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Original Article

# A Clinical Profile and Management of Patients Presenting with Right Iliac Fossa Mass: An Observational Study

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## ABSTRACT

**Background**: Right iliac fossa (RIF) mass is a common surgical condition with diverse etiologies and significant diagnostic challenges. Early diagnosis and appropriate management are essential to reduce morbidity.
**Objective**: To study the clinical presentation of RIF mass and evaluate diagnostic modalities, treatment options, and associated complications.
**Methods**: This prospective observational study was conducted in the Department of General Surgery at Jorhat Medical College and Hospital from November 2024 to November 2025. Patients aged >12 years presenting with RIF mass were included, while gynecological causes and patients <12 years were excluded. A total of 68 patients were studied. Clinical evaluation, laboratory investigations, and radiological imaging were performed. Management was individualized based on etiology, and patients were followed up for outcomes and complications. Data were analyzed using descriptive statistics.
**Results**: Appendicular lump (41%) was the most common cause, followed by appendicular abscess (35%), ileocecal tuberculosis (15%), mucocele of appendix (3%), carcinoma caecum (3%), and psoas abscess (3%). Ultrasonography showed a diagnostic correlation of 51% with clinical findings, while contrast-enhanced CT, colonoscopy with biopsy, and FNAC were useful in equivocal cases. The majority of appendicular masses were managed conservatively with interval appendectomy, with good clinical outcomes, while surgical intervention was reserved for indicated cases.
**Conclusion**: Appendicular pathology is the leading cause of RIF mass. Accurate clinical assessment with appropriate imaging ensures early diagnosis and management.

***Keywords***: *Right iliac fossa mass, appendicular mass, appendicular abscess, ileocecal tuberculosis, carcinoma caecum, ultrasonography.*

## INTRODUCTION

Right iliac fossa (RIF) mass has long been regarded as a “temple of wonders” or a “Pandora’s magic box,” reflecting its diagnostic complexity. It is a common clinical entity in surgical practice and requires considerable skill for accurate diagnosis. As Sir Hamilton Bailey stated, “A correct diagnosis is the handmaiden of a successful operation,” emphasizing its clinical importance(1).

RIF masses may arise from various anatomical structures, including the appendix, caecum, terminal ileum, lymph nodes, iliac vessels, retroperitoneal tissues, iliopsoas muscle, and iliac bone, or may extend from adjacent organs such as the kidney, uterus, ovaries, and bladder. The etiology ranges from benign inflammatory conditions to aggressive malignancies, often requiring a multidisciplinary approach(2,3).

Common etiologies include appendicular pathology, ileocecal tuberculosis, and carcinoma of the caecum, while less common causes include iliopsoas abscess, tubo-ovarian mass, and Crohn's disease. Diagnosis is primarily based on thorough clinical evaluation supported by appropriate investigations.

Early identification of the underlying cause is essential for appropriate management and prevention of complications. However, regional data on clinical presentation, etiology, and outcomes are limited. The current research seeks to address this gap and improve clinical decision-making.

## AIM AND OBJECTIVES

Aim is to study the etiology, pattern of presentation, management and complications in patients presenting with right iliac fossa mass in Jorhat Medical College and Hospital.

**Objectives include**

- To study the various modes of presentation of right iliac fossa mass.
- To evaluate the different investigative modalities, treatment options available, and associated complications in patients presenting with a right iliac fossa mass

## MATERIALS AND METHODS

**Ethical Clearance:** Ethical approval was obtained from the Institutional Ethics Committee of Jorhat Medical College and Hospital.

**Study Design:** Hospital-based prospective observational study.

**Study Setting:** Department of General Surgery, Jorhat Medical College, Assam.

**Study Duration:** November 2024 to November 2025 (1 year).

**Study Population:** All consecutive patients clinically diagnosed with right iliac fossa mass and admitted during the study period.

