ISSN (Online): 2455-3662
EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 12| Issue: 2| February2026|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2026: 8.753|| ISI Value: 1.188

REVIEW ARTICLE: ROLE OF CEFOTAXIME IN THE MANAGEMENT OF APPENDICITIS

E. Kaviyarasu[1], S. Dhamodharan[1], S. Rishikesh[1], V. Thirumurugan[1]
C. Mohammed Mustaq[1], Dr. H. Muhamed Rafeek, Pharm.D[2], Dr. N. Gnanasekar[3]
Dr. D. Rajalingam[4]

[1]*B Pharm student Department of Pharmacology, Kamalakshi Pandurangan College of Pharmacy, Ayyapalayam, Tiruvannamalai-606603, Tamil Nadu, India.*
[2]*Faculty, Department of Pharmacology, Kamalakshi Pandurangan College of Pharmacy, Ayyapalayam, Tiruvannamalai-606603, Tamil Nadu, India.*
[3]*Vice Principal, Department of Pharmacology, Kamalakshi Pandurangan College of Pharmacy, Ayyapalayam, Tiruvannamalai-606603, Tamil Nadu, India.*
[4]*Principal, Department of Pharmaceutical Chemistry, Kamalakshi Pandurangan College of Pharmacy, Ayyapalayam, Tiruvannamalai-606603, Tamil Nadu, India*

ABSTRACT

Acute appendicitis is among the most common causes of acute abdominal pain requiring emergency surgical intervention worldwide. Despite advances in diagnostic imaging and surgical techniques, infection control remains a cornerstone of effective management. Antibiotic therapy plays a crucial role in preoperative prophylaxis, postoperative treatment, and in selected cases, non-operative management of appendicitis. Cefotaxime, a thirdgeneration cephalosporin, is widely used due to its broad-spectrum antimicrobial activity, favourable pharmacokinetic properties, and clinical efficacy against common pathogens involved in appendiceal infections. This review provides an in-depth analysis of the epidemiology, pathophysiology, microbiology, pharmacology, clinical applications, safety profile, resistance concerns, and future perspectives regarding the use of cefotaxime in the management of acute appendicitis.

KEYWORDS: *Appendicitis, Cefotaxime, Third-generation cephalosporins, Intraabdominal infections, Antibiotic therapy*

1. INTRODUCTION

Appendicitis is one of the most common surgical emergencies encountered worldwide and a leading cause of acute abdominal pain requiring immediate medical attention. It refers to inflammation of the vermiform appendix, a small, finger-like projection arising from the cecum of the large intestine. The condition most frequently affects adolescents and young adults, although it can occur at any age. The lifetime risk of developing appendicitis is estimated to be around 7–8%, making it a significant clinical and public health concern.

The pathogenesis of appendicitis typically begins with obstruction of the appendiceal lumen. This obstruction may result from fecaliths, lymphoid hyperplasia, foreign bodies, parasites, or, rarely, tumour's. Once the lumen is blocked, mucus secretion continues, leading to increased intraluminal pressure, venous congestion, and reduced blood flow. These changes promote bacterial multiplication within the appendix. As infection progresses, inflammation worsens, potentially leading to gangrene, perforation, peritonitis, or intra-abdominal abscess formation if left untreated.

Appendicitis is generally a polymicrobial infection involving both aerobic and anaerobic bacteria. Commonly isolated organisms include *Escherichia coli* and *Bacteroides fragilis*. Because bacterial infection plays a central role in disease progression, antibiotic therapy is an essential component of management. Although appendectomy remains the standard treatment, antibiotics are crucial for preoperative prophylaxis, postoperative infection control, and conservative treatment in selected uncomplicated cases.

Among the antibiotics used for appendicitis, Cefotaxime plays an important role. Cefotaxime is a third-generation cephalosporin antibiotic with broad-spectrum activity, particularly against gram-negative bacteria commonly involved in intra-abdominal infections. It exerts its bactericidal effect by inhibiting bacterial cell wall synthesis. Administered intravenously or intramuscularly, cefotaxime achieves effective concentrations in peritoneal fluid and inflamed tissues, including the appendix, making it suitable for treating appendiceal infections.

However, cefotaxime has limited activity against anaerobic bacteria; therefore, it is often combined with metronidazole to provide comprehensive antimicrobial coverage. Its favourable safety profile, effectiveness, and wide availability make it a commonly used antibiotic in hospital settings. This review focuses on the role of cefotaxime in the management of appendicitis, highlighting its pharmacological properties, clinical applications, and therapeutic significance.

