

Acute appendicitis in pregnancy: 50 case series, maternal and neonatal outcomes

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ABSTRACT

BACKGROUND: During pregnancy, the most common indication for non-obstetric surgery in acute abdomen is appendicitis. In pregnancy, appendicitis may be confused with pregnancy-related pathologies and may cause a delay in diagnosis or unnecessary surgery. The present study aims to evaluate the maternal and neonatal outcomes of patients undergoing appendectomy during pregnancy.

METHODS: This study was designed retrospectively between 2011–2017. Appendicitis detection rates, admission and laboratory features, operation results and obstetric results were evaluated in pregnant women who underwent surgery for a preliminary diagnosis of acute appendicitis.

RESULTS: The findings showed that 2593 patients underwent an appendectomy, 1154 of them were women and 50 of them were pregnant. Negative laparotomy was detected in 12 (16%) patients. Six (12%) of these 50 patients had a laparoscopic appendectomy and 44 (88%) had an appendectomy with laparotomy. The mean time to operation after admission to hospital was 10.5±11 hours. No maternal mortality was observed. Preterm labor occurred in four (8%) patients. Two patients (4%) were in the second trimester and two patients (4%) were in the third trimester. Two (4%) newborns born in the second trimester died postpartum. One of these newborns had multiple anomalies. Appendectomy was not characterized by an increased risk of perinatal mortality.

CONCLUSION: Delay in the diagnosis and surgery of acute appendicitis during pregnancy may increase the risk of perinatal mortality and should not be delayed in diagnosis and surgery in pregnancy.

Keywords: Acute appendicitis; appendectomy; pregnancy.

INTRODUCTION

The most common indication for non-obstetric surgery in the acute abdomen during pregnancy is appendicitis. The incidence varies between 1/700–1/4000.^[1,2] Changes in the localization of the appendix, inability to computed tomography during pregnancy and physiological leukocytosis may lead to challenges in diagnosis.^[3,4] Delay in diagnosis and development of appendix perforation may lead to poor obstetric results.^[5,6] There are conflicting results concerning preterm delivery between laparoscopy and laparotomy in systematic reviews. In this study, we planned to evaluate the operation results and obstetric results of the patients undergoing an appendectomy.

MATERIALS AND METHODS

This study was designed retrospectively. This study was planned to include pregnant women who underwent an appendectomy due to acute abdomen in University of Health Sciences Adana City Training and Research Hospital between January 2011 and December 2017. Ethics Committee approval was received from Ethics Committee of University of Health Sciences Adana City Research and Training Hospital for the study. Baseline characteristics, age, gravida, gestational week and systemic disease were recorded according to the electronic records of patients. The results of the operation, L/S or L/T were performed, time to operation, leukocyte,

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CRP, ultrasonographic diagnosis, length of stay and pathology results were determined. Obstetrical results were recorded as preterm labor <37 weeks, gestational week, antenatal and perinatal mortality and morbidity, antepartum hemorrhage, postpartum hemorrhage, normal or cesarean delivery, postpartum infection, neonatal intensive care unit hospitalization, missed abortion (<20 weeks fetal death). Neonatal results were evaluated with low APGAR score 5. minute <7, neonatal hospitalization within 28 days, perinatal (≥ 500 grams including intrauterine death) and neonatal mortality (live neonatal death within 28 days) and morbidity.

Statistical Analysis

SPSS software was utilized for the statistical analysis (Version 17.0; SPSS Inc., Chicago, IL, USA). Categorical measurements were calculated as numbers and percent. If continuous variables were normal, they were described as mean \pm standard deviation (Statistical significance level was taken as 0.05 in all tests). If the continuous variables were not normal, they were described as median and minimum-maximum.