**Sample Size:** A total of **68 patients** fulfilling inclusion criteria were enrolled.

**Inclusion Criteria:**

- Patients >12 years with clinically diagnosed right iliac fossa mass
- Patients admitted via OPD/Emergency during study period
- All consecutive eligible patients

**Exclusion Criteria:**

- Patients with gynecological causes of RIF mass
- Patients <12 years of age

**Study Variables:**

- **Demographic:** Age, socioeconomic status
- **Clinical:** Symptoms (pain, fever, vomiting, mass, weight loss) and examination findings (site, size, consistency, tenderness, mobility)
- **Laboratory:** Hemoglobin, total leukocyte count, differential count, ESR; Mantoux test (selected cases)
- **Radiological:** USG abdomen, X-ray (chest/abdomen), CECT abdomen (when indicated)
- **Special Investigations:** FNAC, colonoscopy, biopsy (selected cases)
- **Disease Variables:** Final diagnosis based on clinical, radiological, operative, and histopathological findings (e.g., appendicular lump/abscess, ileocecal tuberculosis, carcinoma caecum, psoas abscess)
- **Management:** Conservative (Ochsner–Sherren regimen) or surgical (appendectomy, interval appendectomy, hemicolectomy, drainage procedures)
- **Outcome:** Postoperative complications, duration of hospital stay, treatment outcome

**Methodology**: This prospective observational study was conducted in the Department of General Surgery at Jorhat Medical College and Hospital, Assam, from November 2024 to November 2025. Ethical approval was obtained, and informed consent was taken. Patients >12 years with clinically diagnosed right iliac fossa (RIF) mass were included, while gynecological causes and those <12 years were excluded. A total of 68 patients were enrolled.

Data were collected using a structured proforma, including demographics, clinical features, and abdominal examination findings. Investigations included hemoglobin, total leukocyte count, lymphocyte percentage, routine tests, and Mantoux

in selected cases. Imaging included ultrasonography, X-rays, and CECT when indicated, with FNAC, colonoscopy, and biopsy performed selectively.

Diagnosis was based on clinical, radiological, operative, and histopathological findings. Common etiologies were appendicular lump or abscess, ileocecal tuberculosis, carcinoma caecum, mucocele appendix, and psoas abscess. Management was etiology-based, with conservative treatment (Ochsner–Sherren regimen) for appendicular lump and surgery (appendectomy, interval appendectomy, right hemicolectomy, abscess drainage) when indicated. Patients were followed during hospital stay, and outcomes including complications and duration of stay (<10 or >10 days) were recorded.

Data were compiled and analyzed using Microsoft Excel and statistical software, employing descriptive statistics such as frequencies and percentages, and presented in tables and charts.

**RESULTS AND ANALYSIS**

In our study of 68 patients, appendicular pathology predominated (76%): appendicular lump 28 (41%), abscess 24 (35%), ileocecal tuberculosis 10 (15%); mucocele appendix, carcinoma caecum, and psoas abscess each 2 (3%) (Table 1).

Among 68 cases, age ranged 12–86 years. Peak incidence was 41–50 years (16), followed by 21–30 (14) and 31–40 (12). Patients <20, 51–60, and >60 years accounted for 11, 8, and 7 cases, respectively. Appendicular lump was common in 21–40 years (8 cases each) and occurred across all ages. Appendicular abscess was frequent in <20 and 41–50 years (6 each). Ileocecal tuberculosis predominated in 41–50 (4) and >60 years (3). Mucocele appendix and carcinoma caecum occurred mainly >40 years, while psoas abscess was common <30 years (Table 1).

Most patients were from the upper lower class (35, 51%), followed by lower middle (20, 29%). Lower, upper middle, and upper classes accounted for 5 (7%), 6 (9%), and 2 (4%) cases, respectively. Overall, RIF mass was more common in lower socioeconomic groups. Appendicular pathologies predominated, while ileocecal tuberculosis was mainly seen in the upper lower class (Table 2).

Pulse was normal (70–90 bpm) in 35 (51%), 91–100 bpm in 17 (25%), and >100 bpm in 16 (24%). Tachycardia was uncommon in appendicular lump (10%) but higher in appendicular abscess (42%). In ileocecal tuberculosis, 50% had normal pulse and 10% tachycardia. Mucocele appendix and carcinoma caecum showed normal pulse, while psoas abscess had variable rates with 50% tachycardia (Table 3).

All patients (100%) had abdominal pain with a palpable mass. Fever occurred in 46 (68%), highest in appendicular abscess (88%) and psoas abscess (100%). Vomiting was seen in 19 (28%), and weight loss in 8 (12%), mainly in ileocecal tuberculosis and carcinoma caecum (Table 4). Tenderness was present in 53 (78%). Masses were mostly firm (59%) or soft (38%), with diffuse borders (80%) and smooth surface (95%). Most were fixed (93%), with few showing restricted (6%) or free mobility (1%).

Among the patients, Hb ≥10 g/dL in 40 (59%); anaemia in 28 (41%). In appendicular mass, 57% had Hb ≥10 and 43% were anaemic; in appendicular abscess, only 5% had Hb ≥10. All carcinoma caecum cases were anemic (100%) (Table 5).

