

## Apache II Score Evaluation of Routine Ileostomy Results in Ileal Perforation

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### Abstract

**Objective:** Ileal perforation peritonitis is a common surgical emergency in the Indian subcontinent and in tropical countries. It is reported to constitute the fifth most common cause of abdominal emergencies due to high incidence of enteric fever and tuberculosis in these management based on Acute Physiological and Chronic Health Evaluation II (APACHE II) score.

**Method:** This study was conducted in the 60 patients, who were admitted from causality and surgical outpatient department with a proven diagnosis of ileal perforation peritonitis. The patients were scored using by APACHE II into either of the two groups, Group A: < 10 score. Group B: >10 score. Patients were operated for primary closure or ileostomy formation and were divided into two groups of 30 each depending on the surgical management. Group I (n = 30): These patients were managed by primary repair of the perforation with or without resection-anastomosis. Group II (n = 30): These patients were managed by ileostomy formation with closure/resection of the perforation. The outcome was assessed by postoperative complications and duration of hospital stay as related to APACHE II score.

**Results:** Typhoid accounted for 38.3% of ileal perforations, Tuberculosis 15%, trauma 5% and nonspecific 41.6%. The majority of the perforations were single (90%), of size < 0.005) more done in patients with APACHE II score < 0.005) more done in patients with APACHE II score  $\geq 10$ . As the APACHE II score increases the percentage of complication rate and hence hospital stay also increases,  $12.97 \pm 3.50$  days in patients with APACHE II  $P < 0.001$ .

**Conclusion:** Enteric fever is the most common cause of perforation peritonitis. Higher APACHE II scores in secondary peritonitis correlated significantly with the higher mortality and morbidity of the patients.

**Keywords:** Acute Physiology and Chronic Health Evaluation II score, hospital stay, perforation peritonitis, postoperative complication

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### Introduction

Ileal perforation peritonitis is a common surgical emergency in Indian subcontinent and in tropical countries. It is reported to constitute the fifth common cause of abdominal emergencies due to high incidence of enteric fever and tuberculosis in these regions. Despite the availability of

modern diagnostic facilities and advances in treatment regimes, this condition is still associated with a high morbidity and mortality [1,2].

Surgical approach is the standard treatment of ileal perforations and is the only successful modality, but the choice of

procedure continues to be debated. Various strategies are being used to deal with ileal perforations including primary closure of perforation with or without omental patch, repair of perforation with ileotransverse colostomy, ileostomy, exteriorization, trimming of ulcer edge and closure, wedge excision and anastomosis, and segmental resection and anastomosis [3].

Severity scoring is a valuable tool for assessing and quantification of severity of acute illness. Currently Acute Physiological and Chronic Health Evaluation (APACHE II) scoring system is the best available method for risk stratification in abdominal sepsis. In our study, we have compared different surgical procedures for ileal perforation using APACHE II score and what procedure was suitable in different groups of patients with different APACHE II scores.

The proposed study aims to compare and contrast three different surgical approaches to ileal perforation management, i.e. simple closure, resection, and anastomosis and ileostomy, to define the severity of peritonitis based on APACHE II score in cases of ileal perforation, identify the cause, define the criteria for choosing a particular modality of treatment and compare the short- and long-term outcome of the various treatment modalities.

The study will help to establish the criteria for instituting the management modality according to presentation and severity of the disease and the outcome of these procedures. Effective management of the disease will help in decreasing morbidity and mortality associated with the disease.

## Methods

**Study Design:** This prospective study was carried out at Maharaja Krishna Chandra Gajapati Medical College & Hospital, Brahmapur, within a year.

**Methodology:** Detailed history, complete general physical examination, selection of patients into groups by APACHE II

scoring, and investigations were noted from the patients in the study group. The patients were divided into study groups based on their APACHE II scores - Group I: 0–9, Group II: 10–19, Group III:  $\geq 20$ . Patients with APACHE II score between 10 and 19 were blindly randomized into three procedures primary closure, resection-anastomosis, or ileostomy.

Outcome was assessed by the number and duration of hospital stay, wound infection, wound dehiscence, leakage/fecal fistula, intra-abdominal collections/abscesses, ileostomy related complications (output; fluid and electrolyte imbalance; retraction; stenosis), and reoperation(s). The study concluded when the patient recovered fully or the patient expired, and the patients were followed up till 30 days from the date of admission. Those with ileostomy were followed up till the ileostomy was closed and for a further period of 2 weeks in case of complications.

