Abdominal Pain What not to Miss?

Adrian Ireland

Specialism is inevitable, and having accepted it we must examine its limitations....disease is no specialist. Patients do not consult us because certain organs are affected, but because they feel ill.

Ogilvie

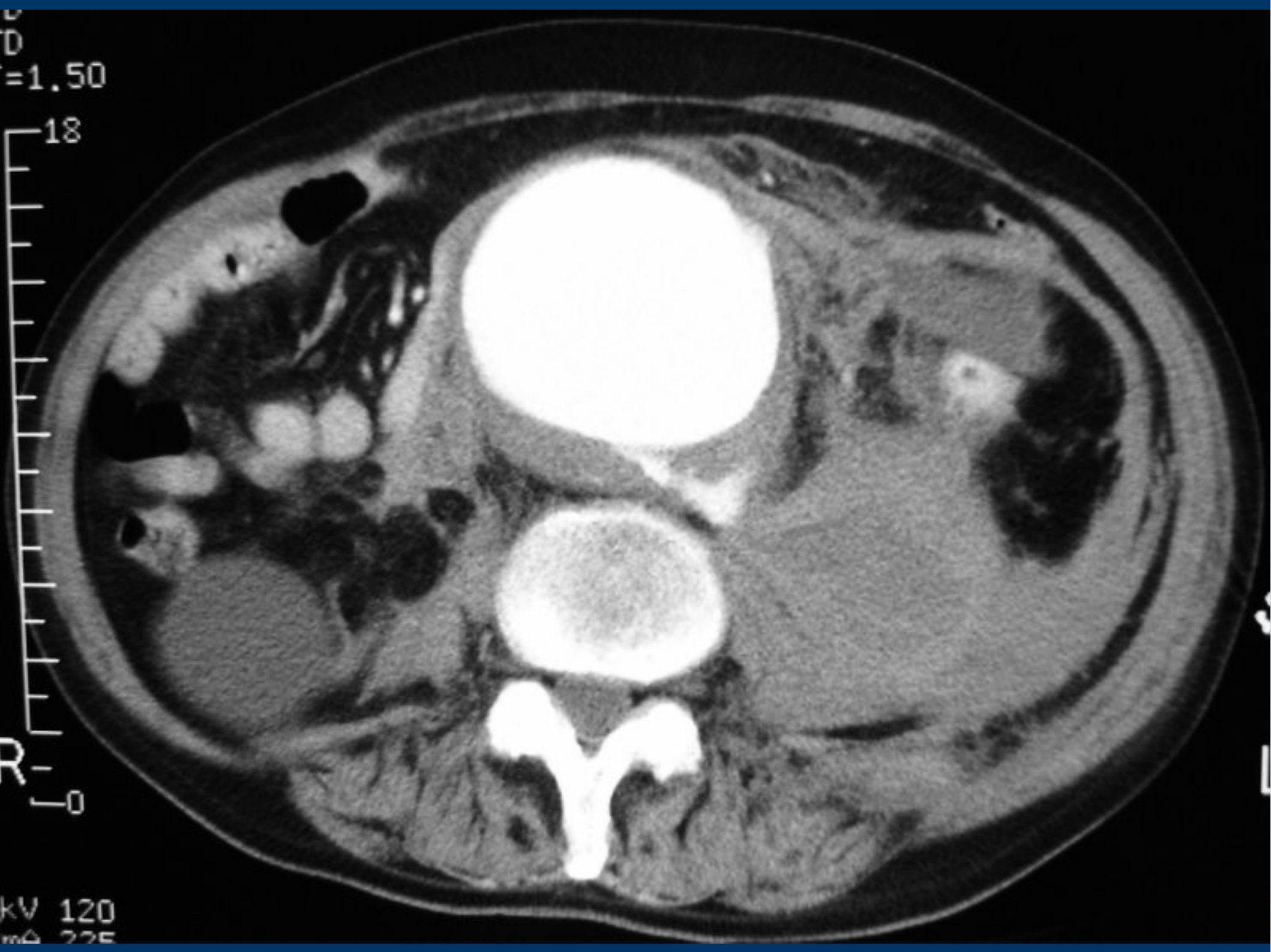
Outline

- Recognise the sick patient
- Try and direct the patient to appropriate service

- Surgical
  - Usual presentations (common and rare)
  - Unusual presentations
- Non surgical presentations

Recognise the sick patient

- 'Unwell'
- Rigors
- Dehydrated
- Pain does not respond to analgesia
- Cold, clammy, sweaty
- Abnormal vital signs
- Delerium / decreased level of conciousness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Major upper abdominal emergencies

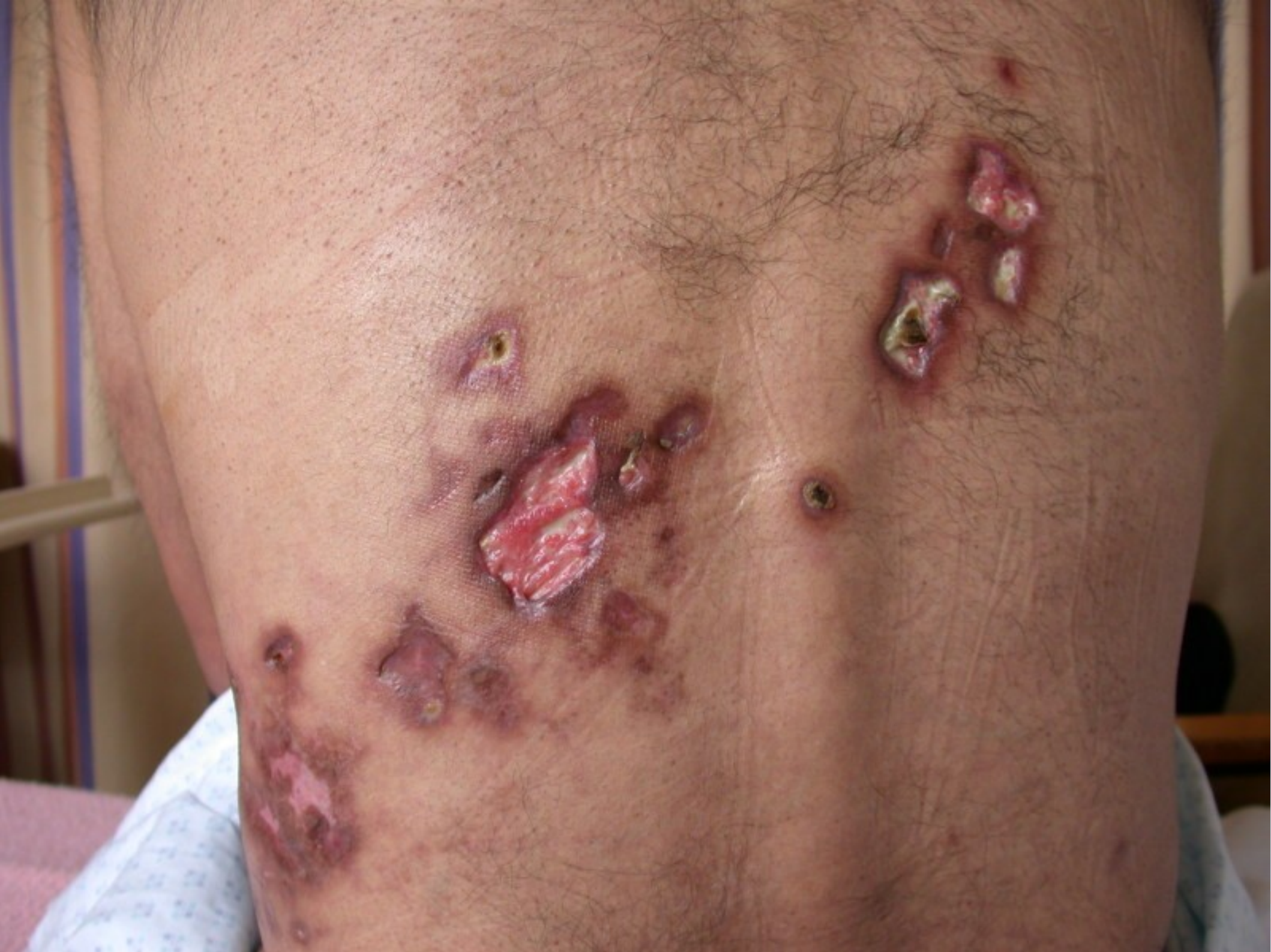
- Unwell, cold, clammy, sweaty
- Shock, generalised tenderness/rigidity, mass
- Big Four
  - Perforated DU
  - Pancreatitis
  - Ruptured AAA
  - Myocardial Infarction

