

Case Report-Atypical presentation of perforated appendix in pregnancy

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- OBJECTIVE-Acute appendicitis is the most common general surgical problem encountered during pregnancy. The diagnosis is particularly challenging during pregnancy because of the relatively high prevalence of abdominal/gastrointestinal discomfort, anatomic changes related to the enlarged uterus, and the physiologic leucocytosis of pregnancy. Appendiceal rupture occurs especially in the third trimester, possibly because of these challenges and reluctance to operate on pregnant people delays diagnosis and treatment. This Case report is a one such atypical presentation during mid-trimester sadly associated with pregnancy loss
- CASE REPORT-
- A 32-year-old woman G4P1+1 at 22 weeks of gestation presented Via the ED for Right sided and lower abdominal pain with diarrhoea and vomiting. Blood tests revealed a normal infection and raised inflammatory markers with Haemoglobin of 110 g/dL and a white cell count of 12×10^3 /L. Ultrasound abdomen was Normal. An initial diagnosis of UTI was made and was treated with iv antibiotics. On the third day of admission, Obstetric team involved due to ongoing lower abdominal pain, bleeding per vagina. On examination, Patient was found to be in active stage of labour with cervix 6 cm dilated and breech presentation. Immediate transfer to delivery suite made and USS done to confirm presentation and viability(present). A single dose of dexamethasone 9.9 mg given to reduce respiratory morbidity and MgSo4 given for neuroprotection. Unfortunately, she progressed and delivered foetus at 23+1 weeks with no signs of life. Owing to the ongoing Right iliac fossa pain and raised CRP and infection markers, a repeat imaging was requested by the Obstetric team. CT abdomen and pelvis revealed a collection of gas and fluid indicating a perforated appendix. Surgical and interventional radiology team involved and proceeded with Interventional radiological guided abdominal drain and started on iv antibiotics. Follow up arranged with surgical team with colonoscopy and interval appendectomy.
- DISCUSSION-Acute appendicitis is diagnosed in 1 in 800 to 1 in 1500 pregnancies, with a higher incidence during the second trimester. The risk of foetal loss during uncomplicated appendectomies is 2%; however, in the presence of generalized peritonitis and peritoneal abscess, the foetal loss may increase to 6%.Gravid women are less likely to have a classic presentation of appendicitis than age-matched nonpregnant women, especially in the late stages of pregnancy. Usually, the curative treatment of acute appendicitis is appendectomy. Delaying surgical intervention for more than 24 hours after the symptoms first appear increases the risk of perforation. If an appendiceal perforation is present, the management will depend on the nature of the perforation.
- The evaluation of a pregnant woman presenting with acute abdominal pain warrants a careful work up due to the possible risks for the foetus and mother. Pain in either the right lower or upper quadrant accompanied by a leucocytosis should raise suspicion of acute appendicitis as a possibility. Depending on the trimester, an ultrasound, MRI or CT can be used to verify the diagnosis. Nonetheless, in a suspected case of acute appendicitis, emergent surgery should not be delayed given the high morbidity and mortality rates due to perforation. Removal of the appendix is warranted even if grossly normal during the operation.
- Intra-operatively, the placement of the trocars depends on the size and location of the uterus and appendix if visualized on imaging studies. The patient should be positioned on the left recumbent position to allow increased venous return to the heart and the foetus monitored with a foetal monitor if older than 20 weeks. Post-operatively, the patient should be monitored for any bleeding and thromboembolism, infection, and signs of foetal distress.
- References
- 1. Babaknia A, Parsa H, Woodruff JD. Appendicitis during pregnancy. *Obstet Gynecol.* 1977;50:40–44. [[PubMed](#)]
- 2. Cilo NB, Amini D, Landy HJ. Appendicitis and Cholecystitis in Pregnancy. *Clin Obstet Gynecol.* 2009;52(4):586–596.