Clinico- pathological study of right Iliac Fossa Mass

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Introduction

A mass in the right iliac fossa is a common diagnostic problem encountered in clinical practice, requiring skill in diagnosis. A swelling in the right iliac fossa may arise from the structures normally present in that region or from structures, which are abnormally situated in the region.\(^1\)

The common swellings which occur in the right iliac fossa are appendicular lump, carcinoma of the caecum, ileocecal tuberculosis and Crohn's disease. Rare swellings are actinomycosis, ameboma, psoas abscess and lymph node masses. A clinical diagnosis is often difficult due to other conditions such as obesity and guarding, with the mass being palpable only when patient is on the operating table.\(^1\)

Patients with a mass in the right iliac fossa are often admitted in surgical departments. Most of the causes need surgical intervention and are curable. A mass in the right iliac fossa mainly arises from appendix, caecum, and terminal part of ileum, lymph nodes, iliopectineos sheath, and retroperitoneal connective tissue. An important differential diagnosis is between an appendicular lump, carcinoma of the caecum and ileocecal tuberculosis. Non-operative management of an appendix mass followed by elective appendicectomy is a safe and effective method of management.\(^1\)

Appendicitis can occur rarely with carcinoma of the caecum, particularly in elderly patients. In India tuberculosis has been reported to be the cause in 3 to 20% of patients with intestinal obstructions. About 5 to 10 % of all gastrointestinal perforations (excluding appendix perforations) have been reported to be due to tuberculosis. Caecal carcinoma is more common in people of the high socio-economic group who use less fibrous diet. Local control continues to be a significant problem in the management of retroperitoneal sarcoma.\(^1\)

As rightly said by Sir Hamilton Bailey "A correct diagnosis is the hand maiden of a successful operation. The diagnosis of appendicitis remains essentially clinical, requiring a mixture of observation, clinical acumen and surgical science. In an age accustomed to early and accurate preoperative diagnosis, acute appendicitis remains an enigmatic challenge and a reminder of the art of surgical diagnosis. A lump in the abdomen has always held a fascination for clinicians. The patients presenting with mass per abdomen form bulk of the cases in surgery. Among the various quadrants of abdomen, the right iliac fossa enjoys the pride of place as far incidence of mass per abdomen is concerned. Although an extensive subject, this study was undertaken to unravel some of mystery of a mass in right iliac fossa, the very presence of mass proving a diagnostic problem. Mass per abdomen by reason of their wide spread complications has since long exercised the mind of many surgeons and is not an uncommon entity.\(^2\)

Patients with mass in right iliac fossa may well be confronted by a general practitioner, a surgeon or a gynaecologist and the correct diagnosis is regarded as a clinical puzzle by many. Thorough understandings of the anatomy and pathological process that may occur within the abdomen are essential for an accurate diagnosis and treatment of a mass in right iliac fossa.\(^2\)

The most common differential diagnosis encountered by surgeons today are:

- Appendicular Lump
- Appendicular Abscess
- Ileocaecal Tuberculosis
- Right Ovarian Mass
- Right Ectopic Kidney
- Rectus Sheath Hematoma
- Ca Caecum
- Amoeboma

The aim of the present study is to recognize clinico-pathological entities presenting as mass in right iliac fossa with respect to their relative incidences, age, gender distribution management and complications and their management.

Aims and Objectives

To study the various conditions/ diseases presenting as mass in the Right Iliac Fossa with relation to:

1. Incidence, Age And Sex Distribution Of Different Conditions.
2. Clinical Presentation.
3. Type Of Management Of The Condition.
4. Comparision Between Clinical Diagnosis And Final Diagnosis.
Materials and Methods

Type Of Study - Prospective

- Period Of Study: July 2011 to September 2013
- Period Required For Data Collection: 2 yrs.
- Period Required For Data Analysis And Reporting: 6 months.
- Place of study: Department of General Surgery

Padamashree Dr. D.Y. Patil Medical College, Hospital and Research Centre, Pimpri, Pune -18.

Sample Size - 50 cases

Inclusion Criteria:
- All patients attending the surgical OPD with pain and mass in right iliac fossa

Exclusion Criteria:
- Pregnant Women
- Terminally ill cancer patients

Plan of Study

Institutional Ethical Committee approval to be taken prior to commencement of study.

All the patients were evaluated as per the proforma.

A written and informed consent was taken from the patient after explaining details of treatment modalities.

