A Great Medical Mimic

By Dr Wong Sin Hee

I performed my first appendectomy when I was a house officer in 1974. I was attached to the Surgical Department at Alexandra Hospital then and had the privilege of being taught by my surgical mentor, Mr BK Ng. The vestigial appendix is a rather fascinating anatomical nuisance and has caused undue pain and anguish to many patients, as well as to many experienced physicians. It remains a great medical mimic.

Recently, my classmate had a bout of gastroenteritis which went on for some time with loss of appetite, lethargy and malaise. He was treated conservatively without much improvement, and it was only realised later that the appendix was the main culprit. Fortunately, he made an uneventful recovery after his inflamed appendix was removed. This speaks volumes of the difficulty in making a "simple" diagnosis of appendicitis – even among our colleagues.

I remember very vividly when a very anxious mother brought her six-month-old infant to see me many years ago. The mother told me that the child was crying and not feeding. Clinically, there was no fever. But abdominal examination revealed marked guarding and tenderness over the right iliac fossa (RIF). I told the mother what I thought: appendicitis. She looked at me with disbelief and then with much trepidation.

"Are you sure?" the mother asked. "She is only six months!"

I told her frankly that the infant needed to be admitted, at least for observation. She believed me and brought her infant to Tan Tock Seng Hospital. The good medical officer admitted the infant and the good surgeon removed an acutely inflamed appendix! The mother was greatly relieved, and the surgeon told her that this was his youngest patient with appendicitis ever!

Appendicitis can occur even in the very young, so do be very careful. It is a common and urgent surgical illness with protean manifestations, which many busy doctors may miss. It is also associated with other equally urgent clinical syndromes like ectopic pregnancy. In addition, appendicitis has a very high and significant morbidity, which increases with diagnostic delay. The Alvarado score, and the RIPASA score recently developed by our Malaysian colleagues are of some help, but no single sign, symptom, or diagnostic test accurately confirms the diagnosis of appendicitis in all cases. Clinical acumen and suspicion remain the cornerstones of making an accurate diagnosis. Failure to do so will result in an unfortunate fatality.

This also brought to my mind a very unfortunate patient who saw a doctor at our Accident & Emergency (A&E) in the morning, complaining of abdominal pain. A diagnosis of urinary tract infection was made. The same patient was later brought to the hospital morgue in the evening with perforated appendix and peritonitis! Do remember to examine all patients with abdominal pain, lying down.

Appendicitis remains a bugbear in my clinical practice. It has become my habit to think of appendicitis in all ages and all cases of gastrointestinal disorders. The clinical presentation has somewhat changed through the years and the classical RIF pain and fever may not be present at all.

I had a patient who presented with acute gastric pain and no other symptoms of appendicitis. There was no migration of pain from the epigastrium to the RIF. But he looked distressed, anguished and fearful, and wanted a quick relief from his pain. I treated him and advised him to go to the hospital if his pain persisted. Fortunately for him and for me, he had his acutely inflamed appendix removed when he went to the A&E in the evening! It was appendicitis – mimicking acute gastritis!

Have I ever missed any acute appendicitis? I guess I must have. My mantra is always to instruct patients and their caregivers to go to the A&E if their abdominal pain persists and if they feel very sick.

So do think of appendicitis in your very busy practice, and never assume that your patient is malingering. Good luck!

Dr Wong is a doctor who continues to be fascinated by clinical and family medicine.