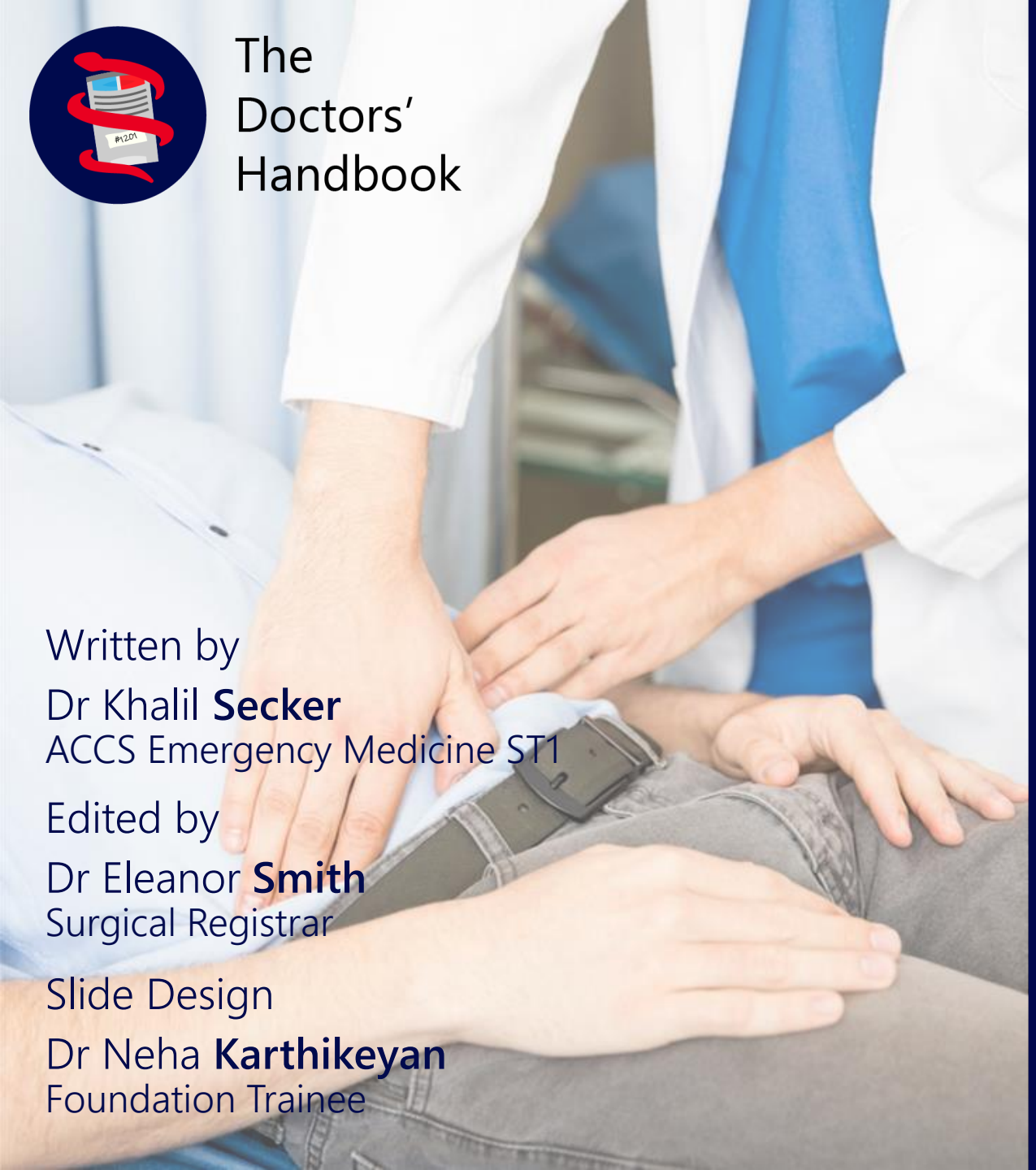


The Doctors' Handbook

You've Been **Bleeped:**

Abdominal pain

Written by

Dr Khalil **Secker**
ACCS Emergency Medicine ST1

Edited by

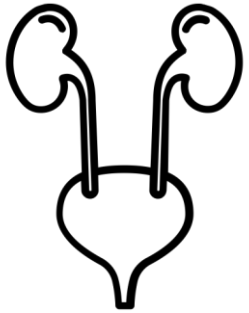
Dr Eleanor **Smith**
Surgical Registrar

Slide Design

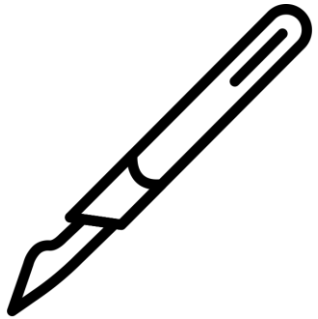
Dr Neha **Karthikeyan**
Foundation Trainee

Differentials

Gastrointestinal

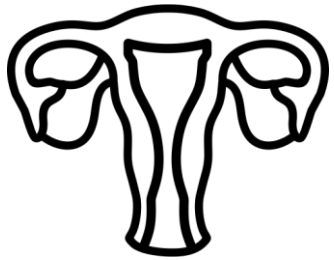


Renal/Urological



Post-Op

Vascular



Gynae

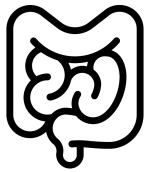
Other

Questions to ask in the **Hx?**

Questions to ask in the Hx

Pain – SOCRATES

Nausea/vomiting

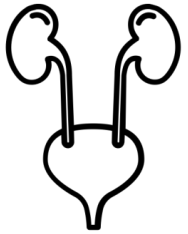


Diarrhoea – blood/mucus/frequency

Constipation/BLO

If BNO, passing wind?

Fevers, rigors, weight loss

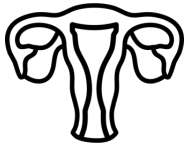


Dysuria

Polyuria

Incontinence

If post-op, what operation and how long ago?