TLC <11,000/mm³ in 39 (58%) and ≥11,000/mm³ in 29 (43%). Leukocytosis was common in appendicular abscess (67%), while appendicular mass showed normal TLC in 60%. Ileocecal tuberculosis (90%), mucocele appendix, and carcinoma caecum had predominantly normal counts. Lymphocytes were <40% in 93% and ≥40% in 7%, mainly in ileocecal tuberculosis (30%) (Table 5).

Ultrasonography was done in all patients (100%), correlating with clinical diagnosis in 35 (49%); 33 (49%) required further evaluation (CECT, colonoscopy with biopsy, FNAC). CT was performed in 33 patients, mainly in complicated/doubtful cases, and in all carcinoma caecum and psoas abscess cases (100%). Colonoscopy with biopsy was done in 2 cases (carcinoma caecum), and FNAC in 2 cases (ileocecal tuberculosis) (Table 6).

Of 68 patients, 53 (78%) underwent surgery and 15 (22%) were managed medically. Appendicular mass: 86% surgical, 14% conservative. Appendicular abscess: 96% surgical, 4% medical. Ileocecal tuberculosis: 100% medical. Mucocele appendix, carcinoma caecum, and psoas abscess: 100% surgical (Table 7).

Among 53 operated patients, 26 (49%) underwent emergency and 27 (51%) elective surgery. Appendicular mass was mostly managed electively (75%), while appendicular abscess required emergency surgery in 83%. Ileocecal tuberculosis was managed conservatively. Mucocele appendix and carcinoma caecum were treated electively (100%), while psoas abscess showed equal emergency and elective distribution (50% each) (Table 7).

Among conservatively treated 28 appendicular lump cases, 22 patients responded to Ocshner-Sherren's regimen (78%) who were planned for interval appendectomy while rest 6 cases (22%) were taken for emergency appendectomy.

Among appendicular mass cases, 6 underwent emergency appendicectomy and 18 interval appendicectomy. Of 24 appendicular abscess cases, 5 were managed conservatively but were lost to follow-up; among the 19 operated, 12 had I&D with emergency appendicectomy and 7 had I&D with interval appendicectomy. Of 2 psoas abscess cases, one underwent emergency I&D and the other pigtail drainage with ATT. Both mucocele appendix cases underwent elective appendicectomy, while both carcinoma caecum cases underwent right hemicolectomy followed by chemotherapy (Table 8).

Wound infection was the commonest postoperative complication, mainly following emergency appendicectomy and abscess drainage in appendicular or psoas abscess (Table 15). In this study, 62% of patients had a hospital stay <10 days, while 38% stayed >10 days, mainly those with surgically treated appendicular abscess, psoas abscess, and carcinoma caecum (Table 9).

**DISCUSSION**

Appendicular pathology predominated as the cause of RIF mass, reflecting an inflammatory etiology, consistent with Norman S. Williams et al.(1). Ileocecal tuberculosis accounted for 15% in endemic regions (2). while carcinoma caecum (3%) typically presented late with mass and anemia(3). Mucocele appendix and psoas abscess were rare(1).

Most RIF masses occurred in young to middle-aged adults, consistent with Behera et al. (4). Appendicular lump and abscess predominated, similar to Samraj et al., findings (5). Ileocecal tuberculosis remained common in endemic regions, especially in middle age(2). Carcinoma caecum, though rare, was seen more in older patients, consistent with increasing malignancy risk with age (4).

Most patients belonged to lower socioeconomic groups. Low socioeconomic status is linked to delayed presentation and higher rates of complicated appendicitis (6). Poverty and malnutrition also contribute to tuberculosis burden, explaining the persistence of ileocecal tuberculosis in endemic regions (7).

Pain (100%), fever (68%), vomiting (28%), and weight loss reflect the typical spectrum of RIF masses. Pain is the cardinal symptom, with a palpable mass suggesting appendicular or ileocecal pathology(1). Fever and vomiting are common in inflammatory conditions, while weight loss suggests chronic infection or malignancy (4). Ileocecal tuberculosis presents insidiously with weight loss and low-grade fever, often mimicking malignancy (8), whereas carcinoma caecum presents with anemia, weight loss, and mass(3). Pain in carcinoma may indicate adhesions, while vomiting in ileocecal tuberculosis may result from subacute obstruction.