RESULTS

Between January 2011 and December 2017, 48120 births took place in our hospital. Appendectomy was performed to 1154 female patients and 75 pregnant patients were operated on because of acute abdomen. Seven of these patients had ovarian torsion, one patient had isolated tubal torsion and five patients had ovarian cyst rupture. No cause was found in 12 patients. Acute appendicitis was detected in 50 pregnant patients. The incidence of acute appendicitis in pregnancy was 1/1000. The findings showed that 17 (34%) of the patients had their first pregnancy and 23 (46%) had their second pregnancy (Table 1). Eight (16%) of the patients were in the first trimester, 25 (50%) in the second trimester and 17 (34%) in the third trimester (Table 1). Two (4%) patients had hypertension, one (2%) patient had diabetes and patient (1%) patient had rheumatoid arthritis. One (2%) patient was smoking during pregnancy (Table 1). The mean duration of symptoms until surgery was 10.5 \pm 11 hours after admission to hospital. In this study, 48 (96%) of these patients had right lower quadrant tenderness; 39 (78%) patients had a rebound, 35 (70%) had nausea and 13 (26%) had vomiting (Table 2). The mean number of white blood cells was 11.8 \pm 4.5 $\times 10^3/\mu\text{L}$ (Table 2). The mean C-reactive protein level was 3.8 \pm 6.8 mg/dl (Table 2). In ultrasound imaging, normal findings in 16 (32%) patients, suspicious findings in 25 patients (50%) and appendectomy findings in nine patients (18%) were detected (Table 2). There was no difference in surgical complications between open and L/S surgical groups. The mean postoperative hospitalization time was 2.4 \pm 1.5 days. Pathology results were 37 (74%) patients with an inflamed appendix, six (12%) with gangrenous appendix and seven (14%) with perforated appendix (Table 2). Two (4%) patients developed wound infection as a complication of surgery (Table 2). When the

Table 1. Baseline characteristics

	n	%	Mean \pm SD
Maternal age			26.8 \pm 7.1
Gravida			
1	17	34	
2	23	46	
3	6	12	
4	3	6	
7	1	2	
Gestational age			
First trimester	8	16	
Second trimester	25	50	
Third trimester	17	34	
Hypertension	2	4	0.04 \pm 0.1
Diabetes mellitus	1	2	0.02 \pm 0.1
Smoker	1	2	0.02 \pm 0.1
Chronic disease	1	2	0.02 \pm 0.1

SD: Standard deviation.

Table 2. Operation outcomes and operation related complications

	n	%	Mean \pm SD
Laparotomy (L/T)	44	88	0.8 \pm 0.3
Laparoscopy (LS)	6	12	0.1 \pm 0.3
Symptoms time (hour)			10.5 \pm 11.03
Defense	48	96	
Rebound	39	78	
Fewer	1	2	
Nausea	35	70	
Vomiting	13	26	0.2 \pm 0.4
White blood cell count ($\times 10^3/\mu\text{L}$)			11.8 \pm 4.5
C-reactive protein (mg/dl)			3.8 \pm 6.8
Ultrasound			
Normal	16	32	
Suspect	25	50	
Certain	9	18	
Operation time (minute)			48.5 \pm 9.3
Hospitalization time (day)			2.4 \pm 1.5
Pathology			
Inflamed	37	74	
Gangrenous	6	12	
Perforated	7	14	
Complication	2	4	0.04 \pm 0.1

SD: Standard deviation.

Table 3. Characteristics of pregnancies

	n	%	Mean±SD
Gestational weeks			2.9±0.3
First trimester	1	2	
Second trimester	2	4	
Third trimester	47	94	
Missed abortion	1	2	
Prematurity	4	8	
Mortality			0.0±0.0
Antepartum haemorrhage			0.0±0.0
Postpartum haemorrhage			0.0±0.0
Postpartum infection			0.0±0.0
Form of birth			
Normal vaginal birth	23	46	
Caesarean	27	54	
Neonatal mortality	2	4	0.04±0.1
Apgar ≤5	2	4	
Apgar >5	48	96	
Neonatal intensive care hospitalization	4	8	0.08±0.2

SD: Standard deviation.

perinatal results were evaluated, one (2%) patient developed the first trimester missed abortion, and two (4%) patients developed second trimester preterm labor (Table 3). Fetal multiple anomaly was present in one patient who developed second trimester preterm labor. 47 (94%) patients gave birth in the third trimester (Table 3). Four (8%) patients developed premature birth (Table 3). 23 (46%) patients had normal vaginal birth and 27 (54%) patients gave birth with C/S (Table 3). The 5-minute APGAR score of two (4%) newborns were <5. Two (4%) newborns born in the second trimester died postpartum. One of these newborns had multiple fetal anomaly (Table 3). There was no difference between the trimesters in pregnancy loss rates. Postpartum four (8%) newborns were hospitalized and followed up in a neonatal intensive care unit due to prematurity (Table 3).

