

Laparoscopic appendectomy now accounts for the majority of all appendectomies performed in Western cultures and is associated with less postoperative pain, shorter lengths of stay, faster return to normal activity, and likely fewer superficial wound complications, although the risk of intraabdominal abscess formation may be higher.

A laparoscopic approach may also be useful when the exact diagnosis is uncertain. A laparoscopic approach may also facilitate exposure in those who are very obese. Absent complications, most patients can be discharged within 24–40 h of operation. The most common postoperative complications are fever and leukocytosis. Continuation of these findings beyond 5 days should raise concern for the presence of an intraabdominal abscess. The mortality rate for uncomplicated, nonperforated appendicitis is 0.1–0.5%, which approximates the overall risk of general anesthesia. The mortality rate for perforated appendicitis or other complicated disease is much higher, ranging from 3% overall to as high as 15% in the elderly.

ACUTE PERITONITIS

Acute peritonitis, or inflammation of the visceral and parietal peritoneum, is most often but not always infectious in origin, resulting from perforation of a hollow viscus. This is called *secondary peritonitis*, as opposed to *primary* or *spontaneous peritonitis*, when a specific intraabdominal source cannot be identified. In either instance, the inflammation can be localized or diffuse.

■ ETIOLOGY

Infective organisms may contaminate the peritoneal cavity after spillage from a hollow viscus, because of a penetrating wound of the abdominal wall, or because of the introduction of a foreign object like a peritoneal dialysis catheter or port that becomes infected.

Secondary peritonitis most commonly results from perforation of the appendix, colonic diverticula, or the stomach and duodenum. It may also occur as a complication of bowel infarction or incarceration,