

Review of Operative vs. Non-Operative Management of Appendicitis in Pregnancy

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Abstract

The last decade has marked a paradigm shift in the care for acute appendicitis in children and non-pregnant adults. Although surgical management remains the safest treatment modality for perforated or complicated appendicitis, antibiotic therapy has been proven to be safe in adult and pediatric patients with non-perforated appendicitis. However, controversy exists for the type of surgery (laparoscopic vs. open) and the post-operative antibiotic regimens which result in optimal patient care of pregnant as well as non-pregnant adults. As several authors have begun to evaluate a non-operative strategy for treating acute appendicitis, whether with antibiotic therapy alone or combined with image-guided percutaneous drainage, others have retrospectively analyzed these strategies to pregnant women with abdominal pain. This collective review presents the epidemiology and diagnostic challenges of acute appendicitis in the pregnant patient and a review of the data that supports non-operative management in non-pregnant adults and pediatric patients as well as the limited data that supports non-operative management in pregnant adults.

Keywords: Acute appendicitis; Laparoscopic appendectomy; Pregnancy; Fetal demise; Pre-term labor; Non-operative management

Introduction

Current estimates of the incidence of acute appendicitis in pregnant women are between 0.04% - 0.2% [1]. Acute appendicitis has a higher lifetime risk in males than females (8.6% vs. 6.7%), yet treatment with appendectomy is actually higher in women than in men (23% vs. 12%) [2,3]. Moreover, if treated without surgery at initial presentation, recurrence is higher for males [4]. Appendicitis in pregnancy is the most common cause of surgical intervention for an acute abdomen, followed by cholecystectomy, pancreatitis and bowel obstruction [5-8]. Non-obstetric surgery in pregnancy, for any gestational age, for a variety of indications, is performed for 1- 2% of all pregnancies [2].

Acute onset abdominal pain in the pre-menopausal woman presents a unique diagnostic challenge as there are a variety of gynecologic concerns and physiological changes during pregnancy that can confound diagnosis [9-13]. Other explanations for acute onset abdominal pain range from menstruation symptoms or endometriosis for any woman of child-bearing age, to the increased incidence of nausea and vomiting, urinary tract infection or complications of early pregnancy [14-18]. The presentation of acute appendicitis is altered in pregnancy due to the displacement of the appendix cephalad during uterine enlargement [19], so that by week 20 of gestation, the appendix sits at the level of the umbilicus and by the 37th week, the appendix sits below the right costal margin [12,20].

Appendectomy has been accepted as an effective treatment for acute appendicitis since Fitz described the technique 120 years ago [21]. However, treatment of acute appendicitis without surgery is as old as reports of treatment with surgery: In his autopsy reports, Fitz detailed previously inflamed appendix specimens that had healed without surgical management [21]. Until recently, there were few efforts to manage appendicitis non-operatively, with the exception of Coldrey in 1959, who published successful case series of non-operative management of acute appendicitis [22]. The last decade has presented compelling evidence for introducing non-surgical management into in the standard of care for acute appendicitis in children and non-pregnant adults. In a recent systematic review of several prospective randomized controlled trials, the American College of Surgeons concluded that an “antibiotic-first” approach was likely safe in the majority of patients

with non-perforated appendicitis, but they and other authors of meta-analysis have maintained that appendectomy is still the gold standard for uncomplicated acute appendicitis [23,24]. While surgical management is standard of care for acute appendicitis in pregnant patients, controversy exists for the type of surgery (laparoscopic vs. open) and whether a non-operative strategy would be appropriate for this population.

Methods

Searches were conducted in PubMed using MeSH search for “appendicitis” + “pregnancy” yielding 997 papers. Filters were added and yielded the following number of papers: “humans” still yielded 997, “Randomized controlled trial” yielded 3 papers, “comparative study” yielded 37 papers, “systematic review” yielded 22 results and “clinical trial” yielded 8 papers. Due to the significant dilemma in diagnostic work-up, additional PubMed searches of “appendicitis” + “pregnancy” and either “tomography”, “ultrasound” or “MRI” were also added to yield a total of 134 papers. Although the literature review started with randomized, prospective controlled trials prospective non-randomized trials were then addressed and finally retrospective case series and case reports. Due to the sparsity of Grade I articles, all of these types were included in review (Figure 1).