DISCUSSION

In this population-based study, 362 thousand pregnant women were evaluated and the rate of antepartum appendicitis was 35% lower than the non-pregnancy period.^[7] In the study performed by Eryilmaz et al.,^[8] the incidence of acute appendicitis during pregnancy was 1/1312. In our study, the incidence of acute appendicitis in pregnancy was 1/1000. Acute appendicitis was detected at least in the first trimester and most in the second trimester.

It has been reported that the peritonitis rate increased 1.3 times in pregnant women with appendicitis and in pregnant women, sepsis, septic shock, transfusion, pneumonia, bowel

obstruction and postoperative infection rates increased by twice. The rate of shock, peritonitis and venous thromboembolism were higher in the conservatively followed pregnant. Conservative treatment is recommended to be avoided.^[9] Appendiceal perforation has been reported as the most important cause of maternal morbidity. It was argued that perforation would be inevitable if the operation was postponed to 20 hours after the onset of the symptom.^[10] In a study conducted by Tracey et al.,^[11] 12 patients (55%) had perforated appendicitis. Preterm delivery took place in five pregnant women with perforated appendicitis in the third trimester. This shows the significance of not delaying surgery. In our study, seven (14%) patients had perforated appendicitis. Postoperative two (4%) patients had wound infection, except no surgical complication was observed. The mean duration of admission to the hospital before surgery is 10.5±11 hours, and non-conservative treatment of patients with acute abdomen may have an effect on the low complication rate.

In the current meta-analysis, patients with L/S appendectomy had fewer surgical complications and shorter hospital stay. The mean gestational week of patients who underwent open surgery was higher. The intrauterine fetal mortality rate was similar in open appendectomy 4.3% and 4.5% in patients undergoing L/S appendectomy.^[12] According to a recent study evaluating laparoscopy in pregnancy, it has been reported that 50% less laparoscopy is performed in pregnant patients, pregnancy has no effect on perforation rates, but negative appendectomy rate has increased in pregnancy.^[13] The mean gestational week of the L/S group was smaller and the postoperative complication rate was lower. It has been claimed that L/S appendectomy does not affect obstetric outcomes in pregnancy.^[14] In this study, L/S appendectomy was performed in the third trimester, intrauterine fetal death was not detected, and it was claimed that the low fetal mortality rate was related to low perforated appendicitis rates.^[15] In a retrospective study of 20 patients, there was no difference concerning fetal or maternal mortality and morbidity between L/S and open appendectomy groups.^[16] In our study, L/S appendectomy was performed on six (12%) patients. There was no difference between the open and L/S surgical groups concerning surgical complications. In our study, L/S appendectomy rates were low due to a lack of an L/S experienced team in an emergency condition.

In our study, preterm labor developed in four (8%) patients who underwent an appendectomy. Considering studies that reported the rate of preterm labor from five to 11%, the preterm labor rate of 8% found in our study does not show an extra risk increase in patients undergoing appendectomy.^[17] Perinatal mortality was 1.5% in uncomplicated appendicitis and 37% in perforated appendicitis.^[18] Perinatal mortality rate was 4%, and the perforated appendicitis rate was 14% in our study. One of these patients had multiple fetal anomaly. Both two patients had perforated appendicitis. The rate of negative appendectomy during pregnancy was reported between

3% and 23%.^[15] In the study conducted by Arer et al.,^[15] the rate of negative laparotomy was 31%. In our study, the rate of negative laparotomy was 16%. In the study conducted by McGory et al., the findings showed that negative laparotomy was compatible with an increase in fetal mortality rates.^[19]

In the current study, white blood cell (WBC) count $>18 \times 10^3/\mu\text{L}$ was reported to increase the accuracy of appendicitis diagnosis 10-fold. In the same study, the diagnosis of appendicitis in the first trimester increased the risk of <24 weeks pregnancy loss.^[20] In our study, the mean number of leukocytes (WBC) was $12.8 \pm 4.5 \times 10^3/\mu\text{L}$, and in seven (14%) patients WBC was $>18 \times 10^3/\mu\text{L}$. The number of leukocytes may increase the accuracy of the diagnosis, but the sensitivity is low. In our study, there was no difference in the rate of pregnancy loss between trimesters. There are also studies reporting that appendectomy is associated with increased neonatal and perinatal morbidity risk in pregnancy.^[21] In pregnancy, appendicitis was associated with increased preterm delivery rates of 2.8 times, increased risk of detachment and a 1.5-fold increase in *c/s* ratios. However, the symptom duration was not specified and the risk of complications could be increased due to delayed operation in this study.^[22] In the study conducted by Zhang et al.,^[23] it was reported that the risk of perforation increased if the intervention was postponed 35 hours after the onset of symptom, and the risk of preterm delivery and fetal mortality increased in patients with perforated appendicitis. In the study performed by Tamir et al.,^[24] it was reported that the appendiceal perforation rate increased to 66% if the surgery was postponed for more than 24 hours.

