

Acute Appendicitis

Department of the Navy

Bureau of Medicine and Surgery

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(1) Introduction

The appendix is a true diverticulum of the cecum, its base originating at the confluence of the *tenia coli*. The appendix is relatively large at birth and progressively decreases in size until age 5 years. Its position with regard to the cecum can be variable and this explains its many potential presentations when inflammation occurs. Variable presentations are also common in the extremes of age.

- Acute appendicitis is the most common surgical disease of the abdomen. The goal of therapy is rapid diagnosis and treatment before rupture. Perforation occurs in up to 20 percent of patients and is reported to occur in 50 percent of patients at the extremes of life (less than 3 years and greater than 50 years of age). Between 6 and 20 percent of the population develop acute appendicitis during their lifetime.

(2) Pathophysiology

By definition, the pathologic finding in acute appendicitis is mucosal disruption with invasive infection and inflammation. The invasive organisms, consistent with normal stool flora, include *E. Coli*, *Klebsiella*, and *Enterobacter*. The inciting event is thought to be luminal obstruction, most commonly from a fecalith (40 percent of perforated appendicitis) or lymphoid hyperplasia (most commonly in children). However, not all luminal obstructions cause acute appendicitis and certainly not all acute appendicitis is caused by obstruction. Following obstruction the appendix continues to secrete into a closed lumen causing increased luminal pressures with eventual venous congestion and infarction along the watershed region. Eventual perforation is preceded by mucosal ulceration and transmural necrosis. Abscess formation or peritonitis may ensue.

(3) Presentation

- (a) Differences in sex and age at presentation will alter the initial clinical scenario. Children less than 5 years of age and adults over the age of 50 will typically present later in the disease process and frequently with vague signs and symptoms.
- (b) With acute appendicitis, vague epigastric and periumbilical pain presents early and is described as a dull ache. This pain is regulated by autonomic visceral pain fibers. Nearly 95 percent of patients will experience a pain similar to this described. Anorexia is present in 90 percent of patient's at this stage. In fact, if a person is hungry upon history taking, the diagnosis of acute appendicitis must be questioned. Approximately 4 to 6 hours after initial onset of illness the inflammation extends, activating the somatic pain fibers and localizing the pain to the region of the appendix. This is most commonly in the right lower quadrant at McBurney's point; however, the variability of anatomic locations of the appendix (retrocecal, etc.) may cause the pain to be localized in almost any region. **A good history is the most helpful tool in making a diagnosis.**
- (c) Acute appendicitis is known as the great imitator and can cause right upper quadrant pain, perineal and rectal fullness and pain, and a collection of other presentations. Acute appendicitis should be in the differential diagnosis for anyone presenting with acute abdominal pain.
- (d) Once the pain localizes, it is common to find the patient very still with voluntary guarding. Cutaneous hyperesthesia is present over the point of maximal tenderness and pain. A low-grade temperature is now very common (38 °C) and now a low-grade leukocytosis is also commonly present (WBC of 12,000 to 16,000). A WBC greater than 18,000 is not generally seen at this point of the process and should suggest another possible diagnosis. Certainly after perforation a high WBC is not uncommon.

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