**Sample Size:** A total of 57 patients were studied and divided in to following groups, Group I: These patients were managed by primary repair of the perforation. Group II: These patients were managed by resection-anastomosis, and Group III: These patients were managed by ileostomy with closure/resection of perforation. Inclusion and exclusion criteria were decided.

## Inclusion criteria:

1. All cases of perforation peritonitis with strong suspicion of small bowel perforation (ileal) without any prior diagnosis of any pathology
2. Patients belonging to Group II according to APACHE II score.

## Exclusion criteria:

1. Previous diagnosis of intestinal tuberculosis
2. Children below 12 years
3. Pregnant females
4. Renal, hepatic, rheumatic, or vascular disease
5. Patients lost to follow-up.

## Results

During the 12 months period of study, ileal perforations were most commonly observed in third and fourth decade of life with males more commonly affected (male:female 1.85:1). Abdominal pain was the most common clinical presentation (100%) followed by fever, abdominal distension, vomiting, and obstipation. The etiology of perforation was typhoid (38.59%), nonspecific (36.84%), tuberculosis (14.03%), and trauma (10.52%). Majority of the patients

presented within 48 h of perforation (73.68%).

APACHE II score was accessed and out of total 57 patients, 6 (10.52%) patients had APACHE II score 0–9, 48 patients (84.21%) had APACHE II score 10–19, and 3 patients (5.26%) had APACHE II score  $\geq 20$ . In APACHE II score 10–19, 15 patients (31.25%) underwent primary closure, 16 patients (33.33%) underwent resection-anastomosis, and 17 patients (35.41%) underwent ileostomy [Table 1].

**Table 1: Clinical presentation**

Symptoms	Number of patients (%)
Pain Abdomen	60 (100)
Fever	48 (80)
Abdominal Distension	45 (75)
Vomiting	40 (66.67)
Obstipation	42 (70)
Trauma	3 (5)

Complications in all the procedures were noted and resulted that wound infection was the most common complication (71.92%). It was present in about 75% cases each in patients having undergone primary closure of perforation and resection-anastomosis for ileal perforation peritonitis as compared to about 66.66% in patients having undergone ileostomy. Morbidity was found more in Group III, which was related to ileostomy related complications ( $P < 0.05$ ). One patient each in Groups II and III expired accounting for mortality.

## Discussion

Nontraumatic perforation of the small intestine is one of the common surgical emergencies encountered by surgeons in developing countries. Surgery is the ideal treatment as it eliminates soiling of peritoneal cavity in an effort to lessen the toxemia and enhance the recovery of the patient. However, there is no uniformity of standardized operative procedure that is most effective for the offending lesion. There are also no criteria which define the

type of surgical procedure based on the sepsis score.

In the present study, all the patients were scores according to the APACHE II score. It was decided that patients with APACHE II score  $< 9$  would undergo primary closure of the perforation since the general condition of the patient and the associated peritonitis were conducive to good healing. In patients with APACHE II score  $< 20$  the policy was to form a ileostomy proximal to the perforation(s), since primary repair in advanced stages of peritonitis in patients with poor general conditions would most likely lead to higher incidence of local complications. The present study in patients with APACHE II score 10–19 aimed to establish whether primary closure of the perforation and formation of a proximal ileostomy would be the best treatment of choice.

Small bowel perforations most commonly affect the young in the prime of their life. In the present study, male preponderance was found with male to female ratio of 1.85:1

that is slightly on the lower side of the ratio 3:1 reported by Wani et al., 4:1 reported by Adesunkanmi et al. and Talwar et al. [4-6].

In the present study, different operative procedures – simple closure of perforation, resection-anastomosis, and ileostomy were performed according to cause and severity of illness. Simple closure was done in 20 patients, 15 of which had APACHE II score 10–19. These patients had single perforation, small in size ( $\leq 1$  cm), located within 60 cm of ileum with less peritoneal contamination. In 16 patients, resection anastomosis was performed, 15 of which had APACHE II score 10–19. Resection-anastomosis was performed because of multiple perforations or large perforation ( $>2$  cm) or when segment of bowel appeared unhealthy for simple closure. In the literature, simple closure is recommended for single perforations with less peritoneal contamination, [2,6-9] while wedge excision, segmental resection and anastomosis, ileotransverse anastomosis have been recommended for multiple perforations, diseased segment of bowel. [2,10-13]