ISSN (Online): 2455-3662
EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 12| Issue: 2| February2026|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2026: 8.753|| ISI Value: 1.188



Fig no.1 Structure of cefotaxime

2. EPIDEMIOLOGY OF ACUTE APPENDICITIS

Acute appendicitis is one of the most common causes of acute abdomen and represents the leading indication for emergency abdominal surgery worldwide. The lifetime risk of developing appendicitis is estimated to be approximately 7–8% in the general population. The condition can occur at any age but is most frequently observed in children, adolescents, and young adults, with peak incidence during the second and third decades of life.

Epidemiological studies consistently show a higher incidence of appendicitis in males than females, with a male-to-female ratio of approximately 1.2–1.4:1. However, diagnostic challenges in females of reproductive age may influence reported incidence rates. Appendicitis is relatively uncommon in very young children and older adults, but these populations are at a higher risk of developing complicated disease due to atypical presentation and delayed diagnosis.

Geographical variation in appendicitis incidence has been widely reported. Higher rates are generally observed in developed countries, which has been associated with dietary factors such as low fibre intake and Western lifestyle patterns. In contrast, lower incidence rates are traditionally seen in developing regions, although recent trends suggest an increase due to urbanization and dietary changes.

Complicated appendicitis, including perforation and peritonitis, accounts for a significant proportion of cases and is more common in Pediatric elderly populations as well as in individuals with delayed access to medical care. Overall, acute appendicitis continues to pose a substantial global health burden, emphasizing the need for early diagnosis and effective medical and surgical management.

3.ANATOMY OF THE APPENDIX

The vermiform appendix is a narrow, blind-ended, tubular structure arising from the posteromedial wall of the cecum, just below the ileocecal valve. It is located in the right lower quadrant of the abdomen and is an important anatomical structure involved in the development of appendicitis. Although once considered a vestigial organ, the appendix contains abundant lymphoid tissue and is thought to play a minor role in immune function, particularly during early life.

The average length of the appendix is about 6–10 cm, but it can range from 2 to 20 cm. Its diameter is normally less than 6 mm. The base of the appendix is relatively constant in position and corresponds clinically to McBurney's point, which lies one-third of the distance between the anterior superior iliac spine and the umbilicus. Tenderness at this point is a classical clinical sign of acute appendicitis.

The position of the appendiceal tip varies, and this variation influences the clinical presentation of appendicitis. The most common position is retrocecal (behind the cecum). Other positions include pelvic, subcecal, pre-ileal, and post-ileal. For example, a pelvic appendix may cause suprapubic pain or urinary symptoms, while a retrocecal appendix may produce flank or back pain. Thus, anatomical variation plays a significant role in symptom pattern and diagnosis.

The blood supply of the appendix is derived from the appendicular artery, a branch of the ileocolic artery originating from the superior mesenteric artery. This artery runs through the mesoappendix and is considered an end artery, meaning it has limited collateral circulation. In appendicitis, obstruction of the lumen increases intraluminal pressure, compresses blood vessels, and leads to ischemia, gangrene, and possible perforation.

The wall of the appendix consists of four layers: mucosa, submucosa, muscularis externa, and serosa. The submucosa contains abundant lymphoid tissue, especially in children and adolescents. Enlargement of this lymphoid tissue can obstruct the narrow lumen, which is one of the common initiating factors in appendicitis.

In summary, the narrow lumen, variable position, rich lymphoid tissue, and end-arterial blood supply of the appendix make it highly susceptible to obstruction, infection, and inflammation, forming the anatomical basis for appendicitis.

ISSN (Online): 2455-3662
EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 12| Issue: 2| February2026|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2026: 8.753|| ISI Value: 1.188

