

Acute Appendicitis

Department of the Navy

Bureau of Medicine and Surgery

Peer Review Status: Internally Peer Reviewed

(1) Introduction

The appendix is a true diverticulum of the cecum, its base originating at the confluence of the *taenia 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.

General Medical Officer Manual

RJ Shavelson



General Medical Officer Manual:

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Table of Contents General Medical Officer Manual

1. Understanding the eBook General Medical Officer Manual
 - The Rise of Digital Reading General Medical Officer Manual
 - Advantages of eBooks Over Traditional Books
2. Identifying General Medical Officer Manual
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an General Medical Officer Manual
 - User-Friendly Interface
4. Exploring eBook Recommendations from General Medical Officer Manual
 - Personalized Recommendations
 - General Medical Officer Manual User Reviews and Ratings
 - General Medical Officer Manual and Bestseller Lists

5. Accessing General Medical Officer Manual Free and Paid eBooks
 - General Medical Officer Manual Public Domain eBooks
 - General Medical Officer Manual eBook Subscription Services
 - General Medical Officer Manual Budget-Friendly Options
6. Navigating General Medical Officer Manual eBook Formats
 - ePub, PDF, MOBI, and More
 - General Medical Officer Manual Compatibility with Devices
 - General Medical Officer Manual Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of General Medical Officer Manual
 - Highlighting and Note-Taking General Medical Officer Manual
 - Interactive Elements General Medical Officer Manual
8. Staying Engaged with General Medical Officer Manual
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers General Medical Officer Manual
9. Balancing eBooks and Physical Books General Medical Officer Manual
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection General Medical Officer Manual
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine General Medical Officer Manual
 - Setting Reading Goals General Medical Officer Manual
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of General Medical Officer Manual
 - Fact-Checking eBook Content of General Medical Officer Manual
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning

- Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
- Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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