

Postoperative complications

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Postoperative complications following appendicectomy are relatively uncommon and reflect the degree of peritonitis that was present at the time of operation and intercurrent diseases that may predispose to complications. Harrith Hasson, 1931–2012, Professor of Gynecology, Chicago, IL, USA. Summary box 76.7 Checklist for unwell patients following appendicectomy /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF Wound infection Wound infection is the most common postoperative complication, occurring in 5–10% of all patients. This usually presents with pain and erythema of the wound on the fourth or fifth

(d) (b) The appendicular artery, ligated with clips, (d) Appendicectomy complete. Examine the wound and abdomen for an abscess Consider a pelvic abscess and perform a rectal examination Examine the lungs – consider pneumonitis or collapse Examine the legs – consider venous thrombosis Examine the conjunctivae for an icteric tinge and the liver for enlargement, and enquire whether the patient has had rigors (pyelephlebitis) Examine the urine for organisms (pyelonephritis) Suspect subphrenic abscess

postoperative day, often soon after hospital discharge. Treatment is by wound drainage and antibiotics when required. The organisms responsible are usually a mixture of Gram-negative bacilli and anaerobic bacteria, predominantly *Bacteroides* species and anaerobic streptococci. Intra-abdominal abscess Approximately 8% of patients following appendicectomy will develop a postoperative intra-abdominal abscess. In an era of hospital discharge 24–48 hours following appendicectomy, patients should be advised prior to discharge that a spiking fever, malaise and anorexia developing 5–7 days after operation is suggestive of an intraperitoneal collection and that urgent medical advice should be obtained. Interloop, paracolic, pelvic and subphrenic sites should be considered. Abdominal ultrasonography and CT scanning greatly facilitate diagnosis and allow percutaneous drainage (Figure 76.14). Surgical exploration should be considered in patients suspected of having intra-abdominal sepsis but in whom imaging fails to show a collection, particularly those with continuing ileus. Ileus A period of adynamic ileus is to be expected after appendicectomy, and this may last a number of days following removal of a gangrenous appendix. Ileus persisting for more than 4 or 5 days, particularly in the presence of a fever, is indicative of continuing intra-abdominal sepsis and should prompt further investigation. Rarely, early during postoperative recovery, a Richter's type of hernia may occur at the site of a laparoscopic port insertion and may be confused with a postoperative ileus. A CT scan is usually definitive. August Gottlieb Richter, 1742–1812, lecturer in surgery, Göttingen, Germany. - Respiratory In the absence of concurrent pulmonary disease, respiratory complications are rare following appendicectomy. Adequate postoperative analgesia and physiotherapy, when appropriate, reduce the incidence. Venous thrombosis and embolism These conditions are rare after appendicectomy. Patients should undergo preoperative assessment of risk factors for venous thromboembolism and appropriate prophylactic measures should be taken. Portal pyaemia

(pylephlebitis) This is a rare but very serious complication of gangrenous appendicitis associated with high fever, rigors and jaundice. It is caused by septicaemia in the portal venous system and leads to the development of intrahepatic abscesses (often multiple). Treatment is with systemic antibiotics and percutaneous drainage of hepatic abscesses as appropriate. Faecal fistula Leakage from the appendicular stump occurs rarely, but may follow if the encircling stitch has been put in too deeply or - if the caecal wall was involved by oedema or inflammation. Occasionally, a fistula may result following appendicectomy in Crohn's disease. Adhesive intestinal obstruction This is the most common late complication of appendicectomy. At operation, a single band adhesion is often found to be responsible. Occasionally, chronic pain in the right iliac fossa is attributed to adhesion formation after appendicectomy. In such cases, laparoscopy is of value in confirming the presence of adhesions and allowing division.

Figure 76.14 (a) Rim-enhancing collection in the right iliac fossa, 1 week after open appendicectomy for perforated appendicitis. radiological drainage with resolution of the abscess (courtesy of Professor P MacMahon, FRCR, Dublin, Ireland). (b) Successful

Rarely, inflammation of the appendix may present as a chronic condition characterised by recurrent episodes of lower abdominal pain. Recurrent appendicitis is thought to arise as a consequence of incomplete self-limiting obstruction of the appendix lumen. The attacks vary in intensity and may occur every few months, and the majority of cases ultimately culminate in severe acute appendicitis. If a careful history is taken from patients with acute appendicitis, many remember having had milder but similar attacks of pain. The appendix in these cases is thickened and shows fibrosis indicative of previous inflammation.

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