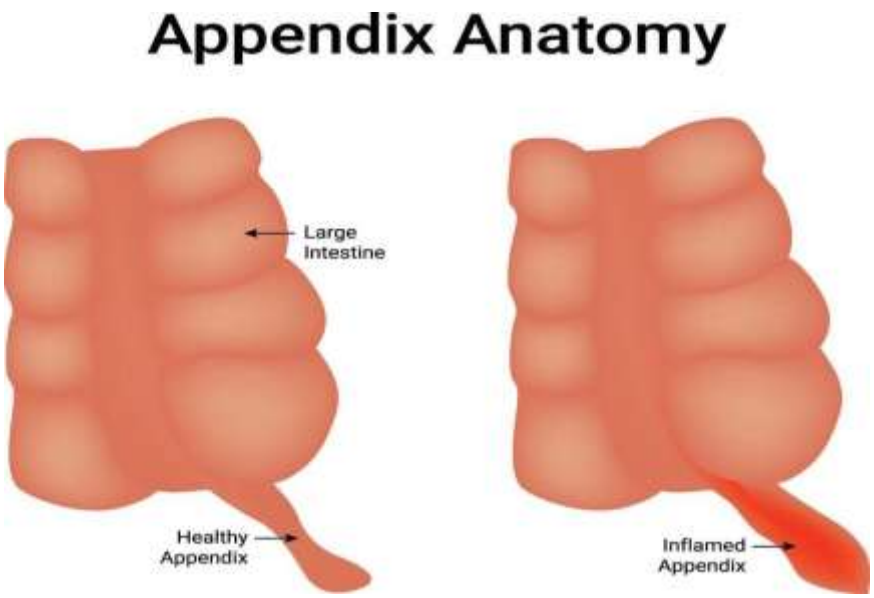


Fig no.2 Anatomy of appendix

4. PATHOPHYSIOLOGY OF APPENDICITIS

Appendicitis usually begins with obstruction of the appendiceal lumen, which is the main initiating factor in most cases. The obstruction may be caused by fecaliths, lymphoid hyperplasia (common in children and adolescents), foreign bodies, parasites, or rarely tumors Because the appendix has a narrow lumen and limited drainage capacity, even minor blockage can lead to accumulation of mucus and increased intraluminal pressure.

As pressure rises, venous outflow from the appendiceal wall becomes impaired, leading to congestion and edema. Continued increase in pressure compromises arterial blood supply, resulting in ischemia. The ischemic mucosa becomes more vulnerable to bacterial invasion. Since the appendix normally contains intestinal bacteria, obstruction creates an environment for rapid bacterial multiplication. Common organisms include *Escherichia coli* and anaerobic bacteria such as *Bacteroides fragilis*.

The bacterial overgrowth triggers an acute inflammatory response characterized by neutrophil infiltration, pus formation, and swelling of the appendiceal wall. If untreated, progressive ischemia may lead to gangrene and perforation. Perforation allows infected material to enter the peritoneal cavity, potentially causing localized abscess, generalized peritonitis, or sepsis. Thus, appendicitis progresses through a sequence of obstruction, infection, inflammation, and possible perforation if timely treatment is not provided.

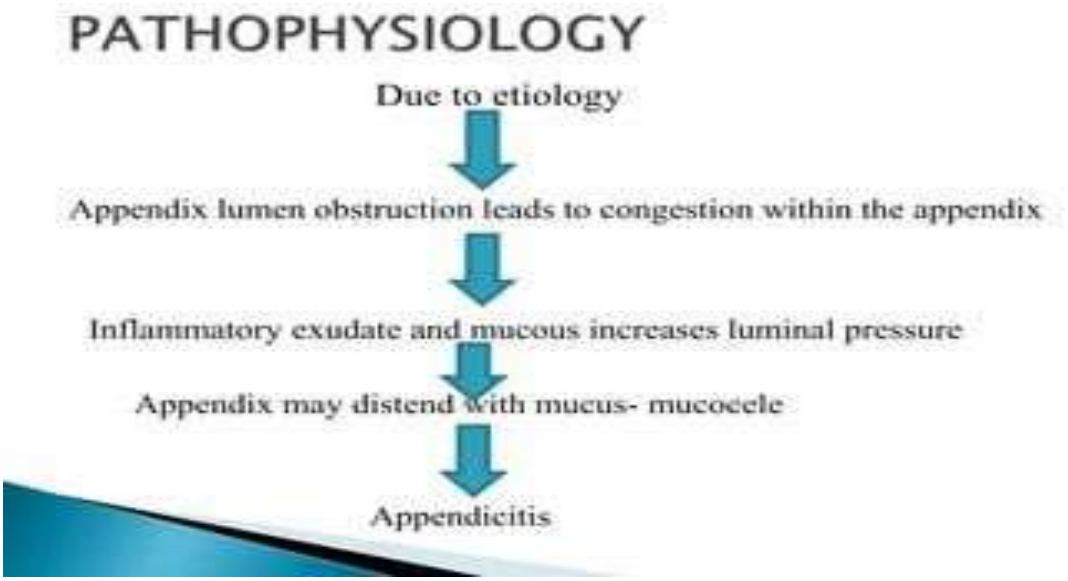


Fig no 3: pathophysiology of appendicitis

ISSN (Online): 2455-3662
EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 12| Issue: 2| February2026|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2026: 8.753|| ISI Value: 1.188