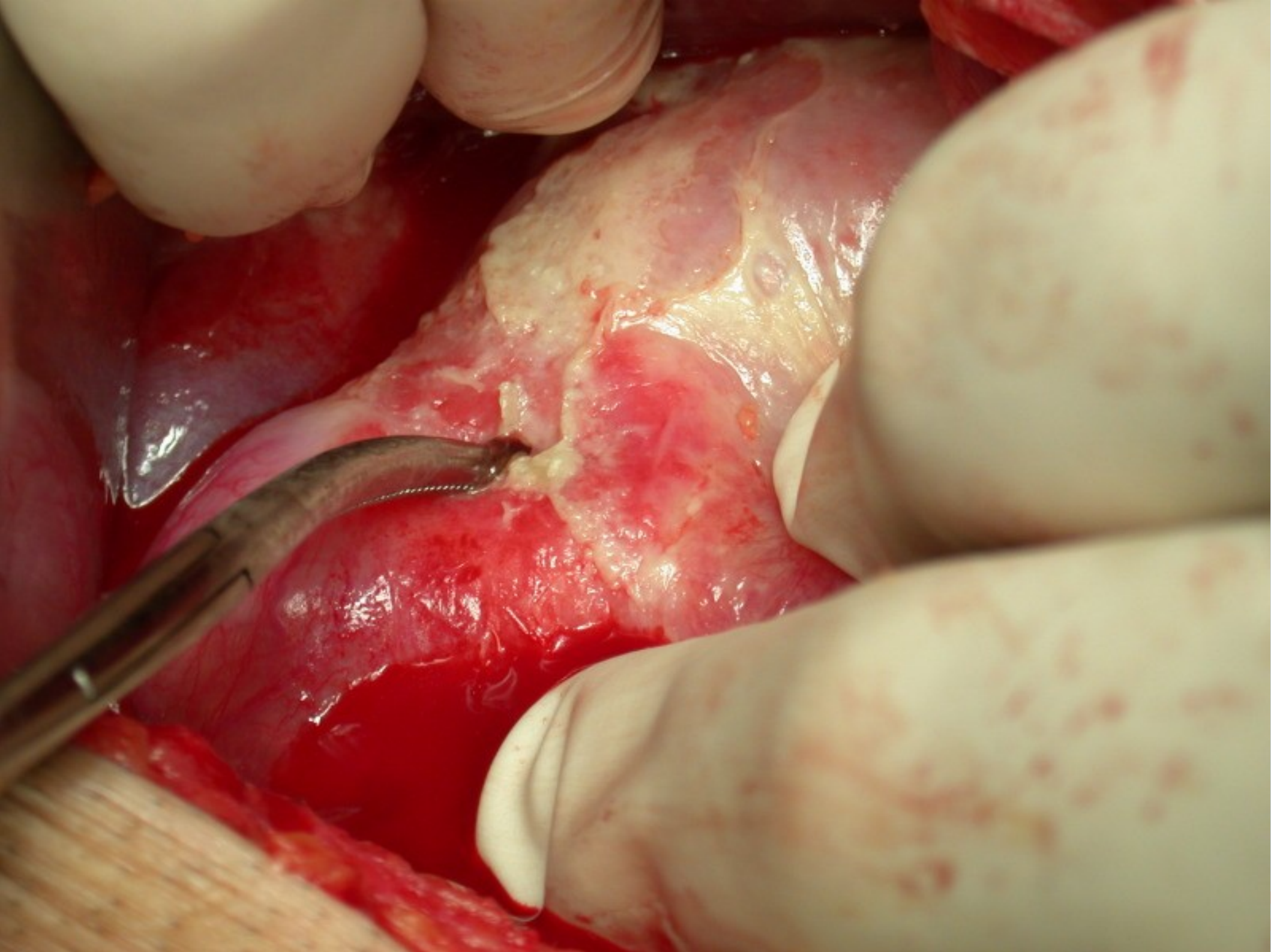
What not to miss

- Inappropriate to refer suspected AAA to hospital where there is no vascular service
  - Refer to appropriate service
  - May result in fatal delay in appropriate treatment
- eg.
  - Known AAA already attending vascular unit.
  - Large palpable AAA with pain or tenderness

Usual presentations

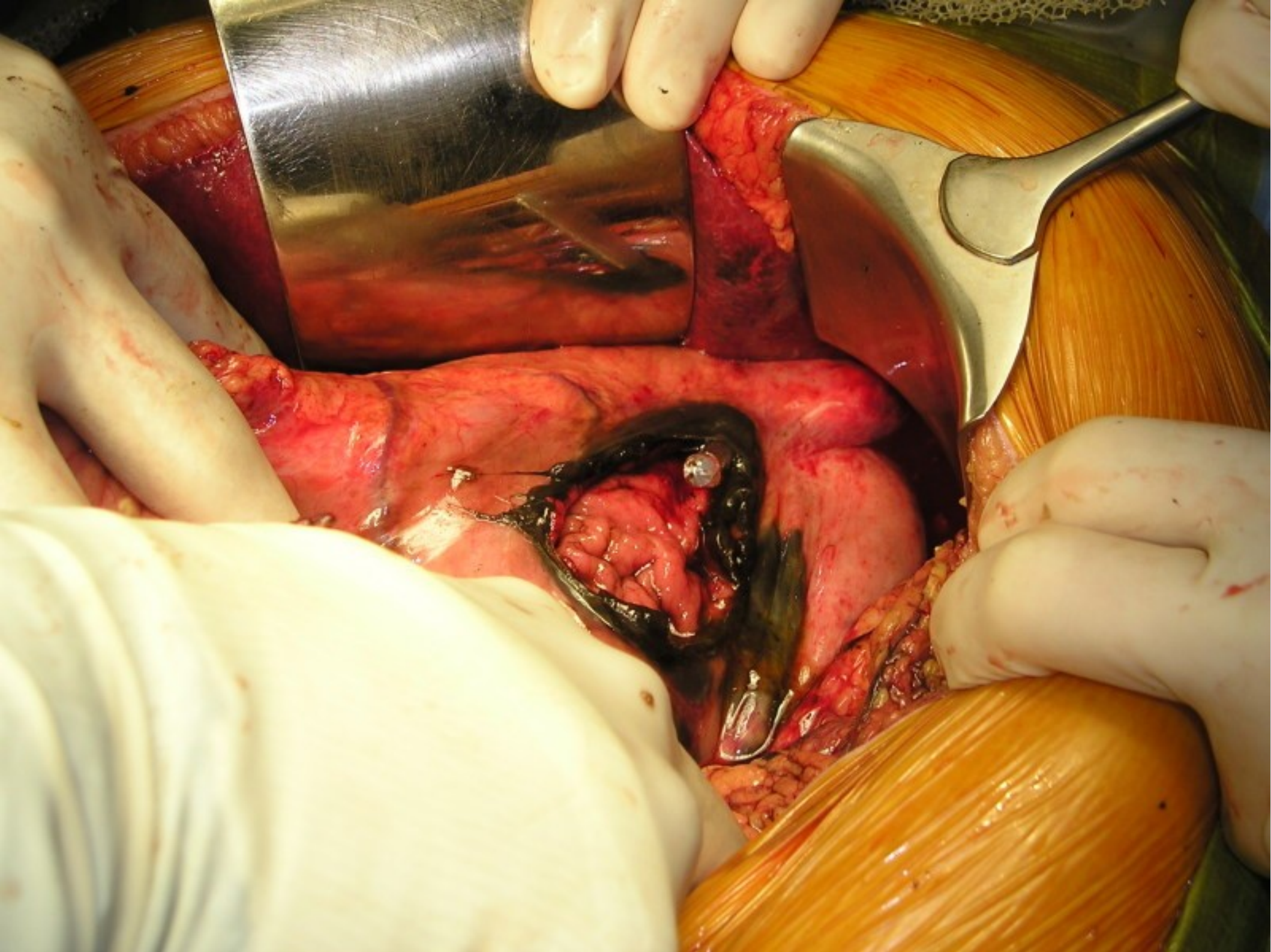
- Common
  - Dyspepsia/ gastritis/ duodenitis/ gastro-enteritis
  - Biliary pains
  - Pancreatitis
  - Peritonitis
  - Intestinal obstruction
  - Urology - Renal/Ureteric colic, Testicular torsion
  - Gynae – Ectopic, complicated cyst.
- Rare
  - Aneurysm (AAA)
  - Splenic rupture
  - Mesenteric ischaemia





