

Case report

Acute nontraumatic torticollis in a patient with right lower quadrant pain: case report

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Key words: Right lower quadrant pain, acute appendicitis, preoperative evaluation, torticollis

Received: 21/12/2014 - Accepted: 21/07/2015 - Published: 27/07/2015

Abstract

Right lower quadrant pain is one of the most common symptoms of the emergency patients. For accurate diagnosis and treatment; the patients must be questioned and examined very well. Also accompanying conditions due to right lower quadrant pain may be noticed. In this case presentation, we discussed a patient who was presented with right lower quadrant pain and cervical dystonia. By limiting the usage of metoclopramide the patient was followed seamlessly. In this case presentation we want to accentuate that a patient who with abdominal pain may be presented with rare symptoms such of dystonia. In such conditions a detailed anamnesis and physical examination are the first steps of the evaluation to prevent potential hazardous outcomes. In particular, a surgeon must be always carefully while taking history and examining the patient.

Pan African Medical Journal. 2015; 21:218 doi:10.11604/pamj.2015.21.218.5984

This article is available online at: <http://www.panafrican-med-journal.com/content/article/21/218/full/>

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Introduction

Acute right lower abdominal pain is a common surgical presentation due to acute appendicitis and merits a thorough clinical evaluation and preoperative assessment in some patients. These procedures should be directed to obtain a conclusive preoperative diagnosis, appropriate preparation for anesthesia and surgery. This approach should not be overwhelmed not only to minimize potential complication in individual patients to prevent medico legal interests and risks but to minimize morbidity and mortality rates. Previously acute dystonic reactions have been presented in some patients with right lower quadrant pain due to medications [1]. In addition, non traumatic torticollis due to nontraumatic atlantoaxial subluxation has been reported after surgery [2]. Thus, such conditions should be recognized and timely managed.

Patient and observation

A 18 years old boy was presented to our clinic with acute lower upper abdominal and back pain from emergency service. In detailed questioning he has confirmed a recent increase in stool frequency without mucus and blood. His previous medical and surgical history was not significant. He denied a specific medical condition in his family. He was a non-smoker and a non-alcohol drinker. Usage of neuroleptics (antipsychotics such as haloperidol), other medications (such as tricyclic anti-depressants, or anticonvulsants) and herbals were questioned and all were refused by the patient. However, emergency service records have documented the usage of anti-emetics (metoclopramide 10 mg, im) and other medications (ranitidin 50 mg iv and Hiyosin-N-butylbromür 20 mg im) two hours prior to development of abnormal cervical posture and muscular spasm on the left arm. Physical examination revealed acute dystonic reaction with right sided torticollis and minimal oculogyric crisis (upward and outward turning of the eyes) were observed. These findings were observed to resolve after a rest of one hour in the bed in the Standard hospital room.

Discussion

The primary intention of this patient was to exclude the need of an emergent surgery for appendicitis. However, due to overall clinical

presentation in this patient with back pain, elevated leukocytes, c-reactive peptide, clusters of lymphadenopathy and acute dystonic reactions have directed us to observe patient. Metoclopramide usage was restricted and the patient was consulted with infectious disease specialist and neurologists. Advised and required tests were performed to exclude the disease. During hospitalization period metoclopramide usage was restricted to prevent an induction of acute dystonic reaction recurrence. With serial physical examination and review of the imaging findings (**Figure 1, Figure 2**), we excluded a need for emergent surgery. Nontraumatic atlantoaxial subluxation has been reported due to an infection or an inflammation at the head and neck region and after surgery [3]. Early diagnosis and treatment is essential to prevent neurological sequelae and/or painful and lasting deformity of the neck pediatric age group and any upper respiratory tract infection are risk factors. However, classical signs such as neck stiffness and torticollis-associated painful neck movements were absent in our patient. Acute dystonic reactions have been reported in a previous report by Oyewole et al. From Nigeria in a single 28-year-old female undergraduate who presented to the medical unit with 4 days history of acute lower abdominal pains, high-grade intermittent fever, and persistent vomiting [1]. Our patient's clinical presentation was comparable with their report. In our case torticollis and upward or outward turning of the eyes were observed. On the other hand other dystonic reactions were not observed. All clinical findings were resolved and recurrence was not observed. Pathophysiology of acute dystonic reactions is not clear. A central dopamine transmission deficit is believed to result with overactive striatal acetylcholine release. Anti-cholinergic medications may reverse this over active release [4]. However, clinical suspicion and early diagnosis is essential to prevent fatal outcomes. Here it is the surgeons' role in such conditions to adequately evaluate the patient and when ever possible prevent the triggering factors such as electrolyte imbalances or usage of anti-emetics prior to neurology consultation. We strictly recommend a consultation of the patient to a neuroimmunologist if it is possible. Previously the authors have reported unusual findings in the appendectomized patients [5]. Together with this case, we commend multidisciplinary approach to patient with right lower quadrant pain with suspicious or unusual presentations. Our case presentation emphasize the significance of evaluating the patient systematically for differential diagnosis. We presented a very rare condition due to an metoclopramide. If the patient had not been evaluated well, the patient would have undergone to surgery for appendectomy.

