

Karakteristik Klinik Tablo Olmaksızın Erken Doğum Tehdidi İle Gelen Bir Gebede Perfore Apandisit: Olgu Sunumu

Mahmut Tuncay Özgün, Çağdaş Türkyılmaz, Mehmet Dolanbay, Semih Uludağ,
Ahmet Cem Batukan

Erciyes Üniversitesi Tıp Fakültesi, Kadın Hastalıkları Ve Doğum Ana Bilim Dalı, Kayseri
Yazışma Adresi: Erciyes Üniversitesi Tıp Fakültesi Kadın Hastalıkları Ve Doğum Abd. Gevher
Nesibe Hast. 38039 Kayseri - Türkiye
Cep Tel: 0533 655 20 14 e-mail: mtozgun@erciyes.edu.tr

ÖZET:

Gebelikte apandisit insidensi normal popülasyondaki kadar olmakla beraber, normal popülasyon ile karşılaştırıldığında gebelikte perforasyon oranı daha yüksektir. Gebeliğinin 34. haftasında uterin kontraksiyonlar ve sağ sırt ağrısı ile başvuran hastaya erken doğum tehdidi tanısı konularak tokoliz ve üriner sistem enfeksiyonu nedeni ile antibiyotik tedavisi başlandı. Tedavinin başlangıcından 24 saat sonra servikal dilatasyonun ilerlemesi ve makat gelişi nedeni ile sezeryan ile doğum gerçekleştirildi. Sezeryan sırasında perfore apandisit saptandı ve apendektomi yapıldı. Tokoliz tedavisine yanıt vermeyen hastalarda, karakteristik klinik belirtiler olmasa dahi, apandisit ayırıcı tanıda düşünülmelidir.

Anahtar Kelimeler: Apandisit, gebelik, erken doğum

SUMMARY:

Perforated appendicitis without characteristic clinical features in pregnancy presented as preterm labor: A Case report

The incidence of appendicitis during pregnancy is equal to that in the normal population; however, a higher perforation rate is found during pregnancy compared to that in the normal population. A 19-year-old woman presented with uterine contractions and right low back pain at 34 weeks of gestation. She treated with tocolysis and antibiotic for premature labor and urinary infection. 24 hours later, due to progression of cervical dilatation, caesarean section was performed because of breech presentation. During caesarean section, perforated appendicitis was detected and appendectomy was performed. Appendicitis should be considered in the differential diagnosis of preterm labor, when the patient fails to respond the tocolysis, even if the patient does not show characteristic features of appendicitis.

Key words: Appendicitis, pregnancy, preterm labor

CASE

A 19-year-old primigravid woman presented at 34 weeks' gestation with painful uterine contractions and right low back pain. Her past medical history and prenatal course were unremarkable. The pain was first on umbilicus and after 12 hours, it was on right low quadrant. Physical examination revealed that her abdomen was soft and non-tender. The uterus was enlarged according to the length of gestation and non-tender. Cervical examination showed a retrovert cervix with 2 cm dilation and 40% effacement. Membranes were intact. Obstetric sonography revealed a single live fetus, which biometry was appropriate for gestational age. The cervical length was detected 22 mm with transvaginal sonography. Uterine contractions were present on abdominal palpation

and non stress test (NST). The fetal heart tracing was reactive. Tocolysis was commenced with nifedipine because of premature labor. The white cell count (12800/mm³) and hemoglobin (11,8 g/dL) were all within normal range for pregnancy. Axillary temperature was 37,6°C, blood pressure 128/76 mmHg and pulse rate 86 beats/minute. Gram negative basils were detected in urine analysis. Then, she was taken to abdominal sonography. It was revealed that there was a Grade 2 hydronephrosis in right kidney. Intravenous ceftriaxone was given 1000 mg twice in a day. After 24 hours of treatment, her contractions occurred every 3 minutes and cervix became 6 cm dilatation and 70% effacement despite of effective tocolysis treatment. She was delivered by cesarean

section due to breech presentation. The birth weight was 2400 gr, 1 and 5 minutes apgar scores were 8 and 10, respectively. In cesarean section, a mass was detected on the location of cecum. There was some purulent fluid around the mass. Perforated appendicitis was suspected. It was difficult to show the origin of the mass from pfannensteil incision and surgeons were included the operation. Midline incision was performed. There was a ruptured appendix to the retroperitoneum in a pocket pus adherent to the intestine. Appendectomy and drainage of the abscess were performed.. She treated with ceftriaxone and metranidazole for 7 days. The post-operative recovery was uneventful. The patient discharged on the eleventh post-operative day.

DISCUSSION

Incidence of appendicitis in pregnancy is similar to general population but it carries a significant risk of fetal loss and maternal mortality because of delayed diagnosis. Pregnant patients are more likely to have perforations (43% v. 4%-19% in general population) (4). The clinical picture was obvious in most cases. However, urinary tract infections are the most common misdiagnosis in complicated cases like our case. The diagnostic difficulty is attributed to the change in the position of the appendix during late pregnancy. Several factors have been reported as an explanation for the difficulty in diagnosing appendicitis during pregnancy and the associated increase in perforation, morbidity, mortality, and fetal loss (5). These factors include anatomical displacement of the appendix during pregnancy, the increase in abdominal laxity during gestation and the reduced ability of pregnant women to demonstrate tachycardia and hypotension. In addition, normal pregnancy may increase leukocyte count. Moreover, the increased incidence of gastrointestinal symptoms, such as abdominal pain and vomiting among pregnant women in general, complicates the diagnosis even more. The most reliable symptom is right lower quadrant pain (6). Rebound tenderness and guarding are not very specific because of the distension of the abdominal wall muscles and the interposition of the uterus between the appendix and the anterior abdominal wall. This displacement of the cecum and the appendix, when associated with retrocecal appendix, can result in flank or back pain, which is often confused with a urinary tract infection or pyelonephritis, especially late in the pregnancy, as in the present case. These may decrease the severity of symptoms (tenderness and rebound tenderness) and thus delay diagnosis. Anorexia and vomiting, very common in the first trimester of pregnancy, are not specific and sensitive predictors. Leukocytosis

ranging from 10,000 in pregnancy to 20,000 during labor is not very helpful either. Ultrasound is the diagnostic imaging procedure of choice with high sensitivity and specificity in diagnosing appendicitis (7). Accuracy is demonstrated in the first and second trimesters, while third trimester accuracy was lower because of technical difficulties. Lower sensitivity (28,5%) was present when perforated appendix was found in contrast to nonperforating appendicitis (80,5%) or an appendiceal mass (89%) (7). In our case, there were no reliable symptoms and signs, laboratory or ultrasonographic findings of perforated appendicitis. Our patient didn't respond to tocolysis and cesarean section was performed because of breech presentation, then perforated appendicitis was suspected due to the mass and purulent fluid on location of cecum. Perforated appendicitis was visualized by midline incision. Therefore, if the cesarean section wasn't performed, perforated appendicitis might not have been noticed and delayed diagnosis of acute appendicitis could increase the possibility of the morbidity and mortality of the patient and fetus. It is very important to diagnose appendicitis in pregnant women because this life-threatening condition for the mother may also affect the fetus by causing preterm labor and delivery. When recurrent preterm labor fails to respond the tocolysis therapy, even when patient does not show characteristic features of appendicitis, the diagnosis of appendicitis should be considered and if delivery is performed by cesarean section, exploration of abdomen for appendicitis must be done.

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