Tachycardia was more frequent in appendicular abscess than in appendicular lump or chronic conditions like ileocecal tuberculosis, reflecting a greater systemic inflammatory response. Tachycardia as a marker of infection severity and complicated appendicitis (9), warranting evaluation for sepsis (10). Chronic infective and neoplastic conditions show fewer acute hemodynamic changes (11).

Tenderness (78%) was common, consistent with previous studies(4). Masses were mainly firm (59%) or soft (38%), typical of appendicular pathology and ileocecal tuberculosis (5). Most were smooth (95%) and fixed (93%), indicating inflammatory etiology (4). Irregular borders (16%) suggested fewer neoplastic cases (3). Limited mobility likely reflected adhesions due to chronic inflammation (5).

Anemiawas more common in chronic conditions like ileocecal tuberculosis and carcinoma caecum, reflecting chronic inflammation and blood loss (4).Some younger females with appendicular lump were also anaemic, likely due to menstrual loss. Acute conditions such as appendicular lump and abscess more often had Hb ≥10 g/dL (4).

Leukocytosiswas common in appendicular abscess, reflecting acute suppurative inflammation and often requiring emergency surgery (4). Ileocecal tuberculosis showed predominantly normal TLC, consistent with its chronic granulomatous nature (12). Lymphocytosis (≥40%) was uncommon but more frequent in ileocecal tuberculosis, reflecting cell-mediated immunity (12). Acute appendicular pathology showed lower lymphocyte counts due to neutrophil predominance (13).

USG was performed in all patients with 51% diagnostic correlation, supporting its primary role(4). CT, used in about half the cases, was valuable in complicated appendicitis, ileocecal tuberculosis, and malignancy due to better anatomical detail and higher accuracy (2). Colonoscopy with biopsy had 100% diagnostic yield in carcinoma caecum(14), while FNAC confirmed ileocecal tuberculosis in selected cases (15).

Surgery was the mainstay, with 78% (53/68) managed operatively. Appendicular pathology predominated, with most lumps (86%) and abscesses (96%) treated surgically(4). All cases of ileocecal tuberculosis were uncomplicated and managed medically with ATT (2), while mucocele appendix, carcinoma caecum, and psoas abscess were managed surgically (3).

Surgery was required in 78%, while 22% were managed conservatively. Emergency and elective procedures were nearly equal (49% vs 51%). Appendicular abscess was mainly managed as emergency (83%), with 17% initially conservative and later interval appendicectomy (4) . Appendicular lump was predominantly elective (75%) after conservative treatment (16). All ileocecal tuberculosis cases were managed medically (2). Carcinoma caecum was managed electively, consistent with oncological principles (7). Psoas abscess required both emergency and elective interventions depending on presentation.

Among 28 appendicular lump cases, 22 (79%) underwent interval appendicectomy after initial conservative management with the Ochsner–Sherren regimen, while 6 (21%) required emergency surgery due to failure. The O–S regimen (bowel rest, intravenous fluids, antibiotics, and close monitoring) remains the standard initial approach and is associated with fewer complications than emergency surgery (16). Although commonly performed, routine interval appendicectomy may not always be necessary due to low recurrence rates, supporting a selective approach (17). Emergency surgery is reserved for clinical deterioration or failed conservative management and carries higher complication risk(16).

Among 53 operated cases, the most common approach was conservative management followed by interval appendicectomy (22, 42%) supporting delayed surgery after inflammation subsides (16). Incision & drainage (I&D) with interval appendicectomy was done in 7 cases (13%), while 12 (22%) required I&D with emergency appendicectomy for abscess/perforation; drainage with antibiotics reduces complications compared to immediate surgery (18). I&D alone was performed in 1 case (2%) of psoas abscess. Emergency appendicectomy alone was done in 6 cases (11%) due to failed conservative management, though early surgery carries higher risk in inflammatory masses (19). Elective appendicectomy was performed in 2 cases (4%) of mucocele appendix. Right hemicolectomy was done in 2 cases (4%) for carcinoma caecum, consistent with oncological resection principles (20). One case (2%) of psoas abscess was managed with pigtail drainage and ATT, reflecting accepted minimally invasive management (2). No cases required adhesiolysis or biopsy alone.

Postoperative complications occurred in 5/53 cases (12%), most commonly surgical site infection (SSI)(8%), followed by lower respiratory tract infection (LRTI) (4%). SSI was mainly seen after emergency appendectomy and I&D for appendicular or psoas abscess, consistent with higher infection rates in complicated appendicitis and emergency procedures (19). The relatively low SSI rate may reflect effective antibiotic prophylaxis and surgical technique(21). LRTI likely occurred in elderly or emergency cases under general anesthesia; risk factors include advanced age and emergency surgery (22).