Conclusion

A systemic evaluation of the patient with acute right abdominal quadrant pain should be routine. Differential diagnosis for right abdominal quadrant pain have to be made. For this purpose we may use computerized tomography. In some instances such as acute nontraumatic torticollis or acute dystonic reactions, review of the initial clinical examination may be necessary to manage concomitant clinical findings or problems.

Competing interests

The authors declare no competing interests.

Authors' contributions

Faik Yaylak: contributed to writing of the manuscript and treated the patient; Sezgin Zeren: contributed to writing the manuscript and treated the patient; Zülfü Bayhan: contributed to writing the manuscript and reviewed the literature; Refik Bademci: reviewed the manuscript and literature; Cigdem Devir: evaluated the images of computerized tomography figures. All authors have read and agreed to the final version of this manuscript and have equally contributed to its content and to the management of the case.

Figures

Figure 1: Distinctive pancreatic tissue in intravenous contrast enhanced abdominopelvic computerized tomography

Figure 2: Mesenteric lymphadenitis in right lower quadrant of the abdomen in intravenous contrast enhanced abdominopelvic computerized tomography

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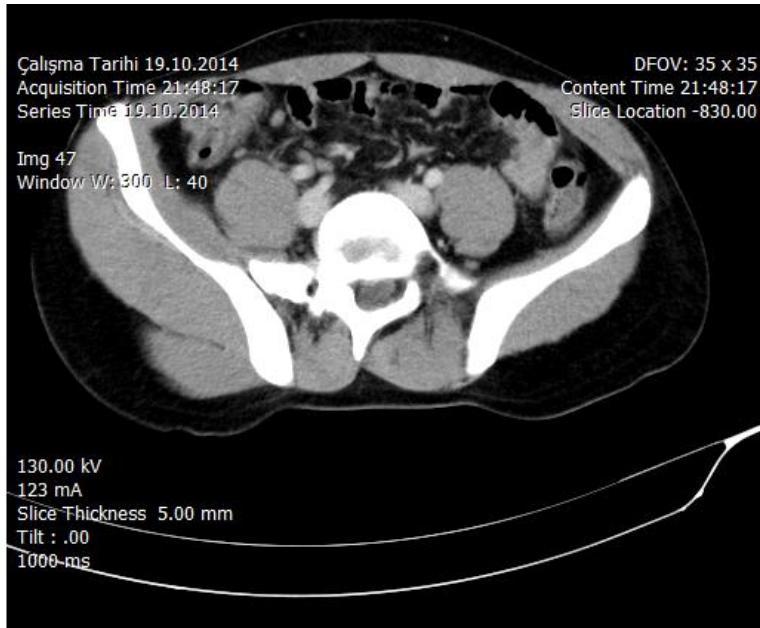


Figure 1: Distinctive pancreatic tissue in intravenous contrast enhanced abdominopelvic computerized tomography

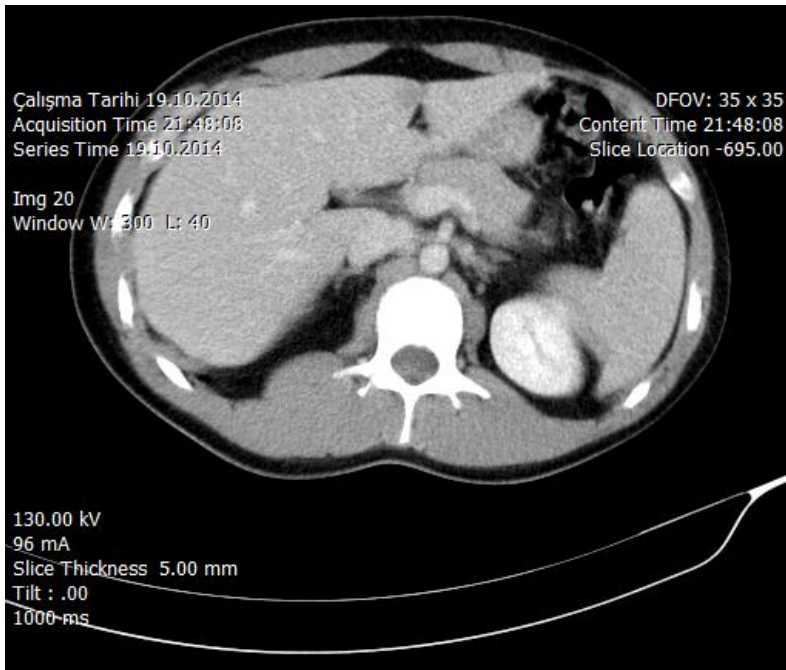


Figure 2: Mesenteric lenfadenitis in right lower quadrant of the abdomen in intravenous contrast enhanced abdominopelvic computerized tomography