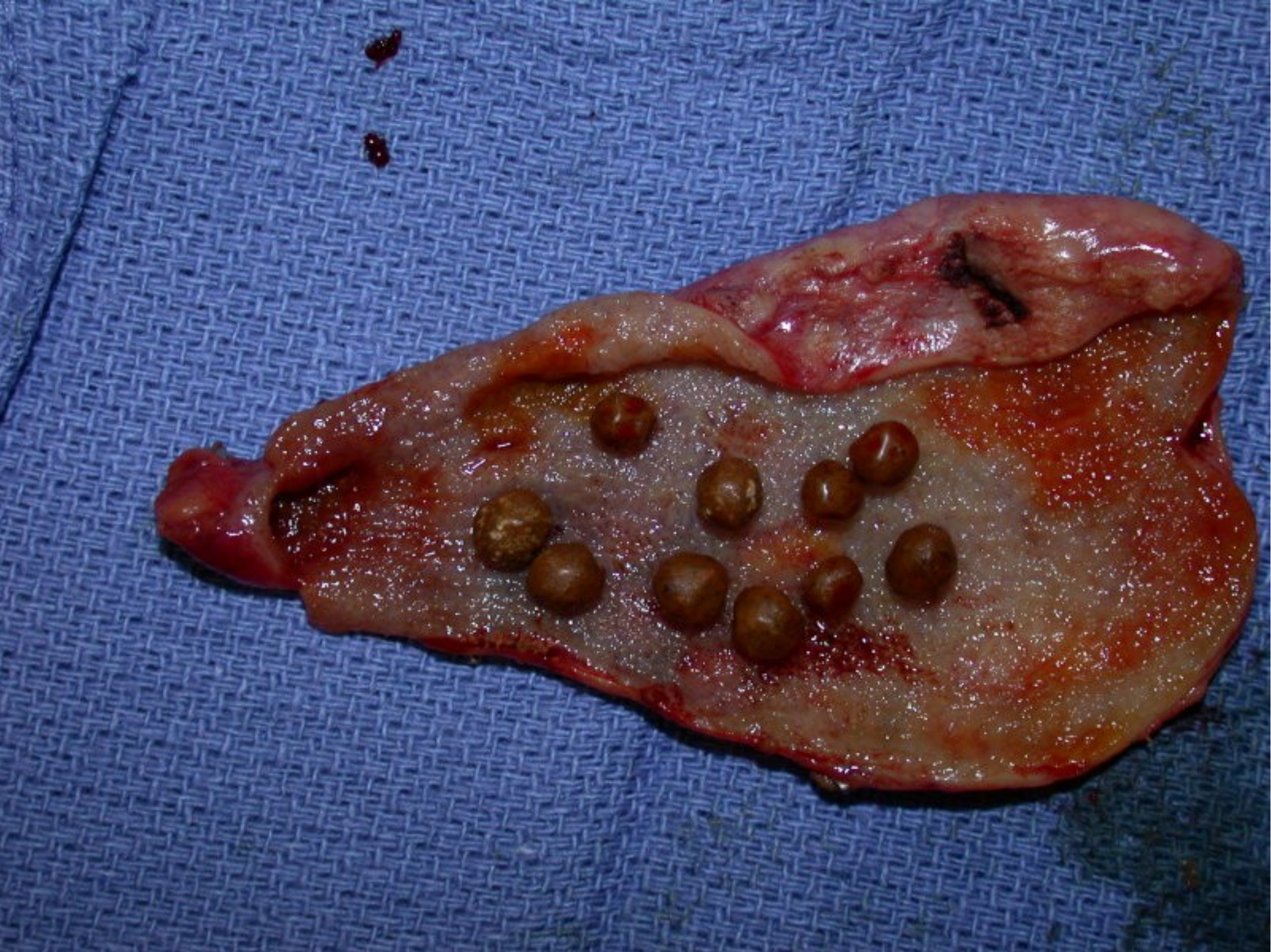
Dyspepsia/ gastritis/ duodenitis

- Check for signs of peritonitis
  - Jump test in children
  - Generalised tenderness in adults
- Check for evidence of major dehydration
  - Thirst, dry mucosae, loss of skin elasticity
  - Little and concentrated urine Sp Gravity
  - BP and PR



