

Original article:

A Prospective Comparative analysis of Clinical presentation and USG findings of Appendix in patients of Appendicitis in Saharsa, Bihar

Ram Nagina Sinha

Assistant Professor, Department of General Surgery, Lord Buddha Koshi Medical College & Hospital, Saharsa, Bihar

Corresponding Author: Dr. Ram Nagina Sinha, Department of General Surgery, Lord Buddha Koshi Medical College & Hospital, Saharsa, Bihar

Abstract:

Background: We have been knowing from our past that appendix is a vestigial organ, useless to man, with no known important function, but sometimes it can cause problems, when it may become the seat of infection. The diagnosis of appendicitis is not very easy, requiring the skills of the most experienced clinician. The objective of this study was to find out and compare accuracy of USG findings with that of per-operative findings of location & status of appendix.

Methods: The present prospective study was carried out in surgery department of Lord Buddha Koshi Medical College & Hospital, Saharsa from November 2012 till April 2013. A total of 75 cases were selected on the basis of inclusion and exclusion criteria and subjected to ultrasound examination by a qualified radiologist to exclude any other associated pathology and also to confirm the diagnosis. During surgery the Position of the appendix was first.

Results: Out of 75 cases, a total of 46 cases presented with clinical features suggestive of retrocaecal appendicitis, out of which 38 had typical presentation & 9 had atypical presentation with overall sensitivity of 73.25%, followed by pelvic position which had a sensitivity of 16.29% in which 6 patients had typical presentation & 6 had atypical presentation.

Conclusions: A total of five modalities that were used for the diagnosis of position of appendix & appendicitis, i.e. clinical features, lab Ix, ultrasound, intraoperative findings & histopathology, only 47% of cases all the modalities were positive.

Keywords: Appendix, Choleystitis, USG, Laboratory investigations

Introduction

Appendicitis is a common sometimes confusing, and treacherous cause of acute abdomen at all ages. The appendix is regarded as a vestigial organ, useless to man, with no known important function, but can be a real nuisance at times, when it may become the seat of infection. The diagnosis of appendicitis can be difficult, occasionally taxing the skills of the most experienced clinician. The delays in the diagnosis arise from errors either from the patient or physicians. The most common position of the appendix is variously described by many authors Wakeley et al as retrocaecal (65.3%),¹ Collins et-al as pelvic (78.5%)² and Pickens G et al as postileal.³ Guidry SP et al have concluded that anatomic variations of the location of appendix are often responsible for delays in the diagnosis of

appendicitis.⁴ Poole GV has stated that the paucity of symptoms and signs, in patients with hidden appendix, is responsible for the delayed diagnosis of appendicitis before perforation.⁵ Varshney et al have concluded that the retrocaecal position of the appendix is less prone to infection,⁶ whereas Collins et al have described higher incidence of perforation and serious complications in acute appendicitis,⁷ other studies one prospective⁸ and two retrospective studies have established that the retrocaecal position of the appendix does not alter the clinical course of acute appendicitis.^{9,10} From the above information it is evident that there are lots of controversies regarding the various positions of appendix and also clinical presentation of appendicitis, in relation to different positions. Hence there is a need for the study of the various positions of appendix in patients with appendicitis and also the clinical picture and complication in the various positions.

Our study is performed in clinical cases representing the inflamed appendix group, in this group the relation between the various positions of the appendix, the clinical presentation, laboratory & radiology investigations, intra operative findings and histopathology is studied.

Methods

The study was carried out in department of Surgery at Lord Buddha Koshi Medical College & Hospital, Saharsa from November 2012 till April 2013. The study was prospective, observational and longitudinal. Study protocol of the procedure was formed along with Proforma. A total of 50 cases were included in our study on the basis of inclusion and exclusion criteria and subjected to clinical assessment using signs, symptoms and laboratory criteria, histopathology and also the position of the appendix, which were recorded in the proforma. All patients were subjected to ultrasound examination by a qualified radiologist to exclude any other associated pathology and also to confirm the diagnosis. Surgery was done either under general anesthesia or spinal anesthesia. Abdomen was opened with Lanz or Mc Burney's, or right lower Para median incision. At surgery the Position of the appendix was first identified before disturbing the structures and the position of the appendix identified and recorded together with the length of the appendix and also whether it was fixed or freely mobile in the peritoneal cavity, peri-appendiceal collection, presence of perforation or other complications of appendicitis. Also a note was made of the status surrounding organs. After completion of the appendectomy the specimen was subjected to histopathological examination by the qualified pathologist only those cases, which were proved as, appendicitis by the histopathology were included in the study.

Results

Out of 75 patients in the study; 40 were Male and 35 were Female. Appendicitis was more common during the 3rd decade (38%), followed by the 4th decade (21%). A total of 46 cases presented with clinical features suggestive of retrocaecal appendicitis, out of which 38 had typical presentation & 9 had atypical presentation with overall sensitivity of 73.25%, followed by pelvic position which had a sensitivity of 16.29% in which 2 patients had typical presentation & 1 had atypical presentation.