Primary closure of perforation was done in 13 patients with single perforation of size 1 cm). The complication rate was 75%. The morbidity associated with primary closure is 75% which is less than the morbidity of 80.9% and 52.3% associated with ileostomy formation and closure, respectively ( $P < 0.05$ ). Simple repair of perforation in two layers is the treatment of choice for typhoid perforation. Two layer closure of the perforation with or without an omental patch has been most successful.[8] Surgical management with primary closure of the perforation (74.5%), closure with omental graft (14.5%), resection and anastomosis (3.6%), and only drainage (7.3%) was done by Talwar et al. The morbidity rate was 79.1% and mortality rate was 16.4%. The mortality was least with early primary closure of perforation. [6]

If there are multiple perforations and any area of bowel seems unhealthy or liable to perforate, a length of small bowel should be resected, including all the diseased part and a two layer anastomosis is performed. Mortality rates were 43% for ileostomy, 36% for primary closure, 15% for those treated with wedge resection. [14] Shah et al. observed that it is better to opt for resection-anastomosis irrespective of the number of perforations and found lower complication rate (35.5%) and mortality rate (21.47%) in comparison to simple closure complication rate (71.25%) and mortality rate (42.96%) to ileostomy complication rate (100%) and mortality rate (77.77%). Pal reported 6.22% mortality with simple closure and ileotransverse anastomosis and found it to be better. [15]

Ileostomy was performed in 21 patients, 10 of which had APACHE II score 10–19. Ileostomy was recommended in cases of poor general condition, extensive contamination, perforation situated near the ileocecal junction, large perforations ( $>1$  cm), intraoperative findings suggestive of strictures, caseating lymph nodes. In 17 patients with single, small perforation (1 cm) and 4 patients with multiple perforations underwent ileostomy formation. The complication rate in them was observed to be 62.5%. Mortality was more in patients with multiple perforations as compared to single perforation ( $P < 0.025$ ). Development of fecal fistula was unrelated to number of perforations. [16]

Closure of the perforation combined with ileotransverse colostomy was found to have a definite improvement in recovery, mortality reduced from 75% to 20%. [11] Eggleston observed mortality was same but morbidity decreased ( $P < 0.02$ ) with closure of perforation and ileotransverse colostomy; this takes the diseased bowel out of the intestinal mainstream. [17] Extensive procedures such as resection-anastomosis and right hemicolectomy should be avoided in patients with poor general condition and toxemia. Ileostomy

as a secondary procedure should be considered once fecal fistula develops in order to avoid peritoneal contamination. The mortality is unrelated to the duration of perforation and the type of operation performed ( $P < 0.05$ ). [18]

Wound infection was the most common postoperative complication-about 75% each in Groups I and II, followed by intra-abdominal collections, wound dehiscence, and anastomotic leak, which is in accordance with previous studies ( $P < 0.05$ ). [4,5,15,16] The other complications in Group II were related to ileostomy which hampered quality of life and significantly added to morbidity in these patients. The average APACHE II score in Group I was 14.95, Group II was 12.375 and was 12.285 Group III. Patients with APACHE II score 10–19 had 73.0% morbidity and mortality 7.6% as compared to 38.7% in those having APACHE II score 0–9. No mortality occurred in patients with APACHE II score 0–9. Two deaths occurred in those with APACHE II score 10–19, one was diagnosed typhoid perforation in an old male, and other was nonspecific perforation in adult female. Chest infection, renal failure, and sepsis accounted for their mortality. One patient with APACHE II score 21 managed to survive.

Studies have reported unfavorable outcome in patients with APACHE II score of 20 or greater. High APACHE II score has predicted prognosis and mortality in various studies. [19-21] APACHE II score predicted postoperative mortality in the study by Adesunkanmi et al. However, its ability to predict postoperative morbidity was not confirmed. In our study high score related to high morbidity as well. [5]

### Conclusion:

Primary closure of perforation is advocated in patients with single, small perforation (<1 cm) with APACHE II score 10–19 irrespective of duration of perforation. Ileostomy is advocated in APACHE II score 10–19, where the terminal ileum is

grossly inflamed with multiple perforations, large perforations (>1 cm), fecal peritonitis, matted bowel loops, intraoperative evidence of caseating lymph nodes, strictures, and an unhealthy gut due to edema. The repair of perforation has been advocated as better procedure than temporary ileostomy due to its cost effectiveness, absence of complications related to ileostomy, and the need for second surgery for ileostomy closure.

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