Case Report

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Appendicovesical Fistula

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Abstract

Diagnosis of appendico-vesical fistula (AVF) is challenging because clinical symptoms are frequently nonspecific. Radiologists have to detect subtle abnormalities from frontline imaging modalities, such as plain abdominal radiograph or ultrasound (US); those may indicate more specific diagnostic modalities to demonstrate the fistula.

Keywords: Appendicitis; Appendico-Vesical Fistula; Entero-Vesical Fistula.

Introduction

Faecaluria is a anomaly issue and it was commonly reported in diverticulitis, Ca colon, Crohn's disease, TB abdomen, Post surgery (Hysterectomy), with other reported case Acute appendix is rarely reported with a complication of Appendicovesical fistula.

Aims and objectives: To report a long term sequel of acute Appendicitis withyaAppendicovesical fistula Faecaluria.

Case Details

52 years old lady presented with isolated faecaluria, gross fecal contaminated urine or fresh contaminated urine, it was the present disease symptoms she was not catheterized with no precious episodes of acute appendix, she did not have fever with chills and rigors. She has only dysuria; examination of the patient was not contributory. There was no ascitis, no mass, and no tender point.

Pelvic Examination

vagina free, cx mobile, no mass, no tenderness on mobiling of cx

Urine Analysis

show Gross fecal matter with pyuria.

USG

revealed No gas in the bladder but mixed echogenicity is seen.

CECT

1. An enhanced small mass with gas and hyper dense lesion in the bladder.
2. Rest of the abdomen was reported normal

Cystoscope: reeve an opening in the dome of the bladder.

Exploratory laporotomy revealed omental adhesion wrapping appendix entering into the bladder. The base of the appendix, Caecum, Ileum was normal. There was no significant mesenteric nodes, no diverticulitis coli. There was no other mass in sigmoid and any part of colon.

Enblock resection with the wedge of bladder and complete appendix resected.

The pat was relied off symptoms dramatically

HPR

HPR of specimen revealed non specific appendicitis, non caseating granulomas, and no

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evidence of malignancy of either end of specimen.

Post operative follow up was recurrence free.

Discussion

Faecaluria is an infrequent and a surgical concern a social taboo alike.

Causes & References Faecaluria

1. Crohn's disease
2. TB
3. Ca
4. Diverticulitis
5. Ethogenic.

Faecaluria evaluation includes cystoscopy, CECT.Diagnostic lap.

The index case was completely evaluated with cystoscopy, CECT.Corelated with operative findings and HPR confirmation. Crohn's a TB produce Faecaluria when the viscera are spread transmural on to the surrounding organs. Diverticulitis is common cause of acute abdomen in Europe also produce colovesical fistula and leads to Faecaluria.

The pathology was attributed prediverticulitis and inflammatory erosion of bladder. Ca rectum, a cervix and other rare malignancy produce entero cystic fistula. Acute appendicitis produce Appendicovesical fistula was rarely reported. Index case was a classical long term sequel of appendicitis excluded TB, Crohn's, and Malignancy.

Conclusion

A rare case of Appendicovesical fistula.

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