



Appendicitis

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What is a Clinical Pathway?

An evidence-based guideline that decreases unnecessary variation and helps promote safe, effective, and consistent patient care.

Objectives of Pathway

- To standardize care of patients with both acute simple (non-perforated) appendicitis, complicated (acute perforated) appendicitis in the pediatric population
- To delineate guidelines on when to consider operative vs non-operative management
- To standardize care of patients with operative and non-operative management
- To provide evidence-based recommendations for key elements of care for appendicitis
- To clearly delineate discharge criteria and instructions

Why is Pathway Necessary?

- Abdominal pain is a common reason for presentation to the Emergency Department, pediatric and surgical offices
- Appendicitis is a common surgical etiology for this type of pain.
- American Pediatric Surgical Association has altered their guidelines to help decrease the following:
 - number of CT scans used for diagnosis
 - inappropriate antibiotic choices and duration
 - need for inpatient management post-operatively
- Pathway was developed to ensure an optimal consistent approach to the surgical management of children who present with appendicitis

Epidemiology of Appendicitis

- Overall lifetime risk is 8.6% in males, 6.7% in females
- Luminal obstruction that subsequently leads to infection
 - Fecaliths are the most common cause; however the cause of the obstruction may not always be clear
 - Hyperplasia of appendiceal lymphoid follicles
 - Associated with :
 - Bacterial Infections: Yersinia, Salmonella, Schistosoma, Enterobius, Ascaris
 - Viral Infections: Measles, Chicken Pox, CMV

- Improved outcomes ≠ Increased resource utilization
- Good evidence-based recommendations to guide care
 - Ultrasound is first line imaging approach for diagnosis
 - The solution to pollution is NOT dilution (irrigation)
 - Once daily dosing for antibiotics (ceftriaxone/metronidazole)
 - Postop labs/imaging should be minimized
 - TPN is not beneficial in the majority of cases
 - The easiest way to improve quality for appendicitis is to lower cost.

- Initial labs: remove iStat chem 7
- Non-operative management:
 - Criteria for non-operative management *must* be present (changed from “consider”)
 - No longer requires 23 hour observation. Can observe in ED.
 - Phone call follow-up can occur 7 days after discharge (previously 24 hours)
- Operative management:
 - Operative management clarified to be “laparoscopic appendectomy”
 - Pain control:
 - Ketorolac should be given ATC x72 hours
 - Acetaminophen ATC added as an option
 - Morphine IV and hydrocodone/acetaminophen PO removed as an option when pain well-controlled

- Operative management:
 - Those with appendiceal abscesses should have both aerobic + anaerobic cultures obtained intraoperatively
 - Continue to follow cultures, even after discharge
 - If multi-drug resistant bacteria or other organisms grow*, consult ID

*** Organisms necessitating ID Consult**

Yeast; *Actinomyces*; bacteria resistant to ceftriaxone; carbapenemase-producing Gram negatives; *Citrobacter freundii*; *Enterobacter*; *Enterococcus*; ESBL organisms; *Klebsiella aerogenes*; *Pseudomonas*; or *Staphylococcus* (MSSA/MRSA)

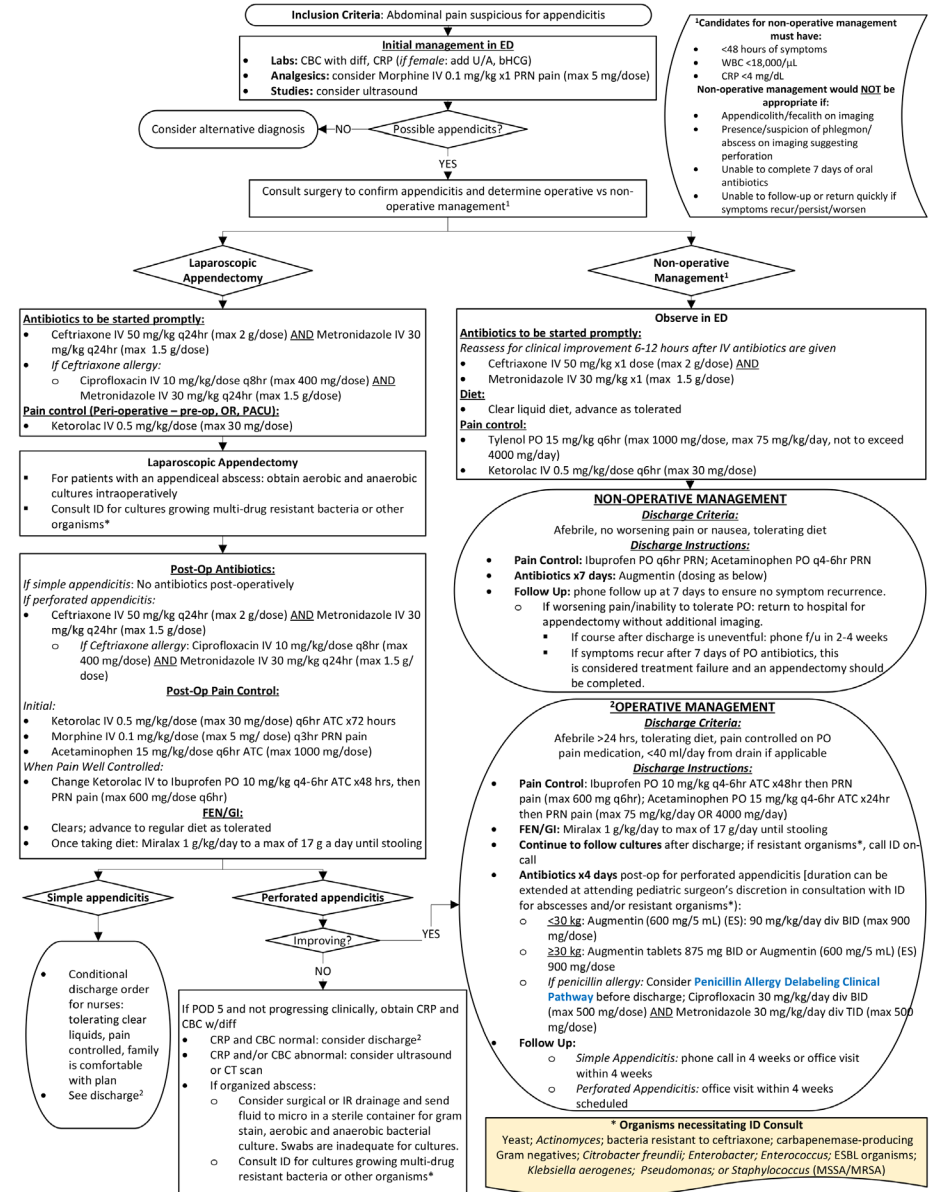
- Perforated appendicitis:
 - If patient is not improving after laparoscopic appendectomy, obtain a CRP *and* CBC w/diff on POD 5
 - If the CRP and CBC are normal, can now *consider* discharge
 - If CRP *and/or* CBC is abnormal, consider ultrasound or CT scan
 - If there is an organized abscess and surgical/IR drainage required, fluid should be sent in a *sterile container* for gram stain, aerobic *and* anaerobic culture. Swabs are not adequate for cultures.
 - Antibiotics for perforated appendicitis:
 - Duration of antibiotics changed to 4 days (from 7 days) – duration can be extended per attending surgeon's discretion in consultation with ID for abscesses and/or resistant organisms
 - Augmentin dosing updated
 - If there is a penicillin allergy, added consideration for Penicillin Allergy Delabeling Clinical Pathway prior to discharge
 - Updated max dosing for ciprofloxacin