5. MICROBIOLOGY OF APPENDICITIS

Appendicitis is primarily a polymicrobial infection resulting from the overgrowth of normal intestinal flora within the obstructed appendix. Under normal conditions, the appendix contains a balanced population of aerobic and anaerobic bacteria. However, when luminal obstruction occurs, bacterial clearance is impaired, and rapid multiplication of organisms takes place. The closed environment, along with reduced oxygen supply due to vascular compromise, promotes the growth of both facultative and obligate anaerobic bacteria.

1. Aerobic and Facultative Anaerobic Bacteria

Aerobic gram-negative bacilli are the most frequently isolated pathogens in appendicitis. The most common organism is *Escherichia coli*, which plays a major role in the initiation and progression of infection. Other commonly identified gram-negative bacteria include:

- Klebsiella species
- Proteus species
- Enterobacter species
- Pseudomonas aeruginosa (especially in complicated or hospital-acquired cases)

Gram-positive organisms are also present, including:

- Streptococcus species (particularly viridans group streptococci)
- Enterococcus species

These bacteria contribute to mucosal invasion, inflammation, and pus formation.

2. Anaerobic Bacteria

Anaerobic organisms are particularly important in advanced stages of appendicitis. The lowoxygen environment created by obstruction and ischemia Favors anaerobic growth. The most significant anaerobic pathogen is *Bacteroides fragilis*, which is strongly associated with intraabdominal abscess formation and peritonitis. Other important anaerobes include:

- Peptostreptococcus
- Clostridium species
- Fusobacterium species

Anaerobes produce enzymes and toxins that damage tissues, promote necrosis, and increase the severity of infection.

4. Overview of Cefotaxime

Cefotaxime is a third-generation cephalosporin antibiotic belonging to the β-lactam group. It has broad-spectrum activity, especially against gram-negative bacteria such as *Escherichia coli*, *Klebsiella*, and *Proteus* species. It works by inhibiting bacterial cell wall synthesis, producing a bactericidal effect.

Cefotaxime is administered intravenously or intramuscularly and is widely distributed in body tissues, including peritoneal fluid. It is commonly used in serious infections such as intraabdominal infections, septicaemia, pneumonia, and meningitis. In appendicitis, it is often combined with metronidazole to provide adequate anaerobic coverage. Its effectiveness and safety make it a frequently used hospital antibiotic.

5. Mechanism of Action

Cefotaxime exerts its antibacterial effect by inhibiting bacterial cell wall synthesis. It belongs to the β-lactam group of antibiotics and acts by binding to specific proteins in the bacterial cell membrane known as penicillin-binding proteins (PBPs). These proteins are essential for the synthesis and cross-linking of peptidoglycan, a major structural component of the bacterial cell wall.

When cefotaxime binds to PBPs, it prevents the final transpeptidation step of peptidoglycan synthesis. As a result, the bacterial cell wall becomes weak and unable to maintain its structural integrity. This leads to osmotic instability, cell swelling, and eventual bacterial cell lysis and death. Therefore, cefotaxime is considered a bactericidal antibiotic.

The drug is most effective against actively dividing bacteria, as cell wall synthesis occurs during bacterial growth and replication. Its action is time-dependent, meaning its effectiveness depends on maintaining drug concentrations above the minimum inhibitory concentration (MIC) for a sufficient duration.

In appendicitis, cefotaxime helps eliminate gram-negative bacteria responsible for infection and prevents the spread of inflammation and complications such as abscess or peritonitis.

6. PHARMACOKINETICS

Cefotaxime exhibits predictable pharmacokinetic properties that make it suitable for treating systemic and intra-abdominal infections such as appendicitis.

1. Absorption

Cefotaxime is not administered orally because it is unstable in the gastrointestinal tract. It is given parenterally, either by intravenous (IV) or intramuscular (IM) injection. After administration, it is rapidly absorbed into the bloodstream and achieves therapeutic plasma concentrations.