Last menstrual period

PV bleeding/discharge

Itching

Difference between **A&E** vs the **ward**?

You've been **bleeped:** Scenario 1

Abdo pain. 78F admitted with #NOF. Operated on 2/7 ago

Is on opiate analgesia

Describes generalised abdominal pain, 4/10 severity with no focal point

BNO 6 days. Passing wind. No nausea/vomiting

Passing urine and is continent of urine

Scenario 1

HR	87	115 76
RR	16	97% RA
T°	37	

Scenario 1

HR 87 | 115 76 | RR 16 | 97% RA | T° 37

A B C D — Unremarkable

E — Abdo distended, generalised tenderness
Some voluntary guarding on deep palpation
No rebound tenderness. Not peritonitic. No palpable masses. Bowel sounds quiet

PR exam — Rectum loaded with soft stool. No tenderness, no masses

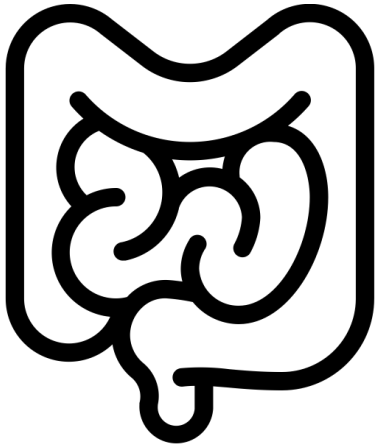
Scenario 1

Differentials?

What do you want to **rule out**?

What **investigations** might you order?

