University Hospital Galway

EMERGENCY DEPARTMENT

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Abdominal Pain (https://galwayem.ie/guidelines/surgical-emergencies/abdominal-pain)

Category
Surgical Emergencies (https://galwayem.ie/guidelines/surgical-emergencies)

The diagnosis of the acutely painful abdomen is difficult and can be testing. Histories are not always typical of any one condition. Patient with significant symptoms will often require an opinion from a specialist team, usually either general surgery or gynaecology. Some patients with upper GI symptoms may be more appropriately treated by the Physicians.

General guidance

- **Withholding analgesia in patients with acute abdominal pain is unacceptable.**
- **All females of childbearing age should have a pregnancy test.**
- Beware the young and the elderly who can present in very atypical ways.
- Remember medical conditions such as diabetes, particularly in children, and MI may present as abdominal pain.
- Abdominal pain in the elderly is associated with a high mortality and a high operative intervention.

Surgical Referral
Patients fulfilling the following conditions should be referred to on call surgical team following resuscitation and analgesia:

- Haemodynamic instability
- Rebound or percussion tenderness, or guarding on physical examination
- Problem occurring in the post-operative setting
- If clinical examination is unreliable due to drugs or alcohol or other impairment
- Pain which required opiate analgesia to be given by GP or in the ED
- When referred by their GP for admission
- When presenting on more than one occasion with the same episode of symptoms

Have a lower threshold for referring the following patients:

- Elderly > 65 yrs.
- Very young < 5yrs
- Immunocompromised e.g. on steroids

Acute Appendicitis.

This should be suspected or considered in any patient with an acute abdomen, a history of migratory pain with right iliac fossa signs. There may be significant rebound or percussion tenderness, or rectal tenderness (do not assess in children). All such patients require surgical review. The differential diagnosis includes mesenteric adenitis and pelvic inflammatory disease. Always check for hernias. **Appendicitis is a clinical diagnosis.** Investigations are rarely indicated. There is no indication for abdominal X-rays. Be aware that some patients may have WBCs in their urine if the appendix is lying on the ureter.

Acute Cholecystitis and Biliary Colic.
Acute cholecystitis is usually due to stones, although stones can also cause biliary colic without inflammation. Patients with right upper quadrant signs should be referred to the surgeons. If cholecystitis, give analgesia, IV fluids and Co-amoxiclav 1.2g and refer to Surgeons for admission. Clinical diagnosis is confirmed by ultrasound after admission. Plain X-rays are not indicated. If the patient is jaundiced remember to check INR. Check amylase to assess for gallstone pancreatitis.

Perforated Peptic Ulcer.
The presentation is usually sudden and dramatic with severe pain and a rigid abdomen. An erect chest X-ray shows free gas under the diaphragm in 70% of cases. The main differential diagnosis is pancreatitis so check amylase. Don't forget analgesia and antibiotics (Co-amoxiclav 1.2g). Refer to surgeons.

Pancreatitis.
Usually the pain comes on over an hour or two, more slowly than with a perforation. Back pain is often a feature. Shock may be profound. Measure amylase (usually raised but does not give indication of severity and is normal in up to 5% of cases) FBC, U&E, LFT, Glucose and Calcium. Consider CRP in cases of doubt. Erect chest X-ray should be performed.

Management includes:

- Correct hypoxia
- Fluid resuscitation (normally 4-6L fluid sequestered)
- Analgesia with IV morphine titrated to effect
- Urinary catheter plus NG tube
- Calculate Ranson's score (see below)
- Consider CT staging if Ranson's score > 2
- Early surgical referral with low threshold for ICU admission.

Ranson's Criteria

Image
(https://galwayem.ie/sites/default/files/images/Ransons%2520Criteria.png)
Small Bowel Obstruction.
The diagnosis is suspected clinically. Plain abdominal X-ray cannot outrule. CT abdomen/ pelvis is investigation of choice. Look carefully for a strangulated hernia which can be missed especially in the obese. Abdominal scars may suggest adhesions. Initial management is with IV fluids and NG tube. Refer to surgeons as laparotomy may become necessary.

Mesenteric infarction.
Classically this presents in elderly patients with abdominal pain out of proportion to clinical findings. Patients have risk factors for vascular disease; Atrial fibrillation, Diabetes, Hypertension, smokers. Lab findings are non-specific; high lactate, WCC, D-dimer, +/- amylase.

Need CT abdomen with IV contract plus surgical consult.

Large Bowel Obstruction.
Start conservative treatment with IV fluids and NG tube. Refer urgently to surgeons.

Acute Diverticulitis.
Often a diagnosis of exclusion, this is suggested by symptoms and signs suggestive of “left sided appendicitis”, and similar complications can occur. Suspected cases should be referred to the surgeons. If the patient is toxic consider starting IV fluids and antibiotics (Co-amoxiclav 1.2g)

Discharging patients with abdominal pain

- Do not give a specific diagnosis unless you are sure of it
- Non-specific abdominal pain is an acceptable diagnosis in low risk patients (i.e. the non elderly with no physical signs)
- Do not prescribe antibiotics unless there is a specific diagnosis that warrants them (e.g. UTI)
- Do not prescribe strong analgesics that will mask progression of disease
- Advise patients to return if symptoms worsen
- Advise all patients to see their GP within a couple of days

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