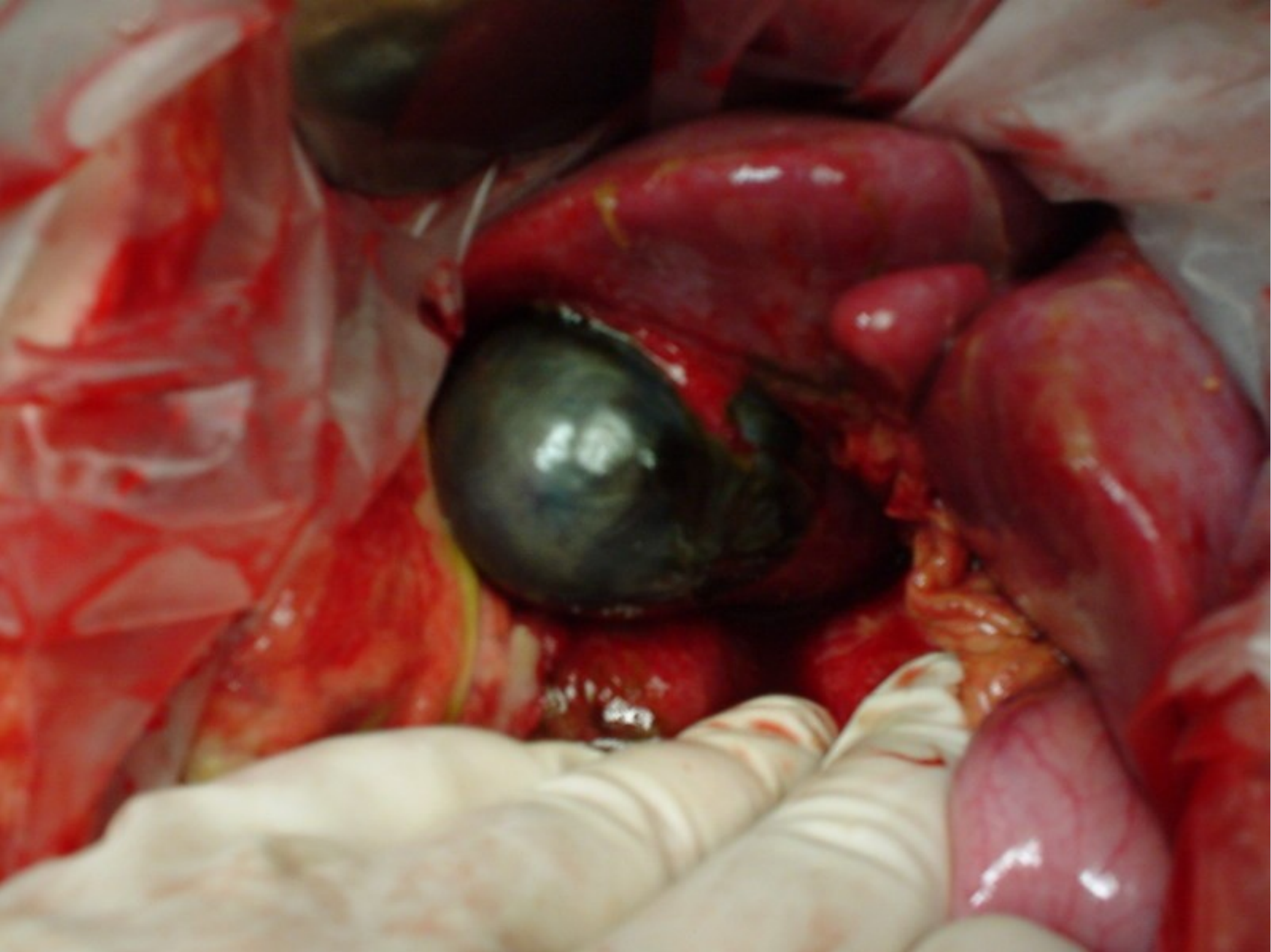
What not to miss - Dypepsia

- MI, Unstable angina
- Avoid admission of patient with gastro-enteritis
  - May close ward in hospital
- Importance of coffee ground vomiting overstated
  - Most common cause is chemical gastritis
    - C2H5OH, ASA, NSAID
      - PPI
      - Review meds



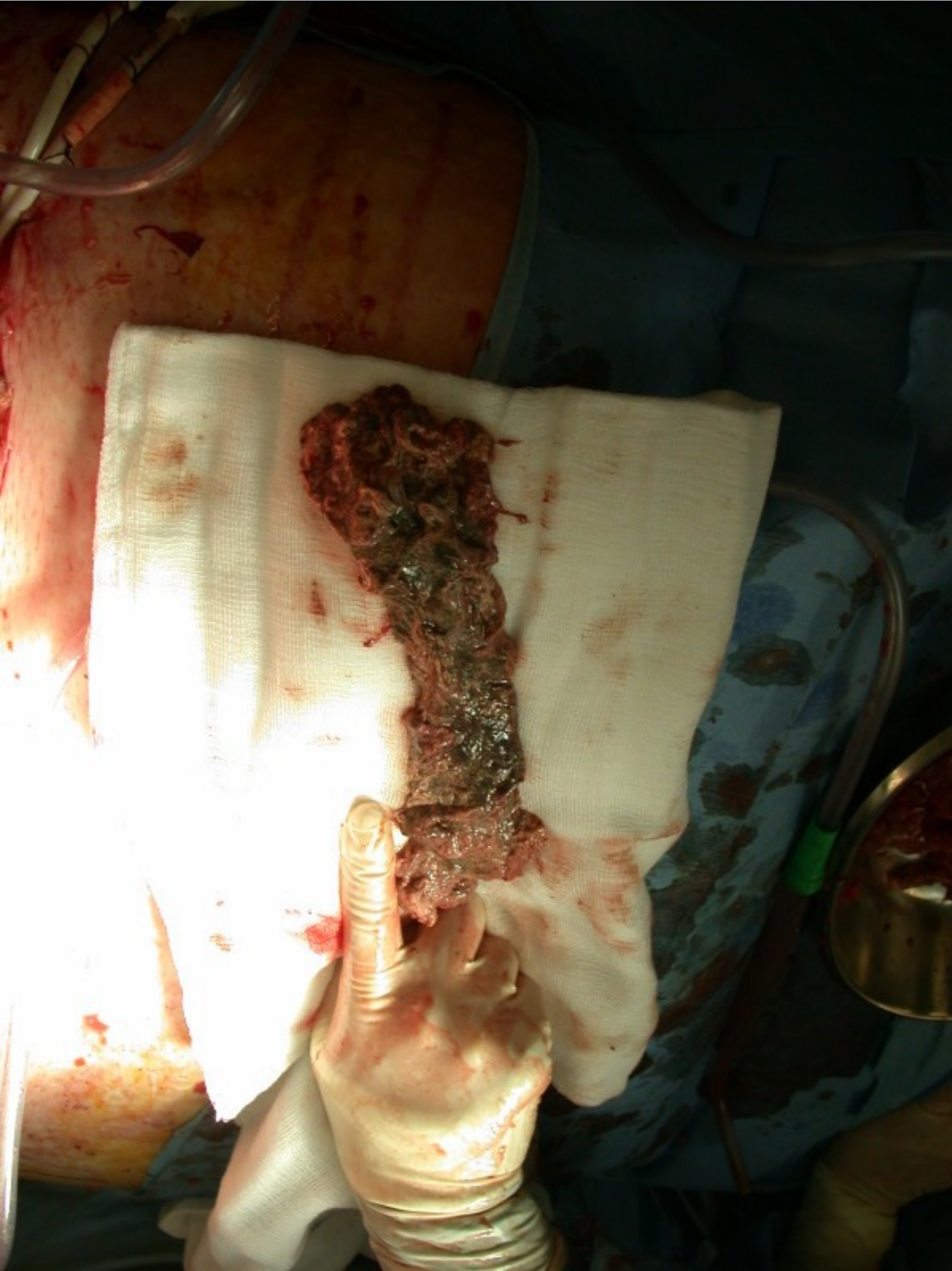
Biliary pains

- Upper and right sided may radiate to back
- Biliary colic: - Severe and short lived
- Acute chole:- Major tenderness, toxicity, long lasting
- Cholangitis risk in patients with obstructive jaundice. Pale stool, dark urine, itch.
- Urinalysis may show;
  - Bilirubin (Elevated in non-haemolytic jaundice)
  - Urobilinogen (Elevated with liver dysfunction, absent with obstruction)



What not to miss – Biliary pains

- Jaundice
- Cholangitis (patient may rapidly deteriorate)
  - Charcots biliary triad
    - Right upper quadrant pain or tenderness
    - Jaundice
    - Fever or Rigors