2. Distribution

The drug is widely distributed throughout body tissues and fluids. It penetrates effectively into:

- Peritoneal fluid
- Inflamed appendix tissue
- Cerebrospinal fluid (especially during meningitis)
- Respiratory and urinary tract tissues

Plasma protein binding is approximately 30–50%. Good tissue penetration enhances its clinical usefulness in intra-abdominal infections.

3. Metabolism

Cefotaxime is partially metabolized in the liver to form an active metabolite called deacetylcefotaxime which also has antibacterial activity and contributes to its therapeutic effect.

4. Elimination

The drug is primarily excreted by the kidneys through glomerular filtration and tubular secretion. Its elimination half-life is about 1 hour in individuals with normal renal function. Therefore, dose adjustment is required in patients with renal impairment to prevent drug accumulation.

ISSN (Online): 2455-3662
EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 12| Issue: 2| February2026|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2026: 8.753|| ISI Value: 1.188

7. CLINICAL ROLE IN APPENDICITIS

Cefotaxime plays an important role in the medical management of appendicitis, particularly in preventing and controlling infection. Since appendicitis is commonly associated with polymicrobial bacterial infection, antibiotic therapy is an essential part of treatment along with surgical intervention.

1. Preoperative Prophylaxis

Cefotaxime is widely used as a preoperative antibiotic to reduce the risk of surgical site infections. It is usually administered 30–60 minutes before appendectomy to decrease bacterial load and prevent postoperative complications such as wound infection and intra-abdominal abscess.

2. Postoperative Management

In complicated cases such as perforated or gangrenous appendicitis, cefotaxime is continued after surgery to control ongoing infection and prevent sepsis. It helps reduce inflammation, bacterial spread, and the risk of peritonitis.

3. Conservative (Non-surgical) Management

In selected cases of uncomplicated appendicitis, especially in early stages, antibiotics may be used as primary treatment. Cefotaxime, often combined with metronidazole, can help control infection and avoid immediate surgery in carefully chosen patients.

4. Combination Therapy

Because cefotaxime has limited activity against anaerobic bacteria, it is commonly combined with metronidazole to ensure complete coverage against both aerobic and anaerobic organisms.

Overall, cefotaxime contributes significantly to reducing complications, improving recovery, and enhancing outcomes in patients with appendicitis.

8. DOSAGE IN APPENDICITIS

Cefotaxime is administered parenterally in the management of appendicitis to ensure rapid and adequate therapeutic levels, especially in moderate to severe infections.

1. Adult Dosage

- **Uncomplicated appendicitis:** 1–2 g IV every 8 hours
- **Complicated(perforated/gangrenous) appendicitis:** 2 g IV every 6–8 hours depending on severity

The exact dose depends on the severity of infection, patient weight, and renal function.

2. Pediatric Dosage

- 100–150 mg/kg/day divided into 2–3 doses
- In severe infections, doses may be increased as per clinical guidelines

3. Duration of Therapy

- **Uncomplicated cases:** 24–48 hours (often stopped after surgery if no complications)
- **Complicated cases:** 5–7 days or longer depending on clinical response



Fig no 4: Cefotaxime powder for injection

9. COMBINATION THERAPY

In the management of appendicitis, antibiotic therapy must provide broad-spectrum coverage because the infection is polymicrobial, involving both aerobic and anaerobic bacteria. Although Cefotaxime is highly effective against many gram-negative organisms such as *Escherichia coli* and *Klebsiella species*, it has limited activity against anaerobic bacteria. Therefore, combination therapy is commonly recommended.

1. Cefotaxime + Metronidazole

The most common and effective combination in appendicitis is:

- **Cefotaxime** (for gram-negative and some gram-positive coverage)
- **Metronidazole** (for anaerobic coverage, especially *Bacteroides fragilis*)

This combination ensures comprehensive antimicrobial coverage against the organisms typically involved in intra-abdominal infections. It is widely used in both uncomplicated and complicated appendicitis.

ISSN (Online): 2455-3662
EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 12| Issue: 2| February2026|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2026: 8.753|| ISI Value: 1.188

2. Cefotaxime + Aminoglycosides
In severe or complicated cases, cefotaxime may be combined with an aminoglycoside (such as gentamicin) to enhance gram-negative coverage, particularly in high-risk or septic patients.

10. ADVERSE EFFECTS

Cefotaxime is generally well tolerated and has a favorable safety profile. However, like all antibiotics, it may produce certain adverse effects, which range from mild to severe.

