infrequent in children. A 6-year-old boy presented with a one-day history of right scrotal pain and swelling, diffuse right lower abdominal pain, nausea, vomiting and low-grade fever. There was no history of abdominal or inguinoscrotal trauma. He had history of occasional inguinoscrotal swelling especially during coughing. On examination the child appeared toxic, febrile and anemic, with dehydration. Local examination revealed tender, edematous, erythematous right hemiscrotum with raised local temperature. The cremasteric reflex was absent. The left scrotum and testes were normal. Abdominal examination showed a soft, non distended abdomen with mild tenderness in the right iliac fossa near the mid-inguinal point.

Investigations: hemoglobin 8 g/dL, WBC 18000/cmm (neutrophils 96%); renal and liver function tests were normal. Plain roentgenogram of abdomen showed no abnormality. Color Doppler study of right scrotum showed increased vascularity of the right testis. Ultrasonography of abdomen and inguinoscrotal region showed presence of fluid collection with debris and internal echoes in the right hemiscrotum and inguinal canal.

Surgical exploration of the inguinoscrotal region revealed a patent processus vaginalis containing purulent fluid with fetid smell. There was evidence of a reactive epididymo-orchitis and the spermatic cord was edematous and thickened. The tip of the appendix was in the hernial sac, projecting about 2 cm through the internal inguinal ring. The appendicular tip was inflamed and perforated. Laparotomy through right infrarambilical transverse incision revealed a long inflamed appendix extending into the patent processus vaginalis through the internal inguinal ring. Appendectomy was performed. The right hemiscrotum and peritoneal cavity were irrigated and herniotomy was performed. The postoperative recovery was uneventful. The child is doing well on regular follow up for the last four months.

Acute scrotum in children can be caused by a number of clinical conditions including testicular torsion, epididymo-orchitis, torsion of testicular appendages, infected hydropscele, incarcerated inguinal hernia, and less commonly by thrombosed scrotal vein, Henoch-Schönlein purpura, and fluid leakage from VP shunt. Acute scrotum secondary to acute appendicitis is rare in children. All such cases had patent processus vaginalis, as in our patient.

Laboratory investigations are of little diagnostic help; evaluation by color Doppler reveals underlying testicular pathologies especially testicular torsion.

In the presence of symptoms of GI dysfunction, the radiological and surgical evidence (on inguinoscrotal exploration) of purulent collection in the hernial sac provides a clue to the presence of intra-abdominal source of sepsis. Appendectomy with drainage of purulent abdominal and scrotal collections under appropriate antibiotic coverage results in satisfactory recovery.

References

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