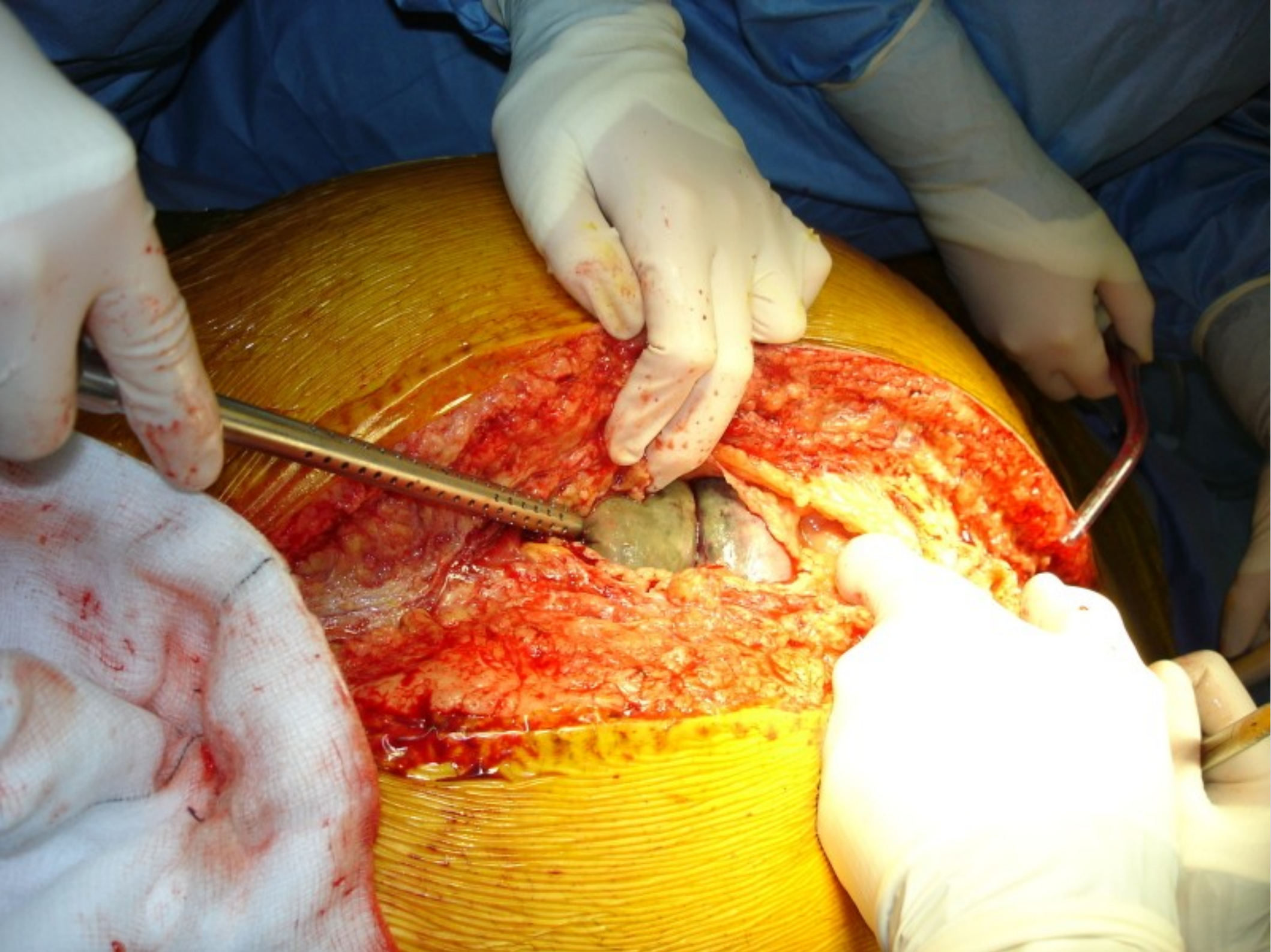


Pancreatitis

- Severe constant upper abdominal pain
  - Back radiation
  - Eased by sitting forward
- Vomiting alot (perf du vomits much less)
- Later on hypovolemia, etc
- DDx
  - Perforated DU, AAA, MI
- Main aid in diagnosis
  - AMYLASE

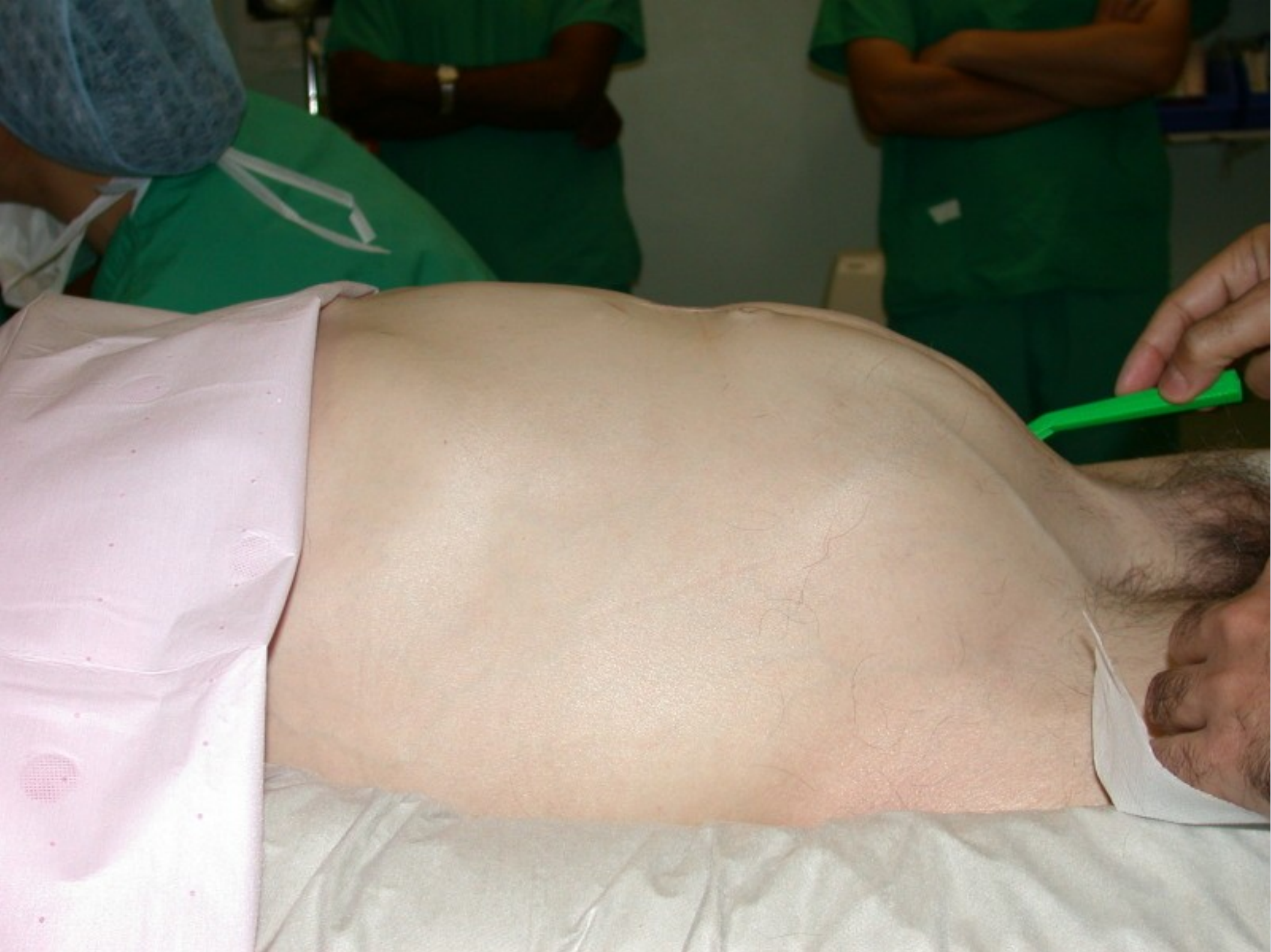
Peritonitis

- Localised
  - Appendix
  - Gallbladder
  - Torsion appendix epiploica
  - Diverticulitis
- Generalised
  - Progress from localised
  - Perf DU
  - Perforated colon/caecum
  - Pancreatitis/ mesenteric ischaemia/ primary peritonitis



What not to miss - peritonitis

- Voluntary and involuntary guarding may be difficult to differentiate
- Retrocaecal appendix
  - Little tenderness anteriorly
    - May have psoas irritation
    - May keep hip flexed
    - May find hip extension painful
- Pelvic appendix
  - Little tenderness in RIF
    - May have tenderness on PR/VE

