<table>
<thead>
<tr>
<th><strong>Title:</strong></th>
<th>The Diagnosis of Acute Appendicitis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Author:</strong></td>
<td>Flemming, R. J.</td>
</tr>
<tr>
<td><strong>Publication Date:</strong></td>
<td>June 1933</td>
</tr>
<tr>
<td><strong>Name of Journal:</strong></td>
<td>The Leech being the University of the Witwatersrand Medical Journal</td>
</tr>
<tr>
<td><strong>Volume:</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>Issue:</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>Pages:</strong></td>
<td>24 - 25</td>
</tr>
</tbody>
</table>

Accessed from  [http://wiredspace.wits.ac.za](http://wiredspace.wits.ac.za)
THE DIAGNOSIS OF ACUTE APPENDICITIS

By R. J. Flemming M.B. Ch.B.

REPORT ON TWO CASES

As a student acute appendicitis is easy to diagnose; as a houseman it becomes one's chief bugbear. The following cases illustrate the difficulty in diagnosing the condition in people who have not read the text-books.

Case 1.

At 1.30 a.m. Wednesday, 3/5/33, a man aged 51 years came into the Casualty department complaining of acute pain in the abdomen which had started six hours previously, after a light evening meal.

Ten months previously he had had his gall-bladder removed. The wound had drained for weeks and the patient had been jaundiced since then.

The pain of which he now complained was severe all over the abdomen and colicky in character. It would last for a minute and then subside. He had not vomited. His bowels were regular and his micturition normal. Examination revealed marked tenderness at McBurney's point. There was no rigidity. Rovsing and Psoas signs were both negative. Temperature was 98.6°, Pulse was 84. The patient was well enough to crack jokes with the doctor.

The patient was admitted, placed in Fowler's position and a half-hourly chart of the pulse and temperature was taken.

The pulse and temperature remained the same until 8 a.m. when the nurse reported that he was well. At 8.30 a.m. the pulse had risen to 96 and the temperature had dropped to 96°. The patient was again examined and the abdomen was found to be rigid.

An emergency operation was performed and a short distended acutely inflamed appendix was removed.

Dense adhesions were found binding the stomach to the liver and to the anterior abdominal wall. A dense adhesion was found tightly stretched across the common bile duct, and this probably accounted for the jaundice as, since the operation it has appreciably decreased.

Thirty-six hours after the operation the temperature rose to 99.8° and the pulse to 108 but both rapidly fell.

Case II.

A man who had just come from Zeerust walked into the Casualty department at 7.30 a.m., Wednesday, 3/5/33. On the preceding Sunday (30/4/33) he had experienced a severe pain all over the abdomen which had doubled him up. He had had pain since then which was most severe below the umbilicus on both sides. The pain was continuous. On Monday morning he had taken castor oil and vomited. His bowels had not been regular.

The patient had had a similar attack last year but it had not been so severe.

Examination revealed a somewhat distended abdomen. There was no rigidity. There was tenderness at McBurney's point, but also above and below this point and on the left side.

The pulse was 96 and the temperature 98.6°.

This case was watched as in the preceding case and here the pulse and temperature rose steadily until at 5 p.m. the pulse was 112 and the temperature 100.4°. There was now some resistance on the right side but no definite rigidity.

An emergency operation revealed an acutely inflamed friable appendix tacked down to the posterior wall of the pelvis. The appendix ruptured during removal.
Conclusions.

Case I.

I would account for the comparatively slow pulse and normal temperature in the first case by the jaundice. I would suggest that a pulse of 88 and a temperature of 98.6° are not inconsistent with an inflammatory lesion in a deeply jaundiced patient.

Case II.

The temperature of 98.6° in an inflammatory appendix of three days standing is difficult to account for. It certainly was not an incorrect observation as it was verified by two other readings with other thermometers.

It is interesting to compare these cases with another case which was admitted on Tuesday, 13/6/33.

A girl of 18 years developed an acute pain in the pit of the stomach on Monday afternoon 12/6/33. The pain moved to the right side of the abdomen and the patient vomited. There was no history of dyspepsia, renal or genital trouble.

Examination revealed marked tenderness and some resistance over McBurney’s point. The pulse was 110 per minute and the temperature 98°. The menstrual history was normal. Rovings’ sign was present.

The Psoas sign was present.

On opening the abdomen an ovarian cyst the size of a golf ball was found on the left side. There was half a cup full of light brown fluid in the abdomen which had come from an ovarian cyst on the right side. The appendix was normal.

"The sphere of our knowledge expands without ceasing but as it increases so does the number of its points of contact with the unknown."