The Supreme Court of South Carolina

Curtis King, Petitioner,

v

South Carolina Dept. of Corr., Respondent, et. al.

Appellate Case No. 2014-001738

The Honorable L. Casey Manning
Richland Canty
Trial Court case No. 2009-CP-4002162

For Authorization to Proceed Leave of Forma Pauperis

Extraordinary Circumstance

Petitioner suffer deadly chronic rupture appendix disease, neglect by official(s) satisifaction that is not the standard of acceptable care ever, even if all the combination symptom(s) are not yet there,

Norman v Taylor 25 F.3d 1259 (4th Cir 1994)

Exceptional circumstances

South Caroline Rules of civil Procedure ; Federal Rules of civil Procedure is one form of action are the same as federal except the name of the state,

C/A No. 2009-CP-4002162 same allegation C/A. No. 0:11-cv-01455-TLW-PJG granted Forma Pauperis, reassign C/A No. 0:11-cv-01455-RBH-PJG, Honor Terry L. Wooten is no longer, it's Honorable R. Bryan Harwell

8th amend. right, as applied to the states under the 14th amend., 14th amendment guarantees at least 8th amendment protections

Bell v Wolfish 99 S.Ct. 1861 (1979)

However exceptional cases. Cook v Bounds, 518 F.2d 779, 780 (4th Cir 1975) circumstances are present depends on the type & complexity of the case, & the pro se litigant's ability to prosecute it. Whisenant v Yuam, 739 F.2d 160 (1984)

Fundamental limitation on the scope of constitutional injury guarantees entitled to relief, exceptional petitioner have no choice of health care or self diagnose, such circumstances even laymen was obvious to know petitioner being neglected for the very purpose of death at the present to exist today, for miracle survivor,

Smith v Blackledge, 451 F.2d 1201 (4th Cir 1971)

Leeker v Collins 574 F.2d 1151, 1153 (4th Cir 1978) F.2d 1147, 1153

Miller v Simmons 814 F.2d 962, 964 4th Cir 1987

Hall v Halsmith C.A. Md. 2009 390 Fed. Appx. 944 WL 2171242

Petitioner has a apparent 8th. amend. claim exhibit negligent, personal injury & Medical malpractice of minimal civilized measure of life threaten necessities that is constitutionally intolerable to meet the constitutional essential muster case to grant leave to proceed Forma Pauperis,

Curtis King
Curtis L. KING

Certificate of Service

Inmate, the petitioner, Curtis King certify that on Dec. 11, 2014 served below exhibit(s) that is all part Circuit court record to S.C. Supreme Court,, Atty. Kay G. Crane Respondent(s) or is possession thereof,

1. S.C Ct. of Appeal order
2. Magistrate Judge Paige J. Gossett backgrand
3. Honorable R. Bryan Harwell exceptional circumstance
4. Respondent backgrand contradiction
5. Dept. of Corr. Dr. John B. McRee excuse thoroughness
6. Dept. of Corr. med. malpractice
7. New World encyclopedia contradict med. malpractice
8. Constitution of Americana encyclopedia of victims neglected
9. Expertise of petitioner rupture appendix

Curtis King
Curtis Lamar KING
LCI
990 Wisecky HWY
Bishopville, S.C 29010

The South Carolina Court of Appeals

Curtis L. King, Appellant,

v.

South Carolina Department of Corrections, Respondent.

Appellate Case No. 2014-001738

~~The Honorable L. Casey Manning~~
Richland County
Trial Court Case No. 2009CP4002162

ORDER

Appellant has failed to provide the notice of appeal filing fee, as required by Rule 203 of the South Carolina Appellate Court Rules, and as directed in the Court's order of October 15, 2014. Accordingly, this matter is dismissed. The remittitur will be sent as provided by Rule 221(b), SCACR.

FOR THE COURT

BY V. Claire Allen, Deputy
CLERK

Columbia, South Carolina

FILED
November 5, 2014

cc:
Curtis L. King, 273504
Kay Gaffney Crowe, Esquire
William Christopher Swett, Esquire

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BACKGROUND

Liberally construing King's Second Amended Complaint and attachments, and viewing the facts in the light most favorable to King, King's allegations primarily stem from the time period of Friday, January 18, 2008 through Tuesday, January 22, 2008. During this time, King was housed at the Broad River Correctional Institution and alleges that he was denied medical care for extreme stomach pain and continued vomiting. King alleges that on January 18, 2008 he was initially "shooed" away from the medical department as his name was not on the sick call list. (2d Am. Compl., ECF No. 112-2 at 3.) He appears to have been seen by the medical department later that day on an emergency basis at which time he alleges he was given "a laxative, 2 shots, a pill and a liquid diet." (Id.; see also ECF No. 112-4 at 2-3.) King alleges that his symptoms continued to worsen over the next three days. Although he contends that he repeatedly requested medical attention, he alleges that the defendants denied his requests. (ECF No. 112-2 at 4.) On January 22, 2008, he was seen by the medical department, at which time he was transferred to a hospital for surgery for a ruptured appendix. (ECF No. 112-1 at 1; ECF No. 112-2 at 3, 5.) King also appears to allege that the defendants retaliated against him by continually denying him medical treatment for his hammer toes and denying him replacement eyeglasses. (ECF No. 112-1 at 1.)

