



PECULIARITIES OF ACUTE APPENDICITIS IN CHILDREN

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Article history:	Abstract:
Received: January 8 th 2023 Accepted: February 4 th 2023 Published: March 7 th 2023	Acute appendicitis is an inflammation of the cecal appendix and one of the most frequent abdominal diseases in children requiring urgent surgical intervention. The course of acute appendicitis in children is somewhat different from that in adults due to age-related peculiarities.
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INTRODUCTION. In childhood, appendicitis develops faster and more often leads to peritonitis (a severe complication of the disease) than in adults, especially in children of the first years of life. Acute appendicitis can occur at any age, but it predominantly occurs after 7 years of age. Girls and boys have the same incidence. In children over 3 years of age, acute appendicitis usually begins gradually. The main symptom is pain, often near the navel, then involves the whole abdomen and only after a few hours localizes in the right iliac area. The pain is usually constant and nagging. Vomiting is usually single, some children have delayed stools. Body temperature in the first hours was normal or slightly elevated in uncomplicated forms of acute appendicitis. As a rule, sleep is disturbed, reduced or absent appetite. The clinical picture of acute appendicitis in toddlers most often develops rapidly, against a background of complete health. The child becomes restless, capricious, refuses to eat, the temperature rises to 38 - 39°C, there is repeated vomiting and often develops repeated liquid stools. There may be blood or mucus in the stool.

If parents notice all or more of the above symptoms in their child, they should contact the doctor urgently to take immediate action or to rule out the need for surgery. Before the doctor arrives, it is important to remember what and when the child last ate, when and how many times the child had stools and vomiting. Be sure to measure the temperature and pay attention to how the child prefers to lie down.

Diagnosis of acute appendicitis

In most cases, the diagnosis can be made by the doctor on examination, without the use of additional tests. Despite this, it is mandatory to perform a clinical blood test, which shows changes characteristic of the inflammatory process. And patients with acute abdominal pain are shown an ultrasound examination (ultrasound), which reveals changes characteristic of acute appendicitis, and identify changes from the abdominal and pelvic organs, which may give a similar picture to acute appendicitis. To obtain reliable information, ultrasound should be performed by a

pediatric specialist who is well versed in the peculiarities of the abdominal cavity organs in children.

When in doubt about the diagnosis requires hospitalization of the child and observation for 24 hours. The child must be under the constant supervision of a surgeon. In some cases diagnostic laparoscopy is indicated, which is the only way of preoperative visual assessment of the appendix, and if acute appendicitis is excluded, allows a sparing revision of the abdominal cavity to identify the cause of abdominal pain.

Acute abdominal pain in children can also be caused by other diseases, such as pleuropneumonia, intestinal infections, viral respiratory diseases, renal colic and other acute surgical diseases of the abdominal cavity, which can be difficult to differentiate from acute appendicitis.

Surgical treatment of acute appendicitis

At the Children's Clinic in Andean preference for surgical intervention is given to laparoscopic appendectomy, which is associated with a lower risk of complications and wound infection, is less traumatic for the child and has an excellent cosmetic effect. However, traditional intervention has not lost its full significance and may be preferable in some cases. For surgical treatment of appendicitis we have all the necessary conditions:

- Highly qualified surgeons of the clinic own all modern methods of laparoscopic interventions and have the appropriate certificates;
- the necessary high-tech equipment and special tools for minimally invasive interventions are used;
- the operation is accompanied by an experienced anesthesiologist, and modern and safe for children anesthesia for laparoscopic interventions is used.

Postoperative period

The postoperative period is no less important. The clinic has created all the conditions for a comfortable stay of children in the intensive care ward, where they can stay with their mother. The ward is equipped with high-tech equipment, there are round-the-clock monitoring systems, and a nurse continuously monitors the condition of young patients. Children after surgical intervention are always given antibiotic therapy. After



traditional appendectomy anesthesia is usually required for 2-3 days, and after laparoscopic surgery - usually during the first day after surgery. The child begins to be fed from the first postoperative day. On the 4th-5th day control ultrasound examination and clinical tests are performed. Within a week after discharge from hospital the child may go to kindergarten or school. For the first two weeks after discharge it is recommended that the child is fed in small portions several times a day to eliminate the possibility of overeating. As a rule, the child is excused from physical training for 1 month.

Analysis of the literature shows that the number of children operated on by pediatric surgeons (in the departments which did not use laparoscopic method of diagnosis) for simple (non-destructive) appendicitis is 30.3-38.7%, reaching 42.3% in children under 3 years of age. Even in the leading clinics of the world before laparoscopy these indices were at the level of 30-36%. The overdiagnosis of acute appendicitis by physicians of various specialties can be considered justified only at the pre-hospital stage. We must fully agree with the opinion of M.R. Rokicki, that it is better to send to the surgeon 10 children with suspected acute appendicitis in vain, than to miss this disease in one of them. Fear of hypodiagnostic error and the possibility of developing perforative peritonitis leads the doctor to overdiagnose. However, this tactic should be considered justified only at the final stage of complex diagnostic cases and by no means the basic rule of treatment of children with abdominal pain. Moreover, in doubtful cases, surgery should necessarily be preceded by a period of dynamic observation of the child, during which a set of necessary diagnostic examinations is performed to clarify the diagnosis and avoid unnecessary surgery. The time after which surgical intervention should be used in doubtful cases varies in pediatric surgery departments and ranges from 6-12 to 24 h.

The literature convincingly demonstrates that tactics based simply on overdiagnosis of the disease also do not save from errors. Consequently, the current tactics for diagnosing appendicitis in children admitted to the department require revision. The pain syndrome can hide a number of diseases that require intensive and sometimes emergency therapy. The findings of Y.F. Isakov et al. found that 40.3% of children operated on with the diagnosis of catarrhal or secondary changed appendicitis had other diseases simulating acute appendicitis. Thus, the performance of unnecessary operations against the background of an undiagnosed underlying disease accompanied by abdominal pain syndrome can aggravate the severity of the condition of a sick child and is fraught with the development of

complications, and in some cases can lead to lethal outcome .

CONCLUSIONS: Thus, the analysis of the literature shows that there is an urgent need for a detailed review of diagnostic and therapeutic tactics adopted in hospitals providing emergency surgical care to the pediatric population.

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