Diagnostic Radiology 1987



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DEDICATION

"Each honest calling, each walk of life, has its own elite, its own aristocracy, based on excellence of performance."

JAMES BRYANT CONANT Harvard Baccalaureate Sermon June 16, 1940

This book is dedicated to the physicians who are residents and fellows in Radiology at the University of California, San Francisco.

Preface

The Department of Radiology of the University of California Medical Center in San Francisco is proud to present this synopsis of the state of the art in the field of radiology. The challenge for us was to select stimulating topics and authorities who could offer both expert commentary on the newest radiologic technologies and critical commentary on their effectiveness. The topics presented are pragmatically oriented; they have been chosen with the intent of aiding clinical radiologists in their medical practice.

The editors thank Mrs. Renee Sauers, Victoria Babcock, and the Postgraduate Education Section of the Department of Radiology of the University of California Medical Center in San Francisco for all the time and effort that they have contributed to ensure the success of this book. We extend our thanks to Al Averbach and Susan Averbach for editing the chapters, to Charlie Scribner and the University of California Printing Services, whose expertise and cooperation made this publication possible, and to Anne Poirier and Wendy Neale for administrative assistance. We would also like to express our sincere thanks to the authors for their contributions to this work.

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San Francisco, California March, 1987

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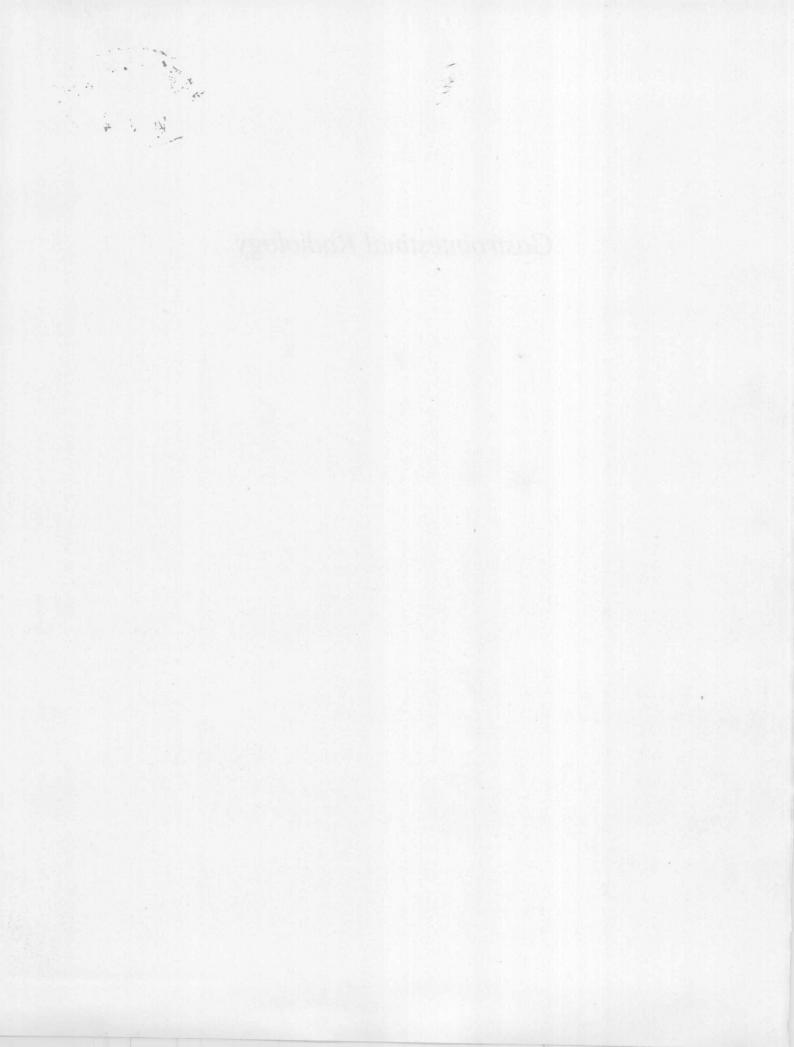
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Gastrointestinal Radiology



Imaging and Intervention in Acute Appendicitis

R. Brooke Jeffrey, Jr., M.D.

Acute Appendicitis

Although acute appendicitis remains the most common indication for emergency laparotomy, its diagnosis is often based on imprecise clinical criteria. Surgeons generally agree that negative appendectomy rates on the order of 20 percent are justified to avoid misdiagnosis. Diagnostic inaccuracy is highest in ovulating women, for whom negative appendectomy rates of 35 to 45 percent are commonly quoted in the surgical literature. 1,2 The main factors contributing to this high negative appendectomy rate have been the nonspecific clinical features of acute appendicitis, which broadly overlap a variety of other acute abdominal disorders, and the inability to directly image the appendix with a readily available noninvasive technique. Although conventional radiologic methods such as plain abdominal radiographs and contrast enemas have been widely used in the evaluation of patients with suspected appendicitis, they are frequently insensitive and nonspecific. This paper focuses on the role of high-resolution sonography and computed tomography (CT) in the diagnosis of appendicitis and its complications.

