

An Unusual Presentation of Acute Appendicitis in Setting of Gall Stones

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ABSTRACT

One of the most frequent reasons for laparoscopic cholecystectomy is cholelithiasis. Intraoperative surprises are frequently experienced, nevertheless, especially in patients with significant intra-abdominal disease. Unexpected anatomical variations and adhesions might make ordinary treatments more difficult. One such uncommon intraoperative discovery is a lengthy appendix with numerous adhesions that, especially during acute inflammation, resembled a pelvic mass and adhered to nearby tissues.

Keywords: Acute appendicitis, Cholelithiasis, Laparoscopic cholecystectomy, Intraoperative findings, Case report.

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Introduction:

Cholelithiasis—gallstones within the gallbladder—is a very common biliary condition and very frequently serves as the indication for a standard laparoscopic cholecystectomy. Over the last few decades, the laparoscopic approach has become the gold standard for symptomatic gallstones, thanks to its less invasive nature and faster recovery.

Despite the routine nature of the procedure, intraoperative surprises are anything but rare, particularly when you encounter patients with prior abdominal surgeries, acute inflammation, dense adhesions or anatomical variants. Various studies have

identified factors that predispose to a more difficult laparoscopic cholecystectomy: things like wall-thickening of the gallbladder, pericholecystic fluid, prior upper abdominal operations, contracted gallbladder or acute cholecystitis. In such situations, what should have been a straightforward operation can become a challenge.

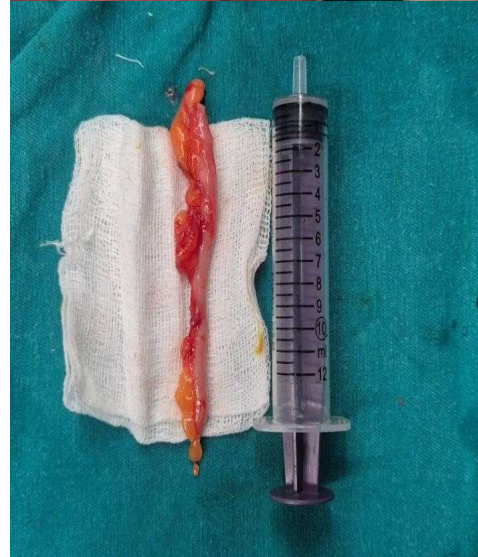
One such rare but clinically significant intraoperative finding is a long, unusually placed appendix entwined in adhesions, acutely inflamed and adherent to adjacent structures such that it mimics a pelvic mass. Though unexpected, the presence of an atypical appendix can interfere with the surgical field, complicate dissection and evoke diagnostic uncertainty—especially when the structure masquerades as something other than what it is.

This unusual scenario underlines two key messages: first, the importance of keeping atypical appendiceal anatomy in the differential when encountering a suspected pelvic mass—even during a gallbladder surgery—and second, the necessity of surgical decision-making flexibility and intraoperative adaptability when one stumbles upon unexpected anatomy or pathology.



**GALL
BLADDER**

**DISTENDED
BOWEL**



ELONGATED 14CMS LONG APPENDIX

Case Report:

Study Design:

This is a single-patient case report, describing a 35-year-old female patient presenting with right-sided abdominal pain.

Patient and Clinical Findings:

A 35-year-old female presented to the outpatient department with a one-week history of right-sided abdominal pain. The pain was intermittent, non-radiating, and described like discomfort on the right side of the abdomen. There were no specific aggravating or relieving factors noted by the patient.

3.3 Personal History:

The patient follows a non-vegetarian diet. Bowel and bladder habits are normal. The sleep and wake cycle is unremarkable.

3.4 Past Medical and Surgical History:

The patient does not report any previous episodes of similar abdominal pain, indicating that this is the first occurrence of such symptoms. She has a past surgical history of a tubectomy, which was performed approximately ten years ago, with no reported postoperative complications. Additionally, there is no known history of any chronic medical conditions or comorbidities such as diabetes mellitus, hypertension, or other systemic illnesses.

3.5 Vital Signs on Presentation:

the patient's vital signs were within normal limits. The pulse rate was 82 beats per minute, indicating a normal heart rate. Blood pressure was recorded at 110/70 mmHg, suggesting stable hemodynamic status. The respiratory rate was 17 breaths per minute, reflecting adequate respiratory effort. The body temperature was 98.3°F, which is within the normal range, indicating that the patient was afebrile at the time of examination.

3.6 Menstrual and Obstetric History:

The patient attained menarche at the age of 13 years, with subsequent menstrual cycles reported to be regular in duration and flow. Her last menstrual period (LMP) was on 31st June 2025. The obstetric history reveals a score of P1L1, indicating one pregnancy that resulted in one live birth. She was married at the age of 19 years, and her first childbirth occurred at the age of 20 years through an institutional delivery, suggesting that the birth took place under proper medical supervision. There is no reported history of miscarriage, abortion, or complications related to pregnancy or childbirth.

3.7 Physical Examination:

The patient was conscious, oriented, afebrile, with no signs of anaemia, cyanosis, jaundice, clubbing, generalized lymphadenopathy or pedal oedema.

3.7.1 Abdominal inspection: The abdomen was protuberant with skin of normal colour. Umbilicus was midline and inverted. A surgical scar (\approx 4 cm horizontal) was present 2 cm below the umbilicus in the midline (from the tubectomy). All abdominal quadrants moved with respiration. No visible mass, peristalsis or pulsations. No dilated veins, scars or sinuses. Hernial orifices appeared free. External genitalia appeared normal.

3.7.2 Palpation: Tenderness was present in the right hypochondriac region without a local rise in temperature. No palpable mass, no pulsations. No organomegaly. There was no guarding, muscle rigidity or rebound tenderness. Murphy's sign was negative. No fluid thrill. Renal angles were non-tender.

3.7.3 Percussion and Auscultation: Liver dullness was noted in the relevant area; resonant note in all other quadrants. Normal bowel sounds were heard.

Ethics and Consent:

The patient provided informed consent for the publication of her clinical information and related images. The study was conducted in accordance with ethical standards, and approval from the institutional ethics committee was reviewed and taken into consideration as per the journal's requirements.

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