Liberally construed, King's Second Amended Complaint alleges that the defendants were deliberately indifferent to his medical needs in violation of the Eighth Amendment of the Constitution, as well as various state law claims against Defendant Thomas A. Moore, Jr.[2] For these alleged violations, King seeks monetary damages.

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[2] Following the court's Order granting the defendants' motion for summary judgment as to King's state law claims, King was granted leave to amend his Amended Complaint to add Thomas A. Moore, Jr. as a defendant in this action. Accordingly, the only state law claims remaining in this action pertain solely to Defendant Moore.

PJG

Court has reviewed the R&R on this point *de novo* and agrees with the magistrate as discussed below.

Defendants initially argue that the affidavit of Plaintiff's cell mate is unclear. The affidavit alleged that "on Saturday at approx. 8:00 p.m. . . . the Unit Officer Young concerning [Plaintiff's] intolerable medical condition. Officer Young never got help. Astounded by this level of gross neglect, I could only walk away . . . [a]nd [Plaintiff] was left to spend yet another night violently vomiting all night long in our cell." [*See* Barnes Aff., Doc. # 112-9, at 3, ¶ 11.] Defendants claim that this does not show deliberate indifference on the part of Defendant Young. However, Defendants fail to cite the other portions of the affidavit relied on by the magistrate. As the magistrate explained, the affidavit states that Plaintiff's cell mate repeatedly complained to staff about Plaintiff's condition, that Plaintiff expressed a need for more attention, and that "[f]or over 96 hours and despite [his] best efforts to get [Plaintiff] adequate medical care for his nigh[t]marish suffering, [Planitiff's] condition was allowed to purposely deteriorate." [R&R, Doc. # 209, at 21 (citing various portions of the Barnes Affidavit).] As the magistrate explained, believing Plaintiff's evidence and drawing all justifiable inferences in his favor, the affidavit does specifically aver that Defendant Young had knowledge of Plaintiff's condition of persistent vomiting and pain and did not get help.

The remainder of Defendants' objection argues that Defendant Young lacked the culpable state of mind by pointing to evidence that Plaintiff was seen by medical staff numerous times and that he was told to wait until his medicine kicked in. [*See* Defs.' Obj., Doc. # 213, at 10–11.] However, while this may in fact be a close case, the Court cannot weight the evidence[10] at the

[10] In putting forth this evidence it is telling that Defendants did nothing to address the magistrate's observation that the record does not contain any affidavit or deposition testimony

[redacted] SJM.S [redacted]

FACTUAL BACKGROUND

The instant action was brought in federal court by the Plaintiff, who is an inmate in the custody of the South Carolina Department of Corrections (SCDC). According to the Amended Complaint, while housed at the Broad River Correctional Institution, the Plaintiff was denied medical care for stomach pain and vomiting between Friday, January 18, 2008, and Tuesday, January 22, 2008. He was seen by the medical department on January 18, 2008, and given medication. (ECF No. 29-1 at 3). He was seen again on Tuesday, January 22, 2008, and was referred to a hospital for surgery for a ruptured appendix. (ECF No. 29 at 1; ECF No. 29-1 at 3, 5). The Complaint also alleges that the Plaintiff was denied medical treatment for his hammer toes and denied replacement eyeglasses in retaliation for filing a complaint. (ECF No. 29 at 1). On March 24, 2009, the Plaintiff filed suit against SCDC in circuit court in Richland County, South Carolina (Case no. 2009-CP-4002162). He filed a Complaint in this Court on June 14, 2011, raising substantively the same allegations as those raised in his pending state court action. The Defendants filed a motion for summary judgment on November 22, 2011 (ECF No. 59). The Magistrate Judge issued a Report and Recommendation (ECF No. 109) on the Defendants' motion for summary judgment on August 17, 2012. In an Order dated September 18, 2012, Judge Wooten overruled the Plaintiff's and the Defendants' objections and accepted the Report and Recommendation (ECF No. 133).

