Further Section

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Comment

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The authors start with the thesis that in a patient with appendicitis and a palpable mass, the patient should not be treated by early operation. They conclude with the statement that 'an interval appendectomy should only be performed on special indications'.

While their review is a retrospective one, they seem to favor the statement that 'after admission with appendiceal mass, the patients were treated by starvation and par-enteral fluid replacement'. I believe that this approach would not find wide favor in the United States and most individuals would attempt an early accurate diagnosis followed by some operative procedure, varying all the way from percutaneous drainage of the abscess to exploration with appendectomy and resection of other involved bowel. The authors would monitor the patient by the erythrocyte sedimentation rate which would rarely be used in evaluation of acute appendicitis in the United States. The suggestion that the erythrocyte sedimentation rate should be repeated every third day suggests a tremendously prolonged hospitalization which is another argument against the proposal that these patients be observed. The added hospitalization costs would be difficult to justify in our present economic environment.

The risk of complications, diagnostic errors and other problems is a fair argument against this approach – 10% of their patients developed complications during the treatment of the appendiceal mass, there was an error of diagnosis in 7 patients or 12%, including Crohn's disease in 2, pseudomyxoma peritonei in 1, continuing active inflammation in 5. All of these are reasons why an early operation would be desirable.

The authors indicate that the appendix was removed in all patients regardless of the findings even to the extent of requiring an ileocecal resection. This more extensive surgery might well be avoided if the surgery had been performed at the time the patient was first seen.

In their 50 patients who did have an interval appendectomy, a subcutaneous abscess was present in 1, damage to the cecum in 2, and a prolonged fever, not identified, was found in 1. When all of this was coupled with the long hospitalization for the original nonoperative approach, the decision not to operate would seem to be a mistake in the majority of such patients.

With present availability of various antibiotic agents, good anesthesia, adequate fluid replacement, preoperative ultrasound and/or CT diagnostic studies, I believe the decision in most cases would be to do some kind of operative procedure to make the diagnosis and eliminate the possibility of some of the complications that have been noted, and to shorten the period of hospitalization.

The risk of an interval appendectomy should be negligible in spite of the complications that are listed here. The risk of an appendectomy in the presence of an abscess is not to be ignored but is probably less than some of the problems discussed in this paper. If when the patient is first seen, the decision is that the abscess presents such a danger that resection is not possible, then perhaps percutaneous drainage can take care of the immediate problem until the patient's overall

condition improves and the risk of contaminating the entire peritoneal cavity is diminished. However, as soon as these various risks have diminished, the appendix should be removed to prevent recurrence, assure the diagnosis, and allow the patient to return to a relatively normal status.