THE SCHUMACHER GROUP
QI/RM NEWSLETTER

OCTOBER 2004 www.tsged.com

APPENDICITIS - THE DISPOSITION DECISION

In our approach to the patient with abdominal pain and potential appendicitis, the patient should be risk stratified into four groups.

High probability group - the patient with classical appendicitis based on the history and physical examination. These patients need immediate surgical consultation.

Moderate probability group - the patient with signs and symptoms that are suspicious but not diagnostic for appendicitis. Ancillary studies (CT scan, Ultrasound, etc) are needed in this group to help determine the likelihood of appendicitis. A 4 to 6 hour period of observation consisting of serial examinations may help to determine if the patient is progressing from early to an obvious appendicitis (such as migration of pain to the right lower quadrant). Depending on the results of the studies and observation period, the ER physician has three options: a surgical consult, a longer period of observation as an inpatient, or the patient is discharged with appropriate follow-up.

Low probability group - These patients should have a period of observation with documented serial examinations. If the course remains benign, the patient may be discharged with appropriate follow-up.

For those patients discharged from the low or moderate probability groups, the diagnosis should be nonspecific abdominal pain (unless the physician is positive that an alternate diagnosis is correct). The patient should be told that no clear cause of their problem was found and it just may be too early to find the etiology. Either their symptoms will resolve or develop into a recognizable pattern. Worrisome symptoms, which would suggest appendicitis, should be discussed and the patient told to return if these occur. It should be stressed that follow-up with a physician for reevaluation within a defined time period (preferably 8 to 12 hours) is necessary.

High-risk abdominal pain patient group – This group consists of the elderly, pediatric, pregnant, or immunocompromised patient. Since these patients have a high complication/perforation rate, one must always maintain a high index of suspicion when dealing with these patients. In an attempt to decrease morbidity and mortality, have a lower threshold for ancillary studies, surgical consultation, or observation admission in this group.

It is important to remember that the condition of appendicitis is a continuum of signs and symptoms from early appendicitis to classic appendicitis. The average time from onset of disease to perforation is 34 hours. There is a period of time where the condition has just not presented itself no matter what diagnostic tests are performed or who evaluates the patient. During this period, it is too early to make a diagnosis. No test will rule out appendicitis with 100% certainty. In up to 40 to 50% of patients seen in the ER with abdominal pain, the origin is never determined. Explain to the patient and their family the disease process and the time frame for the diagnostic process. If the patient with nonspecific abdominal pain is discharged, arrange for a reexamination within 8 to 12 hours to avoid perforation. By taking a few minutes to properly educate the patient, you involve the patient in their follow-up care. The ER physician must always have a high index of suspicion in all patients with abdominal pain and strongly recommend close follow-up.

Reference:

1) Emergency Medicine: A comprehensive study guide, Tintinalli, 5th ed., 2004
2) Assessing Abdominal Pain in Adults: a Rational, Cost-Effective, and Evidence Based Strategy, Emergency Medicine Practice, April 1999.

TSG Risk Management Question: What are my options as an emergency physician when a surgeon refuses to admit a patient with a moderate probability of appendicitis? Possible options may include:

1) Observe the patient for 4 to 6 hours in the ED and see if the patient is progressing to acute appendicitis.
2) Politely tell the surgeon you are uncomfortable with discharging the patient. Ask him to come and evaluate the patient since another specialist is needed for proper patient evaluation and care.
3) If above fails, ask hospital administration/chief of staff to help to resolve the issue.

ABDOMINAL PAIN
AFTER CARE INSTRUCTIONS

There are many causes of abdominal pain. Most pain is not serious and goes away, but some pain gets worse, changes, or will not go away. Sometimes it is just too early for certain conditions to present themselves. There are however some signs to look for which would indicate your problem is getting worse. Please return to the emergency department or see your doctor right away if you (or your family member) experience any of the following:

1. Pain that gets worse or moves to just one spot (especially the right lower abdomen).
2. Pain that gets worse if you cough, sneeze or walk.
3. Pain that does not get better in 24 hours.
4. Inability to keep down liquids – especially if you are making less urine.
5. Fainting or dizziness.
6. Blood in the vomit or stool.
7. You have shaking chills or a fever over 100.4 °F.
8. Swelling of the abdomen.
9. Any new or worsening problem.
10. The pain is in the testicle or scrotum.
11. You get associated shortness of breath.

Follow-up instructions

1. Return to the emergency department or see your local medical doctor in
   - ☐ 8 to 12 hours.
   - ☐ Other _______ hours.

Take the following medications:

____
____
____

Additional Instructions

1. No alcohol or illicit drugs.
2. No caffeine, aspirin, or cigarettes.

____
____
____