In the Report and Recommendation, the Magistrate Judge granted the Defendants' motion for summary judgment as to the Plaintiff's state law claims, but denied the Defendants' motion as to the constitutional claims. Therefore, according to the Report and Recommendation, the remaining causes of action against all Defendants except

[redacted]

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
COLUMBIA DIVISION

Curtis L. King, Plaintiff, v. Jon Ozmint; Warden Cartledge; Major Lewis; Capt. Mursier; Lt. Steven; Lt. Croutch; Sgt. Macky; Sgt. Writ; Ofc. Vang (male); Ofc. Curhley; Dr. McCree; RN Crawford; RN Andrew; RN Black; Cynthia Chernecki, and Thomas A. Moore, Jr., Defendants.	C/A No. 0:11-cv-01455-TLW-PJG **AFFIDAVIT OF DR. JOHN B. MCREE**

PERSONALLY APPEARED BEFORE ME Dr. John B. McRee who, being duly sworn, deposes and states as follows:

1. My name is Dr. John B. McRee. I am a resident of Georgia.

2. I am over the age of eighteen (18) and am competent to give this Affidavit.

3. I am currently employed by the South Carolina Department of Corrections (SCDC) as a Physician.

4. I received my medical degree from the Medical University of South Carolina in 1977. I completed a residency in Family Practice in 1980 and am licensed by the state of South Carolina as a physician.

5. Any opinions expressed in this affidavit are stated to a reasonable degree of medical certainty.

6. As part of my job duties at SCDC, I treat inmates who sign up for sick call

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or come to the medical department on an emergency basis.

7. On January 18, 2008, Curtis King, inmate #273504 presented to the medical department at McCormick Correctional Institution at 7:53 AM complaining of abdominal pain and vomiting. During this visit, I oversaw Mr. King's treatment, which included a prescription of Phenergan for his vomiting and a liquid diet.

8. Several other inmates presented to the medical department with GI symptoms around this time.

9. During Mr. King's visit on January 18, 2008, he did not have signs of appendicitis such as a lack of bowel sounds or tenderness in the abdomen.

10. When Mr. King presented to the medical department on January 18, 2008, medical staff was not aware that Mr. King was at risk of a serious medical condition because his symptoms did not indicate an appendicitis.

11. Considering Mr. King's condition and symptoms at the time, the treatment provided to Mr. King on January 18, 2008 address his medical need. Mr. King did not require immediate hospital admission because his symptoms indicated a GI problem, not a surgical abdomen.

12. Mr. King presented to the medical department a second time on January 18, 2008 and was given another dose of Phenergan.

13. Mr. King was not brought to the medical department on January 19, 20, or 21, but came to the medical department the morning of January 22, 2008. Within minutes of examination by medical staff, Mr. King was sent to the hospital for treatment of appendicitis.

14. When he presented to the medical department on January 22, 2008, SCDC

staff did not disregard his medical needs. Instead, they immediately sent him to the hospital upon discovering the nature of his condition.

15. Taking Mr. King's condition and symptoms into consideration, each time he presented to the medical department between January 18, 2008, and January 22, 2008, the medical staff addressed Mr. King's medical needs.

FURTHER AFFIANT SAYETH NOT.

Dr. John B. McRee

Sworn to and subscribed before me
this 12th day of December, 2012.

Brenda L. Williams
Notary Public for the State of South Carolina
My Commission Expires: 3/3/2014

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5. STOP SMOKING.
6. INSTRUCT INMATE TO RETURN TO CLINIC IF SYMPTOMS HAVE NOT IMPROVED AND/OR SUBSIDED IN 24 HOURS.
GIVEN PO PHENERGAN 25MG PER S.O.. V/O DR MCREE TO ALSO GIVE 30CC GI COCKTAI L TO COAT STOMACH (GIVEN). AFTER APPROX 4-5 MIN, VOMITED INTO TRACHCAN, INT ACT PHENERGAN PILL SEEN IN VOMITUS. V/O DR MCREE TO GIVE PHENERGAN 50MG IM NOW. GIVEN @ 8:05AM PER NURSE ANDREWS IN RIGHT DELTOID, TOL WELL. PLACED IN MEDICAL'S WAITING AREA FOR MONITORING. @ THIS TIME, IS SITTING UPRIGHT MORE COMFORTABLY THAN PREV NOTED. RESP MORE RELAXED & EVEN. WILL REMAIN INMEDICA L UNTIL KNOWN THE PHENERGAN IS EFFECTIVE, THEN WILL ALLOW TO RETURN TO ROOM TO REST. KITCHEN E-MAILED FOR CL LIQ DIET X24 HRS & MEALS TO DORM FOR SAME TIME PERIOD. PILL PACK PULLED FOR PHENERGAN 25MG PO Q8 HRS PRN X24 HRS PER S.O.. ADVISED TO INFORM MEDICAL IF SX'S WORSEN OR IF PERSIST BEYOND 24 HRS. VOICED UNDERSTANDING. RTC PRN. T.SUMNER,LPN
SIGNED OFF ON 01/18/08 @ 8:20 BY TRACY T SUMNER, LICENSED PRACTICAL NURSE
NOTED AND AGREE
SIGNED OFF ON 01/18/08 @ 8:34 BY JOHN B MCREE, PHYSICIAN II