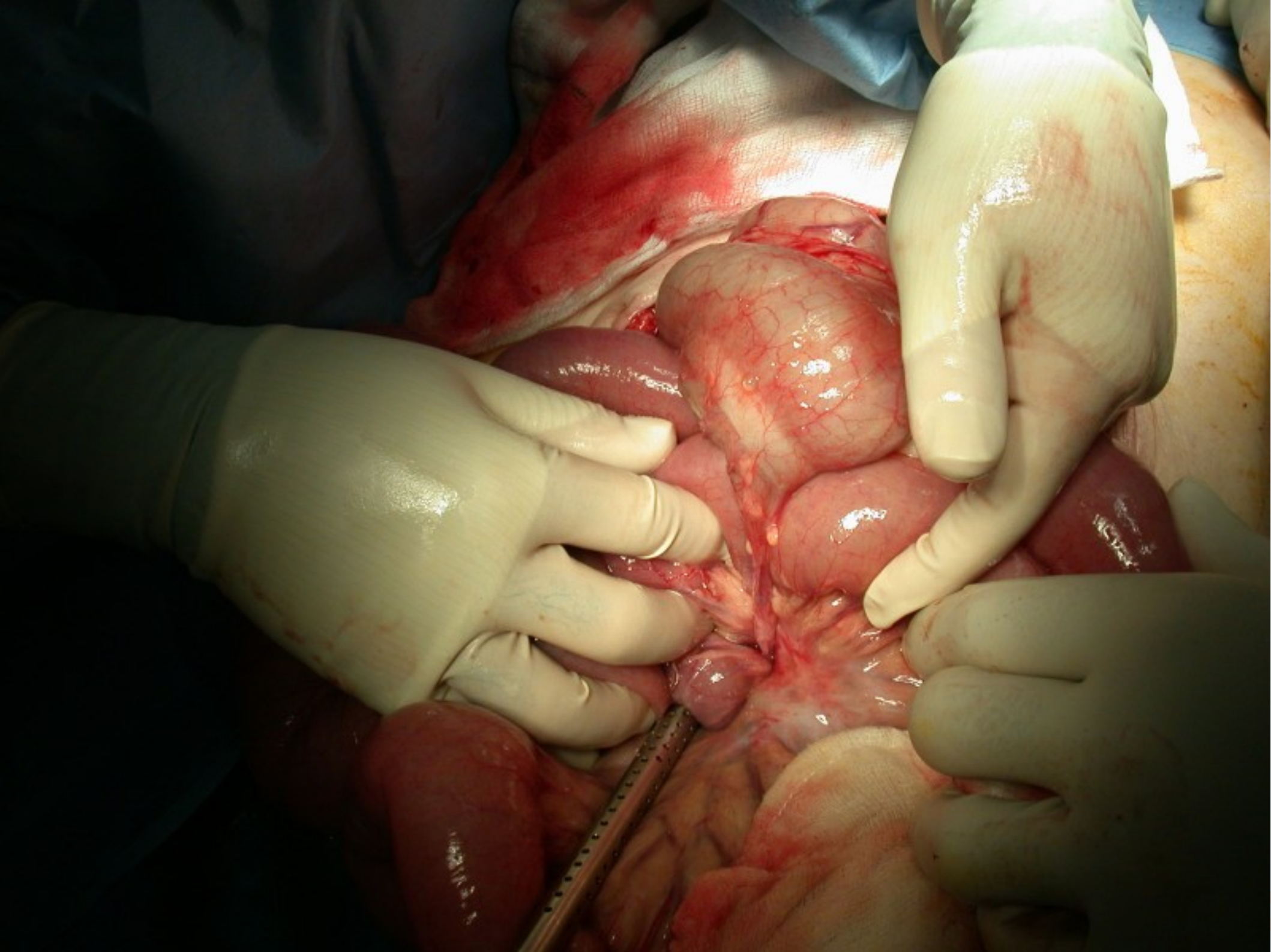


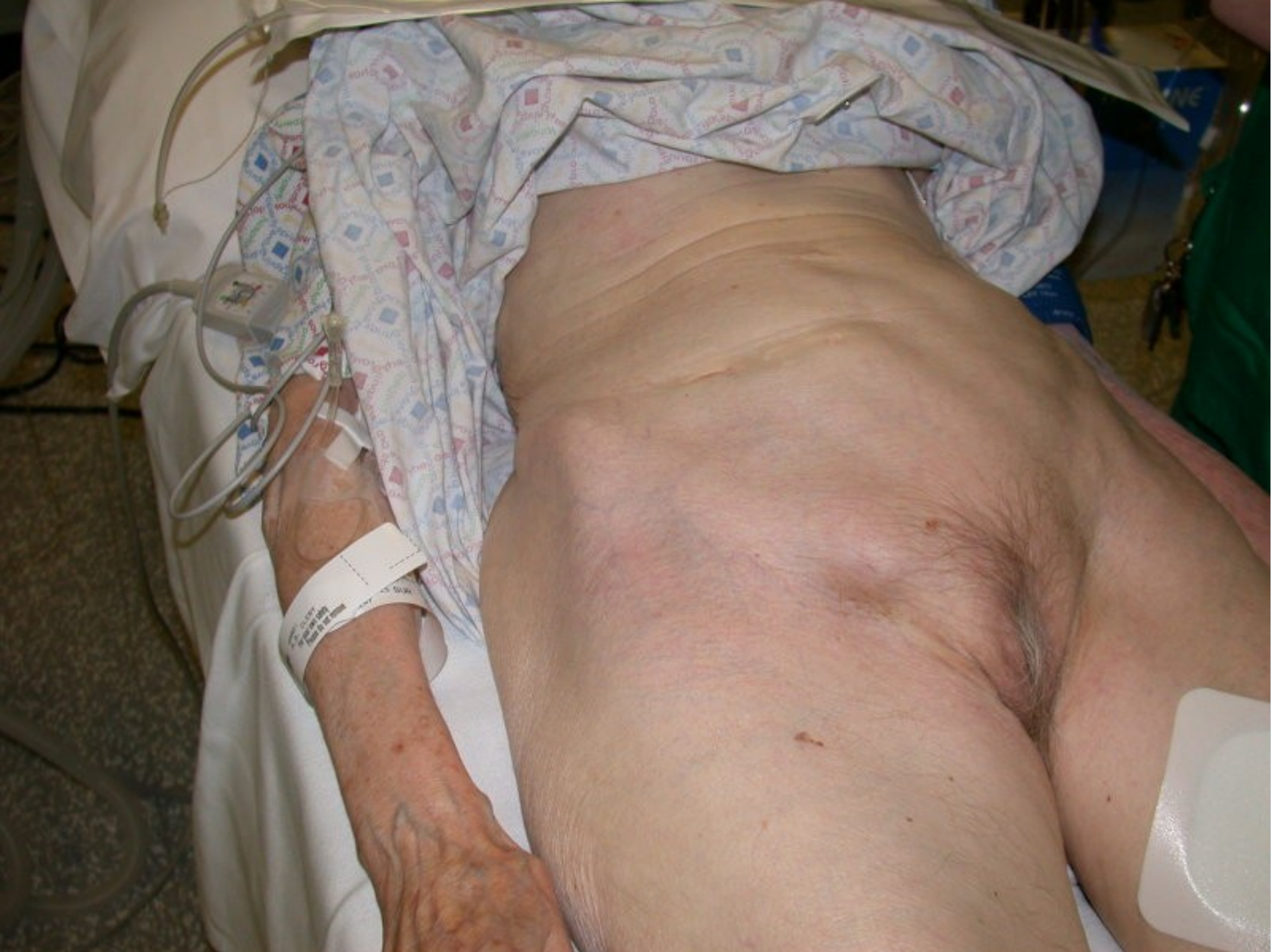
Intestinal Obstruction

- Cardinal four features
  - Pain
  - Vomiting
  - Constipation
  - Distension
- PHx
  - Intra abdominal infections? surgery?
  - Anticholinergics (major psychiatric drugs)
  - Weight loss? Anorexia?

Intestinal obstruction - Causes

- Small bowel
  - Hernia
  - Adhesions
  - Stuck onto tumour
  - Rare causes, Lymphoma, GIST, Gallstone
- Large bowel
  - Tumour
  - Volvulus
  - Rare