CLINICAL PATHWAY: Appendicitis

THIS PATHWAY
SERVES AS A GUIDE
AND DOES NOT
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This is the Appendicitis Clinical Pathway.

We will be reviewing each component in the following slides.



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CLINICAL PATHWAY: Appendicitis

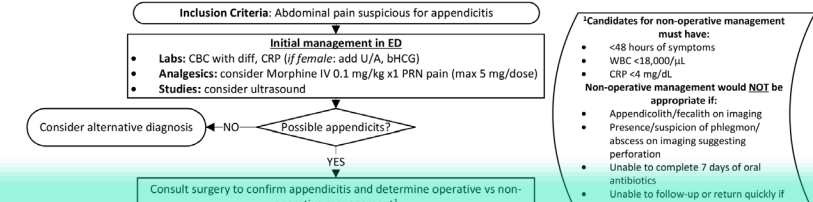
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Initial management in the ED includes obtaining screening labs, managing pain, and considering obtaining an ultrasound to help determine potential for appendicitis.

2026
Update

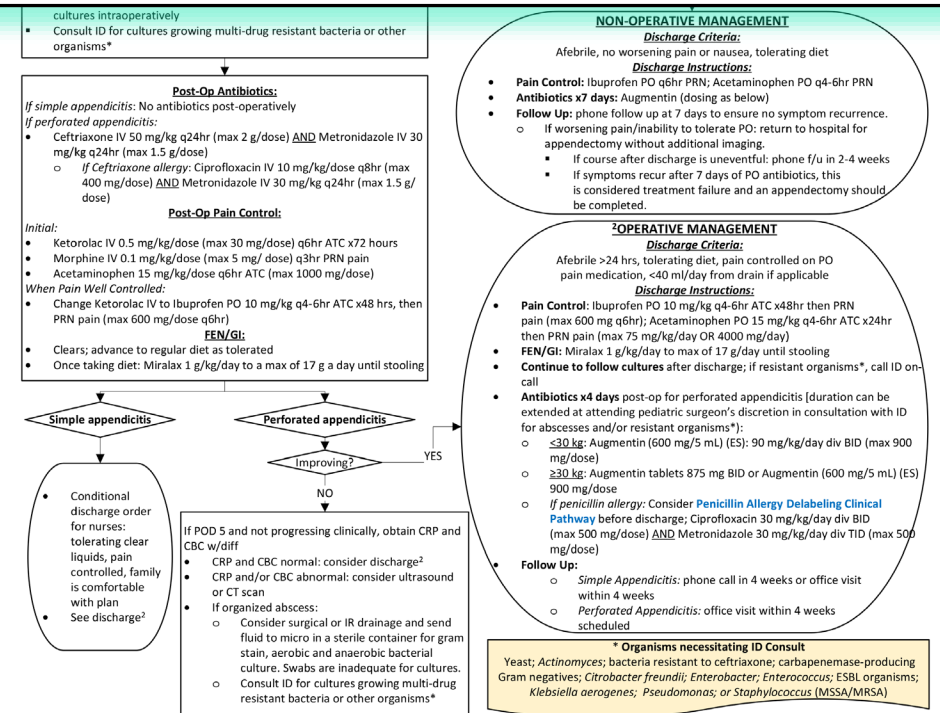
iStat chem 7 no longer
required

Inclusion Criteria: Abdominal pain suspicious for appendicitis



Initial management in ED

- Labs:** CBC with diff, CRP (*if female:* add U/A, bHCG)
- Analgesics:** consider Morphine IV 0.1 mg/kg x1 PRN pain (max 5 mg/dose)
- Studies:** consider ultrasound