In the meta-analysis by Wilasrusmee et al.,^[25] fetal loss rate was significantly higher in the *l/s* group and no significant difference was found concerning operation time and wound infection. In the current study, the fetal loss was detected in seven patients in the *l/s* group. There was no fetal loss in the open appendectomy group. It has been argued that *l/s* increases fetal loss rate during pregnancy.^[26]

The suspicion of appendicitis during pregnancy may lead to difficulty in the diagnosis and anxiety to cause an unnecessary operation to the mother and fetus. Negative appendectomy rates may be less with the use of advanced technology imaging methods in nonpregnant women. Drake et al.^[27] reported that USG is the most widely used imaging modality for suspected appendicitis, is a good method in the diagnosis in the first trimester, but the appendix may not be well visualized in the advanced trimesters. In the study conducted by Israel et al.,^[28] MRI sensitivity and specificity were 100%, USG sensitivity and specificity were 50% and 100%. MRI has been reported to be a very useful and effective method in the diagnosis and differential diagnosis of appendicitis in pregnant women. In our study, US imaging was evaluated as normal in 32%, suspicious in 50% and appendicitis in 18% of 50 patients. MRI could not be performed in emergency surgical situations because of inappropriate conditions due to a lack of team.

The retrospective design was one of the limitations of this study. All operations were not performed by the same surgeon but were performed by experienced surgeons. Ultrasonography was performed not by the same radiologist but by an experienced radiologist.

As a result, there is no significant increase in maternal and perinatal mortality rates until the duration of the time to operation not prolong in the case of appendicitis during pregnancy. Care should be taken to ensure that the symptom duration is not prolonged, and emergency surgery should be performed in case of suspected acute appendicitis in pregnancy. *l/s* may be preferred in early trimesters. In late trimesters, it is necessary not to rely on ultrasonography.

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CASE SERIES - ÖZET

Gebelikte akut apandisit: 50 olgu serisi, maternal ve neonatal sonuçları

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AMAÇ: Gebelikte akut batının en sık obstetrik dışı cerrahi endikasyonu apandisitir. Gebelikte apandisit gebeliğe bağlı patolojilerle karışabilmekte, tanıda gecikmeye veya gereksiz cerrahiye yol açabilmektedir. Çalışmanın amacı gebelikte appendektomi yapılan hastaların maternal ve neonatal sonuçlarının değerlendirilmesi olarak belirlendi.

GEREÇ VE YÖNTEM: Çalışma 2011–2017 yılları arasında geriye dönük olarak tasarlandı. Akut apandisit öntanısı ile cerrahiye alınan gebelerde apandisit saptanma oranları, başvuru ve laboratuvar özellikleri, ameliyat sonuçları ve obstetrik sonuçlar değerlendirildi.

BULGULAR: Toplam 2593 hastaya appendektomi uygulandı, bunların 1154'ü kadın, 50'si gebe idi. Negatif laparotomi 12 (%16) hastada saptandı. Elli gebe hastanın altısı (%12) laparoskopik appendektomi, 44'ü (%88) laparotomi ile appendektomi idi. Hastaneye kabul sonrası operasyona kadar geçen süre ortalama 10.5±11 saat idi. Maternal mortalite izlenmedi. Dört (%8) hastada preterm eylem nedeniyle prematür doğum gerçekleşti. Hastaların ikisi (%4) ikinci trimesterde, ikisi (%4) üçüncü trimesterde idi. İkinci trimesterde doğan iki (%4) yenidoğan postpartum hayatını kaybetti. Bu yenidoğanlardan birinde multipl anomali mevcuttu. Appendektomi perinatal mortalite riskinde artış ile karakterize değildi.

TARTIŞMA: Gebelikte akut apandisit tanı ve cerrahisinde gecikme perinatal mortalite riskini artırabilir, tanı ve cerrahide gecikilmemelidir.

Anahtar sözcükler: Akut apandisit; appendektomi; gebelik.

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