Most patients (62%) had hospital stay ≤10 days, while 38% stayed >10 days. Duration varied by pathology and treatment. Appendicular lump had shorter stays, consistent with better outcomes in non-operative management (16). In contrast, appendicular abscess showed equal distribution reflecting higher morbidity and need for drainage (19). Ileocecal tuberculosis showed moderately prolonged stays, due to chronic disease, need for evaluation, and initiation of ATT. All cases of mucocele appendix and carcinoma caecum had stays >10 days (100%), likely due to major surgery and recovery; oncologic resections like right hemicolectomy are associated with longer hospitalization (19).

## CONCLUSION

This study demonstrates that right iliac fossa mass is a common surgical presentation with diverse etiologies, most frequently due to appendicular pathology, particularly appendicular lump and abscess. Other causes included ileocecal tuberculosis, mucocele of appendix, carcinoma caecum, and psoas abscess. RIF mass was most common in the 20–50 years age group, with appendicular and psoas abscess more frequent in the upper-lower socioeconomic group. The predominant symptom was abdominal pain, and most appendicular cases presented with tachycardia. Characteristic clinical findings aided differentiation: appendicular abscess was soft with diffuse borders, appendicular lump was firm, ileocecal tuberculosis showed irregular margins with restricted mobility, mucocele was smooth with regular borders, and carcinoma caecum presented as a hard, irregular, often fixed mass. Anemia was common in ileocecal tuberculosis and carcinoma caecum, while leucocytosis was seen in appendicular abscess and lymphocytosis in some tuberculosis cases.

Ultrasonography proved to be the primary diagnostic modality, supported by CECT, colonoscopy, and FNAC when required. Conservative management using the Ochsner–Sherren regimen followed by interval appendectomy yielded better outcomes with fewer complications in appendicular lump and selected abscess cases, whereas immediate appendectomy with abscess drainage was associated with higher morbidity. Ileocecal tuberculosis was managed conservatively with antitubercular therapy, mucocele with elective appendectomy, carcinoma caecum with right hemicolectomy followed by chemotherapy, and psoas abscess with drainage procedures. The most common postoperative complication was surgical site infection, followed by lower respiratory tract infection, especially in emergency surgeries.

Early clinical evaluation with appropriate radiological investigations ensures accurate diagnosis and guides effective management, resulting in favorable outcomes in most patients.

**Limitations of study**

Being a single-center study conducted, the findings may not be generalizable to other regions or populations. The relatively small sample size, limited to patients presenting during the study period, may reduce statistical power and lead to underrepresentation of rare etiologies. As an observational study, causal relationships between clinical variables and outcomes could not be established. Long-term follow-up was not performed; therefore, recurrence rates and late postoperative complications could not be assessed. Additionally, advanced diagnostic modalities were used selectively based on availability and clinical indication, resulting in variability in evaluation. Exclusion of female patients with gynecological causes further limits assessment of the full spectrum of right iliac fossa mass.

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**Conflict of interest**: None declared

**Ethical Approval**: Approved by institutional ethics committee.

**Table 1. Distribution Of Subjects According To Various Clinical Conditions And Age**

| Diagnosis | Total Cases (%) | Age in years | | | | | |
|---|---|---|---|---|---|---|---|
| | | ≤20 | 21-30 | 31-40 | 41-50 | 51-60 | >60 |
| Appendicular lump | 28 (41%) | 4 | 8 | 8 | 4 | 2 | 2 |
| Appendicular Abscess | 24 (35%) | 6 | 3 | 3 | 6 | 5 | 1 |
| Ileocecal tuberculosis | 10 (15%) | 0 | 1 | 1 | 4 | 1 | 3 |
| Mucocele ofAppendix | 2 (3%) | 0 | 1 | 0 | 0 | 0 | 1 |
| Carcinoma Caecum | 2 (3%) | 0 | 0 | 0 | 2 | 0 | 0 |
| Psoas abscess | 2 (3%) | 1 | 1 | 0 | 0 | 0 | 0 |
| Total | 68(100%) | 11 | 14 | 12 | 16 | 8 | 7 |