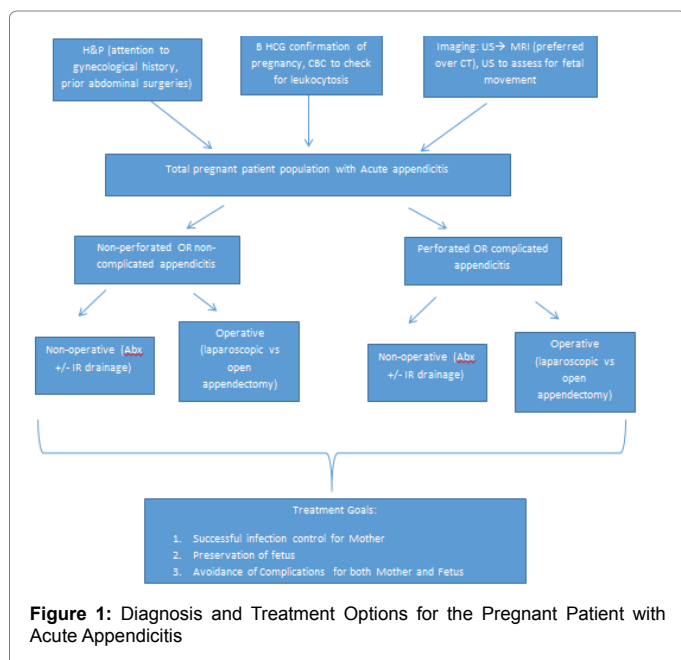
An Embase search was also conducted to examine Emtree (MeSH plus synonyms) terms. “Pregnancy” and “appendicitis” initially yielded 1,153 articles. Two prospective, randomized controlled trials were found that were not found in the PubMed search (Enochsson and Magary). The filters were then widened to just “prospective

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study” or “randomized controlled trial” with both “appendicitis” and “pregnancy”, which yielded 17 and 8 articles respectively. All 23 of these studies were examined in the review. Finally, a PubMed search was conducted to examine the literature of non-operative management of acute appendicitis in non-pregnant adults. MeSH terms of “non-operative management” + “appendicitis” were used and yielded 24 total papers. All but 9 papers were reviewed, and those excluded were because of non-relevant subject matter (alternative causes of abdominal infection, SBO), inappropriate population (interval appendectomy in patients with cancer).

Results

Diagnostic challenges

Obtaining a definitive diagnosis using current laboratory and imaging modalities has remained at the crux of the challenges of evaluating a woman of child-bearing age with abdominal pain [25-30]. Several papers have revealed that there are few, if any, elements of a patient’s clinical and laboratory examinations that can predict need for surgery [16,17]. Several studies have demonstrated that common findings used to diagnose acute appendicitis, such as leukocyte count, CRP and fever, were not helpful in establishing a correct diagnosis in a pregnant patient [16,31]. Others have found that appendicitis is very likely when two or more inflammatory laboratory variables are increased, but is very unlikely when two or more inflammatory variables are normal [32]. Diagnosis of acute appendicitis can be made by physical exam without expected laboratory values to corroborate the diagnosis in 20-33% of non-pregnant patients [33,34].

Ultrasound, CT and MRI serve as the three imaging options for assessing etiology of abdominal pain [5,35-37]. Elevated radiation risk to the fetus can cause teratogenic and carcinogenic effects if excessive CT imaging is used [6,12,14]. CT use has increased, so that now 50% of children receive CT dose radiation in the work-up of acute onset abdominal pain [38,39]. In response, the National Cancer Institute and the American Pediatric Surgical Association, as well as other authors, have advocated for non-radiation based imaging to be

used wherever possible [6,40,41]. Currently, pregnant women with suspected appendicitis need no further imaging to confirm diagnosis if ultrasound reveals visualization of the inflamed appendix [42-44]. However, if ultrasound is non-diagnostic, MRI is recommended instead of CT imaging since it yields a high rate of diagnosis without radiation exposure [45-48]. In the past 25 years, there has been a decline in the rates of non-perforated appendicitis, with an increase in use of CT imaging and laparoscopic appendectomy, but no decrease in rate of perforation [6,49,50]. These findings have led toward efforts to identify two separate patterns for non-perforated and perforated appendicitis, thus identifying which type of patient would be most suited to non-surgical management [32,49,51].