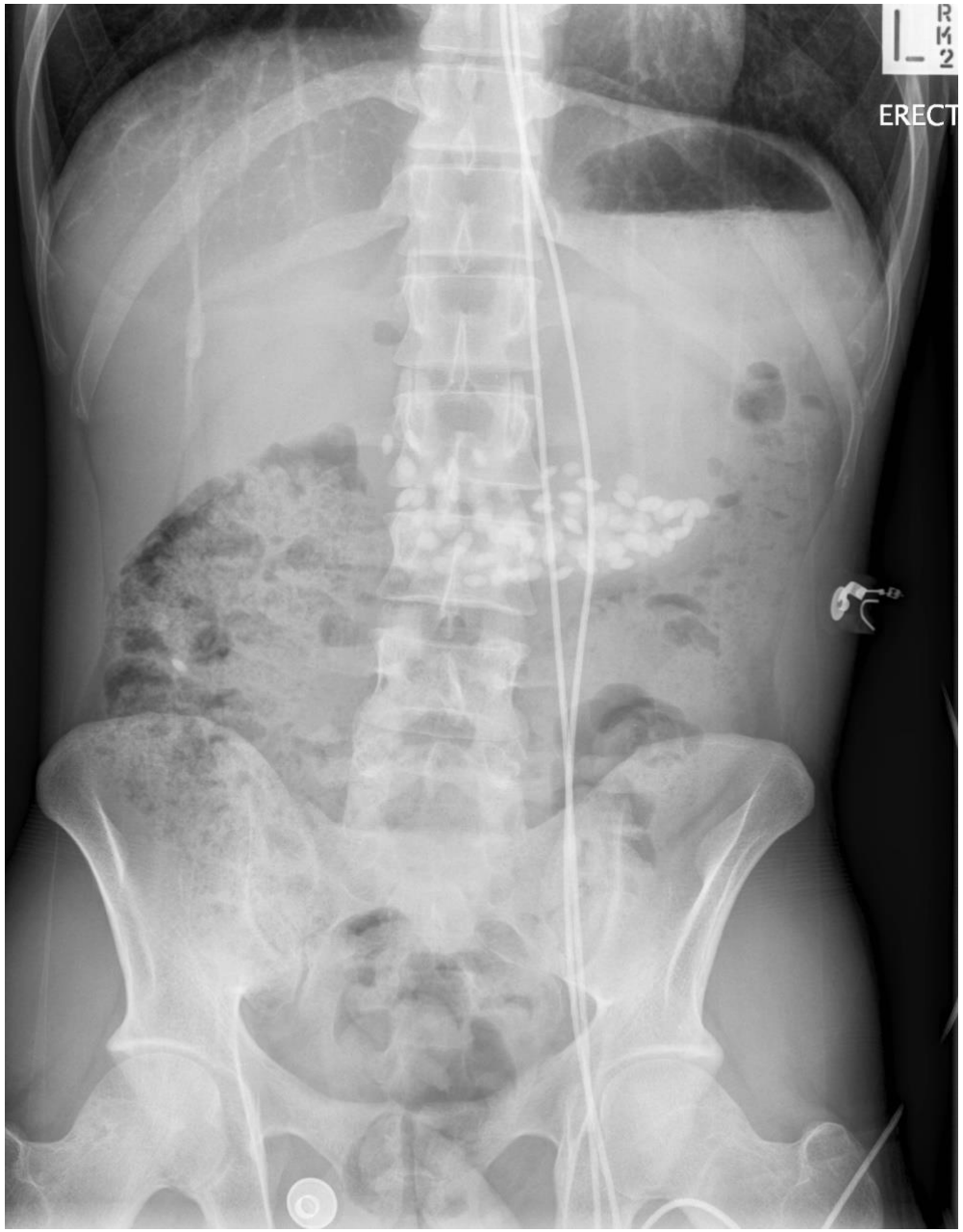
Differentials



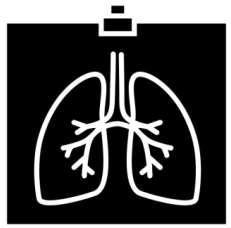
Bowel obstruction

Constipation

Scenario 1



Investigations



AXR — Shows faecoliths

Bloods — Inflammatory markers, U+Es and LFTs all unremarkable

VBG — Lactate and pH both normal

Scenario 1

Impression?

Management plan?

