

son. The article states that "the incidents and characters described . . . are fictitious," but the characterization of the coroner is inaccurate and offensive.

Coroners try to maintain good relations with the medical profession; they do not "barge into the office, demanding an urgent interview" or refer to a physician as a "euphemistic toady." Coroners treat the people who have died with respect and concern; they do not refer to the subjects of their legally and publicly mandated enquiries as an "old Polish broad" or "quite a dame." Inquests are serious matters. They are not treated lightly by the presiding coroner, regardless of whether he or she looks like "a somnolent reptile in the process of blissfully digesting something previously swallowed whole."

The author clearly had a point to make but did so with abandon and without any regard for personal sensibilities and propriety in the situation depicted. His text was crude, sensational and much more appropriate to cheap detective fiction than to an article appearing in a reputable professional magazine.

Sydney F.J. Pilley, MB, BS, FRCS,
DABO, LLB, RD
Coroner, Vancouver region
British Columbia Coroners Service
Vancouver, BC

NOTHING NEW ON APPENDICITIS

Drs. Shi Wu Wen and C. David Naylor have gone to great lengths to review the outcomes among 126 815 patients admitted to Ontario hospitals for a primary appendectomy from Apr. 1, 1981, to Mar. 31, 1992, in the article "Diagnostic accuracy and short-term surgical outcomes in cases of suspected acute appendicitis" (*Can Med Assoc J* 1995; 152: 1617-1626). Their hypothesis is that modern diagnostic

methods (ultrasonography and laparoscopy) and modern antibiotics would lead to more conservative use of surgery in cases of suspected appendicitis and would not result in increased rates of short-term complications in confirmed cases. The Canadian Institute for Health Information (formerly the Hospital Medical Records Institute) was used as the source of data.

The authors' overall results were no surprise to any general surgeon familiar with the clinical challenge of acute appendicitis in a broad spectrum of patients. Diagnosing acute appendicitis in women still remains a problem. (The jump in diagnostic accuracy for women from 71.7% in 1981 to 75.3% in 1992, with a high point of 75.3% in 1987, although statistically significant, is hardly reason to celebrate.) Increased diagnostic accuracy leads to an increase in the perforation rate (although we cannot explain the increased perforation rate among men during the study period, despite a stable diagnostic accuracy rate). Death from appendicitis occurs among patients at the age extremes (young and elderly patients) and, more important, among patients with coexisting illnesses. The overall length of hospital stay for patients (with any illness!) has decreased over the past 10 years. We did not see any data concerning the use of laparoscopy or antibiotics in the Results section; rather, we merely inferred from the discussion that these tools were available.

This lack of focused data is of concern, since laparoscopy has only been popularized since 1992, with the advent of widespread laparoscopic cholecystectomy. We argue that there have been few marked advances in antimicrobial agents that would have made any difference in the management of patients with acute appendicitis. The real clinical problem is the diagnosis of pain in the right lower quadrant. The denominator for the overall data set

was not complete. It should have included all patients admitted with a diagnosis of right lower-quadrant pain and discharged without surgery. Wen and Naylor address this problem by referring to the study database as "administrative data," which "suffer from a lack of clinical detail and are subject to vagaries in the coding of diagnoses and procedures."

Did Wen and Naylor, with their computerized data manipulations and statistical convolutions, tell us anything new about appendicitis that might influence physicians' practices? The answer is simply No. This is the problem faced by investigators who analyse "administrative data" and make deductions concerning clinical practice. The two simply do not compute. Our concern is that health care policymakers, politicians and the public, as a result of this article, will somehow feel that ultrasonography and laparoscopy can be used to diagnose acute appendicitis. Not so!

Surgeons and clinicians familiar with the clinical problem must review these data critically and put them in perspective. The data suggest that we clinicians should focus our attention on a common clinical problem — right lower-quadrant pain — and develop clinical guidelines to improve both the diagnostic accuracy and the outcome from this illness with some regard for the use of health care resources.

Murray J. Girotti, MD, FRCSC

Chief

Department of Surgery

Ronald L. Holliday, MD, FACS, FRCSC

Division head

General Surgery

Victoria Hospital

London, Ont.

[One of the authors responds:]

Drs. Girotti and Holliday are concerned that practitioners not abandon basic clinical judgement in managing patients with acute abdominal pain. Dr. Wen and I share this