

ACUTE APPENDICITIS

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In early appendicitis, there is a fever of 37.3–38.4°C, anorexia, a few vomits and central abdominal pain settling in the right iliac fossa. Persistent guarding in the right iliac fossa Johann Conrad Peyer, 1653–1712, Swiss anatomist. - - - - distinguishes it from self-resolving non-specific abdominal pain (NSAP). Investigations and scoring systems may help but neither replace regular clinical review. Treatment starts with intravenous fluids, analgesia and broad-spectrum antibiotics. Early appendicitis is managed laparoscopically, though some mild cases may resolve with antibiotics alone.

Figure 17.10 Ileocolic intussusception causing small bowel obstruction

tion. Figure 17.11 Air enema reduction of an intussusception (the arrows mark the soft tissue shadow of the intussusceptum).

perforation, abscess formation, a mass or generalised peritonitis. One pitfall is to diagnose gastroenteritis when there are loose stools, and another is to attribute pain on micturition and pyuria to a UTI; both can occur in pelvic appendicitis with a collection. Referred pain from right lower lobe pneumonia should be considered. Antibiotics given for any reason may mollify signs and delay or complicate a presentation. The diagnosis can be difficult in those under 5 years, with many presenting after a perforation. Before 5 years, the omentum is less well developed and inflammation less well contained. An appendix mass in an unobstructed child may respond to non-operative management with antibiotics. An interval appendicectomy can be considered 6 weeks later but is not mandated. ACUTE APPENDICITIS

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