**The 34-Year-Old Patient Evaluation & Management Plan**

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Appendicitis is the inflammation of the vermiform appendix caused by an obstruction and/or infection. It is the most common cause of acute right lower quadrant (RLQ) abdominal pain requiring surgical intervention. One question that should be asked is if the patient is experiencing anorexia, because this is the first symptom and principal indicator of appendicitis. Another important question is asking about where the abdominal pain is because inflammation of the visceral peritoneum usually progresses to the parietal peritoneum, presenting with migratory pain, which is a classic sign of appendicitis. Additionally, ask about presence of fever and vomiting because these are results of inflammation, and if the patient is having menstruation now to rule out other etiologies of abdominal pain (Snyder et al., 2018).

The diagnosis of acute appendicitis is made clinically and is based primarily on the patient’s history and physical exam. The historical presentations of signs and symptoms are important keys to prompt diagnosis and treatment; therefore, it is important to obtain a thorough and accurate account of the events. A rectal exam can be performed, but it is open to greater subjective interpretation. Patients with appendicitis will normally perceive greater tenderness and fullness on the right than on the left during the rectal exam. The provider must keep in mind that both the bowel and the appendix are mobile organs; they can shift posteriorly or suprapubic, causing altered exam findings (Dunphy et al., 2019). Bowel sounds are a nonspecific finding they may be present, absent, or decreased in patients with appendicitis. Other physical exam findings can include alterations in vital signs consistent with increased pain, such as tachycardia or elevated blood pressure. Patients may be reluctant to take a deep breath for fear they will cause themselves pain (Talan & Di Saverio, 2021). If there is perforation of the appendix, there may be a sudden cessation of the pain, which is considered an emergency. Findings consistent with peritonitis include diffuse abdominal tenderness with rigidity. The patient may exhibit signs of septic shock, with marked leukocytosis, fever, and hemodynamic instability (Snyder et al., 2018).

The differential diagnoses of appendicitis include a host of problems, which include, but are not limited to, urinary tract infection, ectopic pregnancy, ovarian cyst, pneumonia, gastroenteritis, Crohn’s disease, diverticulitis, mesenteric adenitis, pancreatitis, PID, and cholelithiasis. Laboratory findings are not diagnostic and are nonspecific, so they must be used in combination with data from the history and physical exam. The complete blood count usually reveals a mild to moderate leukocytosis (white blood cell count 10–20,000 mcg/L) with a left shift (Talan & Di Saverio, 2021). Urinalysis shows microscopic hematuria or pyuria in 25% of patients. Women should have a urine human chorionic gonadotrophin test completed to rule out (ectopic) pregnancy. The lack of laboratory findings should not preclude the diagnosis of appendicitis (Dunphy et al., 2019).

A computed tomography scan of the abdomen is helpful in ruling out other diagnostic possibilities, as well as determining if there has been perforation of the appendix or development of a peri-appendiceal abscess. An abdominal ultrasound helps to visualize the inflamed appendix and is also useful in ruling out other potential diagnoses. Diagnostic laparoscopy may be considered in female patients to rule out ectopic pregnancy, tub-ovarian processes, or pelvic inflammatory disease (PID). The treatment of appendicitis is surgical; therefore, once a definitive diagnosis is made, prompt referral to a surgeon should follow.

**References**

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