Impression

Opiate induced constipation

Management

Senior review/discussion

Phosphate enema/glycerol suppository

Can give senna at night for opiate constipation and regular movicol

Review analgesia. Could attempt to wean down opiates or to switch to NSAIDs if appropriate (though try to avoid NSAIDs for elderly patients)

You've been **bleeped:** Scenario 2

90F admitted from a nursing home following a fall, background of Alzheimer's dementia

MFFD but awaiting PT/OT

Usually she can engage in conversation and is quite cheerful, and is able to recognise some members of the staff team

You've been **bleeped:** Scenario 2

Nurses say she is off her baseline. Today she will not engage in conversation with anyone

She is crying, and appears to be in pain. Unable to give any type of history

Nurses say she has been passing urine but is incontinent of urine

BLO yesterday, type 4 (i.e. normal consistency)

Scenario 2

HR 92	119 70	
RR 18	98% RA	
T° 36.6		

Scenario 2

HR 92 | 119 70 | RR 18 | 98% RA | T° 36.6

A B C Unremarkable

D GCS 14/15, confused. PEARL

E Patient smells of urine. Nurses say she's passing urine but is incontinent

Abdomen is very tender to palpation in suprapubic region. Can feel a firm mass in the suprapubic region. Bowel sounds present

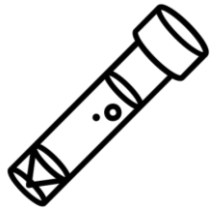
Scenario 2

What bedside **investigations** might you request for this patient?

Investigations

Bladder scan

Shows 600ml



Urine dip

Negative

Scenario 2

Impression?

Management plan?

Scenario 2

Impression

Urinary retention with overflow

Management

Catheterise and re-bladder scan afterwards

Record the post-void residual volume

Post-void residual volume: amount drained into the catheter bag after 15 minutes

Scenario 2

1. Why are we interested in the **post-voidal** volume?

2. What's a step in male catheterisation often **missed out** which can have dire consequences later?

Scenario 2

1. In case they later need to be referred to **TWOC clinic**

2. Rolling the foreskin forward after the catheter is in place so you don't cause a **paraphimosis**

You've been **bleeped:** Scenario 3

ATSP on gastro ward

65M admitted with flair up of Crohn's disease

Nurses say he is usually alert, however has now become delirious and is writhing in pain. He is unable to give any further history

Scenario 3

	HR 110	**107** 60
	RR 22	97% RA
	T° 37	

Scenario 3

	HR 110	**107** 60		**RR** 22	97% RA		**T°** 37

A **B** Airway patent, chest clear

C HS normal. CRT <2s, JVP not raised. Calves SNT. No pedal oedema

D GCS 14/15, confused. PEARL. BM 6

E Extremely tender to palpation. Guarding, rigidity. Absent bowel sounds

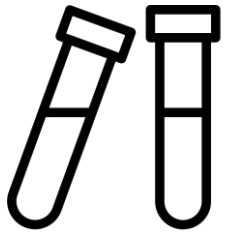
PR exam — Refused

Scenario 3

What **investigations** might you order for this patient?

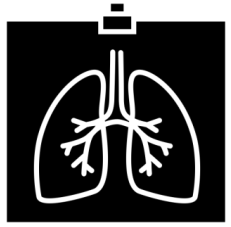
Scenario 3

Investigations



VBG

Lactate – 3.1



Erect CXR

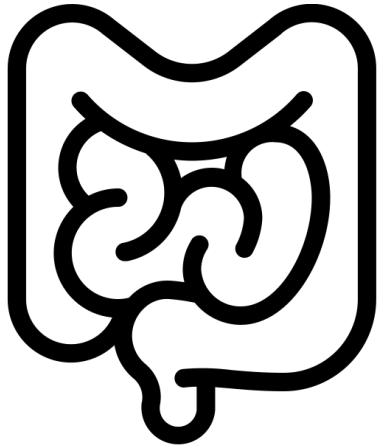
Gas under diaphragm
(Portable CXR if possible)

NB In reality, unlikely to be able to get an erect CXR in someone so unwell. In this instance go straight to CT AP

Scenario 3

Impression?

Impression



Perforated bowel with peritonic abdomen

Scenario 3

Management?

