If it walks like appendicitis and talks like appendicitis . . .

Kirk Hollohan, MD

A 32-year-old woman presented to the emergency department (ED) with right-sided abdominal pain that had started slowly the previous day. She described the pain as sharp and rated its severity at 6/10. It was constant in nature and did not radiate. It was worse with movement and deep inspiration. The pain progressively worsened over 24 hours, forcing her to come to the ED. She denied urinary tract symptoms, vaginal discharge or gastrointestinal symptoms other than anorexia. There was no history of fever, shortness of breath or chest pain. Her last menstrual period was 2 weeks before.

Department of Emergency Medicine,
St. Paul's Hospital, Vancouver, BC

Past medical history included a cesarian section 10 years earlier, and a cone biopsy for cervical dysplasia. She had no history of sexually transmitted diseases and was currently in a monogamous relationship. She was taking no medications and had no known allergies.

Examination revealed an alert woman in minimal distress. Respiratory rate was 18 breaths/min, oxygen saturation was 99% on room air, heart rate was 100 beats/min, blood pressure was 110/70 mm Hg, and temperature was 36.5ºC. Physical findings included diffuse right-sided abdominal tenderness, maximal at McBurney's point. There was moderate guarding but no rebound. Rovsing's sign was positive, and Murphy's sign was negative. No tenderness was noted on digital rectal exam. A speculum exam showed a small amount of white, odourless cervical discharge. Bimanual examination revealed no cevical motion tenderness and no adnexal masses or tenderness.

White blood count was 9800/mm^3. Other investigations, including liver function, urinalysis and abdominal x-rays were normal, and the beta-HCG was negative.

The correct diagnosis in this case is:

1. Appendicitis
2. Fitz-Hugh–Curtis Syndrome
3. Mittelschmerz
4. Terminal ileitis

For the Answer to this Challenge, see page 108.