Clinical diagnosis was confirmed by relevant investigations (routine investigations of blood/urine and ultrasonography and CT scan if required) and patient will be managed appropriately.

After confirming the diagnosis and depending on patient's condition appropriate surgery was performed if necessary.

All patients were given antibiotics as per requirement according to the condition.

The case data's was analyzed systematically and tabulated in the same master chart. The relevant data of each case was tabulated in the master chart. All the data's were compared with regards to various parameters and was statistically analyzed, results were drawn & conclusions were made.

Method of Analysis - Chi Square Test.

Results

In our study 56 patients were enrolled, out of which 6 were excluded as per the exclusion criteria. The cases selected were from patients coming to surgical opd. between the periods July, 2011 to March, 2013. Totally, 50 patients were included in our study, who were assessed and treated.

The data was collected, analyzed and the following observations were made and results were drawn.

The majority i.e. 25 of cases had appendicular lump. 11 cases with appendicular abscess, 8 cases with ileocaecal tuberculosis, 2 cases of Intususception and 1 case with Ca. Caecum. Amoebic Typhilitis, Rt Tuboovarian mass and Rt. Ovarian cyst each.

The age wise distribution of cases with various conditions in study group. Majority of cases i.e. 16 were in age group of 21 to 30, followed by 12 cases in age group ≤20 yrs. 10 cases were in age group of 31 to 40 yrs, 7 cases were in age group of 41 to 50 yrs and only 5 cases were in age group of more than 50 yrs. (Table no 1)

The sex wise distribution of cases with various conditions in study group. Majority of cases i.e. 26 were females with 16 cases suffering from appendicular lump, followed by 3 cases with appendicular abscess, 3 cases with ileocaecal tuberculosis and one cases with Intususception, Ca Caecum, Rt Tuboovarian mass and Rt ovarian cyst.

Among 24 males, 8 had appendicular abscess and 9 had appendicular lump respectively. 5 cases with ileocaecal tuberculosis and one case with Intususception and amoebic typhilitis. To test whether this difference is statistically significant or not, Pearson's chi square test used as test of significance. Chi-square value worked out to be 5.66 which is statistically not significant (p>0.05). (Table no 2)

The pain duration wise distribution of cases with various conditions in study group. Majority of cases i.e. 24 had pain duration for 6 to 10 days with 11 cases suffering from appendicular lump, followed by 5 cases with appendicular abscess, 5 cases with ileocaecal tuberculosis. and one cases with Intususception, Rt tuboovarian mass. And Rt ovarian cyst. Among 24 males, 9 had appendicular abscess and appendicular lump respectively. Pain duration of 1 to 5 days was seen in 22 cases, with 11 cases of appendicular lump followed by 6 cases with appendicular abscess and 2 case with Intususception. Only 4 cases had pain duration of more than 10 days including one case of...
appendicular abscess and 3 cases with ileocaecal tuberculosis. 1 case of amoebic typhlitis had pain duration of 1-5 days while 1 case of rt ovarian cyst & tuboovarian mass had pain duration of 6-10 days. Only 1 case of ca. caecum had pain duration of >10 days. To test whether this difference is statistically significant or not, Pearson's chi square test used as test of significance. Chi-square value worked out to be 29.49 which is statistically highly significant (p< 0.0001)

The symptoms wise distribution of cases with various conditions in study group. Among the appendicular abscess cases 11 cases had pain and fever, 7 cases vomiting and 11 cases had loose motion. Among 25 cases with appendicular lump all the cases had pain, 16 had fever, 17 had vomiting and 10 cases had loose motion. Among 8 cases with ileocaecal tuberculosis pain was the common presentation among all the cases, 6 had weight loss and vomiting, and 3 had loose motions. In 2 cases with intussusception both had pain, 1 had fever and vomiting respectively and both of them had red coloured jelly stool. 1 case of Ca caecum had pain and vomiting and loss of wt associated with episodes of loose motions. 1 case of Rt tuboovarian mass and rt. ovarian cyst had pain, fever and vomiting. To test whether this difference is statistically significant or not, Pearson's chi square test used as test of significance. Chi-squared value worked out to be 22.59 for weight loss which is statistically highly significant (p< 0.0001) and 13.98 for loose motion which is statistically significant (P< 0.001). (Table no 3)

