To separate wheat and chaff

Sir,

I read with great interest the paper entitled "Right lower quadrant pain in females: Is it appendicitis or gynecological?" by Archibong et al published in the Saudi Medical Journal.[1] Those of us who, on almost daily basis, see, evaluate and manage female patients in their reproductive years with right lower quadrant pain would find this paper most enlightening. Understandably, to pigeonhole these patients' complaint as gynecological or non-gynecological in origin is really an insurmountable diagnostic difficulty. In the current state of clinical practice, unfortunately, there is a palpable tendency to overdiagnose acute appendicitis in female patients presenting with right lower quadrant pain. As a corollary, in the great majority of cases, this diagnosis entails appendicectomy. Broadly speaking, at least 3 pitfalls are inherent in this clinical approach. Firstly, it may lead to, as what could be inferred in hindsight and substantiated by this paper's findings, unnecessary appendicectomy, a surgical intervention with its attendant risks of morbidity and mortality. Let us not forget our watchword: First do no harm.[2] Secondly, its notorious far - reaching added morbidity of postoperative adhesions formation which jeopardizes the reproductive capacity of the young female population. This adds to the gravity of this intervention in this very group of patients. Thus, embarking on this management option should only be entertained whenever a degree of diagnostic certainty is attained to justify the acceptance of this potential risk. However, the matrix of the whole clinical problem should be precisely examined and its individual components carefully dovetailed.[3,4] Thirdly, given this age of cost-conscious medical care market, the cost- effectiveness of this approach is, at best, questionable. Unfortunately, it is well beyond the scope of this contribution to try to elaborate on this crucial point. To try to analyze the rationale of this approach, it is evident that its proponents tend to ride on the back of the fact that acute appendicitis is a common clinical problem and if not diagnosed and treated early grave consequences ensue with unacceptably high morbidity and mortality rates. Well, I emphatically agree. Nevertheless, the adoption of this approach should, by necessity, neither dwarf nor skew attention to the potential possibilities that a gynecological pathology causing right lower quadrant pain might masquerade as acute appendicitis. As this study showed, this was a snare for the unwary. Obviously, early liaison between general surgeons and gynecologists, which this paper showed its lack, in the diagnostic work-up of female patients with right lower quadrant pain would materially improve the diagnostic accuracy and in turn averts unnecessary surgical intervention. I think it is relevant to allude to the fact that there is mushroom growth of interest in utilizing laparoscopy early on in those equivocal cases. I am sure the time and effort invested in its inclusion in the diagnostic work-up of such cases are more than repaid. Lastly, this paper served to stir what once we, as budding and seasoned clinicians alike, were given as vivid take-home messages in our medical school days. With no corners to be cut, complete history, thorough physical examination and judicious use of laboratory investigations and imaging techniques, the great majority of patients' pains will be diagnosed.

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