



## Key Hole Appendectomy :A Case Study

### KEYWORDS

**DR.MANSING GHATAGE**

PROFESSOR, M.S. (GEN.SURGERY)

**DR.ABHINANDAN khaliyal**

LECTURER ,(DNB GEN.SURGERY)

**DR.VINOD KARAGI**

3RD YEAR RESIDENT, M.S.(GENERAL SURGERY)

**DR.ANKUSH SHARMA**

3RD YEAR RESIDENT , M.S.(GENERAL SURGERY)

**ABSTRACT** A case study on Key Hole Appendectomy.

**MATERIAL AND METHODS:** 150 patients with clinical signs and symptoms of appendicitis where interval and elective appendectomy were planned and were subjected to various modalities of appendectomy either under SA or GA from June 2013 to June 2015 at Dr. D.Y. Patil hospital and research institute, Kolhapur with the help of 1.5 to 2cm transverse incision in the right lower quadrant abdomen appendectomy was successfully performed in 98% (n=49) and in 2% (n=01) incision had to be extended to 3cm maximum.

50 patients underwent Laparoscopic appendectomy.

50 patient underwent conventional open appendectomy. 50 patient underwent key hole appendectomy

**CONCLUSION:** Success rate of key hole appendectomy was 98% with 01 cases requiring extension of incision to maximum 3cm. we gave it the name of extended key hole appendectomy.

### INTRODUCTION

Acute appendicitis is one of the most common "acute surgical abdomen" world over, requiring surgical intervention for total cure as well as to avoid complications. As the notification of the disease is not required its exact incidence is unknown. Since the days of Mc Burney who devised muscle-splitting incision for appendectomy there have been very few incisions devised like Rocky Dave's Rutherford Morison's, Battle's incision and lately Lanz incision etc for appendectomy<sup>3</sup>. But after invent of minimally invasive procedures in the field of surgery especially after the invent of Laparoscopic surgery a tidal wave have been set in with much enthusiasm among the surgical fraternity for minimally invasive surgery in order to give better comfort, better cosmesis and early recovery to the patients<sup>3</sup>. Added to it is the fact that modern advertising continues to glorify the blemish free face and body, an exposed abdominal scar is viewed as most objectionable. The strong desire of patients especially females to avoid abdominal scar has encouraged many surgeons to use a variety of incisions for abdominal visceral surgery that are hidden from exposure<sup>5</sup>. Surgeons have tried from time to time cosmetically better incision for appendectomy but without following them thereafter.

### AIM

To compare the various modalities of appendectomies in presence scenario of minimal access surgery.

### OBJECTIVE

To compare key hole appendectomy with Laparoscopic and conventional open appendectomy.

To check success rate and patient compliance and cost effectiveness in various modalities.

INCLUSION CRITERIA	EXCLUSION CRITERIA
All patients eligible for interval elective appendectomy.	Morbid obese patient
	Appendicular abscess
	Appendicular lump
	Not ready for consent for conventional open appendectomy.



IMAGE SHOWING KEY HOLE APPENDECTOMY, SINGLE, SMALL INCISION



IMAGE SHOWING LAPAROSCOPIC APPENDECTOMY, MULTIPLE INCISIONS AS COMPARED TO KEYHOLE.

## CONCLUSION

The time taken to complete the operation was 11minute postoperative analgesics used were 2.13 dose per patient (2-5 doses), postoperative hospital stay of two to three days (2-4 days) including one day prior to surgery there was no mortality and negligible morbidity in the form of wound infection (n=00), anterior abdominal wall hematoma (n=00), subcutaneous emphysema (n=00). Better cosmesis and almost invisible scar is the hallmark of key hole appendectomy that is what we have observed in the study. Enthusiasm among surgical fraternity for minimally invasive surgery have almost made the aphorism " **the bigger the surgeon, the bigger the incision** " lose its essence. Success rate of key hole appendectomy was 98% with 01 cases requiring extension of incision to maximum 3cm. we gave it the name of extended key hole appendectomy

## REFERENCES

1. Shah RC, key hole open appendectomy. J Indian Med Assoc 2004-oct; vol 102 (issue 10) : pp 565-7.
2. Sanjay kumar shasin, satyendra dhar mini-appendectomy (an experience of 100 cases) JK-practitioner2005;12(1):11-13.
3. Farquharson's textbook of operative surgery. Eighth edition (1995), publisher Churchill livingstone; pp 452-54.
4. Jelarko C,Davis L. A transverse lower abdominal appendectomy incision with minimal derangements. Surg Gynecol Obstet 1973; 136:451.
5. Delany HM, carnevale N.J.A "Bikini" incision for appendectomy. Am J Surg 1976; 132(1): 126-7.
6. Temple WJ. Bikini appendectomy incision, an alternative to the Mcburney's approach for appendectomy. Canadian J Surg 1990; 33(5): 333-4.
7. Chauve A, Le Pape Y, Carmeela JP. Anesthetic approach for appendectomy: public incision (French). Presse Medicale 1996; 15(21): 980.
8. Harold E, L. Keith Nathason. Appendix and appendectomy. In Mangot's abdominal operations. Teenth edition (1997), vol-II; Editor Michael J. Zinner, Publisher Appleton & Lange Stanford,CT: pp 1191-1225.
9. Fitz RH. Perforating inflammation of the vermiform appendix; with special referenceto diagnosis and treatment. Am J. Med Sci 1886; 92: 321-46.
10. Mcburney C Experience with early operative inference in case of disease of vermiform appendix.N.Y. Med (1889);50:676.
11. Mouret P: from the first laparoscopic cholecystectomy to the frontier of laparoscopic surgery; the future prospects. Dig Surg 1991; 8 : 124-5.
12. Semm K. endoscopic appendectomy. Endoscopy (1983); 15: 59-64.
13. Schrieber J. Early experience with laparoscopic appendectomy in women. Surg Endosc (1987); 1: 211-16.