Several scoring systems have been developed to help differentiate appendicitis from other causes of abdominal pain and minimize usage of imaging that exposes patients to radiation and hospital systems to excess cost [52]. These include the Appendicitis Inflammatory Response (AIR), Adult Appendicitis Score (AAS), and the Raja Isteri Pengiran Anak Saleha Appendicitis (RIPASA), with the most commonly used being the Alvarado Score (also known as MANTRELS) and the Pediatric Appendicitis Score (PAS) [53-63]. Of the clinical scoring systems used to aid in diagnosis of acute appendicitis, the Alvarado and Appendicitis Inflammatory Response scores have been the longest standing and most thoroughly evaluated [2,60,63-65]. According to the World Society of Emergency Surgery’s recent Jerusalem guidelines for diagnosis of acute appendicitis, Alvarado or AIR scores can be used to triage patients into further treatment categories [66]. For patients with scores <5, no further imaging is needed and patients can be reassessed in 6-8 hours or discharged. With scores 5-8, ultrasound is used to see if patients can be further observed or imaged with CT scan for more definitive imaging. Lastly, patients with a high probability of appendicitis and scores >8 can be considered for CT initially and expedited for surgical care. However, these scoring systems have only been validated by level 2 and 3 evidence and are plagued by inadequate or inconsistent definitions for clinical variables [67]. Moreover, no data exist that demonstrates improvement in outcomes after implementation of any of the scoring systems [2,68-70].

High-risk patients with high Alvarado scores may not require ultrasound, CT or MRI before surgery [66]. However, these images are routinely performed for pregnant and non-pregnant patients alike, particularly in the US [63]. Although this strategy has been recommended in young women, it presents significant risks and cost when compared to other strategies [71], and only established a diagnosis in 45%-95% of patients [72-75]. However, a “wait and see” approach with imaging was able to establish diagnosis 84% of the time [71].

Controversies in surgical management

Several landmark studies revealed the importance of surgical management in pregnant patients with acute appendicitis. In 1962, a retrospective study of 74,000 patients in California demonstrated higher rates of fetal loss and premature delivery, with the degree of prematurity proportionate to the delay in operating [76]. Ensuing papers through the 1970s- 2000s calculated the risk of fetal loss to be approximately 10% in simple appendicitis and greater than 30% in complicated appendicitis [5,77-79]. Surgical therapy was further encouraged to reduce complications associated with abscess, such as ureteric obstruction needing decompression of upper urinary tract [80]. Emphasis was placed on early surgical intervention because pregnant patients are more likely to present with appendiceal rupture, compared with non-pregnant patients, leading to increased risk of fetal loss [12,81]. In 1992,

a case series of over 700 pregnant patients demonstrated maternal death in 5 cases, all of which had perforated appendicitis [82]. By the late 1990s, there was documentation of decreased rates of maternal mortality, but the rates of negative appendectomy and appendiceal perforation were unchanged over past 50 years [15]. Other studies show decline in rate of perforated appendicitis in 25 years since 2007 [49].

Historically, pregnant women who were suspected of having acute appendicitis were treated with open appendectomy [71,77,79] with shorter time to treatment than for non-pregnant pts [83]. There have also been a variety of techniques introduced within the field of surgical treatment of appendectomy, including a McBurney (oblique), Rockey-Davis (transverse), modified McBurney (oblique following Langer's lines), "cul-de-sac" (transvaginal), multiport laparoscopy or single port laparoscopy [84-86]. As laparoscopy became adopted by general surgeons and gynecologists for non-obstetric procedures, controversy grew over optimal approaches to the treatment of acute appendicitis in the pregnant patient. Pregnancy was initially considered a contraindication to laparoscopy [87] and subsequent papers questioned whether laparoscopic appendectomy was feasible in pregnant patients [88]. Challenges of performing laparoscopy during pregnancy include difficult visualization due to gravid uterus with laparoscope and potential risk of decreased blood flow due to increased intraabdominal pressure, possible carbon dioxide absorption for the mother or fetus [89].

Several systematic reviews and meta-analyses showed higher rates of fetal loss with laparoscopy as compared to open appendectomy, with the rate of fetal loss with laparoscopy approximately 5.6% versus 3.1% with open appendectomy [50,90-93]. However, there was no difference in length of hospitalization, wound infection rate or APGAR scores between the two surgical techniques [93]. One study also calculated open appendectomy to be less expensive [94]. The latest Cochrane systematic review in 2014 determined that although there was no high grade evidence to support either laparoscopic or open appendectomy as the safer approach for treatment; however, there was low grade evidence that showed a higher rate of fetal loss [95].