** ENCOUNTER: 88 OUTSIDE RECOMMENDATI 09/11/07 19:30 MCCORMICK COMP
RETURNED FROM CAPITAL PROSTHETICS PER DR. OK TO PROVIDE SHOES. SHOES TO BE D ROPPED OFF AT KIRKLAND WHEN IN. PAPERWORK PLACED ON MD'S DESK. K. ACKERMAN, LP N
SIGNED OFF ON 09/11/07 @ 19:34 BY KAREN S ACKERMAN, LICENSED PRACTICAL NURSE
NOTED
SIGNED OFF ON 09/12/07 @ 8:00 BY JOHN B MCREE, PHYSICIAN II

** ENCOUNTER: 87 OUTSIDE APPOINTMENT 09/11/07 7:11 MCCORMICK COMP
APPT AT KCI CAPITAL PROSTHETICS ON 9/11/07 .
D. CUNNINGHAM/CNA
SIGNED OFF ON 08/15/07 @ 7:12 BY DEBORAH A CUNNINGHAM, MEDICAL ASSISTANT TEC

** ENCOUNTER: 86 SICK CALL 08/03/07 5:59 MCCORMICK COMP
S> INMATE TO MEDICAL WANTING SHOES FOR HIS HAMMER TOES
O> TEMP=098.1 PULSE= 56 RESP=18 BP=124/ 60 (WEIGHT=194) PPD= 0
LAST RECEIVED SHOES IN 2005 ENC 61 ALSO SEE ENC 57 AND 59 FOR DOCUMENTATION OF HAMMER TOES. INMATE WEARS SIZE 10 SHOES BILATERAL FEET NOTED TO HAMMER TOES.
A> HAMMER TOES BY HX
P> WILL SEND TO MD FOR EVAL CHART ON MDS DESK ALONG WITH STATEMENT FROM 08/01/ 04 WHEN I/M WAS IN LOCK UP AT LEE AND SHOES WERE TAKEN DURING SHAKE DOWN.
M. BLIGHTON LPN
SIGNED OFF ON (08/03/07) @ 6:03 BY MELISSA J BLIGHTON, LICENSED PRACTICAL NURS
NEED OBJECTIVE FINDINGS OF THE HAMMER TOES....
IF CANTEEN SHOES WILL MEET HIS NEEDS, I AM OK WITH THAT.
HAVE WE SUPPLIED HIM WITH BOOTS? DONT THINK MEDICAL PAYS FOR BOTH.
SIGNED OFF ON 08/03/07 @ 12:02 BY JOHN B MCREE, PHYSICIAN II
I/M BROUGHT TO MEDICAL FOR ASSESSMENT OF HAMMER TOES TO SECOND AND THIRD TO ES, MD WILL DO CONSULT FOR CAPITAL PROSTHETICS. T. ANDREWS, RN
SIGNED OFF ON 08/03/07 @ 13:46 BY TERRY L ANDREWS, NURSE ADMINISTRATOR/MGR II
CHART REVIEWED AND CONSULT COMPLETED.

in the central part of the Appalachians. The southern Blue Ridge Mountains, the Cumberland Mountains, the Black Mountains, and the Great Smoky Mountains are the chief southern Appalachian ranges.

Chief Peaks of the Appalachian range include Mount Washington in New Hampshire (6,288 feet, or 1,917 meters), Clingmans Dome in Tennessee (6,643 feet, or 2,025 meters), and the highest peak of the entire system, Mount Mitchell in North Carolina (6,684 feet, or 2,037 meters).

Wind and Water Gaps. Rivers draining into the Atlantic Ocean have cut many valleys with steep sides, especially in the central Appalachians. Geographers call these valleys water gaps or wind gaps, depending upon whether a river now runs through them. The best known of these gaps include Crawford Notch in New Hampshire, the Mohawk and Hudson valleys in New York, the Delaware Water Gap in Pennsylvania and New Jersey, the Shenandoah Valley in Virginia, and the Cumberland Gap on the borders of Kentucky, Tennessee, and Virginia. E. WILLARD MILLER

Related Articles in WORLD BOOK include:

Adirondack Mountains	Cumberland Mountains
Allegheny Mountains	Great Smoky Mountains
Berkshire Hills	Green Mountains
Blue Ridge Mountains	Mount Mitchell
Catskill Mountains	White Mountains

APPALACHIAN NATIONAL SCENIC TRAIL is a footpath that extends 1,995 miles (3,211 kilometers) from Mt. Katahdin in Maine to Springer Mountain in Georgia. The trail passes through 14 states, two national parks, and eight national forests. It follows the crests of the White and Green Mountains and the Berkshires of New England, the Blue Ridge Mountains from Pennsylvania to North Carolina, and the Unakas and Great Smokies of North Carolina. It became a part of the National Park System in 1968. E. WILLARD MILLER

APPALOOSA. See HORSE (Color; picture).