The different investigations which were done to confirm the diagnosis. In 25 cases of appendicular lump total leukocyte count were raised (>10,000) in all the cases. USG abdomen and pelvis were done in all the cases to confirm diagnosis. Similarly in all the 11 cases of appendicular abscess total counts were raised and USG abdomen and pelvis was done for confirming the diagnosis. In ileocaecal koch's total counts were normal in all the 8 cases. 2 patients came positive for sputum AFB and USG abdomen and pelvis, CECT abdo/pelvis and colonoscopy were done in all the cases. 7 patients out of 8 came out to be positive for tuberculin test. In 2 cases of intussusception total counts were raised and USG abd/pelvis were done in all the cases. In 1 case of Ca caecum total counts were normal, USG abdomen and pelvis, CECT abdo/pelvis and colonoscopy was done to plan definitive treatment. In 1 case of amoebic typhlitis counts were raised and USG abd/pelvis and CECT abdo/pelvis was done to confirm the diagnosis. In 1 case each of Rt. T. O. mass and Rt ovarian cyst count was raised and was normal respectively. In both the cases USG abdomen and pelvis was done to confirm the diagnosis. (Table no 4)

The clinical signs wise distribution of cases with various conditions in study group. Majority of cases i.e. 50 had lump palpable, followed by tenderness in 36 cases, 22 cases had rebound tenderness and 13 cases had local rise of temperature. (Table no 5)

The different method of management wise distribution of cases with various conditions in study group. Majority of cases i.e. 45 had undergone surgical management and 5 were managed conservatively.

The treatment wise distribution of cases with various conditions in study group. In 11 cases with appendicular abscess drainage of abscess was done. In 25 cases of appendicular lump who were on OS regimen regression of the size of the AL was seen and hence interval appendicectomy was done. All 8 cases of ileocaecal tuberculosis were started on ATT and 5 out of them required rt hemicolecotomy eventually along with 1 case of ca caecum who also underwent rt hemicolecotomy. 2 cases of intussusception underwent laparotomy. and 1 case of rt ovarian cyst underwent oophrectomy. 1 case of amoebic typhlitis and rt T.O. mass were managed conservatively.

The association between clinical diagnosis and final diagnosis after investigations or operation in study group. Among 25 cases of appendicular lump 22 were diagnosed clinically and 3 were diagnosed after investigations. Similarly 05 cases of appendicular abscess were diagnosed clinically and 6 were diagnosed after routine investigations. Out of total 50 cases 32 could be diagnosed clinically and rest 18 cases were diagnosed after the investigations or operation.

Discussion

The present study was carried out to study the various conditions/ diseases presenting as mass in the Right Iliac Fossa with relation to incidence, Age and Sex distribution of different conditions, clinical presentation, management of the condition and clinical diagnosis and the diagnosis done after investigations or operation.

After detailed history and thorough clinical examination provisional diagnosis was made. Later on patients were subjected to relevant investigations and operations if necessary and final diagnosis was made after the investigations and or operation. The following were the observation and inference which was taken out.
Majority of the cases had appendicular lump (50%), followed by appendicular abscess (22%), 8 cases had ileocecal tuberculosis and only 2 cases had intussusception. There was 1 case each of ca. caecum, amoebic typhlitis, rt. T.O. mass and rt ovarian cyst. Incidence of appendicular lump was 32%, followed by appendicular abscess 22%, ileocecal tuberculosis 16%. The other conditions causing right iliac fossa mass were carcinoma of caecum, amoebic typhlitis, rt ovarian cyst and rt T.O. mass. Incidence of these conditions like appendicular abscess, appendicular lump was common in age group 21 to 30 yrs followed by less than 20 yrs and 31 to 40 yrs. Only 7 cases were seen in age group of 41 to 50 and remaining 5 cases had ileocecal tuberculosis and appendicular lump in age group of more than 50 yrs. (Table no 1). Majority of cases of appendicular mass, appendicular abscess and ileocecal tuberculosis were in age group of 21 to 30 yrs followed by 13 to 20 yrs and 31 to 40 yrs. Only 7 cases were in age group of 41 to 50 yrs and 6 cases were in a group of 51 to 60 yrs. 

