LETTERS TO THE EDITOR

February 15, 1994

Dear Editor:

We read with interest the excellent work by Nitecki et al., reporting one of the largest published series about appendicular adenocarcinoma. They describe the different clinical presentations, including acute appendicitis, palpable mass, ascites, and nonspecific gastrointestinal or genitourinary complaints. We have reported one extremely uncommon case of mucinous appendicular adenocarcinoma.² We believe that because of the low frequency of these tumors, surgeons should know the different ways of clinical presentation, strange as they could be, to avoid misdiagnosis or diagnostic delays. We present the case of a 61-year-old woman with a right Scarpa triangle abscess and no previous history of trauma, puncture, or skin injury. A right pelvic liquid collection in communication with the external abscess was detected by means of ultrasound and computed axial tomography study. An external cecal compression with normal mucosa was found after a barium enema. We first performed an extraperitoneal pelvic abscess drainage, followed by systemic antibiotic treatment. Suspecting an acute appendicitis or a cecal tumor, a celiotomy was performed 30 days later, finding an appendiceal tumor without cecal involvement, with surrounding peritoneal mucus and no peritoneal, lymphatic, or hepatic metastases. The intraoperative biopsy was reported as mucinous appendicular cystadenocarcinoma, so a right hemicolectomy was performed. The patient had an uneventful recovery, and she is alive and tumor-free 16 months later.

Mucinous appendicular cystadenocarcinoma presentation as a Scarpa triangle abscess is extremely uncommon. Just a few cases presenting as inguinal fistula or mass, but no abscess, have been reported.³ ⁴ A colic origin must be suspected when an unexplained inguinal abscess is found, reminding the existence of the appendicular adenocarcinoma.

References


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Dear Editor:

My co-authors and I have reviewed the letter from Dr. Rodríguez-Sanjuan and colleagues. We are not questioning your decision as editor, but we question whether this warrants publication as a Letter to the Editor regarding our article, “The Natural History of Surgically Treated Primary Adenocarcinoma of the Appendix.”

I believe these authors are describing a femoral hernia presenting as an “abscess,” but filled with “jelly” from the peritoneal cavity. It is unclear to us whether this represents just a femoral hernia or possibly a hernia within which was the appendix. It is well known that patients often will present with a hernia filled with mucus or intraperitoneal metastases from other sources, which represent the first sign of intra-abdominal pathology. For instance, we recently took care of a patient who had had a right inguinal hernia repaired elsewhere; jelly was found in the hernia, and this was the first sign of pseudomyxoma peritonei.

Because of this relative frequent association, I do not see any major benefit or educational value in publishing this letter to the editor, when it looks like this is a right femoral hernia (right Scarpa’s triangle mass). On the other hand, it might be worthwhile if the authors could modify their letter so that this is documented to be a perforated appendiceal cancer with a frank retroperitoneal abscess that presents out into the femoral triangle. However, this would be more commonly the presentation of a perforated cancer rather than that specific for an appendiceal cancer.

Support for our concept comes from their letter, where they talk about “surrounding peritoneal mucus.” If the authors could confirm the fact that this indeed was an abscess filled with purulent material and not filled with mucocoele-like material and that there was no femoral hernia present, we would modify our response to the following:

Dr. Rodríguez-Sanjuan and colleagues tell of an interesting presentation of a patient with an appendiceal carcinoma. It appears that this carcinoma perforated retroperitoneally and the abscess dissected up to the femoral triangle, passing medial to the femoral vein. This should be differentiated from a hernia containing the appendix with local perforation and from a femoral hernia presenting with the sac filled with mucus. The latter two are more common presentations of appendiceal pathology. As with other perforated colon and rectal cancers, distal dissection of the retroperitoneal perforation should be considered whenever an abscess presents in the groin region without obvious external source.

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