1. Common Adverse Effects

- Pain, redness, or swelling at the injection site
- Nausea and vomiting
- Diarrhea
- Mild skin rash
- Fever

These effects are usually mild and resolve after discontinuation of the drug.

2. Gastrointestinal Effects
Prolonged use may disturb normal intestinal flora, leading to antibiotic-associated Diarrhea. In rare cases, it may cause **Clostridioides difficile–associated colitis**, which presents with severe Diarrhea and abdominal pain.

3. Hypersensitivity Reactions
Patients with a history of allergy to cephalosporins or penicillins may develop:

- Skin rash
- Urticaria
- Itching
- Anaphylaxis (rare but serious)

4. Hematological Effects
Rarely, cefotaxime may cause:

- Eosinophilia
- Leukopenia
- Thrombocytopenia
- Hemolytic anemia

11. CONTRAINDICATIONS

Cefotaxime is generally safe, but it is contraindicated or should be used with caution in certain conditions.

1. Hypersensitivity to Cephalosporins
Cefotaxime is contraindicated in patients with a known history of hypersensitivity or severe allergic reaction to cephalosporins. Administration in such patients may lead to serious reactions, including anaphylaxis.

2. Severe Penicillin Allergy
Patients with a history of severe penicillin allergy (such as anaphylaxis, angioedema, or severe skin reactions) should use cefotaxime with caution due to possible cross-reactivity between penicillins and cephalosporins.

3. Renal Impairment (Caution)
Although not absolutely contraindicated, dose adjustment is necessary in patients with significant renal dysfunction to prevent drug accumulation and toxicity.

4. History of Antibiotic-Associated Colitis
Caution is required in patients with a history of gastrointestinal diseases, especially colitis, as cefotaxime may increase the risk of antibiotic-associated diarrhea or *Clostridioides difficile* infection.

5. Neonates with Hyperbilirubinemia (Caution)
Careful use is recommended in neonates, especially premature infants, as cephalosporins may affect bilirubin binding.

12. COMPARISON WITH OTHER ANTIBIOTICS

Bacteria isolated (no. tested)	Cefuroxime Strains with MIC ≤4 µg/ml (%)	Cefoxitin Strains with MIC ≤4 µg/ml (%)	Cefotaxime Strains with MIC ≤4 µg/ml (%)	No. Isolated in Intra-abdominal Infections
Aerobic bacteria (36,392)				
Escherichia coli (10,413)	82	80	100	422
Klebsiella spp. (5279)	66	67	99	123
Enterobacter spp. (3180)	30	18	79	51
Proteus spp. (6566)	54	68	96	125
Pseudomonas spp. (4683)	0	0	10	56
Streptococcus spp. (1049)	100	97	100	107
Enterococcus spp. (952)	11	0	19	150
Staphylococcus spp. (4270)	97	84	92	46
Anaerobic bacteria (5035)				
Bacteroides spp. (1020)	26	73	45	318
Bacteroides fragilis (2345)	27	46	45	303
Fusobacterium spp. (171)	81	87	92	114
Veillonella spp. (168)	70	82	87	51
Propionibacterium spp. (144)	100	99	100	50
Clostridium spp. (503)	81	89	97	177
Peptostreptococcus spp. (316)	95	88	92	117
Peptococcus[a] spp. (368)	92	93	100	71
All bacteria (41,427)				2281

13. SAFETY IN SPECIAL POPULATIONS

Cefotaxime is generally considered safe and well tolerated, but its use in certain special populations requires careful consideration and monitoring.

1. Pregnancy
Cefotaxime is classified as **Pregnancy Category B**. Animal studies have not demonstrated fetal harm, and it is generally considered safe when used during pregnancy if clearly needed.

ISSN (Online): 2455-3662
EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 12| Issue: 2| February2026|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2026: 8.753|| ISI Value: 1.188

It is commonly used to treat serious infections in pregnant women when the benefits outweigh potential risks.

2. Lactation

Cefotaxime is excreted in small amounts in breast milk. Although adverse effects in breastfed infants are rare, caution is advised. Monitoring for diarrhea or fungal infections in the infant may be necessary.

3. Pediatric Patients

Cefotaxime is widely used in neonates, infants, and children. It is effective and safe when administered at appropriate weight-based doses. However, dosage adjustment is required in premature neonates due to immature renal function.

4. Elderly Patients

In elderly patients, renal function may be reduced. Since cefotaxime is primarily eliminated by the kidneys, dose adjustment may be necessary to prevent drug accumulation and toxicity.