**Table 2. Distribution Of Subjects According To Socioeconomic Status (Modified Kuppuswamy Scale) And Diagnosis**

| Diagnosis | Total Cases | Socioeconomic Status | | | | |
|---|---|---|---|---|---|---|
| | | Upper | Upper Middle | Lower Middle | Upper Lower | Lower |
| Appendicular lump | 28 | - | 1 | 15 | 11 | 1 |
| Appendicular Abscess | 24 | 1 | 3 | 4 | 15 | 1 |
| Ileocecal tuberculosis | 10 | - | - | - | 7 | 3 |
| Mucocele of Appendix | 2 | - | 1 | 1 | - | - |
| Carcinoma Caecum | 2 | 1 | 1 | - | - | - |
| Psoas abscess | 2 | - | - | - | 2 | - |
| Total | 68 | 2 | 6 | 20 | 35 | 5 |

**Table 3. Distribution Of Subjects According To Clinical Presentation**

| Diagnosis | No. of | Pain & | Fever | Vomit | Weig | Pulse Rate in beats per minute | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | 70-9 | 91-1 | >100 |
| Appendicular Lump | 28 | 28 | 17 | 10 | 0 | 8 | 17 | 3 |
| Appendicular Abscess | 24 | 24 | 21 | 7 | 0 | 6 | 8 | 10 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Ileocecal tuberculosis | 10 | 10 | 6 | 2 | 5 | 5 | 4 | 1 |
| Mucocele of Appendix | 2 | 2 | 0 | 0 | 0 | 1 | 1 | 0 |
| Carcinoma Caecum | 2 | 2 | 0 | 0 | 2 | 2 | 0 | 0 |
| Psoas abscess | 2 | 2 | 2 | 0 | 1 | 1 | 0 | 1 |
| Total | 68 | 68 | 46 | 19 | 8 | 35 | 17 | 16 |

**Table 4. Examination Findings Of Subjects**

| **Clinical Findings** | | **No of cases** | **Percentage** |
|---|---|---|---|
| Tenderness | | 53 | 78 |
| Consistency | Soft | 26 | 38 |
| | Firm | 40 | 59 |
| | Hard | 02 | 3 |
| Borders | Diffuse | 53 | 80 |
| | Regular | 3 | 4 |
| | Irregular | 11 | 16 |
| Surface | Smooth | 64 | 95 |
| | Nodular | 4 | 5 |
| Mobility | Mobile | 1 | 1 |
| | Restricted | 4 | 6 |
| | Fixed | 63 | 93 |
| Mass in right iliac fossa | | 68 | 100 |

**Table 5. Total Leukocyte Count, Lymphocyte Percentage&Hemoglobin Of Subjects On Admission**

| Diagnosis | No. of cases | TLC (1000 cells/µL) | | Lymphocyte percentage | | Hemoglobin (g/dl) | |
|---|---|---|---|---|---|---|---|
| | | <11 | ≥11 | <40 | ≥40 | ≥10 | <10 |
| Appendicular lump | 28 | 17 | 11 | 26 | 2 | 16 | 12 |
| Appendicular abscess | 24 | 8 | 16 | 24 | 0 | 17 | 7 |
| Ileocecal tuberculosis | 10 | 9 | 1 | 7 | 3 | 4 | 6 |
| Mucocele ofAppendix | 2 | 2 | 0 | 2 | 0 | 2 | 0 |
| CarcinomaCaecum | 2 | 2 | 0 | 2 | 0 | 0 | 2 |
| Psoas abscess | 2 | 1 | 1 | 2 | 0 | 1 | 1 |
| Total | 68 | 39 | 29 | 63 | 5 | 40 | 28 |

**Table 6: Radiological Investigations Matching Clinical Diagnosis**

| Findings | Clinical Diagnosis | Ultrasound Diagnosis matching clinical Diagnosis | |
|---|---|---|---|
| | Number | Number | Percentage |
| Appendicular lump | 28 | 16 | 58 |
| Appendicular abscess | 24 | 13 | 55 |
| Ileocecal tuberculosis | 10 | 4 | 40 |
| Mucocele of Appendix | 2 | 2 | 100 |
| Carcinoma Caecum | 2 | 0 | 0 |

| | | | |
|---|---|---|---|
| Psoas abscess | 2 | 0 | 0 |
| Total | 68 | 35 | 51 |

**Table 7. Treatment Modalities And Mode Of Surgery**

| Diagnosis | Number | Non-surgical | Surgical | Emergency Surgery | Elective surgery |
|---|---|---|---|---|---|
| Appendicular lump | 28 | 4 | 24 | 6 | 18 |
| Appendicular abscess | 24 | 1 | 23 | 19 | 4 |
| Ileocecal tuberculosis | 10 | 10 | 0 | 0 | 0 |
| Mucocele ofAppendix | 2 | 0 | 2 | 0 | 2 |
| CarcinomaCaecum | 2 | 0 | 2 | 0 | 2 |
| Psoas abscess | 2 | 0 | 2 | 1 | 1 |
| Total | 68 | 15 | 53 | 26 | 27 |

