Abdominal Pain (see also Abdominal Aortic Aneurysm)

Evaluating abdominal pain is difficult – misdiagnosis of this symptom generates more formal complaints than any other clinical mistake made in our department. Did you know that computers are better at diagnosing abdominal pain than doctors? This is because the computer follows a rigid system of history-taking and interprets physical signs in the light of this. You need to take a medical student history – no short cuts! Blood tests and x-rays are less important than history and examination. Abdominal x-ray has a limited role – see section one.

When you have made your diagnosis you have two options

- **Discharge with a meticulous recorded disposal plan (see General Information Section)**
- **Admit to surgical / gynae/ medical ward**

ALL PATIENTS TO BE ADMITTED TO WARD WITH SUSPECTED ACUTE ABDOMEN SHOULD BE FASTING AND IV FLUIDS SHOULD BE ERECTED IMMEDIATELY.

This is not an exhaustive list but these are useful things to remember:

- **Diabetes + Abdominal Pain – ECG & Admit**
- **AAA : See previous section**
- **Perforated Peptic Ulcer : Unable to get comfortable or severe pain that settles very quickly. Can become asymptomatic but still leaking. Erect CXR is mandatory but up to 50% may have no free air especially if history is short.**
- **Ectopic pregnancy: Child-bearing age and positive urinary HCG and serum HCG**
- **Ovarian Cyst : Usually not pathological but cyclical pain may be due to ovarian cyst so recommend GP review to refer to gynae OPD. If abdominal signs consider equesting USS(X-ray dept) and admit to SSW or speak to O&G. Always do HCG.**
- **Constipation: Not acutely painful. Don't forget bowel cancer as a cause of altered bowel habit – GP review to refer to Surgical OPD. X-RAYS NOT INDICATED!**
- **Biliary Colic : RUQ pain but no signs. Can be discharged if settles with analgesia. WCC, amylase and temp will be normal. GP review. Recurrent attendances with biliary colic – admit and *don't forget to exclude pancreatitis*!**
- **Pancreatitis: These patients can be very sick (or occasionally surprisingly well!). Vomiting is common. Check amylase but will be normal in around 6% of cases. Check ECG & blood glucose. Vigorous resuscitation and early senior surgical opinion.**
- **Appendicitis: History is the key but presentation may be atypical in the over 50s. Never disregard significant tenderness in RIF- re-evaluate if necessary. (Can have leucocytes and haematuria on urine dipstick)**
- **Ischaemic Colitis: Usually very sick elderly patients with severe abdominal pain, shock, ileus– often with history of IHD etc. Pain relief ++, ECG and early surgical advice. Have a very high lactate level.**
- **Toxic Megacolon: All patients with history of inflammatory bowel disease, abdominal pain and any alteration of vital signs require surgical assessment/ admission. If sick consider TMC – x-ray may be diagnostic. Resuscitate++ and get help.**
- **Shingles: Pain days before rash. Dermatomal distribution and dysaesthesiae are clues. You will feel very clever if you diagnose this before the rash appears!**

GI Bleeding & varices (see 'Shock')

Not all patients presenting with haemataemesis require admission. Use the guidelines given below to help you devise a management plan.

Patients may require "immediate" endoscopy if

- **Ongoing bleeding and haemodynamically unstable**

Patients may require endoscopy "soon" if

- **Suspected varices (see next page)**
- **aged > 60**
- **clinical signs of shock (compensated or uncompensated)**
- **recurrent bleeding.**

Fast patient, give O_2 via NRRM, monitor and give iv protium. Notify Medical SHO (and surgical registrar if no GI physician on call) at once

Patients require admission to a medical ward for next available endoscopy if they have suspected haematemisis and ANY of the following apply:-

- **they have had proved haematemesis in the past**
- **they describe any episode of faintness or dizziness since the onset of haematemesis**
- **a further episode of haematemesis is witnessed by the Emergency Department staff**
- **melaena is found on rectal examination**
- **haemoglobin < 12 gd/L**
- **urea > 8 mmol/L**
- **underlying liver or cardiac disease**
- **evidence of coagulation defect (including anticoagulant medication**

Patients may be considered for outpatient endoscopy referral if there is a strong suspicion of a relatively minor haematemesis, and they are otherwise well low Glasgow Blatchford score with adequate home circumstances. Dispense a PPI and suggest this to the GP.

Management of variceal haemorrhage

Get senior help bleep gastro registrar or surgical reg if out of hours

Resuscitation

- Insert two 16g peripheral cannulae
- Check FBP, U+E, LFTs, Coagulation screen, Cross match 6U blood
- Consider intubation if there is evidence of severe encephalopathy, inability to maintain O2 sat >90%, uncontrolled bleeding or aspiration. Also consider central venous access in such circumstances
- Catheterise to monitor urine output
- Start iv Augmentin

- Fluid management
  - Blood transfusion, aim for Hb 10 g/dl (no higher)
  - Give FFP if PT >18sec and give platelets if platelet count <60,000
  - If no blood is available use crystalloid 1 litre of N. saline to begin with 0.9% normal saline
  - Aim for CVP 5-10mmHg (if central line present)

- Endoscopy
  - OGD should be performed when patient is rescusitated as best as possible
  - Variceal banding is treatment of choice for oesophageal varices

Vasoconstrictors may be required

- Give stat dose of terlipressin (Glypressin) as a 2mg iv bolus
- Glypressin is then given 1-2mg, 4-6 hourly for up to 48 hrs

- Insert Sengstaken-Blakemore tube if there is uncontrolled bleeding and senior ED staff and anaesthetic staff are present
  - Intubate patient
  - Insert tube orally
  - Confirm tube is in stomach by aspiration and auscultation
  - Inflate gastric balloon with 250mls WATER
  - Secure tube at side of mouth with balloon pulled up against gastric fundus (Beware of pulling tube into oesophagus. Use Xray to confirm position if necessary)
  - Oesophageal balloon is rarely needed (<10%). If required it should be inflated to 20-30mmHg and deflated for 5mins every hour.
  - Maintain aspiration of oesophagus and stomach via appropriate ports.