However, advocates of the laparoscopic approach have cited long-term studies that demonstrate its safety for the fetus and mother, independent of trimester, and relate complications to the degree of underlying severity of appendicitis [93,95-98]. Several retrospective reviews have shown a lack of complications in newborns, including adequate weight for gestation age, well-being at birth [99-101] and one prospective paper showing no association with developmental delays of motor, sensory or social skills by 3 years of age [1]. Arguments for laparoscopic appendectomy include improved accuracy of diagnosis and preventing complications related to delayed diagnosis [14,71] in a population with many confounding diagnoses and incorrect pre-op diagnosis in as many as a quarter of the patients [16,102] as well as ability to identify other intra-abdominal pathology which may mimic appendicitis and harbor fetal loss [96]. Also, other studies show benefits of laparoscopic technique in other fields can be applied to these patients, including shorter hospital stay than for open [71,94,103] and shorter time to first flatus, earlier time to oral intake than for open appendectomy [101], less operating time, less use of post-operative analgesics [104] and lower rate of wound infection [93]. By 2004, some authors had termed it the "new standard of care" [105].

Challenges to surgical approaches

Proponents of early surgical intervention recommended this strategy because it was assumed that a negative appendectomy is well

tolerated and that laparoscopy is safe for both the mother and fetus [5]. As a result of differing physiology as well as other confounding diagnoses, the rate of negative appendectomy is considerably higher in pregnant women when compared with non-pregnant women. Several studies have established the rate of negative appendectomy to be between 10-30% [71,93,98] and up to 56% in one study that performed histopathological confirmation [106]. These rates are in contrast to the rate of 18% negative appendectomy rate in women of childbearing age found in a retrospective review of over 94,000 women [90]. Interestingly, one study found no difference in the rate of negative appendectomy or perforation in high volume centers (>100 appendectomies / year) vs. low volume or between teaching vs. community hospitals [15]. In pregnant patients, negative appendectomy is associated with substantial complications: 6% infectious complications and 2% rate of reoperation, in addition to longer length of hospital stay and, of course, higher total admission charges [71]. One study also documented statistically significant increased risk of fetal loss with negative appendectomy [90]. These adverse consequences of surgical management are in light of the increased risks that have been published compared to non-operatively managed pregnant women including uterine infections, ovarian torsion [107], maternal shock, peritonitis and venous [108] and even necrotizing fasciitis [109].

Discussion

To help determine if literature that supports non-operative management could apply to pregnant patients is the question of whether appendicitis is the same disease in pregnant patients than in non-pregnant women. Changes in maternal physiology during pregnancy are dramatic, including a baseline increase in plasma volume of 45%, cardiac index by 40% and clotting factors by 50-200%, making the risk of any type of surgery higher than for a non-pregnant patient [50]. Large case registries have almost two-fold increase in sepsis, septic shock, transfusion requirement, pneumonia, bowel obstruction, post-operative infection and length of stay greater than 3 days [108]. Indeed, evidence exists for a possible common pathophysiology between ectopic pregnancy and appendicitis, which highlights the variability in causes of acute appendicitis [110]. However, a recent smaller series found equivalent duration of surgery, duration of antibiotic use and incidence of surgical site infection among pregnant women and non-pregnant women of child-bearing age [111]. And, recent literature has highlighted a common physiology for appendicitis in pregnant and non-pregnant patients [112].

Recently, the American College of Surgeons performed collective review on 6 key prospective randomized trials of antibiotic therapy vs. appendectomy in non-pregnant adults and concluded that antibiotic therapy is safe for approximately "3 out of 4 adults" [23,113-118]. One of the most compelling studies showed 91% efficacy of antibiotics alone with a 14% rate of recurrent appendicitis at 1 year, but it excluded populations (children and elderly) at high risk of perforation [114]. These data have been mirrored by success of non-operative treatment in children who have had symptoms for three or more days, or absence of diffuse peritonitis, bowel obstruction or mass; moreover, failure of conservative treatment has not been associated with increased morbidity [119]. Subsequent meta-analyses and Cochrane reviews in the 2010s revealed that antibiotics was safe in the majority of patients with uncomplicated appendicitis [51,120-122].

