Revista de Medicină de Urgență, Vol. 4, Nr. 1: 11-12

Christide's appendectomy technique in the laparoscopic era

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Introduction

Traditionally, appendectomy is the procedure by which the young resident (sometimes student) makes his debut in abdominal surgery. This moment involves natural and sometimes memorable emotions, enhanced by the difficulty or even failure of finding the appendix through an usual incision (Mc Burney, Phocas, Roux etc.). It is interesting that the same emotions may reoccur for the senior surgeon in cases of difficult appendectomy and leads to a similar attitude: a wider incision and more abdominal wall damage [1]. The postoperative hernia following this incision it is not so unusual.

Christide's appendectomy technique [2] described in 1934 is an elegant and pragmatic alternative, unfortunately less known in nowadays surgery. The principle of this procedure originates in problematic spotting of the appendix and even the caecum. In such cases a safe and prudent approach is required in order to achieve both a safe appendectomy and a minimal damage to the abdominal wall, and to avoid the postoperative wall deficiencies, which often occur when a wider incision is made. In other words, Christide's technique improves the classic approach by finding the exact location of the appendix and guiding the final incision accordingly. **(Revista de Medicină de Urgență, Vol. 4, Nr. 1: 11-12)**

Operative technique

The first incision is the classic one. If intraperitoneal exploration assesses a particular topography of the caecum or the appendix (*e.g.* caecum in upper positions, inaccessible appendix), the technique requires a new incision of the muscular wall according to the actual position of the appendix. This new access provides an easier way to perform the appendectomy. This two separate muscular and peritoneum breaches are closed separately. The muscular and cutaneous incisions could be a single one (original procedure – fig. 1), or separate (occasional personal procedure – photo

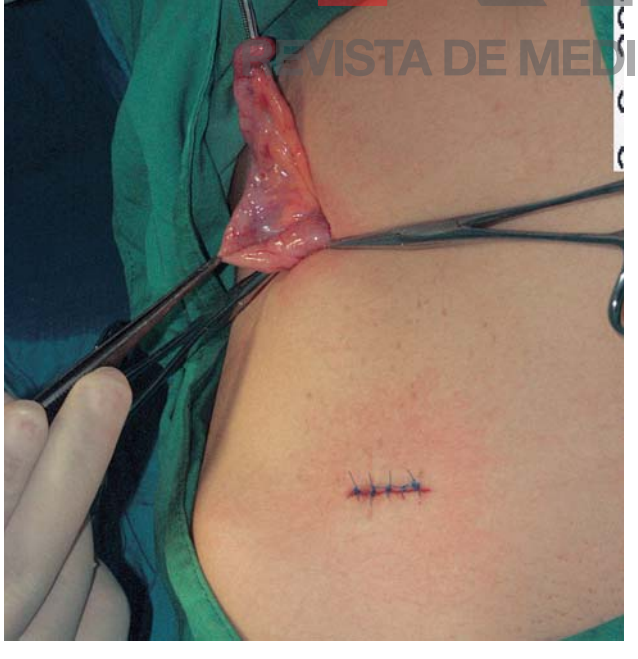

Photo1: Apendix extraction through the second incision corresponding to the real topography

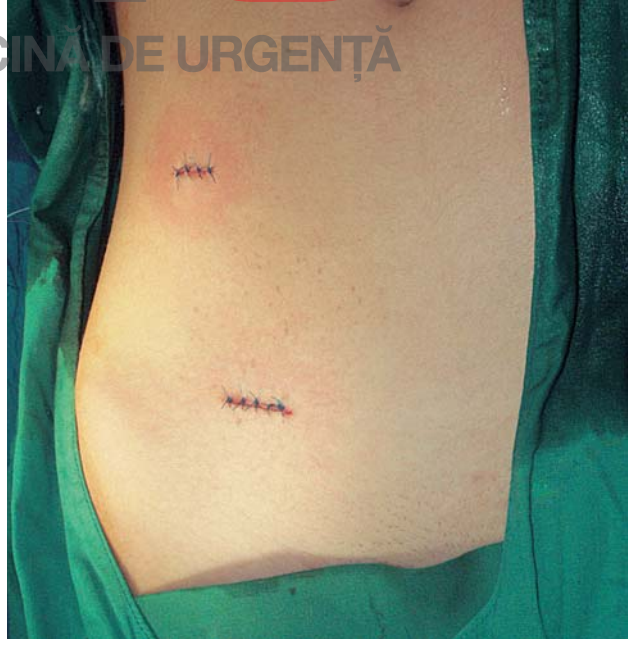

Photo 2: Final aspect after appendectomy and cutaneous suture

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1, 2). If outer tube drainage is needed, one of the two incisions could be used, usually the lower one. Finally, a neat cutaneous suture provides a fine aesthetics.

Discussion

In certain cases of predictable difficult appendectomy, the classic median incision or the modern laparoscopic exploration are recommended. Nevertheless, median incision has some early or late drawbacks (pain, prolonged hospitalization, adhesions and unaesthetic scar). On the other hand, laparoscopy is not always an option, due to technical or economical reasons. Abdominal ultrasound could be used to assess the real topography of the appendix, but, in practice, it is used rather for differential diagnosis and usually the appendectomy is indicated on the clinical criteria. Intraoperative, the classic incision may allow a visual or palpatory exploration, but performing the appendectomy through this obviously improper incision could be very difficult and risky.

The reposition of the abdominal incision according to the real topography of the appendix allows an adequate length of the incision, orientated according to functional-aesthetic criteria, and anatomical parietal suture with minimum tissue sacrifices. Therefore, the postoperative pain and hospitalization are minimal, the recovery and healing are fast, with no further postoperative wall complications.

Conclusion

This procedure is useful and valuable even in present-day. A better aesthetic is achieved by using the new techniques and suture materials. Therefore, it is fully recommended that young surgeons should know and learn this procedure.

References

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