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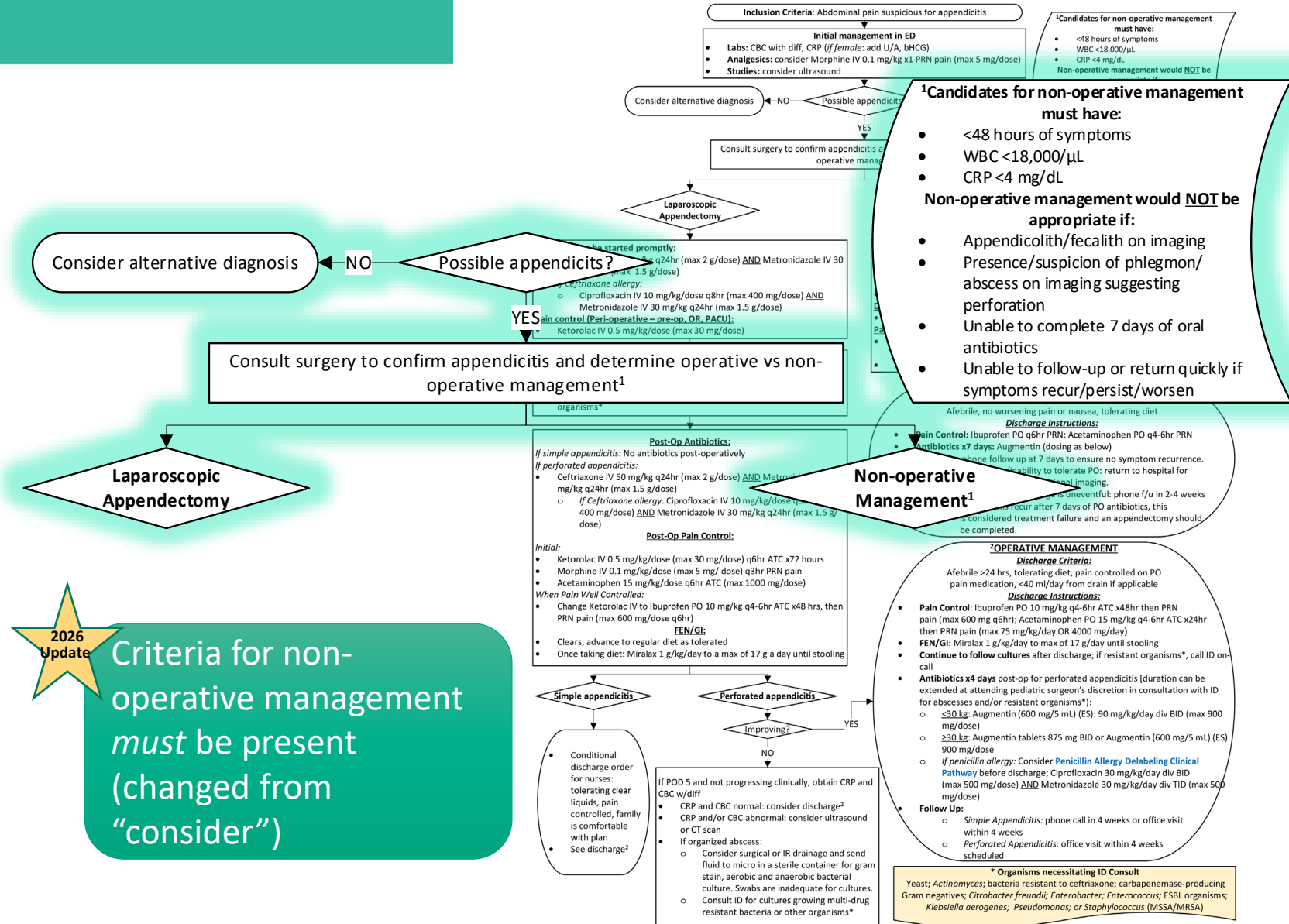
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- If appendicitis is suspected, consult surgery to confirm the diagnosis.
- Surgery will decide on operative vs non-operative management based on certain criteria.
- Non-surgical management should be based on duration of symptoms and reassuring WBC and CRP.
- Criteria have been outlined for when non-operative management would NOT be appropriate.



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Non-Operative Management

If the patient meets criteria for non-operative management, observe in the ED.

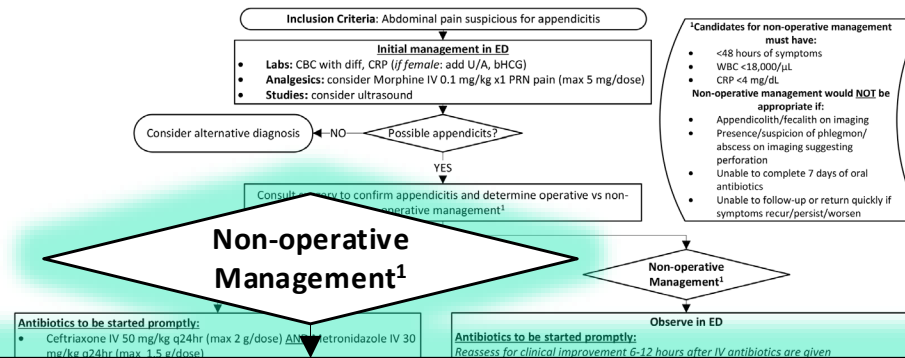
2026 Update

No longer requires 23 hour observation.