The clinical presentation of retrocaecal type has sensitivity of 87.09% as compared with the pelvic types as shown in table 1.

On comparing the position of appendix with USG and intra operative findings; USG has sensitivity of 88.88% in detection of pelvic type followed by 85.41% in retrocaecal type appendicitis as shown in table 2.

The following pie chart shows that; on the basis of individual modality 85% were suspected to have appendicitis on clinical presentation, 78% were suspected to have appendicitis on lab Ix, 69% were ultrasound proven appendicitis and histopathology proved appendicitis in all the cases (100%). Table 3

Position of appendix	Clinical presentation	Intra operative	Sensitivity
Retrocaecal	46	40	87.09
Paracaecal	3	3	100.0
Post- ileal	5	3	80.00
Pre-ileal	1	3	50.00
Pelvic	9	12	76.47
Sub-hepatic	0	2	00.00
Sub-caecal	2	3	50.00
Left sided	0	0	00.00
Total	66	66	

Table 1: comparison between position of appendix with clinical presentation and intra operative findings.

Table 2: Comparison between position of appendix with USG findings and intra operative finding.

Position of appendix	USG finding	Intra operative	Sensitivity
Retrocaecal	32	34	85.41
Paracaecal	1	3	50.00
Post- ileal	3	2	100.0
Pre-ileal	3	1	20.00
Pelvic	12	10	88.88
Sub-hepatic	2	2	50.00
Sub-caecal	1	2	33.33
Left sided	0	0	00.00
Total	54	54	100

Table 3: Association between presentations of appendix with laboratory investigations.

Laboratory Investigation					
Presentation of appendix	TLC			DC	
	Elevated	Normal	Total No.	Neutrophilia	Lymphocytosis
Acute	48	8	55	50	
Subacute	2	5	9	2	6
Recurrent	6	3	10	8	
Total	56	16	74	60	30

Discussion

An accurate preoperative diagnosis of Appendicitis has always remains a challenge because of the various other conditions, which mimic appendicitis. The problem is further compounded by the variations in the position of the appendix and the associated varied clinical picture of the appendicitis.

In our series appendicitis was more common during the 3rd decade (39%), followed by the 4th decade (20%). Appendicitis is slightly more common in males, (60%) in our series. Lewis et al¹¹ (1975) in their study found that the 2nd and 3rd decades to be the most common age groups for acute appendicitis. Men outnumbered women in our study, men are believed to suffer from appendicitis more often because, probably the male is being subjected to more stress and strain, as highlighted by Boyd (1961). Addis et al & Korner et al, have reported a slight male preponderance (with male to female ratio of 1.2 to 1.3:1).^{12, 13}

All the patients with acute appendicitis had pain and most of the patients had pain in the right iliac fossa. Even though many of the patients presented with atypical symptoms 25 of the 75 cases (34%). The site of maximum pain was in the right iliac fossa in 70 of 75 cases. Only 5 cases had maximal pain at a site other than right iliac fossa. In pelvic appendix patients had supra-pubic pain, in retro-caecal appendix patient had pain in the right lumbar region or right flank, in sub- hepatic position the patients had pain in the right hypochondriac region. Atypical pain was more common in cases of fixed retro-caecal appendix and in cases of pelvic appendicitis.

Tenderness in the right iliac fossa is a constant feature in all the cases of appendicitis. The site of maximum tenderness was in the right iliac fossa in 89 of 100 cases even though few had tenderness at other sites leading to difficulty in the diagnosis. Only 6 cases had maximal tenderness at a site other than right iliac fossa. In retro-caecal position tenderness may be present in the right flank or in the right lumbar region more so if the appendix is fixed either by the adhesions or because of its extra-peritoneal location (in these cases tenderness will be more in this region rather than right iliac fossa). In case of pelvic position tenderness may be present in the suprapubic region or the patient may have rectal tenderness. In sub-hepatic position patient may have tenderness in the right hypochondriac region.

Leukocytosis or neutrophilia was present in 60 of the 75 cases, with an accuracy of 78%.

The position of the appendix and its relation to the clinical presentation and course of acute appendicitis has been a subject of controversy with various authors giving various results and conclusions.

A total of 46 cases presented with clinical features suggestive of retrocaecal appendicitis, out of which 26 had typical presentation & 5 had atypical presentation with overall sensitivity of 72.25%, followed by pelvic position which had a sensitivity of 16.29% in which 12 patients had typical presentation & 3 had atypical presentation. The clinical presentation of retrocaecal type when compared with intraoperative has sensitivity of 87.09% as compared with the pelvic type which has sensitivity of 76.47% in our series.

