Giant Colonic Diverticulitis in Young Patient Mimicking an Ovarian Mass

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Abstract

Giant colonic diverticulitis is a rare entity, is increasingly being recognized in younger patients. A pelvic pain and abdominal mass in young adults are common symptoms that require careful surgical assessment with an ovarian cyst being a common cause. The correct diagnosis is often only made intraoperatively at the time of surgical exploration. We report a rare case of a large pelvic mass in a 16-year-old female which mimicked an ovarian mass. The ability to recognize such condition is vital as its management is different and worse outcome can be prevented by earlier detection and proper management.

Introduction

Diverticular disease, generally thought to be disease of older age, is becoming increasingly recognized and reported in young patients. The estimated incidence of diverticulitis is patients > 40 years of age has risen from 2 to 4% of all reported cases of diverticulitis in the 1940s to 1960s (1, 2), to 4.9 to 26% in the 1980s and 1990s (3,4). A low fibre diet has been implicated in the increasing prevalence of diverticulitis in young patients. We report a case of giant colonic diverticulitis mimicking an ovarian cyst in 17 year old patient.

Case report

17 year old patient, presented with pelvic pain and abdominal volume increase. There was no medical history. She has the first menstruation at the age of 12 years and she has irregular menstruation. The clinical examination, she had no fever, in good general condition. Abdominal examination revealed a pelvic mass exceeding the umbilicus, not painful. Her laboratory investigation showed an elevation of CA 125, the BHCG were negative. Abdominal ultrasound showed right ovarian mass echogenic without partitions or vegetation. A laparotomy was decided; an exploration found a coecal mass, right ovary was normal (figure 1). We performed an ileocaecal resection with side to side anastomosis. Post operative recovery was smooth, with no complications and the patient was discharged home on the 6th post operative day. She remained well six months later. Histologically, there was a marked acute inflammatory exudate around the coecum diverticulum. The colon, terminal ileum and appendix were unremarkable.

Discussion

Giant colonic diverticulitis is rare entity first described in 1946 by Bonvin and Bonte and later, in 1953 by Huges (5, 6). As other Diverticular, they can be congenital when they are due to an intestinal duplication, having muscular layer and myenteric plexus, or acquired being an exaggerated presentation of colonic Diverticular disease (7).

Patients with giant colonic diverticulitis may have an asymptomatic course with a palpable abdominal mass in 60% of the cases or present with non specific symptoms, like fever, anemia, tenesmus, early satiety, vomiting, diarrhea, constipation, abdominal pain, weight loss, abdominal distention or with complications like lower gastrointestinal bleeding, intestinal obstruction, volvulus and acute abdomen.

There is no gold standard diagnostic test for this entity. Radiological investigations that might aid in diagnosis are based on ultrasound and computed tomography (CT) scanning. Ultrasound finding that favours the diagnosis include hyper echoic or hypo echoic out pouching of the right colonic wall and localized circumferential colonic wall thickening at the level of diverticulum (8). Characteristic CT findings include direct visualization of the diverticulum at the level of maximum circumferential wall thickening (8).

However, the correct diagnosis is often only made intraoperatively at the time of surgical exploration. Several studies report that there are significantly higher operative rates in young patients with diverticulitis in comparison to older patients. However, this is complicated by the fact that diverticulitis is often initially misdiagnosed preoperatively in young patients, up to 27-88% of the time (9,11) in comparison with 14% of the time in older patients (3). Therefore, young patients may be diagnosed as having appendicitis,
small bowel obstruction, or pelvic inflammatory disease (4, 10, 11). Intraoperatively diagnosis of caecal diverticulitis is not always clear. Correct diagnosis can only be made in 60-70% of cases. Some authors recommend careful mobilization of the coecum and careful palpation to detect the ostium of diverticulum (12).

Controversies exist regarding the most appropriate treatment for young patients who present with acute uncomplicated diverticulitis. Some suggest they should undergo surgical resection of the diseased colon (13, 14). Others suggest that these patients will have favourable outcomes when treated with medial management, while avoiding the potential complications of surgery (15). However, in the presence of complications, such as free perforation or localized abscess formation, colectomy should be considered (16).

References

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