APPARENT SOLAR DAY. See TIME (Measuring Time).

APPEAL is a legal term now generally used for the transfer of a lawsuit that has been decided by a lower, or inferior, court to a higher court for review. The *appellant* (the person who appeals) seeks to have the decision of the lower court changed. Usually, a dissatisfied party to a suit must file a notice of appeal with the court within a specified time and show a reason why the appeal should be granted. The discovery of new evidence or of an error in the trial are reasons often given. But there is an absolute right of appeal in most criminal cases. Many states also allow an automatic appeal in criminal cases where a death sentence has been imposed.

Every state has at least one court to which appeals may be taken from trial courts. The federal court system includes 11 Courts of Appeals to review cases tried in lower federal courts. In some cases, the Supreme Court of the United States considers and reverses cases decided by a Court of Appeals or by a state supreme court.

A party in a state court action cannot appeal directly to the U.S. Supreme Court. He can only ask that court for a writ of certiorari. A *writ of certiorari* is an order from a higher court to a lower court to send up the records of a case for review (see CERTIORARI, WRIT OF). The court can refuse such an "appeal" unless it feels there has been a violation of federal law or of the party's constitutional rights. THOMAS A. COWAN

See also APPELLATE COURT; BONDING.

APPELLATE COURT hears *appeals* (requests) for reexamination of the decisions of lower courts in the judicial system. See APPEAL.

The *trial court* (lower court) first hears the witnesses and decides the case. If both parties are satisfied with the trial court's decision, the case ends. But a party who is not satisfied may seek, as *appellant*, to persuade the appellate court that the trial court decided the case wrongly, and thus win a reversal of the decision.

In some cases, a person automatically has the right to carry a case to the appellate court. In others, the appellate court has the right to decide which cases it will review. Appellate courts rarely hear oral evidence from witnesses. Instead, they study a printed or typewritten *record* of the trial, prepared from a court stenographer's notes. An appellate court does not use a jury. Lawyers present the appeal by written arguments called *briefs*, and by oral arguments.

Each state in the United States has an appellate court. Some states have two levels of appellate courts above the trial court. Federal courts include 11 Courts of Appeals and the final appellate court, the Supreme Court. ARTHUR E. SUTHERLAND

See also COURT; COURT OF APPEALS; SUPREME COURT OF THE UNITED STATES.

APPENDICITIS, *uh PEN dih SYE tiss*, is an inflammation of the vermiform appendix (see APPENDIX, VERMIFORM). It results from an infection caused by bacteria. The appendix becomes swollen and fills with pus. The pus may be walled off and form an abscess. Or the appendix may break, allowing the infection to spread to surrounding body organs. It may also cause *peritonitis*, an inflammation of the membrane that lines the abdominal cavity (see PERITONITIS).

Symptoms. An attack of appendicitis usually begins with pain in the region of the navel. Then it moves to the right lower side of the abdomen. At first the pain is not constant—it comes and goes. But soon it becomes continuous, and soreness develops over the appendix region. The abdominal muscles tighten, and the patient becomes nauseated and usually has a fever. A blood count shows an increase in white blood cells.

Treatment. It is very important that no laxatives or cathartics, such as castor oil, be given to a person with appendicitis. Purgatives should never be given to a person with an abdominal disorder that might be appendicitis. Any such medicines may cause the appendix to rupture, spreading the bacteria through the abdominal cavity. The patient should remain quiet. A doctor should be called immediately. The usual treatment for acute appendicitis is surgery. In mild cases, the inflammation may subside by itself. Some persons may have recurrent appendicitis. E. CLINTON TEXTER, JR.

See also SURGERY (A Typical Operation).

APPENDIX, VERMIFORM, is a narrow tube, closed at one end. The open end attaches to the first part of the large intestine, called the *cecum*, in the lower right part of the abdomen. The *vermiform* (wormlike) appendix is found in human beings, the higher apes, some rodents, and various other animals. Rodents, such as the rat, have a long appendix that functions in digestion. In human beings, it probably has no function. Some persons be-

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mate friends. After Judas Iscariot died, Matthias took his place. FREDERICK C. GRANT and FULTON J. SHEEN

Related Articles in WORLD BOOK include:

APOSTLES OF JESUS

Andrew, Saint
Bartholomew, Saint
James (apostles)
John, Saint
Judas Iscariot
Jude, Saint
Matthew, Saint
Matthias, Saint
Peter, Saint
Philip of Bethsaida, Saint
Simon the Canaanite, Saint
Thomas, Saint

OTHER RELATED ARTICLES

Acts of the Apostles
Barnabas
Jesus Christ
New Testament
Paul, Saint

APOSTLE BIRD is a quick-moving, almost completely black bird about as big as a large blue jay. It is native to Australia, where it roams the woodlands, feeding on insects and seeds. Apostle birds travel about in groups of 12, and for this reason have been named after the apostles in the Bible.

