



CODEN [USA]: IAJ PBB

ISSN: 2349-7750

**INDO AMERICAN JOURNAL OF
PHARMACEUTICAL SCIENCES**Available online at: <http://www.iajps.com>

Research Article

**COMPARISON OF THREE WRONGLY PERCEIVED
PATIENTS OF APPENDICITIS: IMPORTANCE OF TIMELY
AND ACCURATE DISEASE DIAGNOSIS****¹Dr. Bariq Zaeem Mirza, ²Dr. Hafsa Mansoor, ³Dr Shagufta Anwar, ⁴Dr. Saad Bahussein,
⁵Dr Muhammad Sohaib Yousaf**¹Medical Officer, Mohy ud Din Islamic Medical University Mir Pur Azad Kashmir²Madina Teaching Hospital Faisalabad³Children Hospital Faisalabad⁴Midland Regional Hospital, Portlaoise, Ireland⁵Medical Officer, BHU 67 ML**Abstract:**

This research is about three male patients with young age who were studied at Services Hospital, Lahore (January to July 2017). These patients were detected with perforated duodenal a Ker. With appendectomy, it was treated as appendicitis. Treatment was done on the basis of detection. These patients spent long period of time in the Hospital due to wrong perception. If the pre-operative findings, history and examination is taken attentively, this problem could have been prevented.

Keywords: Duodenal ulcer, Appendicitis.**Corresponding author:****Dr. Bariq Zaeem Mirza,**

Medical Officer,

Mohy ud Din Islamic Medical University Mir Pur Azad Kashmir

QR code



Please cite this article in press Bariq Zaeem Mirza et al., Comparison of Three Wrongly Perceived Patients of Appendicitis: Importance of Timely and Accurate Disease Diagnosis., Indo Am. J. P. Sci, 2018; 05(12).

INTRODUCTION:

Among usual surgical emergency situations, appendicitis is the one [1]. Clinical detection is the appropriate base for diagnosis up till now. A little investigation support is involved in this detection [2, 3]. There involved well-known defects in this approach. In young ladies, the chance of high disorder is always high. However, in history, the significant negative appendectomy rate changes from 9% – 20% [4]. In history, pathology is a similar problem which is not mesenteric adenitis etc are non-surgical situations related to appendicitis. The results of these situations are not adverse, if treated with an appendectomy. However, appendicitis may be similar to surgical pathology somewhere in abdomen. Surgeon may not be able to observe the area of primary pathology due to cut in traditional right lower quadrant. Appendectomy is carried out mistakenly by the operator if appendix is present in the peritoneal inflammatory response detection of the primary pathology delays and so does the treatment. It results in drastic results. Appendectomy along with perforated duodenal ulcer present one such case. In 1926, Rudolph Valentine, a famous American film actor, died because of complexities which included perforated duodenal a Ker. This was treated with appendectomy and defected wrongly [5]. In this study, we present 3 cases. The time duration was three years. These cases were conducted at a tertiary care Hospital.

Case – I: This case was about male patient whose age was 30 years old. After on open appendectomy technique, for three days, the patient was admitted to emergency room (ER). The patient was suffering from high-grade fever, continuous abdominal discomfort and vomiting. The indications of peritonitis, tachycardia and dehydration were illustrated through examination. A perforated duodenal a Ker (DU) was observed at laparotomy. A computed tomography (T) scan was carried out. Through this, oral contrast spillage is being observed in the duodenal area. The patient was ventilated for two days after operation. After 12days of operation the patient was able to intake anything and then discharged.

Case – II: In this case male patient was presented with age 48 years old. He was suffering from pain and abdominal discomfort. Seven days before the admission of emergency room, the patient was examined. On examination, the patient was observed with febrile and tachycardia. A perforation in the duodenum was revealed through laparotomy. From the injured through laparotomy. From the injured area, three observed an excretion of bilious. These

showed the symptoms of appendectomy and laparotomy and graham patch repair was carried out. After the operation, the patient was given with ventilation. The patient was able to consume anything orally. There was requirement of care for injured area of patient. After 13 days of operations, the patients were discharged.

Case – III: This case was about male patient whose age was 28 years old. He was suffering from vomiting and abdominal pain distention. After 10 days of experiencing appendectomy, the patient was shifted to emergency room. A perforated DU was observed at laparotomy. The patient was examined and found with septic shock with the indications of peritonitis. The patient showed complex recovery. The patient was provided with ventilation for 5 days and then discharged. After 6 months, incisional hernia was needed.

DISCUSSION:

Among the usual surgical emergency situations in young adults, acute appendicitis is the done, depletion can be observed in demonstration of peri-umbilical discomfort switching to right iliac fossa with variable features. Insufficient investigation, unusual demonstration or changes in clinical demonstration may contribute to this issue. Appendicitis was difficult to identify in emergency room. When a perforated DU is indicated wrongly as appendicitis, in this condition, valentine appendix is well-narrated. Prior to physical assessment of patient, the significance of careful history-taking is illustrated by this unusual framework. In appendicitis, two clear routes of pain are involved. So, progression of pain has clear arrangement. Due to activation of visceral pain pathway, the starting pain occur. From a mid-gut derivative, the pain pathway begins. Principal pain type becomes corporal if there is involvement of inflammation in peritoneal surface of appendix. For the purpose of indication, the variation in location and feature is significant, this is referred as migration of pain. The discomfort is very identical if because of perforation of a DU. In some patients, the abdominal discomfort is long-lasting. There observed complexities in beginning of this sudden event. From the start, the pain of perforation is somatic. When peritoneal cavity is exposed to irritant upper gastrointestinal contents, the pain of perforation results. There observed no variation of pain feature. If the surgeon enwantered bile stained contents in right lower quadrant incision for appendectomy. By means of upper midline incision, to undertake a formal laparotomy would be secure thing in presence of such incidence. Reverse conversion would be another secure approach [6]. In future, there is a chance of

reduction of low incidence of missed perforated DU.

CONCLUSION:

Among surgical emergency situations, the most common is appendicitis. On the basis of physical and clinical assessment, the disorder is identified. Perforated DU is a similar situation to appendicitis. Through right lower quadrant incision, surgeon experiencing appendectomies should distrust perforated DU. This will happen if the surgeon in presence of non-perforated appendix experience bile-stained fluid in the peritoneum.

REFERENCES:

1. Paddle KC. Perforated Duodenal Ulcer Simulating Acute Appendicitis. *Br Med J* 1928; 2: 699.
2. Navez B, Delgadillo X, Cambier E, Richir C, Guiot P. Laparoscopic approach for acute appendicular peritonitis: efficacy and safety: a report of 96 consecutive cases. *Surg Laparoscope Endosc Percutan Tech* 2001;11: 313-6.
3. Brigand C, Steinmetz JP, Rohr S. [The usefulness of scores in the diagnosis of appendicitis]. *J Chir (Paris)* 2009; 146: 2-7.
4. Seetahal SA, Bolorunduro OB, Sookdeo TC, Oyetunji TA, Greene WR, Frederick W, et al. Negative appendectomy: a 10-year review of a nationally representative sample. *Am J Surg* 2011; 201: 433-7.
5. Addiss DG, Shaffer N, Fowler BS, Tauxe RV. The epidemiology of appendicitis and appendectomy in the United States. *Am J Epidemiol* 1990; 132: 910-25.
6. Pickhardt PJ, Lawrence EM, Pooler BD, Bruce RJ. Diagnostic performance of multidetector computed tomography for suspected acute appendicitis. *Ann Intern Med* 2011; 154: 789-96, W-291.