5. Renal Impairment

Patients with renal dysfunction require dosage modification because the drug is excreted mainly through the kidneys. Failure to adjust the dose may increase the risk of adverse effects.

6. Hepatic Impairment

Although cefotaxime is partially metabolized in the liver, significant hepatic adjustment is usually not required. However, monitoring may be advisable in severe liver disease.

15. CONCLUSION

Cefotaxime plays a significant role in the management of appendicitis, particularly in preventing and controlling intra-abdominal infections. As appendicitis is commonly caused by a polymicrobial infection involving gram-negative and anaerobic bacteria, effective antimicrobial therapy is essential alongside surgical intervention. Cefotaxime provides strong coverage against gram-negative organisms and demonstrates good tissue penetration, including peritoneal fluid and inflamed appendiceal tissue.

Although it has limited activity against anaerobic bacteria, its combination with metronidazole ensures comprehensive antimicrobial coverage. The drug is generally well tolerated, has a favorable safety profile, and can be safely used in various patient populations with appropriate dose adjustments when necessary.

With increasing concerns about antimicrobial resistance, rational use and adherence to clinical guidelines are important to preserve its effectiveness. Overall, cefotaxime remains a reliable, cost-effective, and widely used antibiotic in the treatment of both uncomplicated and complicated appendicitis.

REFERENCES

1. *Brunton LL, Hilal-Dandan R, Knollmann BC. Goodman & Gilman's The Pharmacological Basis of Therapeutics. 13th ed. New York: McGraw-Hill Education; 2018.*
2. *Katzung BG. Basic and Clinical Pharmacology. 15th ed. New York: McGraw-Hill Education; 2021.*
3. *World Health Organization. WHO Model List of Essential Medicines. Geneva: WHO; Latest edition.*
4. *Surgical Infection Society. Guidelines for the management of intra-abdominal infections. Surgical Infection Society Guidelines.*
5. *Infectious Diseases Society of America. Clinical practice guidelines for the diagnosis and management of intra-abdominal infections.*
6. *Townsend CM, Beauchamp RD, Evers BM, Mattox KL. Sabiston Textbook of Surgery: The Biological Basis of Modern Surgical Practice. 21st ed. Elsevier; 2022.*
7. *Williams NS, O'Connell PR, McCaskie AW. Bailey & Love's Short Practice of Surgery. 28th ed. CRC Press; 2023.*
8. *Mandell GL, Bennett JE, Dolin R. Mandell, Douglas, and Bennett's Principles and Practice of Infectious Diseases. 9th ed. Elsevier; 2020.*
9. *Bennett PN, Brown MJ, Sharma P. Clinical Pharmacology. 12th ed. Elsevier; 2019.*
10. *Recent articles from journals such as Clinical Infectious Diseases, The Lancet, and Journal of Antimicrobial Chemotherapy related to appendicitis and cefotaxime therapy.*
11. *World Society of Emergency Surgery (WSES). Jerusalem guidelines for diagnosis and treatment of acute appendicitis. World Journal of Emergency Surgery.*
12. *Centers for Disease Control and Prevention (CDC). Antibiotic use in hospitals and antimicrobial stewardship guidelines.*
13. *American College of Surgeons. Surgical Infection Prevention Guidelines and Clinical Practice Recommendations.*
14. *National Institute for Health and Care Excellence (NICE). Acute appendicitis: antimicrobial prescribing guidelines.*
15. *Andersson RE. Meta-analysis of the clinical and laboratory diagnosis of appendicitis. British Journal of Surgery.*
16. *Sartelli M, et al. Management of intra-abdominal infections: Recommendations by the World Society of Emergency Surgery. World Journal of Emergency Surgery.*
17. *Solomkin JS, et al. Diagnosis and management of complicated intra-abdominal infection in adults and children. Clinical Infectious Diseases.*
18. *Brook I. Microbiology and management of abdominal infections. Digestive Diseases and Sciences.*
19. *Talan DA, et al. Antibiotics-first strategy for uncomplicated appendicitis. New England Journal of Medicine.*
20. *Puylaert JB. Acute appendicitis: Imaging and diagnostic approach. Radiology Clinics of North America.*
21. *European Association for Endoscopic Surgery (EAES). Clinical practice guidelines for laparoscopic appendectomy.*
22. *Indian Council of Medical Research (ICMR). National guidelines for antimicrobial use and resistance control.*