Appendectomy and appendicitis

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It is fascinating that appendicitis and appendectomy remain a subject of interest and study more than 100 years after the initial procedures were done and the operation became technically "standardized." In this issue of the Journal (page 138), the paper "Day-care laparoscopic appendectomies" by Drs. Brosseuk and Bathe demonstrates what is and can be done in the real world of the community hospital and, as always, raises some controversial points.

Being retrospective, the study is open to the usual criticisms raised in this era of prospective randomized trials. However, by being inclusive, the study also functions for the Williams Lake, BC, community as an evaluation of quality of care. When the accreditors visit our hospital and ask "what audits have you done?" our reply has been to point out the clinical trial or studies under way or published. The reality is that many of us don't like to do audits and as a result they are often poorly performed and therefore not publishable. We have here, in the paper by Brosseuk and Bathe, an excellent record of the care patients receive in the management of suspected appendicitis.

Surgeons have always been defensive about the number of normal appendices removed. Indeed, at rounds it is occasionally stated that a certain number must be normal or some abnormal appendices will be missed. There are no data to support this contention. There are continuing attempts to improve diagnostic accuracy with nuclear scanning, ultrasonography or computed tomography.

One of the referees of the paper was particularly critical of the use of laparoscopy as a diagnostic tool in place of clinical evaluation. We may be face to face with the real world where the conflict with number and availability of beds, personnel and laboratory testing meets the quick diagnostic solution, which is pragmatic and appears safe but conflicts with the clinician's solution to a clinical problem. In the series of Brosseuk and Bathe, the number of normal appendices in the laparoscopic group (35%) is not much different from that in the open group (26%). The population served (40 000) is spread out along the Cariboo trail and does not have the same access or culture seen in cities. So, although I might be somewhat skeptical of the quick diagnostic laparoscopy with *en passant* appendectomy, I am sympathetic; that sympathy was enhanced recently when I removed what looked like a normal appendix, the patient having been through the diagnostic mill of a university hospital, to find that the pathologist termed it "early acute." So we tempered the reviewer's demand to decry the diagnostic laparoscopy in this community setting.

A second area of controversy is the use of antibiotics. Without getting into a battle over 7 days of intravenous therapy for perforated appendicitis, the use of orally administered antibiotics for short-stay or day surgery patients makes sense. There is an ongoing study evaluating this kind of therapy in intra-abdominal infections. We have all noted that most patients, once their infection has been managed and the source controlled, seem remarkably well despite the intravenous therapy, which makes patients look and feel sick. Oral therapy seems an excellent solution, and the antibiotics used have therapeutic serum levels with oral administration, allowing for treatment on an outpatient basis.

The day-care approach to appendicitis in selected patients is reasonable and has been shown in the study of Brosseuk and Bathe to be safe and effective. Although laparoscopic appendectomy, as pointed out by Brosseuk and Bathe, has not been proven in randomized controlled trials to be vastly superior, for those patients in whom it was feasible the benefits were apparent.

It is almost certain that advancing technology will confirm that there is rarely a single approach to any problem. Finding the best one for each patient remains the challenge.

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