APOSTLES' CREED is a statement of the main Christian beliefs. It was in use as early as A.D. 150, and is supposed to have been used by the apostles. Roman Catholic and Protestant churches use it today. The creed was probably derived from the Old Roman Creed and from baptismal rites. Here are two forms:

In the Roman Catholic Church: I believe in God, the Father Almighty, Creator of heaven and earth; and in Jesus Christ, His only Son, Our Lord; Who was conceived by the Holy Ghost, born of the Virgin Mary, suffered under Pontius Pilate, was crucified, died, and was buried. He descended into hell; the third day He arose again from the dead; He ascended into heaven, sitteth at the right hand of God, the Father Almighty; from thence He shall come to judge the living and the dead. I believe in the Holy Ghost, the Holy Catholic Church, the communion of saints, the forgiveness of sins, the resurrection of the body, and life everlasting. Amen.

In Some Protestant Churches: I believe in God the Father Almighty, Maker of heaven and earth; And in Jesus Christ his only Son our Lord; who was conceived by the Holy Ghost, born of the Virgin Mary, suffered under Pontius Pilate, was crucified, dead, and buried; He descended into hell; the third day He rose again from the dead; He ascended into heaven, and sitteth on the right hand of God the Father Almighty; from thence He shall come to judge the quick and the dead. I believe in the Holy Ghost; the holy catholic Church; the communion of saints; the forgiveness of sins; the resurrection of the body; and the life everlasting. Amen.

FULTON J. SHEEN and MERVIN MONROE DEEMS

APOSTROPHE. See PUNCTUATION.

APOTHECARIES' WEIGHT, *a POTH ee KAIR iz,* is a system of weights once widely used by druggists for prescriptions. The metric system is replacing it. Apothecaries' weight divides the pound into 12 ounces, the ounce into 8 drams, the dram into 3 scruples, and the scruple into 20 grains. In the apothecaries' and the troy systems, 5,760 grains make 1 pound (0.37 kilogram) and 480 grains make 1 ounce (31 grams). In the avoirdupois system, there are 7,000 grains in 1 pound (0.45 kilogram), and 437½ grains in 1 ounce (28 grams). See also GRAIN; OUNCE; SCRUPLE; TROY WEIGHT; WEIGHTS AND MEASURES; METRIC SYSTEM. E. G. STRAUS

APOTHECARY. See PHARMACY.

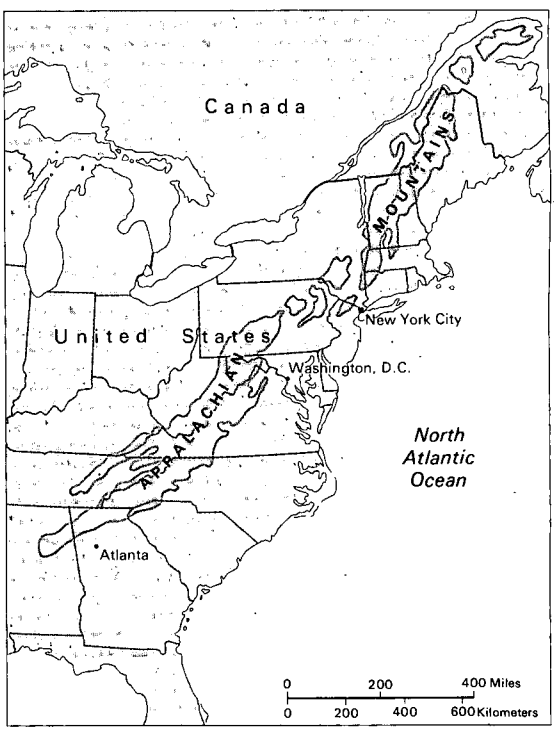
APPALACHIA is the name given to an economically deprived region in the Appalachian Mountains of the eastern United States. It includes parts of 13 states, ranging from southern New York to eastern Mississippi.

APPALACHIAN MOUNTAINS

About 18 million persons live in Appalachia. Family incomes and the literacy rate there are lower than the national average. In 1965, Congress passed the Appalachian Regional Redevelopment Act. The legislation provided funds for new highways to make the area more accessible. The act also financed new schools and health facilities, land reclamation, and timber and water conservation. During the 1970's, incomes in Appalachia increased faster than those in the nation as a whole, partly due to a boom in the region's coal industry. Manufacturing industries and tourism also prospered, aided by the new highways. But income and educational levels remained low in much of the region.