- IV Antibiotics should be started promptly
- Reassessment should be done every 6-12 hrs after IV antibiotics given
- Pain should be controlled and diet should be advanced as tolerated

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Candidates for non-operative management must have:

- <48 hours of symptoms
- WBC <18,000/ μ L
- CRP <4 mg/dL

Non-operative management would NOT be appropriate if:

- Appendicitis/fever on imaging
- Presence/suspicion of phlegmon/abscess on imaging suggesting perforation
- Unable to complete 7 days of oral antibiotics
- Unable to follow-up or return quickly if symptoms recur/persist/worsen

Antibiotics to be started promptly:

Reassess for clinical improvement 6-12 hours after IV antibiotics are given

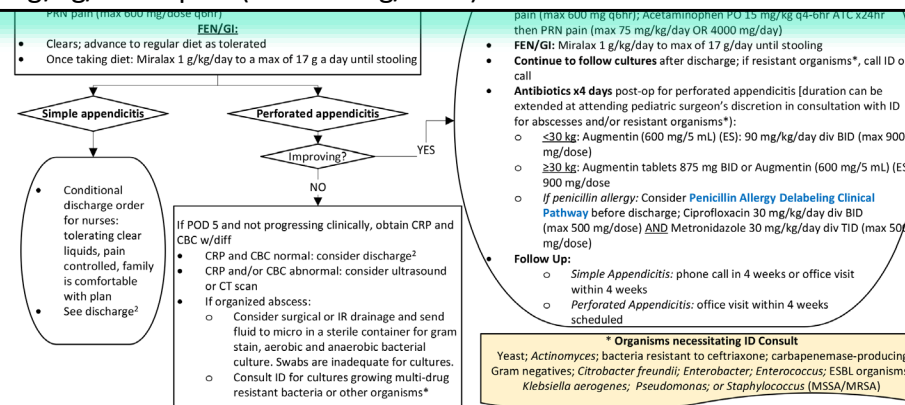
- Ceftriaxone IV 50 mg/kg x1 dose (max 2 g/dose) AND
- Metronidazole IV 30 mg/kg x1 (max 1.5 g/dose)

Diet:

- Clear liquid diet, advance as tolerated

Pain control:

- Tylenol PO 15 mg/kg q6hr (max 1000 mg/dose, max 75 mg/kg/day, not to exceed 4000 mg/day)
- Ketorolac IV 0.5 mg/kg/dose q6hr (max 30 mg/dose)



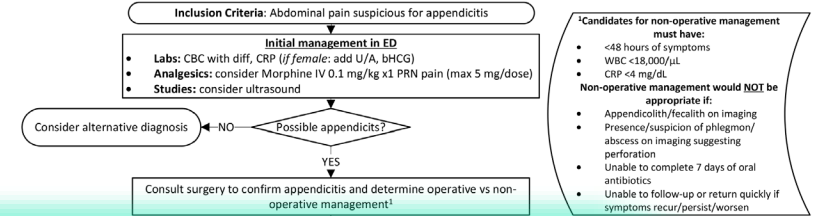
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Non-Operative Management

- Upon discharge, antibiotics should continue for 7 days with follow up at discontinuation.
- Guidance is given for further management, including surgical intervention if necessary.

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Phone call follow-up can occur 7 days after discharge (previously 24 hours)

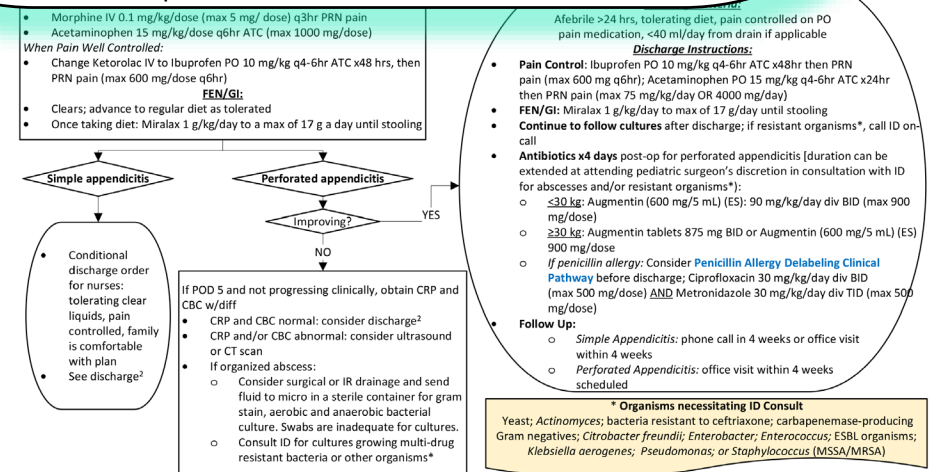
NON-OPERATIVE MANAGEMENT

Discharge Criteria:

Afebrile, no worsening pain or nausea, tolerating diet

Discharge Instructions:

- Pain Control:** Ibuprofen PO q6hr PRN; Acetaminophen PO q4-6hr PRN
- Antibiotics x7 days:** Augmentin (dosing as below)
- Follow Up:** phone follow up at 7 days to ensure no symptom recurrence.
 - If worsening pain/inability to tolerate PO: return to hospital for appendectomy without additional imaging.
 - If course after discharge is uneventful: phone f/u in 2-4 weeks
 - If symptoms recur after 7 days of PO antibiotics, this is considered treatment failure and an appendectomy should be completed.



