CLINICAL REFERENCE GUIDE

APPENDICITIS

EPIDEMIOLOGY

- Most common in second and third decades with risk falling for every decade thereafter.
- Males: females = 1.5:1

PATHOGENESIS

- Inflammation → ischaemia → perforation → peritonitis +/-abscess formation
- Referred pain to peri-umbilical region: Stimulation of visceral afferent nerve fibres entering the spinal cord at T8-T10
- Localisation of the pain to RIF occurs when overlying parietal peritoneum is involved

CLINICAL PRESENTATION

- Pain: Peri-umbilical region → RIF
- Nausea +/- vomiting, anorexia
- Low-grade pyrexia
- Localised tenderness in right iliac fossa/over McBurney's point
- Change in bowel habit – especially in the case of a retrocaecal appendix
- DRE may elicit tenderness in the case of an appendiceal abscess
- *Rovsing's sign:* Deep palpation of the left iliac fossa will illicit RIF tenderness
- *Psoas sign*: RIF pain associated with passive extension of the hip (retrocaecal appendix)
- *Obturator sign:* Passive flexion, internal rotation of hip with flexed knee → RIF pain

INVESTIGATIONS

- Labs: FBC, inflammatory markers, betaHCG in females of reproductive age
- Urinalysis: Out rule urinary tract infection and renal colic
- Radiology: Ultrasound or CT abdomen

DIFFERENTIAL DIAGNOSIS

Caecal Diverticulitis	**Ruptured Ovarian Cyst**	**Renal Colic**
Meckel's Diverticulitis	**Ectopic Pregnancy**	**Testicular Torsion**
Ovarian/fallopian tube Torsion	**Endometriosis**	**Epididymitis**

CLINICAL REFERENCE GUIDE

APPENDICITIS

APPENDICECTOMY

- Open appendicectomy is usually performed via a Lanz incision - muscle splitting approach
- No evidence that burying the stump reduces the infection rate
- If appendix is not inflamed, look for Meckel's diverticulum/Tubo-ovarian pathology/Terminal Ileitis (Crohn's disease)

WHO ANALGESIC LADDER