Is it worth operating on the moribund with an end-stage diffuse community-acquired peritonitis in settings with limited technical background? A Retrospective analysis of 36 cases managed over a 10 years period in a middle-income country.

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Resumo

INTRODUÇÃO

Community acquired diffuse peritonitis is one of the commonest surgical emergencies worldwide. Management consists of timely control of the infection source, restoration of gastrointestinal tract function, systemic antimicrobial therapy and support of organ function. Mortality after secondary peritonitis is still high, especially in low-income settings where patients often present late with an end-stage multi-organ dysfunction syndrome (MODS). Delay to surgical intervention and inability to obtain source control have been described as major determinants of outcome. Such patients are often managed under the principles of damage control laparotomy and it is questionable if this strategy can be applied to patients with end-stage MODS.

OBJETIVOS

The aim of this study is to report the outcome of the operative management of diffuse peritonitis in the moribund patient defined as the patient displaying the highest qSOFA score (i.e. 3) and after failure of initial resuscitation to restore basic physiological functions.

MATERIAIS &MÉTODOS

Retrospective review of records of all patients with diffuse community-acquired peritonitis who presented with severe sepsis. We included only patients who combined a respiratory rate >22/mn, a systolic blood pressure < 100 mm of hg and a Glasgow Coma Scale <15. All patients underwent a laparotomy after the failure of the initial resuscitation measures to correct these variables. Determinants of survival were analyzed.

RESULTADOS

The study involved 36patients (mean age 30.5 years, 22 males). The mean number of days between consultation and admission was 6.9 days and 58.3% of patients were referred from another institution. The most common causes of the peritonitis was Peptic ulcer perforation (n=8), complicated appendicitis (n=9) and typhoid fever-related perforation of the terminal ileum (n=6). The respiratory rate ranged from 78 with a mean of 38.3 cycles/mn. The mean GCS was 12.8 and the systolic blood pressure ranged from 0 to 98 with a mean of 58.9 mm of Hg. Other findings included a mean diuresis of 39.5 ml/hour, a mean neutrophil count of 14722/ml and a mean platelet count of 136477/ml. The operative room mortality rate was 33.3% and the overall mortality was 55.6%. Significant predictors of survival included temperature on arrival, diuresis and neutrophile count. It is likely that in the absence of appropriate resuscitation facilities, rupture of the vicious circle of sepsis by suppression of its source is likely to save a significant number of lives.

Palavras-chaves: Community acquired peritonitis, end-stage organ failure, limited setting, Laparotomy, Outcome