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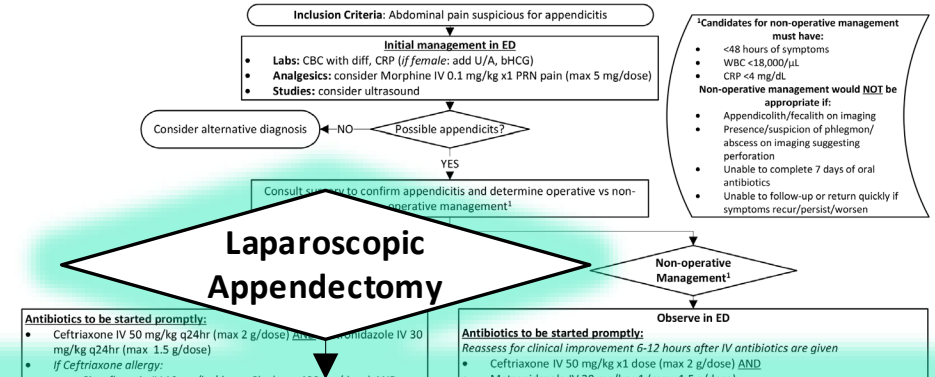
Operative Management

If the patient meets criteria for operative management:

- Surgery to give the “OK” for ED provider to order Ceftriaxone AND Metronidazole prior to incision
 - If Penicillin and/or Ceftriaxone allergy, use Ciprofloxacin AND Metronidazole
- Peri-operative pain control includes Ketorolac

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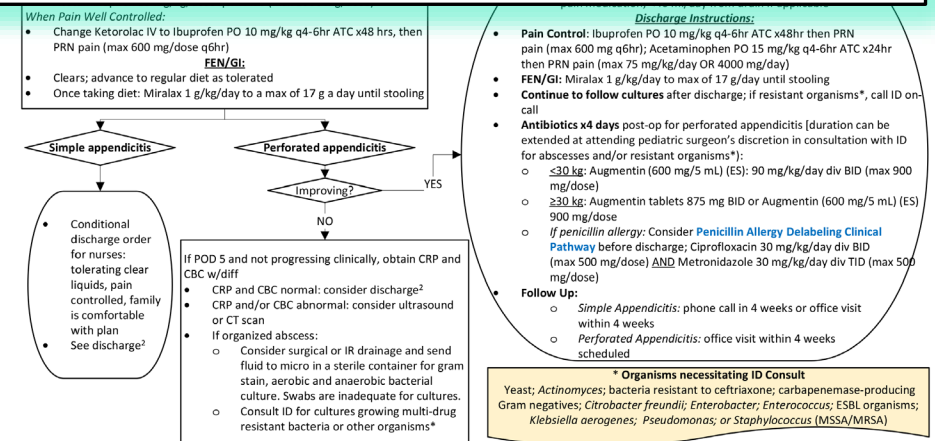


Antibiotics to be started promptly:

- Ceftriaxone IV 50 mg/kg q24hr (max 2 g/dose) AND Metronidazole IV 30 mg/kg q24hr (max 1.5 g/dose)
- *If Ceftriaxone allergy:*
 - Ciprofloxacin IV 10 mg/kg/dose q8hr (max 400 mg/dose) AND Metronidazole IV 30 mg/kg q24hr (max 1.5 g/dose)

Pain control (Peri-operative – pre-op, OR, PACU):

- Ketorolac IV 0.5 mg/kg/dose (max 30 mg/dose)



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Operative Management

Those with appendiceal abscesses should have both aerobic + anaerobic cultures obtained intraoperatively

- Continue to follow cultures, even after discharge

If multi-drug resistant bacteria or other organisms grow*, consult ID

* Organisms necessitating ID Consult

Yeast; *Actinomyces*; bacteria resistant to ceftriaxone; carbapenemase-producing Gram negatives; *Citrobacter freundii*; *Enterobacter*; *Enterococcus*; ESBL organisms; *Klebsiella aerogenes*; *Pseudomonas*; or *Staphylococcus* (MSSA/MRSA)

Laparoscopic Appendectomy

For patients with an appendiceal abscess: obtain aerobic and anaerobic cultures intraoperatively

- Consult ID for cultures growing multi-drug resistant bacteria or other organisms*

Post-Op Antibiotics:

If simple appendicitis: No antibiotics post-operatively

If perforated appendicitis:

- Ceftriaxone IV 50 mg/kg q24hr (max 2 g/dose) AND Metronidazole IV 30 mg/kg q24hr (max 1.5 g/dose)
 - *If Ceftriaxone allergy:* Ciprofloxacin IV 10 mg/kg/dose q8hr (max 400 mg/dose) AND Metronidazole IV 30 mg/kg q24hr (max 1.5 g/dose)

Post-Op Pain Control:

Initial:

- Ketorolac IV 0.5 mg/kg/dose (max 30 mg/dose) q6hr ATC x72 hours
- Morphine IV 0.1 mg/kg/dose (max 5 mg/dose) q3hr PRN pain
- Acetaminophen 15 mg/kg/dose q6hr ATC (max 1000 mg/dose)

When Pain Well Controlled:

- Change Ketorolac IV to Ibuprofen PO 10 mg/kg q4-6hr ATC x48 hrs, then PRN pain (max 600 mg/dose q6hr)

FEN/GI:

- Clears; advance to regular diet as tolerated
- Once taking diet: Miralax 1 g/kg/day to a max of 17 g a day until stooling

stain, aerobic and anaerobic bacterial culture. Swabs are inadequate for cultures.
○ Consult ID for cultures growing multi-drug resistant bacteria or other organisms*