Additional trials showed that non-operative management was safe with 2 year follow up [54], and that no increase in complications was observed, even with perforation [16]. Moreover, complications

of laparoscopic appendectomy, such as stump appendicitis, can be managed with an antibiotics only strategy [123], and that interval appendectomy is not needed in adults [124] or children [125]. Additional review in 2014 revealed that patients who present with phlegmon, abscess <5 cm, who smoke, have generalized abdominal tenderness or tachycardia were more likely to fail non-operative management than patients without these features [126]. Other papers have demonstrated resolution of sepsis and abscess control with percutaneous drainage if an abscess has already developed [127,128]. One review demonstrated success with CT guided drainage if the patient failed to improve at 48-72 hours after diagnosis, and it found that percutaneous drainage was frequently not necessary [129].

Interestingly, some of these papers report usage of ultrasound in diagnosis and treatment, which would be of particular benefit in the pregnant population. Limiting doses of ionizing radiation as well as contrast agents that carry potential for fetal injury recommend ultrasound and MRI as preferred imaging techniques for pregnant patients [18,130-132]. Since rates of fetal loss and early delivery are higher in women with perforation, and negative appendectomy rate higher in pregnant women, reducing risk of fetal loss relates directly to accuracy of diagnosis, with particular attention to accurate imaging interpretation, as most women have undergone some kind of imaging prior to evaluation by a surgeon.

Once a diagnosis is achieved, there is no consensus on the true risks that pneumoperitoneum and anesthetic agents are incompletely defined [1,133,134]. Risks to the fetus, however rare, are still present, such as case reports of accidental gas insufflation into amniotic cavity leading to fetal loss [135], or stump appendicitis leading to chorioamnionitis [136]. In five reviews of laparoscopic technique, all published since 2001, there was increased risks of miscarriage or premature labor [9,137-140]. In the most recent of these reviews, there have been rates of 8.2% for premature delivery and 2.5% of fetal loss, even with laparoscopic appendectomy [140]. Moreover, this review also found a rate of 3.9% for major birth defects among women who underwent surgery in the first trimester, and that surgery induced labor occurred at 4.6% during appendectomy [140].

Although no prospective randomized controlled trials exist for pregnant patients receiving non-operative management, a small case series of pregnant women with ruptured appendicitis demonstrated successful management with antibiotic therapy alone, despite one needing repeat medical management for recurrence at 32 weeks gestation of her fetus [141]. Future prospective studies are needed to determine whether antibiotics alone or with percutaneous drainage is a non-inferior treatment to surgical therapy in pregnant patients with appendicitis. Although several different antibiotic regimens have been proposed [142-144], the type, duration and indications for these antibiotics are yet to be determined in pregnant patients.

Cost-effective analysis (cost per expected successfully treated patient) is beginning to appear in the literature [145] and will help determine the most cost-effective options given equivalent efficacy and safety. In a 2014 retrospective review of 231,678 patients with uncomplicated appendicitis, over 3 thousand of these patients were managed non-operatively; and of those patients, approximately 6% required appendectomy at that admission and 4.4% experienced recurrence of appendicitis after discharge during 7 year follow up. Of note, total charges were not statistically different between operative and non-operative patients, but length of stay was significantly longer in the non-operative group [146].

Conclusion

Management of acute onset abdominal pain the pregnant patient presents several diagnostic and treatment-based challenges. Pregnant women have a variety of other causes of acute onset abdominal pain that confound a diagnosis of acute appendicitis, compared to non-pregnant patients. Given the uncertainty of long-term risks to the fetus of radiation exposure in CT imaging, antibiotic therapy and general anesthesia and surgical manipulation, pregnant patients also present unique challenges with management of appendicitis once the diagnosis is made. Early studies of non-operative management revealed significantly higher rates of pre-term labor, fetal demise as well as maternal sepsis and abscess: Thus, the past decades have marked emergent laparoscopic appendectomy as the standard of care. However, new studies in pediatric and adult populations reveal that appendicitis can be safely managed with antibiotic therapy or a combination of antibiotic therapy with percutaneous drainage, if the appendix is already perforated. Given the unique risks and challenging facing pregnant women, optimizing management remains an important topic of future study in this population.

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