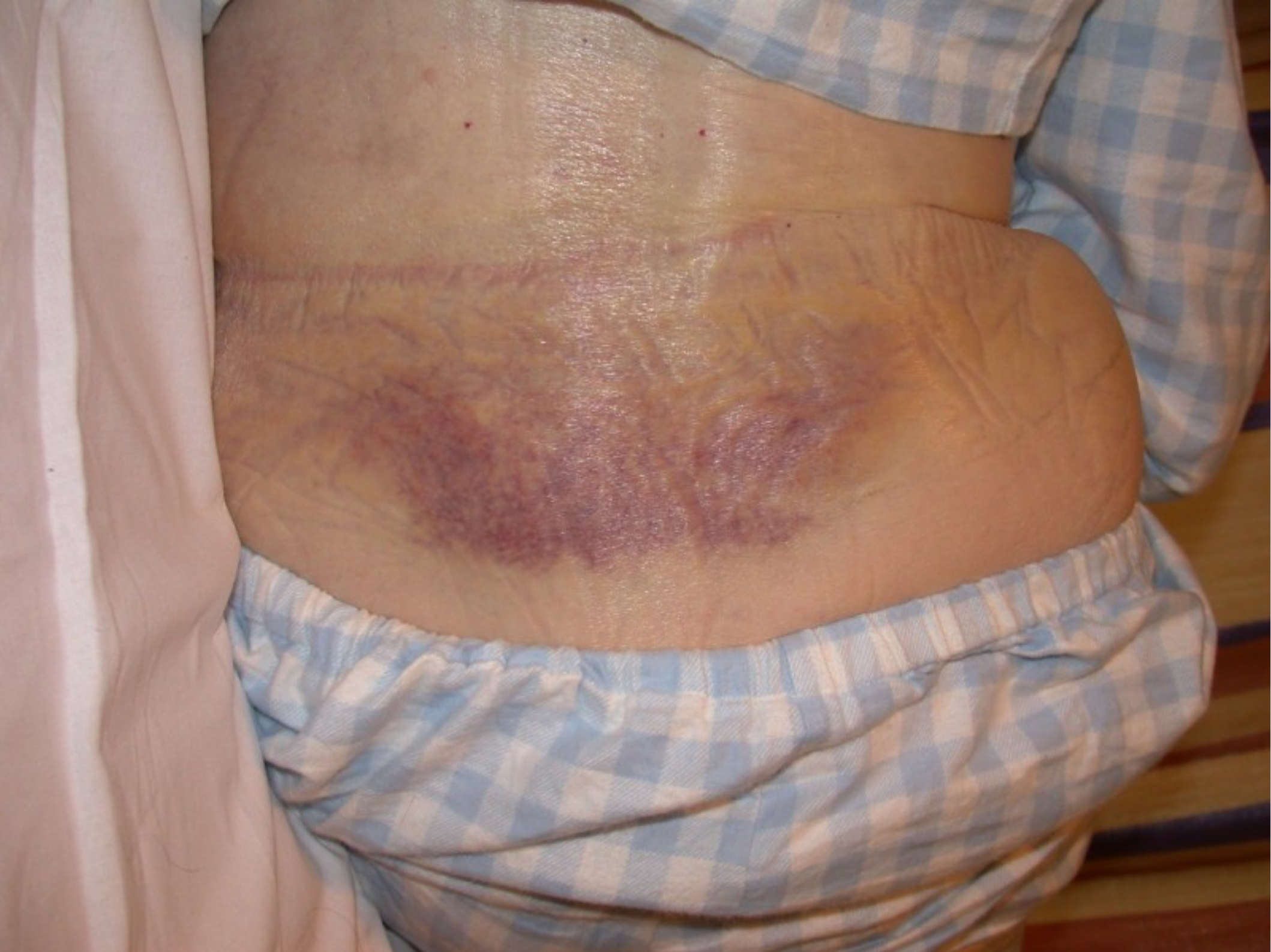
Main things not to miss – Int Obs

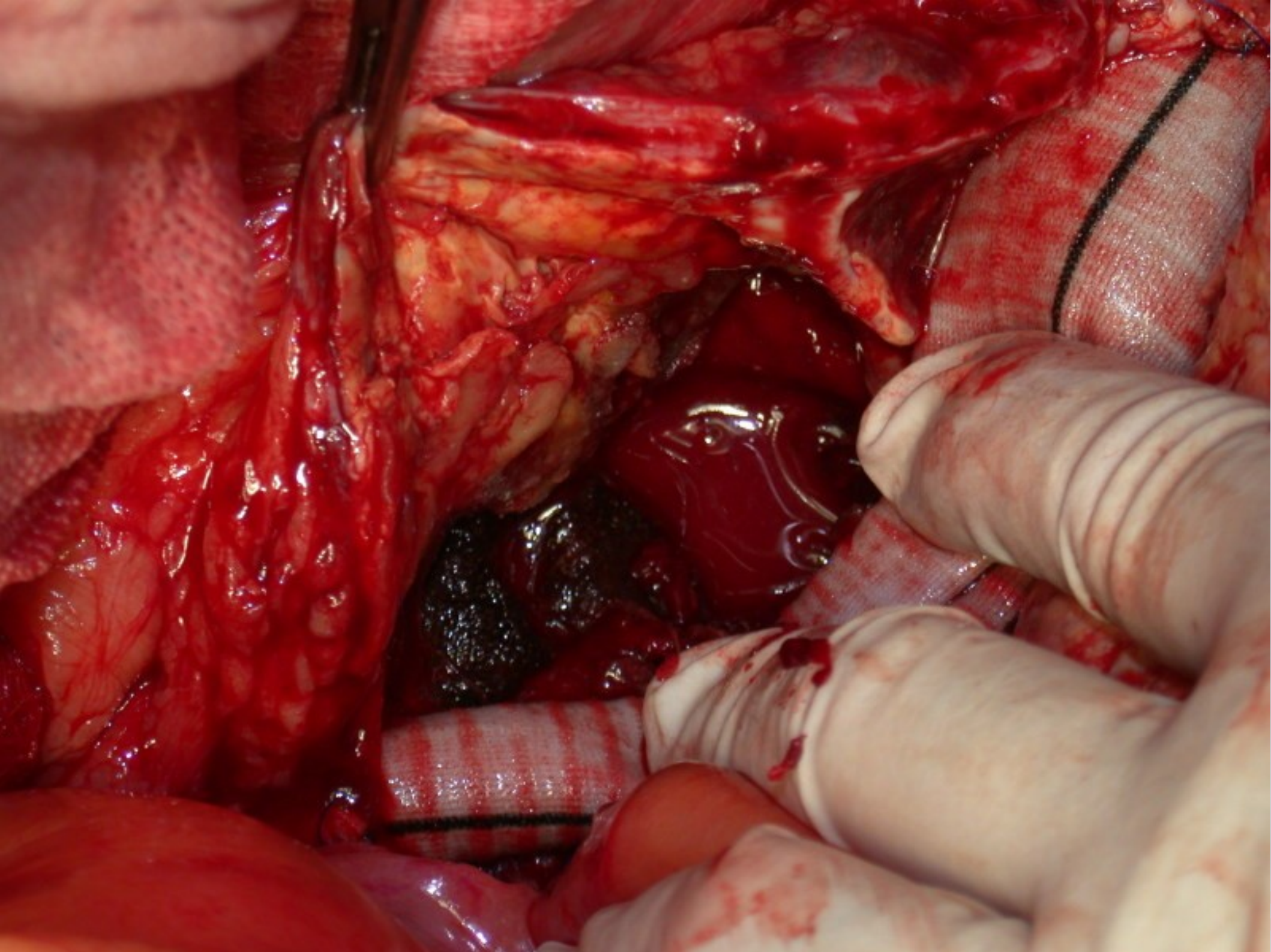
- Proximal obstruction little distension
- Partial obstruction no constipation (Ricters)
- Hernia may be easily missed unless you specifically look for it