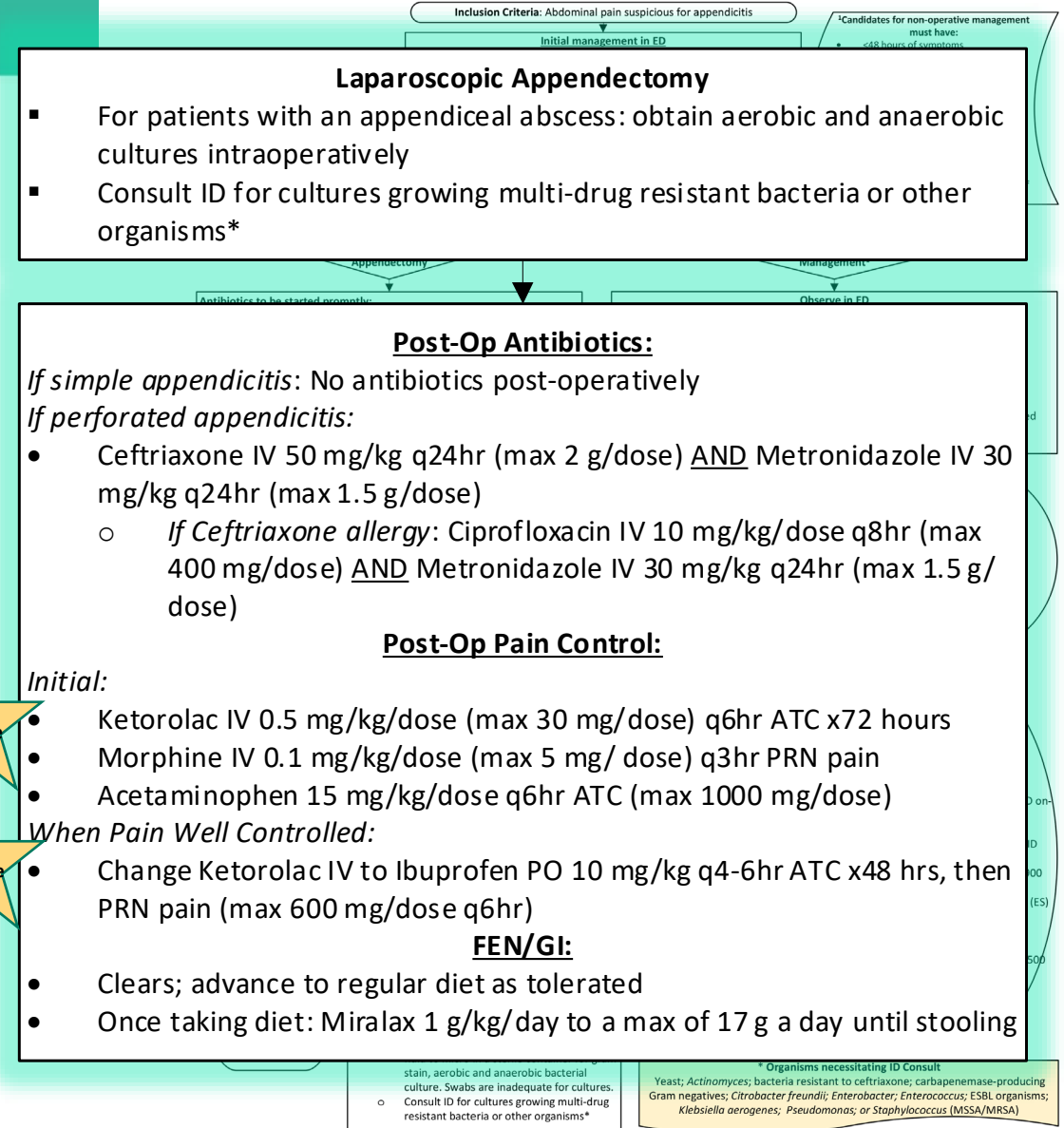
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Operative Management

- After laparoscopic appendectomy, post-op antibiotics are only given if there is a perforated appendicitis. Otherwise, antibiotics are not indicated and should be discontinued.
- It is important to continue to assess pain level and adjust medications as needed
- Diet should be advanced as tolerated; Miralax should be started and continued until the patient is stooling

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- Pain control:
 - Ketorolac should be given ATC x72 hours
 - Acetaminophen ATC added as an option
 - Morphine IV and hydrocodone/acetaminophen PO removed as an option when pain well-controlled



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Simple Appendicitis Management:

During surgery, if the appendix is noted to be normal, inflamed, or abnormal *without* perforation:

- No additional antibiotics post-op should be given
- To facilitate discharge, there is a conditional discharge order for nurses. Patients can be discharged when they are tolerating clears, pain is well controlled, and the family is comfortable with the plan.
- Discharge instructions include pain control, Miralax, and follow up via phone or office visit

Simple appendicitis

- Conditional discharge order for nurses: tolerating clear liquids, pain controlled, family is comfortable with plan
- See discharge²

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Inclusion Criteria: Abdominal pain suspicious for appendicitis

Initial management in ED

- Labs: CBC with diff, CRP (if female: add U/A, bHCG)
- Analgesics: consider Morphine IV 0.1 mg/kg x1 PRN pain (max 5 mg/dose)
- Studies: consider ultrasound

¹Candidates for non-operative management must have:

- <48 hours of symptoms
- WBC <18,000/ μ L
- CRP <4 mg/dL

Non-operative management would **NOT** be appropriate if:

