VANDERBILT UNIVERSITY MEDICAL CENTER

Department of Emergency General Surgery

Practice Management Guidelines: Acute Appendicitis

I. **Purpose:** Acute appendicitis is one of the most common reasons for presentation to the Emergency General Surgery service. This document outlines the management considerations of patients presenting with acute appendicitis.

II. **Guideline:**

A. **Initial Evaluation with Concern for Acute Appendicitis**

a. Labs
   i. CBC
   ii. BMP

b. Imaging
   i. CT Abdomen/Pelvis with IV Contrast

B. **Management**

a. Without Shock
   i. First-line: Ceftriaxone/Metronidazole
   ii. Severe Penicillin Allergy: Levofloxacin/Metronidazole

b. Shock/Multidrug Resistance Risk
   i. First-line: Piperacillin/Tazobactam
   ii. Severe Penicillin Allergy: Vancomycin/Cefepime/Metronidazole

c. Antibiotic Therapy Duration
   i. Nonoperative management – 7 days (Oral Levofloxacin/Metronidazole)
   ii. Uncomplicated appendectomy – Stop postoperatively.
   iii. Complicated appendectomy (perforated, suppurative, abscess) – 4 days postoperatively

d. NPO Except Meds Order pending operative plan.

e. Emergency General Surgery Consultation/Admission

f. Operative Management with Laparoscopic Appendectomy
   i. Drains should **not** routinely be placed for complicated appendicitis.
   ii. Complicated appendicitis – suction and lavage or suction alone is based on surgeon preference.

g. Considerations for Nonoperative Management
    i. Patient preference
    ii. Severe inflammation/phlegmon/perforation on CT which would necessitate ileocecectomy
    iii. Excessive surgical/perioperative risk factors
    iv. Appendicolith on CT is associated with higher rate of recurrent appendicitis
    v. Failure of nonoperative management in the pregnant patient could result in fetal demise
    vi. Strongly consider interval appendectomy in patients $\geq$ 40 years old with perforated appendicitis due to cancer risk (6-34% rate of neoplasm)

h. Follow-up
    i. 7-14 day follow up either telemedicine or in-person with review of pathology (if operative)
    ii. Consideration of colonoscopy referral if risk for colon cancer

III. References

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IV. Author

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