Renal / Ureteric colic

- Lateral pain, severe
- Blood on urinalysis

- Best treated in hospital with urology service



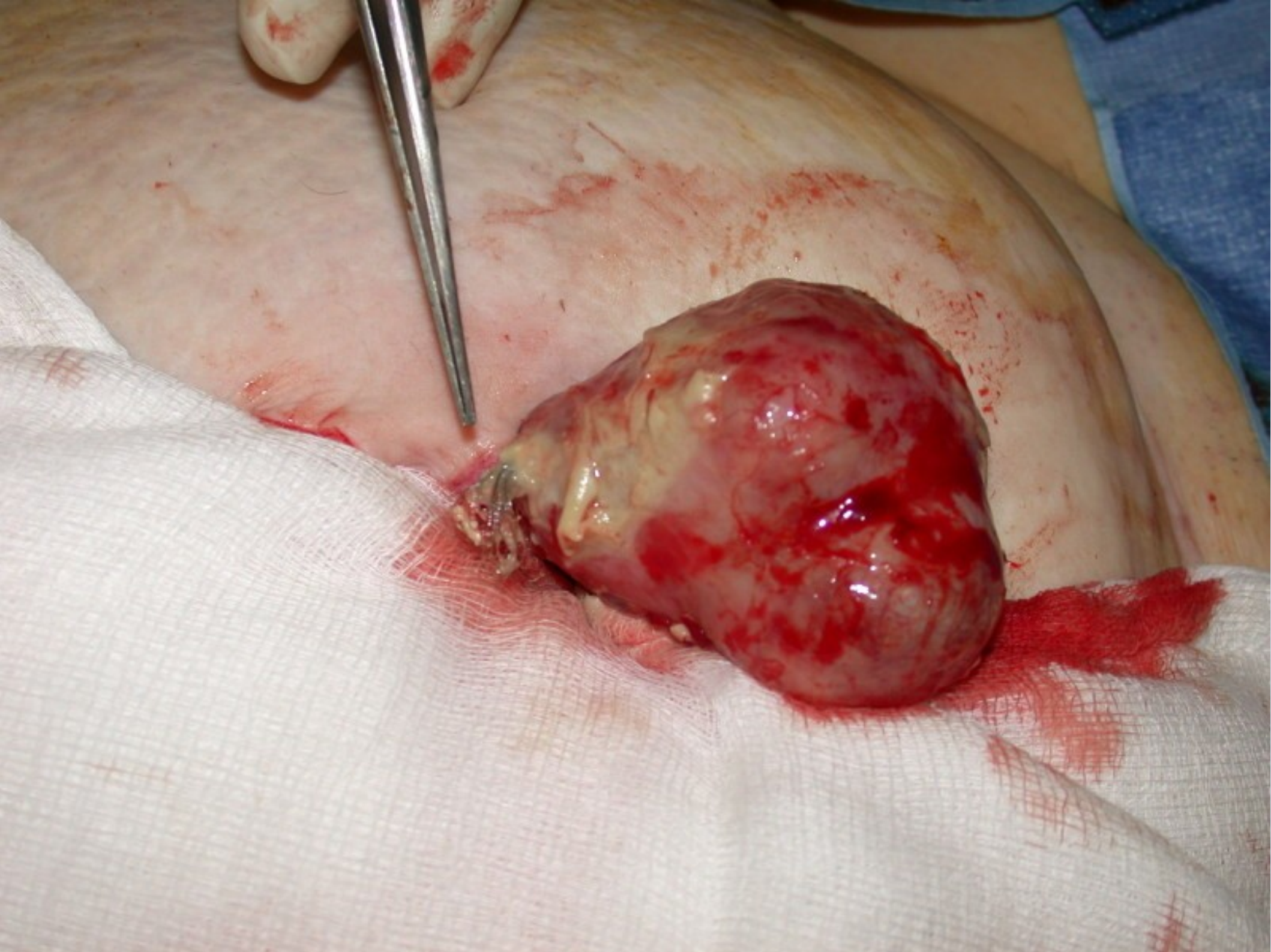


What not to miss – Renal / Ureteric

- Superimposed infection in obstructed kidney
  - Nearly as bad as cholangitis
- Patients over 55 do not usually get stones if they have not had them at a younger age
  - Main cause of renal colic in this age group is;
    - AAA
- Testicular torsion in young man who complains of RIF pain

Gynae

- Ectopic
  - Pregnancy test may be negative
  - Lower abdominal pain with peritonism
  - Hypovolaemia
  - Shoulder tip pain
- Complicated cyst (rupture or torsion)
  - May feel mass if not too tender



What not to miss Gynae

- Mild hypo-volemia
  - Postural hypotension
- Shoulder tip pain
  - when lies down or head down
  - evidence of intraperitoneal blood

Rare Presentations

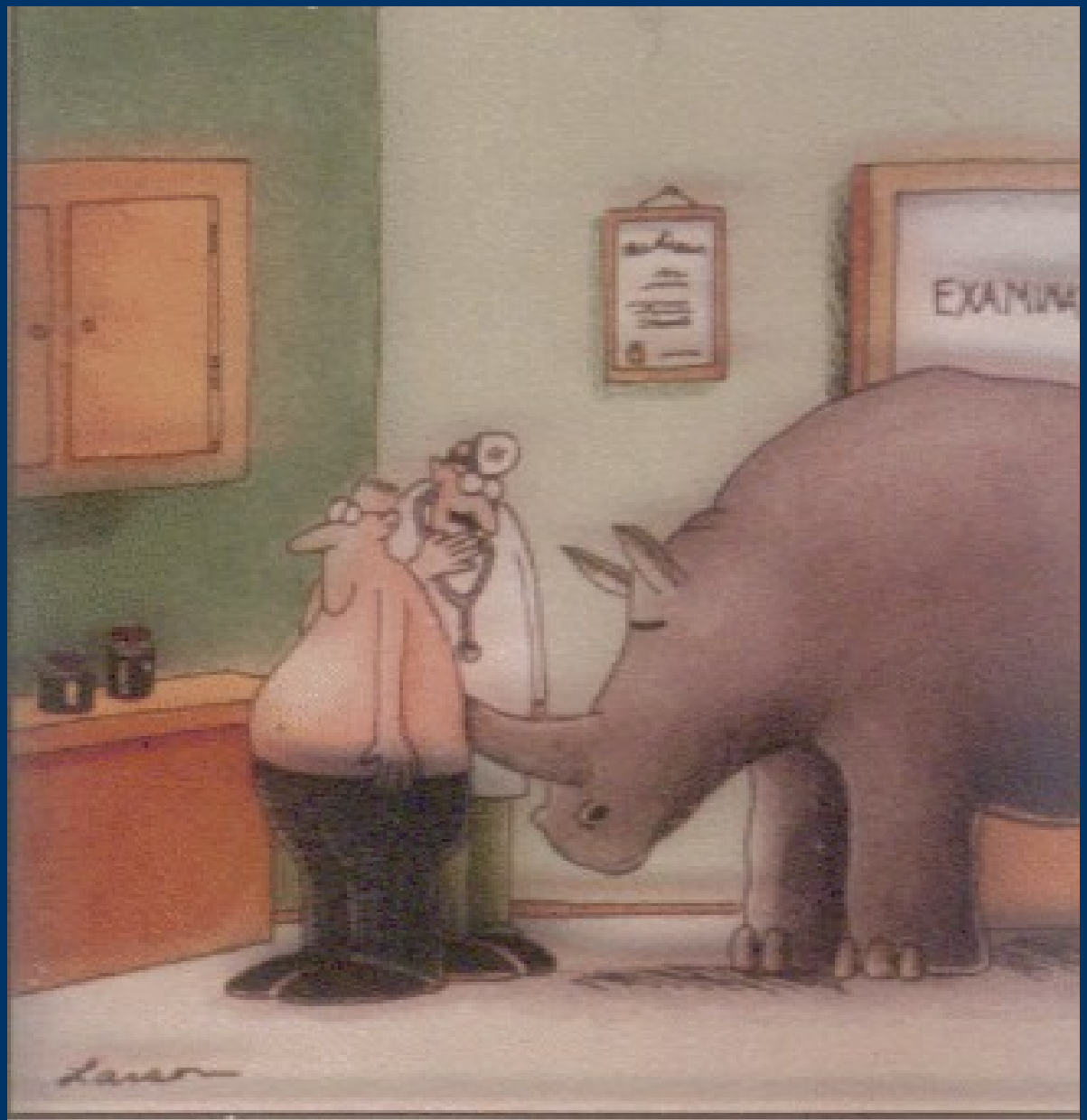
- AAA with renal colic or testicular pain
- Spontaneous splenic rupture
  - Commonest cause of death in Inf Mono
  - May occur with other viral infections
- Ruptured visceral artery aneurysm
- Perforated small bowel due to bone
- Perforated rectum/vagina due to self instrumentation (patient may not volunteer history)

Unusual presentations

- Breathless
  - Faeculant peritonitis
  - Acidosis due to mesenteric ischaemia

Non surgical

- Pneumonia / PE/ MI
- Henoch Schonline Purpura
- Mechanical back pain
- Sickle cell crises
- Neuropathic pain
  - Porphyria
  - Herpes Zoster (Shingles)
- Coagulopathy eg Warfarin with bleeding
- Psychiatric illness
  - Somatoform disorders
  - Munchenhausen



"Wait a minute here, Mr. Crumbley. ... Maybe it isn't kidney stones after all."