- Appendicitis/fever on imaging
- Suspicion of phlegmon/abscess suggesting
- Need for oral
- Need for IV

²OPERATIVE MANAGEMENT

Discharge Criteria:

Afebrile >24 hrs, tolerating diet, pain controlled on PO pain medication, <40 ml/day from drain if applicable

Discharge Instructions:

- **Pain Control:** Ibuprofen PO 10 mg/kg q4-6hr ATC x48hr then PRN pain (max 600 mg q6hr); Acetaminophen PO 15 mg/kg q4-6hr ATC x24hr then PRN pain (max 75 mg/kg/day OR 4000 mg/day)
- **FEN/GI:** Miralax 1 g/kg/day to max of 17 g/day until stooling
- **Continue to follow cultures** after discharge; if resistant organisms*, call ID on-call
- **Antibiotics x4 days** post-op for perforated appendicitis [duration can be extended at attending pediatric surgeon's discretion in consultation with ID for abscesses and/or resistant organisms*]:
 - <30 kg: Augmentin (600 mg/5 mL) (ES): 90 mg/kg/day div BID (max 900 mg/dose)
 - $\geq$ 30 kg: Augmentin tablets 875 mg BID or Augmentin (600 mg/5 mL) (ES) 900 mg/dose
 - If penicillin allergy: Consider **Penicillin Allergy Delabeling Clinical Pathway** before discharge; Ciprofloxacin 30 mg/kg/day div BID (max 500 mg/dose) AND Metronidazole 30 mg/kg/day div TID (max 500 mg/dose)
- **Follow Up:**
 - Simple Appendicitis: phone call in 4 weeks or office visit within 4 weeks
 - Perforated Appendicitis: office visit within 4 weeks scheduled

tolerating clear liquids, pain controlled, family is comfortable with plan

- CRP and/or CBC abnormal: consider ultrasound or CT scan
- If organized abscess:
 - Consider surgical or IR drainage and send fluid to micro in a sterile container for gram stain, aerobic and anaerobic bacterial culture. Swabs are inadequate for cultures.
 - Consult ID for cultures growing multi-drug resistant bacteria or other organisms*

- Simple Appendicitis: phone call in 4 weeks or office visit within 4 weeks
- Perforated Appendicitis: office visit within 4 weeks scheduled

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Perforated Appendicitis:

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If patient is not improving after laparoscopic appendectomy, obtain a CRP *and* CBC w/diff on POD 5

- If the CRP and CBC are normal, can now *consider* discharge
- If CRP *and/or* CBC is abnormal, consider ultrasound or CT scan
- If there is an organized abscess and surgical/IR drainage required, fluid should be sent in a *sterile container* for gram stain, aerobic *and* anaerobic culture. Swabs are not adequate for cultures.
- Consult ID if multi-drug resistant bacteria or other organisms are growing*

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If POD 5 and not progressing clinically, obtain CRP and CBC w/diff

- CRP and CBC normal: consider discharge²
- CRP and/or CBC abnormal: consider ultrasound or CT scan
- If organized abscess:
 - Consider surgical or IR drainage and send fluid to micro in a sterile container for gram stain, aerobic and anaerobic bacterial culture. Swabs are inadequate for cultures.
 - Consult ID for cultures growing multi-drug resistant bacteria or other organisms*

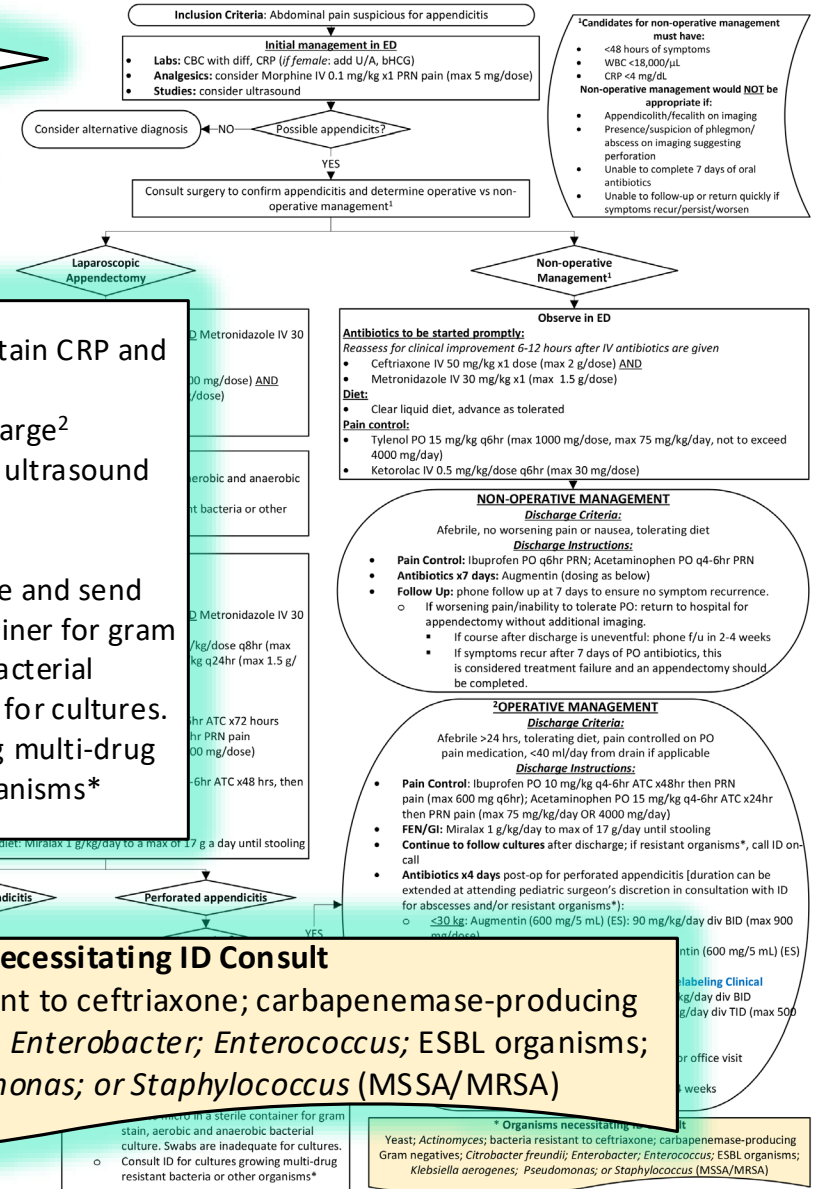
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Perforated appendicitis