Puylaert³ has recently described a graded compression technique using high-resolution real-time sonography in evaluating patients with suspected uncomplicated acute appendicitis. The technique employs a linear array transducer (5-7.5 MHz) that can directly image an inflamed appendix after all of the gas and fluid have been gradually compressed out of the cecum and ascending colon. In normal patients the appendix is not routinely visualized. The main sonographic criteria for acute appendicitis include the visualization of a noncompressible appendix with a thickened wall (3 mm or greater). The presence of appendicoliths, periappendiceal abscess, mesenteric adenopathy, and mural thickening of the cecum can be readily discerned by this method. In Puylaert's study there were no nondiagnostic examinations and no false-positive examinations. A small number of false-negatives were encountered in patients with surgically proven acute appendicitis but no sonographically visible appendix.

We recently completed a study at San Francisco General Hospital evaluating the diagnostic efficacy of graded compression real-time sonography in evaluating 90 patients with suspected acute appendicitis (Fig. 1). Although our overall accuracy (93%) suggested that this is a very promising new method, several important limitations of sonography were encountered in our series

that had not been noted by Puylaert.³ In three patients (3%) the study was nondiagnostic owing to an inability to adequately compress the cecum and right lower quadrant. The normal bowel is quite distensible and easily collapses with moderate degrees of pressure. However, the distended inflamed appendix does not collapse when compressed. Two of the three patients had marked peritoneal findings in the right lower quadrant and could not cooperate to complete the study. Both had proven appendicitis (one with a ruptured appendix) at surgery. A third patient had tense abdominal ascites that precluded adequate compression of the right lower quadrant.

Three patients in our series had a sonographically visible appendix compatible with acute appendicitis, but their symptoms resolved and they did not require surgery. The exact explanation for this is unclear; however, "chronic appendicitis" has been referred to in the surgical literature, and it is possible that in some patients appendiceal inflammation may be reversible. 4.5

In our clinical series a very low percentage of women (only 6 of 49, or 12%) had proven appendicitis. Often their clinical symptomatology overlapped with acute gynecologic disorders such as ovarian cysts and pelvic inflammatory disease. However, routine scanning of the pelvis with a 3.5-MHz transducer using a full-bladder technique did not significantly improve the diagnostic specificity in patients without sonographic evidence of acute appendicitis. Nonetheless, it is likely that one of the main impacts of sonography will be in the evaluation of appendicities in women, in whom clinical criteria often result in a disturbingly high negative appendectomy rate.

Periappendiceal Abscess

Patients with periappendiceal abscesses often present with longer-lasting symptoms, a palpable right lower quadrant mass, pain, fever, and leukocytosis. In this subset of patients, CT appears to be of considerable clinical value in differentiating pericecal phlegmon from a liquified periappendiceal abscess (Fig. 2). In patients with a well-localized liquified abscess, percutaneous catheter drainage is often the therapeutic method of choice and has a high degree of success. Over the past 3 years, 24 of 26 patients with periappendiceal abscesses have been successfully managed by percutaneous drainage at San Francisco General Hospital (Fig. 3).

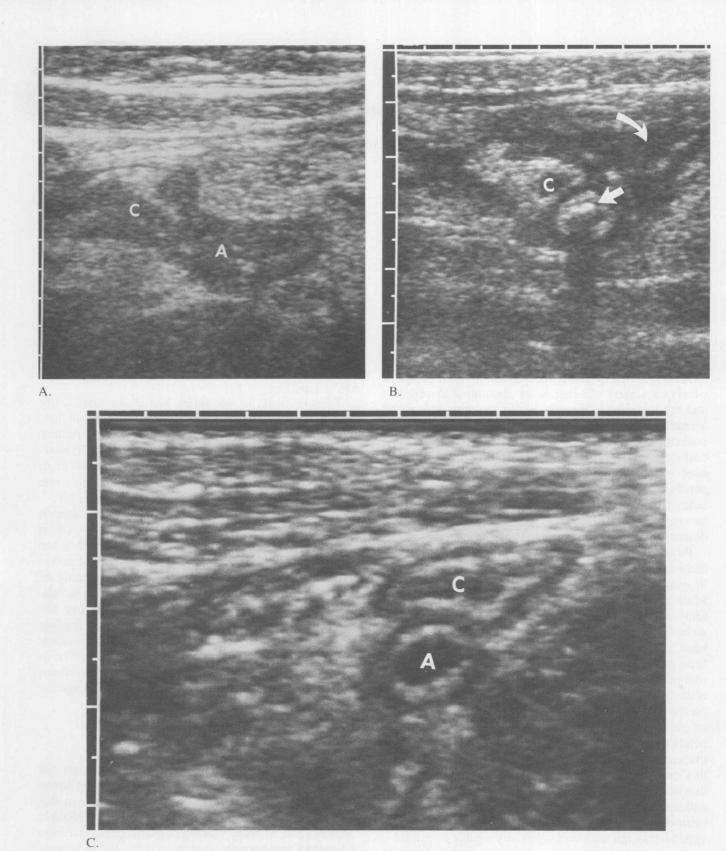


Figure 1. Sonographic diagnosis of acute appendicitis.

A. Longitudinal scan of noncompressible appendix with distended lumen and edematous wall. (A, appendix; C, cecum)

B. Transverse scan of calcified appendicolith (straight arrow). (C, cecum; curved arrow, mesenteric edema)

C. Transverse scan of retrocecal appendix (A). (C, cecum)