APPALACHIAN MOUNTAINS, *AP uh LATCH ih un,* are the chief mountain system of eastern North America, and the oldest mountains in the United States. They stretch southwestward for about 1,500 miles (2,410 kilometers) from the Gaspé Peninsula in Quebec to central Alabama. The mountains are part of the Appalachian Region which extends into Newfoundland. They form a divide between the rivers that flow into the Atlantic and those that drain into the Gulf of Mexico (see DIVIDE). Wind, rain, and frost have worn these mountains smooth over millions of years.

Chief Ranges. The chief ranges of the northern Appalachians are the Notre Dame Mountains in Quebec, the Green Mountains in Vermont, the White Mountains in New Hampshire, and the Adirondack Mountains in New York. The Allegheny Mountains of Pennsylvania, Maryland, West Virginia, and Virginia and the northern part of the Blue Ridge Mountains are



WORLD BOOK map

Location of the Appalachian Mountains

immature forms of white cells, better known as "a shift to the left," gives the physician a good index of the severity of the inflammation in appendicitis.

An X-ray of the abdomen is helpful in certain circumstances because it reveals significant changes. In chronic appendicitis, examination of the colon by means of a barium enema often indicates localized tenderness in the region of the appendix.

After a careful diagnostic survey is completed, the diagnosis may remain in doubt in a small percentage of cases. In these instances, the astute physician may withhold a final diagnosis during an observation period of 8 to 24 hours in the hope that further developments may clarify the problem.

In the great majority of cases, the diagnosis of appendicitis is a relatively simple one based on the symptoms described. However, the characteristic symptoms do not develop in about one third of appendicitis cases. For example, diagnosis is difficult in individuals whose appendix is in an abnormal position. Also, there are many acute inflammatory conditions of other organs that may simulate appendicitis. Inflammation of the lymph glands of the mesentery of the small intestine (acute mesenteric adenitis) in young patients is almost indistinguishable from appendicitis because the lymph glands in a child are conspicuous in the region of the intestine where the appendix is located. Disease of the right uterine tube or ovary in the female may be extremely difficult to differentiate from appendicitis because these organs are near the appendix. Inflammatory disease of the end portion of the small intestine (regional enteritis) sometimes is identified for the first time when the patient is operated on with a preoperative diagnosis of acute appendicitis. In the older patient, cancer of the cecum may simulate acute appendicitis. In addition, it may cause appendicitis if the tumor obstructs the intestine where the appendix branches off.

Treatment. The treatment of appendicitis primarily and basically is surgery in which the diseased organ is removed. This operation is called an *appendectomy*.

An appendectomy usually is carried out under general anesthesia. Spinal anesthesia may be preferable under certain circumstances, and there are clinical situations in which local anesthesia using novocaine or a similar agent is employed after appropriate preoperative medication.

When the diagnosis of appendicitis is clear, a small two- to three-inch oblique, muscle-splitting incision is used in the male patients. However, in the female and in instances where the diagnosis is not definite, a larger vertical incision permittng exploration is made. The operation itself consists of tying off the blood vessels that supply the appendix and then removing the appendix.

The operative procedure commonly requires 30 to 45 minutes. The patient has relatively little postoperative discomfort for a period of one to two days and, barring complications, leaves the hospital on the fifth to seventh day.

There are a few instances in which this standard surgical treatment is inadvisable. For example, if appendicitis occurs in a hemophiliac, the danger of uncontrolled bleeding must be weighed against the likelihood that the appendicitis will progress to a fatal stage. An extremely debilitated, aged person may be such a poor operative risk that treatment with antibiotics is substituted for surgery. In those unusual circumstances in which a surgeon is not available, the patient with acute appendicitis should be treated with antibiotics and other conservative measures rather than undergo surgery by untrained and inexperienced personnel.

When the diagnosis of appendicitis is in doubt, surgery usually is delayed temporarily. While this practice involves the danger that an acute appendicitis will progress to an advanced stage, it ordinarily can be used safely if the individual is under continual medical observation. In such instances, it is a common procedure to place the patient in the hospital where repeated examinations and laboratory tests during a period of 8 to 24 hours may clarify the diagnosis of appendicitis or one of the other conditions mentioned. Under such circumstances, prompt and alert surgical intervention must be undertaken once the diagnosis becomes clear. After a reasonable period of observation, surgery occasionally is undertaken in spite of the fact that the diagnosis remains somewhat clouded.

Removal of the inflamed appendix is as clearly recommended in the case of subacute appendicitis as in acute appendicitis. Also, removal of a chronically diseased appendix ordinarily is indicated. However, this diagnosis must be based on a clear history of one or more previous acute attacks, and the complaints of the individual must be persistent or recurrent.