Improving?

NO



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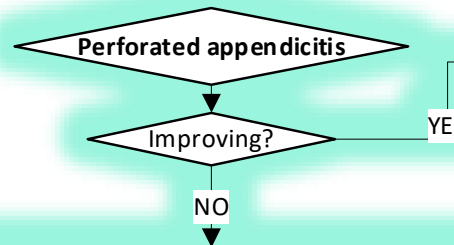
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CLINICAL PATHWAY: Appendicitis

Perforated Appendicitis:

Duration of antibiotics changed to 4 days (from 7 days) – duration can be extended per attending surgeon's discretion in consultation with ID for abscesses and/or resistant organisms

- Augmentin dosing updated
- If there is a penicillin allergy, added consideration for Penicillin Allergy Delabeling Clinical Pathway prior to discharge
- Updated max dosing for ciprofloxacin



If POD 5 and not progressing clinically, obtain CRP and CBC w/diff

- CRP and CBC normal: consider discharge²
- CRP and/or CBC abnormal: consider ultrasound or CT scan
- If organized abscess:
 - Consider surgical or IR drainage and send fluid to micro in a sterile container for gram stain, aerobic and anaerobic bacterial culture. Swabs are inadequate for cultures.
 - Consult ID for cultures growing multi-drug resistant bacteria or other organisms*

²OPERATIVE MANAGEMENT

Discharge Criteria:

Afebrile >24 hrs, tolerating diet, pain controlled on PO pain medication, <40 ml/day from drain if applicable

Discharge Instructions:

- **Pain Control:** Ibuprofen PO 10 mg/kg q4-6hr ATC x48hr then PRN pain (max 600 mg q6hr); Acetaminophen PO 15 mg/kg q4-6hr ATC x24hr then PRN pain (max 75 mg/kg/day OR 4000 mg/day)
- **FEN/GI:** Miralax 1 g/kg/day to max of 17 g/day until stooling
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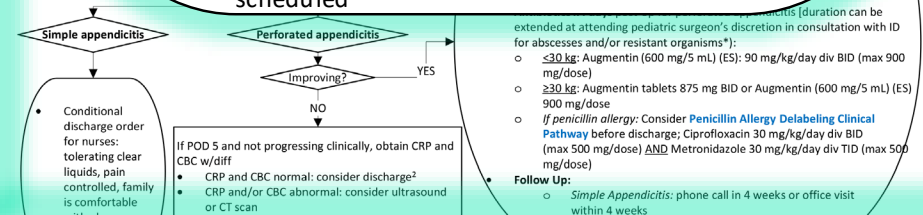
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If penicillin allergy: Consider **Penicillin Allergy Delabeling Clinical Pathway** before discharge; Ciprofloxacin 30 mg/kg/day div BID (max 500 mg/dose) AND Metronidazole 30 mg/kg/day div TID (max 500 mg/dose)

Follow Up:

- **Simple Appendicitis:** phone call in 4 weeks or office visit within 4 weeks
- **Perforated Appendicitis:** office visit within 4 weeks scheduled



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CONTAIN

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Review of Key Points

- Once pediatric surgeon attending has confirmed diagnosis of appendicitis, Ceftriaxone (or Ciprofloxacin) AND Metronidazole should be given promptly
 - Antibiotics should be given prior to surgery
- There are certain situations where non-operative management may be appropriate
- Simple appendicitis does not require additional antibiotic therapy post-operatively
- Duration of antibiotics for perforated appendicitis is 4 days but can be prolonged if abscess or resistant organisms present
- Pain relief should include Ketorolac, and should be transitioned to oral medication as soon as patient is tolerating a regular diet
- Uncomplicated patients with simple appendicitis may have a conditional discharge order placed in the PACU

Quality Metrics

- % use of pathway order set (automated)
- NSQIP variables:
 - SSI
 - Unplanned readmissions and/or ED visits
 - Unplanned returns to OR

Pathway Contacts



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 - Department of Pediatric Surgery and Trauma
- Evan Fusaro, PA-C
 - Department of Pediatric Surgery and Trauma

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Thank You!



About Connecticut Children's Pathways Program

Clinical pathways guide the management of patients to optimize consistent use of evidence-based practice. Clinical pathways have been shown to improve guideline adherence and quality outcomes, while decreasing length of stay and cost. Here at Connecticut Children's, our Clinical Pathways Program aims to deliver evidence-based, high value care to the greatest number of children in a diversity of patient settings. These pathways serve as a guide for providers and do not replace clinical judgment.