mycobacteria, *Cytomegalovirus*, or other fungi. Enterocolitis is a concern and may be present in patients who present with abdominal pain, fever, and neutropenia due to chemotherapy. CT imaging may be very helpful, although it is important not to be overly cautious and delay operative intervention for those patients who are believed to have appendicitis.

TREATMENT

Acute Appendicitis

In the absence of contraindications, most patients who have strongly suggestive medical histories and physical examinations with supportive laboratory findings are candidates for appendectomy. In many instances, imaging studies are not required but are often obtained before surgical consultation is requested. Certainly, imaging and further study are appropriate in patients whose evaluations are suggestive but not convincing.

CT may accurately indicate the presence of appendicitis or other intraabdominal processes that warrant intervention. Whenever the diagnosis is uncertain, it is prudent to observe the patient and repeat the abdominal examination over 6–8 h. Any evidence of progression is an indication for operation. Narcotics can be given to patients with severe discomfort.

All patients should be fully prepared for surgery and have any fluid and electrolyte abnormalities corrected. Either laparoscopic or open appendectomy is a satisfactory choice for patients with uncomplicated appendicitis, although most procedures are now performed in a minimally invasive fashion to the patient's benefit in terms of recovery time and complications. Management of those who present with a mass representing a phlegmon or abscess can be more difficult. Such patients are best served by treatment with broad-spectrum antibiotics, drainage if there is an abscess >3 cm in diameter, and parenteral fluids and bowel rest if they appear to respond to conservative management. The appendix can then be more safely removed 6–12 weeks later when inflammation has diminished.