Forenames **Lastname** **Hospital No.** **D.O.B.**	St Helens and Knowsley Teaching Hospitals NHS Trust **SDEC management of RIF pain**

Right iliac fossa pain/appendicitis pathway

Right iliac fossa pain is one of the most common presentations to the acute surgical take. The lifetime risk of having appendicitis is 7% - 8% with an overall incidence of 11 cases per 10,000 population per year.

Some patients, who present with a typical history and convincing examination signs, it is easy to determine what their management should be, those with less specific signs can be more of a diagnostic challenge. It is these patients that require further time and investigations to determine the correct diagnosis and subsequent treatment.

Investigations

- Observations, urinalysis (including pregnancy test) and blood tests
- In patients suspected of having appendicitis, an elevated WCC (neutrophilia) and CRP should prompt either imaging or a laparoscopy
- A raise in both inflammatory markers gives a sensitivity of over 95% for the diagnosis. Positive predictive value is increased by having both a raised WCC and CRP.
- If the duration of symptoms is less than 12 hours then a rise in CRP may not be seen compared to WCC which will show an early rise
- In patients with both a normal WCC and CRP either a watch and wait policy or imaging is advocated as they have a very low likelihood of appendicitis.

Ambulatory care **may** be appropriate.

- Patients assessed in the acute surgical unit with an atypical history, no peritonism and a normal WCC and CRP may be suitable for discharge with a planned ambulatory care review in clinic with or without, an USS scan
- These patients are only suitable for this kind of management if they are generally well, have easy access to return to the hospital, have no other reason to be admitted and have no serious comorbidities
- They should all be given an abdominal pain information sheet and a contact number to ring, along with full details of when and where to return the following day

Imaging

- Imaging is a useful diagnostic tool in right iliac fossa pain and the group of patients that most benefits from imaging is those who have an indeterminate diagnosis
- Both USS and CT are useful, USS being preferred in young women due to the high preponderance of gynaecological disease and also the radiation risks with CT

Criteria for immediate appendicectomy:

High suspicion of appendicitis with severe sepsis or septic shock

In case of uncomplicated acute appendicitis without exclusion factors (below) confirmed on CT scan or ultrasonogram, calculate the Saint-Antoine Score :

Exclusion criteria: History of pelvic surgery, pregnancy, severe comorbidities,

severe sepsis, excessive pain, no accompanying person, home located

over 1-hour travel time away, insufficient understanding, patient choice to decline SDEC. Patients

with clinical or radiological evidence of appendix mass, abscess or peritonitis were immediately

operated.

Saint-Antoine Score

Variables	
BMI <28 kg/m2	1 point
WCC <15,000/μL	1 point
CRP <30 mg/L	1 point
No radiological signs of perforation	1 point
Appendix (radiological) diameter ≤10 mm	1 point

For a score of 4 or more & no exclusion criteria consider SDEC

If acceptable to patient the day of surgery depends on the time of diagnosis.

Between 7:00 and 13:00, the patient is directly admitted and operated on that afternoon/ evening.

After 13:00, the operation may be delayed until the next morning and the patient returned home with oral antibiotics and analgesics.