Sex wise distribution in study group showed that females had more commonly affected with these conditions as compared to males but the difference was statistically not significant. Among 26 females 16 had appendicular lump, 3 had appendicular abscess, 3 had ileocecal tuberculosis and 1 each having intussusception, ca. caecum, rt tuboovarian mass and rt ovarian cyst. Among 24 males, 9 had appendicular lump and appendicular abscess in 9 cases respectively followed by 5 cases with ileocecal tuberculosis and 1 each having amoebic typhlitis and rt ovarian cyst. Among 13 cases with ileocaecal tuberculosis managed surgically, appendicular abscess was identified to lie free in the abscess cavity. In 18 cases of ileocaecal tuberculosis and appendicular lump, intussusception and ca. caecum, fever and vomiting was seen more commonly in appendicular lump and fever was seen in appendicular abscess. (Table no 3) S. Howell and P.J. Knapton (1964) studied the clinical and pathological nature of tuberculous lesions of the bowel situated at, or in fairly close proximity to the ileocaecal valve. Among the 13 cases with ileocecal tuberculosis 8 cases had significant weight loss. Other clinical features included dull aching abdominal pain in 11 patients and mass in right iliac fossa. 

Clinical signs wise distribution among study group showed tenderness as most prominent sign among cases with various conditions presenting with right iliac fossa mass. The other signs included were guarding, rigidity, tenderness and local rise of temperature. (Table no 5) Similar finding was observed in a study conducted by Juniorsundresh.N, Narendran.S, Ramanathan.M (2009) who evaluated pathological nature of the right iliac fossa mass and its management. Tenderness was observed in 70% of cases with right iliac fossa mass. 

OS regime was given to 50% of cases, drainage was given to 30% of cases, rt hemicolectomy was done in 10% of cases, ATT was started on 8 cases and 2 cases underwent laparotomy. Appendicular abscess was given treatment like drainage, appendicular lump required OS regime, ileocaecal TB required hemicolectomy and ATT, Intussusception required laparotomy. Similar finding was observed in a study conducted by K Shetty, M Shankar (2013) who did a clinical study of right iliac fossa mass in fifty patients. All cases of appendicular mass were managed by O-S regimen initially and appendicectomy later. All 9 cases of ileoceleal tuberculosis managed surgically underwent right hemicolectomy. One patient with caecal carcinoma underwent right hemicolectomy, the remaining ones underwent right hemicolectomy. 

Similar finding was observed in a study conducted by Juniorsundresh.N, Narendran.S, Ramanathan.M (2009) who evaluated pathological nature of the right iliac fossa mass and its management 8 cases of appendicular abscess, abscess alone was done for 4 cases while abscess drainage with appendicectomy for 14 cases, where the appendix was identified to lie free in the abscess cavity. In 18 cases of ileoceleal tuberculosis, all cases were started on ATT- 2 cases.
were operational who presented with feature of appendicitis. Diagnostic test evaluation in study cases showed increased TLC count in appendicular lump, appendicular abscess, intussusception, amoebic typhylitis and rt ovarian mass. Sputum for tuberculosis showed positive result in 2 cases of ileocaecal tuberculosis. USG abdomen showed positive finding in all the types of cases studied. Tuberculin test was positive in 7 cases with ileocaecal tuberculosis. (Table no 4) Similar finding was also observed in a study conducted by Haider Kamran et al (2008) who evaluated role of TLC in acute appendicitis. Elevated total leucocyte count was observed in cases with acute appendicitis. The gastrointestinal tract is reported to be the sixth most common extra pulmonary site. The efficacy of most commonly available investigations and evaluated the response of abdominal tuberculosis to conventional antitubercular therapy wherein the cases had ileocaecal tuberculosis and all of them were had positive mantoux test result with normal TLC count. Abdominal pain, vomiting, fever and weight loss are the commonest symptoms in abdominal tuberculosis. A mass in the ileocaecal region was one of the commonest lesions. Definitive surgical procedure like resection and anastomosis, and right hemicolectomy are the main surgical treatment.

Ileo-caecal region was the most commonly bowel involved in abdominal Kochs. Abdominal tuberculosis is a major public health problem in our country and presents a diagnostic challenge. Early diagnosis, early anti-tuberculous therapy and surgical treatment of the associated complications are essential to reduce morbidity and mortality.

Conclusion

In our study maximum incidence of RIF mass was the appendicular lump and which was the most common in the age group of 21 to 30 years and having female predominance.

In our study maximum cases of appendicular lump and appendicular abscess presented with the chief complaints of fever and vomiting whereas the patients of ileocaecal kochs came to the surgical opd with chief complaints of fever and loss of weight. Out of the total 50 cases only 5 cases could be managed conservatively while 45 cases required surgical management immediate or later.

