



Incidental Finding of Subhepatic Appendix during Open Cholecystectomy

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Abstract

Subhepatic appendicitis is a rare cause of right upper abdominal pain. We are sharing an incidental case of subhepatic appendix during cholecystectomy. A 40 years aged woman with cholelithiasis was booked for cholecystectomy. Cholecystectomy was successfully completed and just before closing abdomen, a normal looking subhepatic appendix was encountered and removed.

Keywords: Subhepatic appendix; Cholecystectomy; Right upper abdominal pain

Introduction

Acute appendicitis is a common surgical emergency. In most of the cases, it has classical presentation and diagnosed clinically [1]. Ultrasound is usually performed to exclude renal or right ovarian pathologies [2]. However, typical clinical presentation of migratory pain, anorexia and nausea and rebound tenderness may not be found due to variation in positioning of appendix. Appendix is commonly located in retrocecal (74%), pelvic (21%), subcecal (1.5%), preileal (1%), and postileal (0.5%) positions [3].

The rare locations of appendix are subhepatic, lateral pouch, mesocolic, left-sided, intraherniary, and lumbar. Reports of appendicitis in these rare positions are very infrequent. Our case report is about coincidentally found appendix in subhepatic space.

Case Presentation

A 40 year's aged lady presented with history nonspecific upper abdominal pain since two years. Her appetite was normal and no history of vomiting or nausea. On examination she was afebrile and non tender on abdominal examination. Her ultrasound report revealed gall stones. We advised her laparoscopic cholecystectomy but she insisted on open cholecystectomy. Therefore she underwent open cholecystectomy. We made right sub costal incision and performed cholecystectomy. At the end of procedure, while removing abdominal gauze from the hepatic flexure of colon, we felt a tube like structure. We carefully brought it out in the wound and found that it was appendix as shown in Figure 1. Therefore appendectomy was performed to avoid diagnostic difficulties in future.

Discussion

Subhepatic appendix is rarely reported [4]. First ever case of subhepatic appendix was reported in 1955 by King [5]. In a study Out of 7210 appendicitis incidence of subhepatic appendix was only 0.08% [6]. Subhepatic appendicitis does not present with classical features and therefore either misdiagnosed or diagnosed late as perforation/abscess formation [7-9]. Ball et al. [10] diagnosed a case of subhepatic appendicitis through laparoscopy one month after laparoscopic cholecystectomy [10]. The same scenario may would have created in our case if we would not be able to find appendix at cholecystectomy. Algin et al. [11] reported a case of subhepatic appendicitis which was preoperatively reported as acute cholecystitis surrounded by fluid.

Rangarajan et al. [12] reported the case of a perforated subhepatic appendix, which was labeled liver abscess on ultrasound and CT scan.

Ong et al. [1] reported four cases of right upper abdominal pain which were labeled as acute cholecystitis and subhepatic abscess on ultrasound but were confirmed to have sub hepatic appendix on CT scan.

Although advance investigations like CT scan and MRI have high specificity and sensitivity

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Figure 1: Sub hepatic appendix.

to detect subhepatic appendicitis but per operative review of the surrounding anatomy of gall bladder cannot be underestimated.

Conclusion

Subhepatic appendix is rare but if misdiagnosed, it may lead to perforation or abscess formation. Therefore threshold of suspicion should be kept low for subhepatic appendicitis while dealing with pain in right upper abdomen and CT abdomen should be advised when required. General survey of regional anatomy during open or laparoscopic cholecystectomy should be practiced.

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