Acute appendicitis is a common surgical emergency that requires prompt diagnosis and treatment. The presence of abdominal pain, particularly in the right lower quadrant, is a common feature. Other symptoms may include nausea, vomiting, and fever. Appendicitis is often diagnosed through the use of imaging studies such as ultrasounds and computed tomography scans.

In the case presented, a 49-year-old man presented with symptoms characteristic of appendicitis. His medical history included morbid obesity and diabetes, which may have contributed to his presentation. The patient had a history of abdominal pain and vomiting, with a reported duration of 24 hours. Upon physical examination, the patient was noted to have a tender right lower quadrant, indicative of appendicitis.

The patient’s diagnostic work-up included imaging studies, which confirmed the presence of appendicitis. A computed tomography scan revealed a thick-walled appendix, consistent with inflammation. The patient was then taken to the operating room for an exploratory laparoscopy.

During the procedure, the appendix was identified and removed. The postoperative course was uneventful, and the patient was discharged home on the second postoperative day. The patient was instructed to follow up with his primary care physician for follow-up care.

In conclusion, this case highlights the importance of a thorough history and physical examination in the diagnosis of appendicitis. Imaging studies play a crucial role in confirming the diagnosis and planning the appropriate treatment. Prompt diagnosis and surgical intervention are necessary to prevent complications such as perforation and peritonitis.

References:

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Incomplete rotation. This is produced during the final counter-clockwise 180° rotation of the small bowel or the final counter-clockwise 180° rotation of the colon. The intestine is in an intermediate position between non-rotation and the normal postnatal arrangement.

- Reversed rotation. The duodenum is in front of the superior mesenteric artery and the transverse colon is behind the superior mesenteric artery.

Different cases of appendicitis with atypical location have been described, and the same as in our case, initial diagnosis is often incorrect, delaying diagnosis and treatment. Abdominal tomography provides sufficient information for the surgical plan. It is not necessary to perform dynamic studies to evaluate intestinal malrotation. The typical tomographic findings in malrotation are: duodenal-jejunal junction on the right side, colon on the left side, and an abnormal orientation of the mesenteric vein and artery. The treatment options for left-side appendicitis are the same as those in cases of its habitual location, and open or laparoscopic appendectomy can be performed. The laparoscopic approach is viable with good results. It is also useful for evaluating the differential diagnoses and resolving different pathologies. With respect to the treatment of intestinal malrotation, there is still no consensus on the asymptomatic patient.

Intestinal malrotation in adults is diagnosed incidentally when detected in imaging studies or during the evaluation of another intra-abdominal pathology (as was the case of our patient). The diagnosis and treatment of an acute surgical pathology, such as diverticulitis, or in this case, acute appendicitis, should not be delayed.

Ethical responsibilities

Protection of persons and animals. The authors declare that no experiments were performed on humans or animals for this study.
Primary signet ring cell carcinoma of the colon: A rare condition with a poor prognosis. A report on two cases²

Carcinoma primario de colon con células en anillo de sello: una rara entidad de mal pronóstico. Comunicación de 2 casos

Signet ring cell carcinoma of the colon is a rare subtype of mucinous adenocarcinoma, making up less than 1% of all tumors of the colon and rectum.¹ There must be a primary origin in the colon or rectum and at least 50% of the tumor must have a signet ring cell pattern to make the diagnosis. Its presentation is usually late and associated with a high degree of aggressiveness.²

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² We describe 2 cases herein of patients with signet ring cell carcinoma of the colon. The first case was an 89-year-old woman with no family history of colon cancer. She presented with insidious clinical symptoms of 3-month progression that included anorexia, weight loss, and abdominal pain. Laboratory workup results reported hypochromic anemia, leukocytosis with no neutrophilia, and elevated C-reactive protein. A computed tomography (CT) scan identified irregular thickening of the cecum, with infiltration of the pericolic fat and the terminal ileum wall, and no signs of obstruction, as well as numerous regional and retroperitoneal adenopathies (fig. 1A). Long colonoscopy detected an ulcerated and structured mass that took up almost the entire cecal lumen and impeded the passage of the endoscope. Biopsies were positive for signet ring cell adenocarcinoma. Right oncologic hemicolectomy was performed and infiltration at the level of the right parietocolic peritoneum and the mesocolon was observed.

Anatomopathologic report: poorly differentiated adenocarcinoma of the colon with > 50% signet ring cell pattern (fig. 1B) with multiple tumor nodules and countless lymphatic embolisms, disperse tumor implants, and stage T4aN2bM1b (2010 ICC/AJCC TNM classification, 7th Edition). Immunohistochemistry showed microsatellite instability in