In our study it was found that out of 50 cases 32 cases were diagnosed clinically whereas the remaining 18 cases were diagnosed after the investigations and operation if necessary. So from our study it is observed that the detail history and thorough clinical examination is very much helpful for correct clinical diagnosis.

References


Illustrations

Illustration 1

Table 1: Age wise distribution of cases with various condition in study group

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>≤20</th>
<th>21 – 30</th>
<th>31 – 40</th>
<th>41 – 50</th>
<th>&gt;50</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendicular lump</td>
<td>6</td>
<td>10</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>Appendicular abscess</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Ileo-caecal TB</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Intussuception</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Ca. Caecum</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Amoebic Typhilitis</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Rt. Tuboovarian mass</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Rt. Ovarian cyst</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>16</td>
<td>10</td>
<td>7</td>
<td>5</td>
<td>50</td>
</tr>
</tbody>
</table>
Table 2: Sex wise distribution of cases with various condition in study group

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendicular lump</td>
<td>9</td>
<td>16</td>
<td>25</td>
</tr>
<tr>
<td>Appendicular abscess</td>
<td>8</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Ileo-caecal TB</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Intussusception</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Ca. Caecum</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Amoebic Typhilitis</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Rt. Tuboovarian mass</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Rt. Ovarian cyst</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>24</td>
<td>26</td>
<td>50</td>
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</table>

Chi-square = 5.66, P>0.05
Illustration 3

Table 3: Symptoms wise distribution of cases with various condition in study group

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>No of cases</th>
<th>Pain</th>
<th>Fever</th>
<th>Vomiting</th>
<th>Loss of weight</th>
<th>Loose Motion</th>
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<tr>
<td>Appendicular lump</td>
<td>25</td>
<td>25</td>
<td>16</td>
<td>17</td>
<td>2</td>
<td>10</td>
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<tr>
<td>Appendicular abscess</td>
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<td>11</td>
<td>11</td>
<td>07</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Ileo-caecal TB</td>
<td>8</td>
<td>8</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>3</td>
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<tr>
<td>Intussucception</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>2</td>
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<tr>
<td>Ca. Caecum</td>
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<td>1</td>
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<td>1</td>
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<td>Amoebic Typhilitis</td>
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<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Rt. Tuboovarian mass</td>
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<td>0</td>
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<tr>
<td>Rt. Ovarian cyst</td>
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<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Total</td>
<td>50</td>
<td>50</td>
<td>34</td>
<td>33</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td>Chi-square</td>
<td>3.84</td>
<td>1.04</td>
<td>22.59</td>
<td>13.98</td>
<td></td>
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<tr>
<td>P Value</td>
<td>&gt;0.05</td>
<td>&gt;0.05</td>
<td>&lt;0.0001</td>
<td>&lt;0.00</td>
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</table>
Illustration 4

Table 4: Comparison between cases diagnosed clinically & diagnosed after investigations or operation.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Clinical (provisional) diagnosis</th>
<th>Diagnosed after investigations or operations.</th>
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<tbody>
<tr>
<td>Appendicular lump</td>
<td>22</td>
<td>03</td>
</tr>
<tr>
<td>Appendicular abscess</td>
<td>05</td>
<td>06</td>
</tr>
<tr>
<td>Ileo-caecal TB</td>
<td>03</td>
<td>05</td>
</tr>
<tr>
<td>Intusucception</td>
<td>01</td>
<td>01</td>
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<tr>
<td>Ca. Caecum</td>
<td>00</td>
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</tr>
<tr>
<td>Amoebic Typhilitis</td>
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</tr>
<tr>
<td>Rt. Tuboovarian mass</td>
<td>00</td>
<td>01</td>
</tr>
<tr>
<td>Rt. Ovarian cyst</td>
<td>01</td>
<td>00</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>18</td>
</tr>
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</table>
Illustration 5

Table 5: Clinical sign wise distribution of cases in study group

<table>
<thead>
<tr>
<th>Clinical signs</th>
<th>No of cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local rise of temper</td>
<td>13</td>
<td>26</td>
</tr>
<tr>
<td>Tenderness</td>
<td>36</td>
<td>72</td>
</tr>
<tr>
<td>Lump palpable</td>
<td>50</td>
<td>100</td>
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<tr>
<td>Rebound tenderness</td>
<td>22</td>
<td>44</td>
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