Varshney et al⁶ have described that advanced appendicitis (perforation or gangrene) is more common in those with retro-caecal appendicitis. They have given the explanation that some early cases may have been misdiagnosed, as urinary tract infection, leading to delay in the diagnosis, and increased incidence of complications. In Collins⁷ series of 751 patients with retro-caecal appendicitis, only 19% had typical symptoms, 18% had non-localizing pain, 28% had right flank pain and 12% had right shoulder pain. In his series 53% of the cases were perforated. Guidry S et al⁴ in 1994, have concluded that the patients with gangrene and perforation were more likely to have pain and tenderness at a site other than right lower quadrant. The appendix was in hidden location (retro-caecal, retro-ileal, pelvic appendicitis) as compared with 68% of the patients with gangrenous or perforated appendicitis.

On comparison with intraoperative findings Ultrasound has sensitivity of 88.88% in detection of pelvic type followed by 85.41% in retrocaecal type appendicitis.

On the basis of individual modality 85% were suspected to have appendicitis on clinical presentation, 78% were suspected to have appendicitis on lab Ix, 69% were ultrasound proven appendicitis and histopathology proved appendicitis in all the cases (100%).

In our study the Retrocaecal appendix was found to be most common (65%) position followed by pelvic (20%), post-ileal (6%), paracaecal (4%), subcaecal (2%), pre-ileal (1%) & sub-hepatic (2%) when seen intraoperatively.

In our study a total of five modalities are used for the diagnosis and confirmation of appendicitis. Out of which 86% were suspected to have appendicitis based on clinical presentation. 65% were suspected to have appendicitis on combining clinical presentation with laboratory investigations. On combining clinical presentation, lab Ix and USG 58% were suspected to have appendicitis. On combination of clinical presentation, lab Ix, USG with intraoperative findings 51% had appendicitis. And on combination of above mentioned four modalities with histopathology only 47% had appendicitis i.e. all five modalities were suggestive of appendicitis.

Conclusion

Appendicitis is a very common surgical entity with a wide of complications and post appendectomy symptoms. The accurate diagnosis of appendicitis still remains a challenge for the surgeon and the rate of negative appendectomy with post appendectomy symptoms are increasing due to inaccurate diagnosis. In our study we used a total of five modalities for the diagnosis of position of appendix & appendicitis, i.e. clinical features, lab Ix, ultrasound, intraoperative findings & histopathology.. So the accurate diagnosis of position of appendix & appendicitis is a combination of all the modalities and not just dependent on one basis in order to prevent post appendectomy complications and symptoms.

References

1. Wakeley CPG. The position of vermiform appendix as ascertained by the analysis of 10,000 cases. *J Anat* 1933; 67: 277-283.
2. Collins DC. 71,000 human appendix specimens: a final report, summarizing 40 years study. *Am J Proctol* 1963; 14:365-381.
3. Pickens G, Ellis H. The normal vermiform appendix at C.T visualization and anatomical location. *Clin. Anat.* 1993; 6:9.
4. Guidry SP, Poole GV. The anatomy of appendicitis. *Am Surg.* 1994 Jan; 60(1): 68-71
5. Poole GV. Anatomic basis for delayed diagnosis of appendicitis. *South Med J.* 1990 Jul; 83(7): 771-773.
6. Varshney S, Jhonson CD, Rangnekar GV. Retrocaecal appendix appears to be less prone to infection. *Br J Surg* 1996; 83:223-224.
7. Collins DC, Acute retro-caecal appendicitis. *Arch Surg.* 1938; 36:729-743.
8. Shen GK, Wong R, Daller J, Melcer S, Tsen A, Awry S, et al. Does the retrocaecal position of the vermiform appendix alter the clinical course of acute appendicitis? *Arch Surg.* 1991; 126:569-570.
9. Williamson WA, Bush RD, William LF. Retrocaecal appendicitis. *Am J Surg* 1981; 141:507-509.
10. Grunditz T, Rayden CI, Janzon L. Does the retrocaecal position influence the course of acute appendicitis? *ActaChir Scand.* 1983;249:707-710.
11. Lewis FR, Holcroft JW, Boey, et al. Appendicitis: a critical review of the diagnosis and treatment in 1000 cases. *Arch Surg* 1975;110:677-684.
12. Addis DG, Shaffer N, Fowler BS. The epidemiology of acute appendicitis in United States. *Am J Epidemiol* 1990;132:910.
13. Korner H, Sondenna K, Soreide JA. Incidence of acute non-perforated and perforated appendicitis: Age specific and sex specific analysis. *World J Surg.* 1997; 21:313.
14. Berry J, Malt RA. Appendicitis near its centenary. *Ann Surg* 1984; 200:567.
15. Collins DC. Acute retro-caecal appendicitis. *Arch Surg.* 1938; 36:729-743.