**Table 8. Various Types Of Surgery**

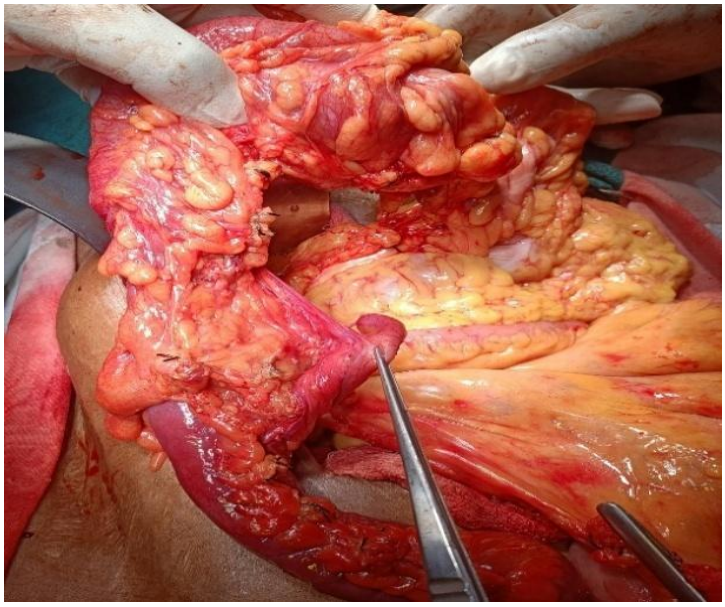
| Type of surgery | No ofCases | Percentage |
|---|---|---|
| Ocshner-Sherren's regimen followed by interval appendectomy | 22 | 42 |
| Incision & drainage followed by interval appendectomy | 7 | 13 |
| Incision & drainage with emergency appendicectomy | 12 | 22 |
| Incision & drainage | 1 | 2 |
| Adhesiolysis & limited resection | 0 | 0 |
| Adhesiolysis & biopsy | 0 | 0 |
| Only Appendectomy | 2 | 4 |
| Emergency appendectomy | 6 | 11 |
| Right hemicolectomy | 2 | 4 |
| Pigtail drainage & ATT | 1 | 2 |
| Total | 53 | 100 |

**Table 9. Duration Of Stay In Hospital**

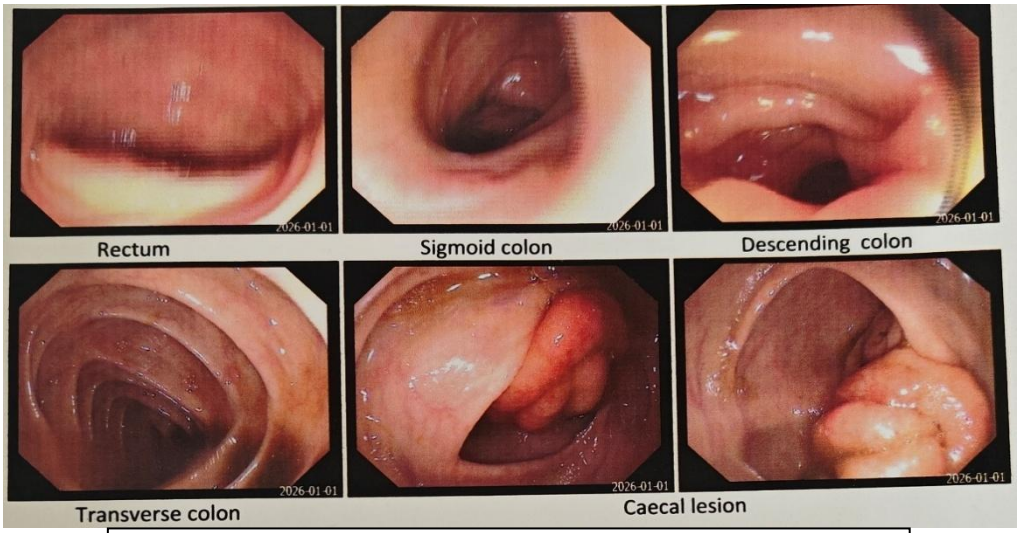
| Diagnosis | No of | IP Duration | Percent | IP Duration | Percent |
|---|---|---|---|---|---|
| Appendicular lump | 28 | 23 | 82 | 5 | 18 |
| Appendicular abscess | 24 | 12 | 50 | 12 | 50 |
| Ileocecal tuberculosis | 10 | 6 | 60 | 4 | 40 |
| Mucocele of Appendix | 02 | 0 | 0 | 2 | 100 |
| Carcinoma Caecum | 02 | 0 | 0 | 2 | 100 |
| Psoas Abscess | 02 | 1 | 50 | 1 | 50 |
| Total | 68 | 42 | 62 | 26 | 38 |

