





Letter to *A rare cause of acute abdomen: Isolated necrosis of the cecum*

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Dear Editor,

We value the article by Eyvaz et al. highlighting a rare case of isolated caecal necrosis with a classic presentation of acute appendicitis (1). It is a very interesting case as the cause of isolated necrosis of the caecum is not determined. Nevertheless, we believe that the value of this article could be improved further if certain issues are addressed. Firstly, we believe that readers will appreciate the description of the case to be made universally and widely understood. Authors have mentioned that there was no feature on direct abdominal graphy in the upright position, in which the features they meant to highlight are not grasped. Were they addressing the air-fluid level with dilated bowels as would be seen in the ileus and intestinal obstruction or features of pneumoperitoneum such as Riger's sign or gas under the diaphragm from the abdominal or chest radiograph (2)?

Secondly, we advocate that the preoperative diagnosis must be aligned to the complementary imaging modality, especially in acute surgical abdomen (3). It was presumed that he had acute appendicitis but computed tomography (CT) did not highlight such tomographic evidence. Certain diagnostic radiological features including a dilated and thickened appendix, presence of faecolith or free fluid that are pathognomonic for the diagnosis of acute appendicitis were not addressed. In fact, the CT scan showed thickening of caecal wall which could be guided towards malignancy or typhilitis. We hope that the authors could comment on the contrast uptake which suggests hollow and solid organ viability (4). In addition, radiological signs such as pneumatosis intestinalis, thumbprinting sign and pericolic fat streakiness would add to clinching a diagnosis pre-operatively. We believe the value of CT angiography of the bowel mesentery will give added value for diagnostic purposes and surgical planning in managing this patient.

Thirdly, in the era of minimally invasive surgery, such cases with a diagnostic dilemma will benefit from diagnostic laparoscopy with avoidance of unnecessary open surgery. Based on the laparoscopic findings, further interventions namely diverticulectomy and limited right hemicolectomy could follow especially in a tertiary centre with a presence of colorectal surgeon. As compared to performing an oncological resection, laparoscopic right hemicolectomy for benign cases requires less technical expertise and in return provides better surgical outcomes to the patient (5).

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Lastly, pertaining to the specimen, we reckon that there was no proper orientation of the gross specimen in addition to the lack of a gauge to objectively portray the specimen's measurement. The picture of the specimen provided depicts excision of the Meckel's diverticulum only. This is in contrast to the conventional resection of Meckel's diverticulum with a 2 to 5 cm margin of the ileum both proximally and distally to encompass the removal of ectopic gastric and pancreatic tissue, which may be present within this region and could cause complications at a later date. Despite providing the microscopic image of the histopathological examination, it is not well-magnified to be appreciated. We suggest that the provision of images with higher magnification may aid in solving this diagnostic dilemma.

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