

To the Editor:

Re: Stringel G, Berezin SH, Bostwick HE, Halata MS. Laparoscopy in the management of children with chronic recurrent abdominal pain. *JSLs*. 1999;3:215-219.

This article is intriguing, and I am compelled to communicate with you because the authors unequivocally recommend performing an appendectomy during laparoscopy when an organic etiology causing the abdominal pain is not identified. The location of the pain is not disclosed in this article; therefore, I am assuming that the recurrent abdominal pain (RAP) so described is in the right lower abdominal quadrant (RLQ).

In this article, when the etiology of the RAP was identified, the pain was resolved with its own specific surgical treatment. In the cases involving cecal adhesions in five patients and mesenteric node enlargement with a pathologically verified normal appendix the pain also resolved after appendectomy. One is somehow made to infer that the appendix is the only etiology of the pain.

Being diffident about the diagnosis of appendicular colic in the absence of pathological proof, I wonder whether an underlying unrecognized organic etiology like a recurrent cecocolic torsion, may have been present which the authors fortuitously corrected by happenstance in carrying out appendectomy and detorsion of the cecocolon. This in one diagnosis that is often underrated and forgotten.

The question arises whether the described cecal adhesions were in fact Jackson's membrane.¹ This structure may be funicular and can act as an obstructing band or a fulcrum on which a mobile or floppy cecum can fold upon itself producing a symptomatic cecal bascule. Ladd's membrane,² another such structure, may be found at the area of the distal ascending colon and may also act like a Jackson's membrane in the causation of cecocolic torsion which may also lead to a vascular compromise.

Did the authors note whether the cecum was high lying, under-rotated and malrotated? Was it elongated, over-rotated and in a pelvic location? Was it mobile and floppy? Were the alleged adhesions

resected? Was the cecum in any of these instances ballooned, cystic looking, or hyperemic? Did the authors in effect detorse the cecum by replacing it in the right iliac fossa after the incidental appendectomy? Was a redundant sigmoid colon detorsed in the process of exploration?

Several modalities were noted as failed adjuncts to diagnosis. The CT scan may document the cystic configuration of a recurrent cecal volvulus³ but is a matter of lucky timing. Not mentioned is the use of contrast enema³ which can define a poorly rotated large bowel and a mobile and floppy or over-rotated cecocolon by an alert or alerted radiologist. This diagnostic maneuver may also detorse the floppy cecocolon. Endoscopy does not offer any diagnostic advantage in this instance.

Recurrent cecocolic torsion causes recurrent RLQ pains with spontaneous resolution in most instances. It should be sought for during the laparoscopy and corrected by cecocolopexy. A right hemicolectomy is recommended when viability is in question or when the cecocolon is too elongated for cecocolopexy. Ladd's and Jackson's membrane when present should also be transected.

Yours truly,

Francisco T. Tirol, MD

Pioneers Memorial Health Care District, 207 West Legion Road, Brawley, CA 92227, USA. Telephone: (760) 351-3333, Fax: (760) 344-4401

References:

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2. Frantzidez CT, et al. Laparoscopic Ladd procedure and cecopexy in the treatment of malrotation beyond the neonatal period. *Surg Laparosc Endosc*. 1996;6:73-75.
3. Tirol FT. Recurrent cecal volvulus, "Phantom Tumors," the role of CT scan. *Abdm Surg*. 1998;Fall:12-13.