**PHOTOGRAPHS**

***Specimen of Mucocele of Appendix***

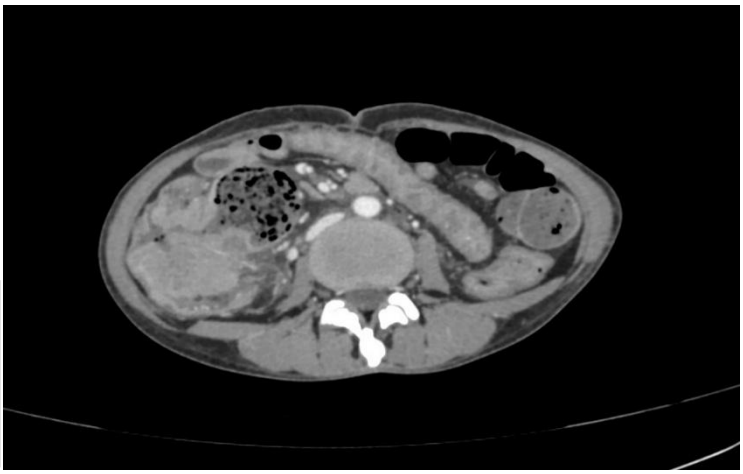


***Carcinoma Caecum intra-operative photo***



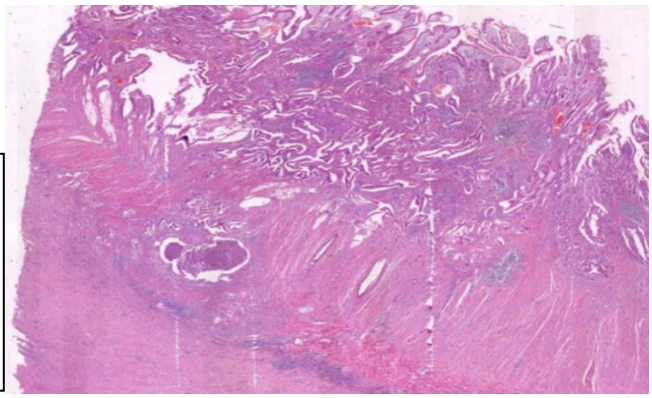

**Colonoscopy showing caecal mass**

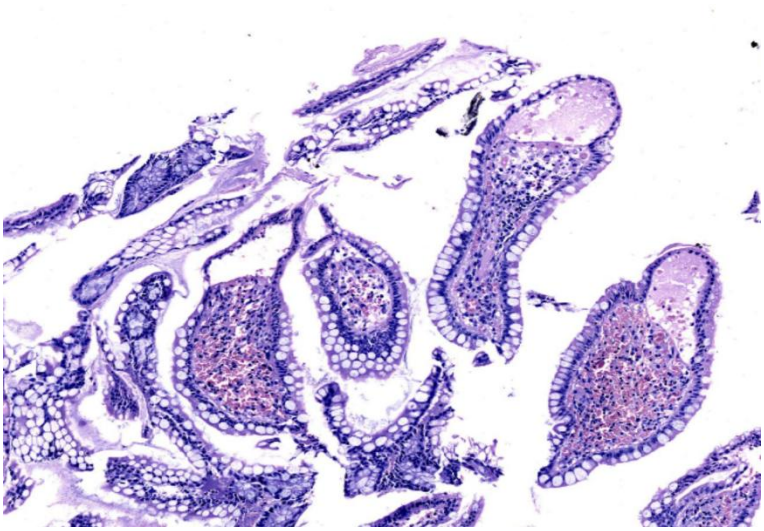
***CECT WA - Right sided Psoas abscess***



***CECT WA – Carcinoma of Caecum***

***HPE-Moderately differentiated Adenocarcinoma of cecum***





**HPE - Ileocecal tuberculosis**

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