Complications. The complications of appendicitis may be fatal in neglected cases. These are avoided by prompt removal of the appendix early in the course of the disease. The most feared and lethal complication is perforation of the appendix leading to contamination of the peritoneal cavity and the development of *peritonitis*. Peritonitis is identified by the spreading of the tenderness from a localized area to the entire abdomen. The abdomen becomes distended, the fever becomes more elevated, and the patient appears extremely ill. In the "preantibiotic" days, the majority of these victims died. However, at the present time, the use of antibiotics, even in the far-advanced cases, has reduced this mortality to an extremely small figure. Thus the surgeon can remove the appendix even after it has ruptured, in order to prevent continued contamination of the peritoneal cavity.

Another serious complication is the development of an intraperitoneal abscess. This is the body's method of localizing the products of perforation into a confined area, thereby avoiding infection of the entire peritoneum (peritonitis). Such an abscess develops most commonly in the region near the appendix and is known as a *periappendiceal abscess*. If this abscess does not respond to intensive antibiotic treatment, an operation must be performed to drain it.

A final but extremely lethal complication is that resulting from the spread of the infection of the appendix to the veins that drain the organ. Known as *septic pyelophlebitis*, this infection results in abscesses of the liver. These abscesses often do not respond to specific antibiotic therapy and in many cases terminate fatally.

ROBERT J. COFFEY, M.D.
Georgetown University Hospital

Further Reading: Schwartz, Ellis H., *Maingot's Abdominal Operations*, 2 vols., 8th ed. (Appleton 1984).

12 & 14

ADVANCED SURGICAL ASSOCIATES

Self Medical Group

August 26, 2010

Curtis L. King.
Inmate number 273504-Saluda 215
Broad River Correctional Institute
4460 Broad River Road
Columbia, SC 29210

Dear Curtis:

I am writing in response to your letter with questions regarding your previous care and appendicitis. I will do my best to answer these questions for you. In the letter you sent, that was dated August 2, 2010, you had a series of questions, 1 through 13 which I will attempt to repeat and answer.

Question #1. Do you know if a camera / video down throat into abdomen to clip the inflamed appendix and pole exist?
Answer: No video was used during the course of your open surgical procedure.

Question #2: What is the standard of care and common knowledge of an inflamed appendix?
Answer: Appendectomy and treatment with antibiotics.

Question #3: What is the standard of care and common knowledge of ruptured appendix / peritonitis / perforation?
Answer: Appendectomy with antibiotics.

Question #4: How long does it take peritonitis perforation to be fatal to the body?
Answer: This varies based on the patient's condition and the cause of the peritonitis or perforation.

Question #5: Is there any first aid to make the disease above better?
Answer: No.

Question #6: Do disease above naturally discontinue?
Answer: No.

Question #7: Why is a preoperation and postoperation needed on different days?
Answer: I do not understand the question, however I assume you mean why did you have two separate operations. If that is your question, the answer is that you had so much infection

13 & 14

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at the first operation that a second look operation was required to wash out additional infection and ensure that healing would take place.

Question #8: What does respiratory failure mean?
Answer: Difficulty breathing, often requiring ventilator assistance.

Question #9: Why is bowel surgery needed?
Answer: Bowel surgery can be needed for any number of complications or diseases such as diverticulitis, cancer, perforated appendix.

Question #10: What does not responding to commands mean?
Answer: It means the patient is either sedated or for some reason not answering or following commands for some other neurologic reason.

Question #11: What do critical tests results reporting via phone mean?
Answer: Typically if a laboratory report is significantly abnormal, that result will be called to the physician.

Question #12: What is the main outcome once gangrene pus flood the abdominal cavity into the veins, kidneys and other bodily organs?
Answer: Again depending on the patient's age and other diseases once peritonitis sets in the patient may recover with abdominal wash out and antibiotics and supportive care, or they may develop multiple system organ failure and ultimately go on to death.

Question #13: Why does complication of recovery is told to mother?
Answer: Again, I do not quite understand this question but you did have a postoperative wound infection I recall which would be a typical complication of a perforated appendix.

I hope this helps with your investigation into your medical records.

I understand you have called several times in the past, however I am typically in the operative suite which makes it challenging for you to get in contact with me during those times that you call and it was my understanding that a phone number was never left for me to attempt to recontact you. It is also my understanding that some question was raised as to me being an expert witness which I do not think is appropriate given that I was involved in the case. Typically an expert witness is someone who reviews the case but does not have any first hand knowledge or involvement in the case.

Again Curtis, I hope all goes well with you and that you have recovered well from your surgery. If I can provide any additional information, please feel free to contact me via mail as that seems to be the most effective way.

Sincerely,

Jeffrey B Thomas, MD

cc: Jeffrey B Thomas, MD

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