Appendicitis

Science, Epidemiology

In the position of the appendix, age of the patient, and degree of inflammation make the clinical presentation of appendicitis notoriously inconsistent. Statistics report that 1 of 5 cases of appendicitis is misdiagnosed; however, a normal appendix is found In 15-40% of patients who have an emergency appendectomy. Niwa et al reported an Interesting case of a young woman with recurrent pain In who was referred for appendicitis, treated with antibiotics, and was found to have an ppendiceal diverticulitis associated with a rare pelvic pseudocyst at laparotomy after 12 months. 15] Her condition was probably due to diverticular perforation of the pseudocyst_ Symptoms The classic history of anorexia and perlumblllcal pain followed by nausea, right lower quadrant (RLQ) pain, and vomiting occurs in only 50% of cases. Nausea is present in 61-92% of patients; anorexia is present in 74-78% of patients. Neither finding is statistically different from findings in patients who present to the emergency epartment with other etiologies of abdominal pain. In addition, when vomiting occurs, it nearly always follows the onset of pain.

Vomiting that precedes pain Is suggestive of Intestinal obstruction, and the diagnosis of appendicitis should be reconsidered. Diarrhea or constipation Is noted In as many as of patients and should not be used to discard the possibility of appendicitis. The most common symptom of appendicitis is abdominal pain. Typically, symptoms begin as periumbilical or epigastric pain migrating to the right lower quadrant (RLQ) f the abdomen. This pain migration is the most discriminating feature of the patient's history, with a sensitivity and specificity of approximately 80%, a positive Ilkellhood ratio of 3. 8, and a negative likelihood ratio of 0. 5. [3] Patients usually Ile down, flex

their hips, and draw their knees up to reduce movements and to avoid worsening their pain. Later, a worsening progressive pain along with vomiting, nausea, and anorexia are described by the patient. usually. a fever is not present at this stage. The duration of symptoms Is less than 48 hours In approximately 80% of adults but tends to be longer In elderly persons and In those with perforation.

Approximately 2% of patients report duration of pain in excess of 2 weeks. A history of similar pain is reported in as many as 23% of cases, but this history of similar pain, in and of itself, should not be used to rule out the possibility of appendicitis. In addition to recording the history of the abdominal pain, obtain a complete summary of the recent personal history surrounding gastroenterologic, genitourinary, nd pneumologlc conditions, as well as consider gynecologic history In female patients.

An inflamed appendix near the urinary bladder or ureter can cause Irrltatlve v0101ng symptoms ana nematurla or pyurla. cystltls In male patlents Is rare in the absence of instrumentation. Consider the possibility of an inflamed pelvic appendix in male patients with apparent cystitis. Also consider the possibility of appendicitis in pediatric or adult patients who present with acute urinary retention.