

# Appendicitis

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Introduction:

Acute appendicitis is the most common presentation of the acute abdomen in the UK. Although in most cases this is an easily reached diagnosis, presentation is not always typical and there are certain other conditions which may mimic appendicitis. Diagnostic adjuncts usually provide the additional information required to make a confident diagnosis; however, in some circumstances, the safest and most reliable course of action is appropriate surgical intervention.

A case report is presented of a 46-year-old man who presented with history of peri-umbilical pain migrating to the right iliac fossa. Following further investigation,

with routine blood tests, plain radiographs. He eventually underwent an open appendectomy.

Case report:

46 years old married male patient. Presented to ER complaining of abdominal pain for three days. Site of pain was in the right ilia fossa. Past medical history and past surgical history are negative. Associated with fever, vomiting and loose of appetite.

On examination patient looks ill, weight: 80 kg and height:162 cm. Blood pressure 102/60 mmHg, pulse rate 88 beats/min, respiratory rate 24 breath/min, temperature: 39.2°C. Jugulars were not distended, no jaundice, pallor or cyanosis. Abdominal examination revealed sever

tenderness and rigidity. CBC reveals high neutrophils, X-ray is unremarkable.

Laboratory Investigation		
Test	Result	Reference range
hemoglobin	14.4 g/dL	13 - 17
leukocytes	<b>17.60</b> K/ $\mu$ L	4 - 10
platelets	<b>243</b> K/ $\mu$ L	150 - 410
Neutrophils	<b>15.74</b> K/ $\mu$ L	2 - 7
hematocrit	48.40 %	40 - 50
sodium	135 mmol/L	135 - 145
potassium	4.4 mmol/L	3.5 - 5



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Directly patient shifted from ER to OR, I.V fluid normal saline D5 1/2 NS - 125 ML / HOUR. Metronidazole 500 mg TID I.V. omeprazole 40 mg once per day Intravenous. Cefuroxime 1.5 mg BID I.V. Consent was taken for laparotomy and cross match tow blood units just in case if it is needed. Under general anesthesia, McBurney-McArthur incision performed, and the appendectomy done. All pus is drained with post-operative antibiotics continued for 7 days. Wound is left open after closing the facia and healed by delayed primary closure.

Picture showing the large appendicitis and fecalith .



Discussion :

A perforated appendix is one of the complications of acute appendicitis. If appendicitis is left untreated, ischemic

necrosis of a portion of appendiceal wall may occur, leading to perforation. The time interval between onset of symptoms and rupture of the appendix is about 36 to 72 hours. The severity of ruptured appendicitis is different for every patient. Some patients have a small rupture, while others may have a big spillage of stool and pus into the abdomen. Still others can have problems with intestinal blockage from the inflammation and infection. Although in most cases this is an easily reached diagnosis, presentation is not always typical and there are certain other conditions which may mimic appendicitis.

The hallmark of perforation is a hole in appendix can lead to peritonitis. Peritonitis is inflammation of the membrane that lines the abdominal cavity. Symptoms usually begin with chills ,fever , nausea , vomiting. When the patient had a perforation and peritonitis occurs, the abdomen feels very tender. Pain often worsens when someone touches or palpates the area or when the patient moves. Pain is generally better when lying still. The abdomen may stick

outward farther than normal and feel hard. In addition to the general symptoms of perforation, symptoms of peritonitis may include: fatigue , passing less urine, stools, or gas ,shortness of breath a fast heartbeat , dizziness.

As in our case, physical examination may reveal severe abdominal tenderness. Presence of severe pallor should raise the suspicion of rupture and hemoperitoneum. One should always be on the lookout for pleural and pericardial effusion, thromboembolism and adult respiratory distress syndrome (ARDS). These should be picked up early and managed to decrease morbidity and mortality.

Laboratory data is characterized by raised white blood cell counts. Electrolyte disturbances in the form of hyponatremia and hyperkalemia may be seen.

When the diagnosis is confirmed, The patient should be NPO and receive I.V hydration, analgesia , antiemetics and



antibiotics with anaerobic and gram negative coverage. Immediate open or laparoscopic appendectomy is the definitive treatment. If the appendicitis is not found, complete exploration of the abdomen is performed. In case of perforation, administration of antibiotic until the patient afebrile with a normalized WBC count, the wound should be closed by delayed primary closure.

In case of appendicular mass (phlegmon), treat the patient with broad spectrum antibiotics and elective appendectomy should be performed 6 – 8 weeks later.

Conclusion:

There are no clear guidelines in the treatment of a perforated appendicitis associated with periappendiceal

abscess without generalized peritonitis. Acute appendicitis should be considered in any patient presenting with abdominal pain and loss of appetite. The symptoms can range from mild to life-conditions. Prompt recognition and initiation of appropriate treatment plan can reduce morbidity and prevent mortality.

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