Management

- Ensure IV access for IV fluids
- Catheter and strict input/output monitoring
- Repeat set of bloods including G&S x2 and clotting
  X match – **NB** 1x G&S needs to be w/in last 72hrs
- Analgesia, IV Abx
  O2 – 2L (he's maintaining his sats)
  NBM – document to place an NG tube if he vomits
- Urgent surgical review. Bleep the oncall surgical SpR

You've been **bleeped:** Scenario 4

55M on surgical ward

Post-op – R hemi-colectomy 2 days ago for bowel cancer

The operation went well with no complications

However the nurse has just bleeped you because he's started vomiting

You've been **bleeped:** Scenario 4

On speaking to him he appears alert but distressed. Vomiting into a bowl for last few hours. No blood in vomit

He complains of colicky, griping abdominal discomfort and bloating

He says he has not opened his bowels in 2 days, and is not passing wind

Bladder normal

Scenario 4

HR	120
95	80
RR	97%
24	RA
T°	
36.6	

Scenario 4

HR 95 | 120 80 | RR 24 | 97% RA | T° 36.6

A Patent

B Chest clear

C Normal

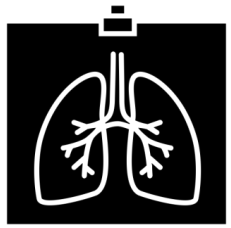
D Alert, PEARL

E Abdomen distended. Soft, not peritonitic. No hernias. Surgical site appears clean with good wound healing. Absent bowel sounds

Scenario 4

What **investigations** might you order for this patient?

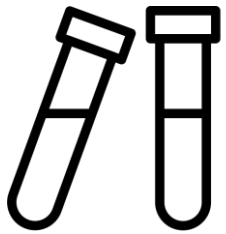
Investigations



AXR

Distended bowel loops of both large and small bowel. Look for valvulae conniventes/haustra

3, 6, 9 rule - small bowel, colon and caecum



VBG

Lactate and pH both normal

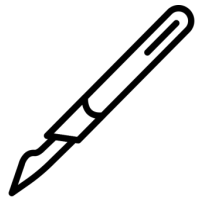
K – 3.3 (vomiting)

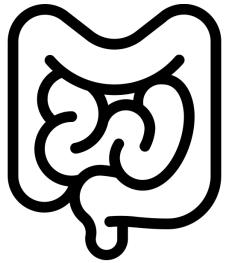
Send off repeat bloods

Scenario 4

Differentials?

Differentials





Post-operative ileus

Mechanical obstruction

volvulus, hernias, intussusception, foreign bodies, or neoplasms, post-op anastomotic leak, postoperative adhesions (adhesions less likely so early post-op)

Pseudo-obstruction

Scenario 4

Management?

Management

Senior review to rule out mechanical obstruction

'Drip and suck'
IV fluids – consider electrolyte replacement
NG tube – bowel can produce up to 9L/day of fluid

Catheter and strict input/output monitoring

Review meds which reduce motility e.g. opiates

Management

Consider electrolyte replacement e.g. if K on VBG is low. Electrolyte imbalances can prolong/contribute towards paralytic ileus

Bloods including refeeding bloods (renal profile, Mg, Ca, phosphate)

Explain to the patient that ‘the bowel has temporarily gone to sleep’ but that it will self-resolve
Physiological issue not structural

You've been **bleeped:** Scenario 5

27F with sudden onset, severe abdo pain

Was admitted 2/7 ago for gallstone cholecystitis and was initially responding well to treatment, however she's suddenly begun to feel very unwell and is in severe pain

PMHx

Nil

DHx

Co-amoxiclav
Paracetamol
Ibuprofen
Codeine
Buscopan

Scenario 5

HR	97	108 64
RR	22	97% RA
T°	37.6	

History

Patient describes the pain as in the epigastric region

Sharp, 8/10 severity and radiates through to back

This is a **new** pain and is **different** to the pain she was admitted with

Accompanied by nausea and vomiting – no blood in the vomit, just bile

Bowels and bladder normal. BLO 1/7 ago, normal consistency

No chest pain, no SOB

Scenario 5

HR	108	RR	97%	T°
97	64	22	RA	37.6

General appearance: patient appears very sweaty, slightly breathless and distressed

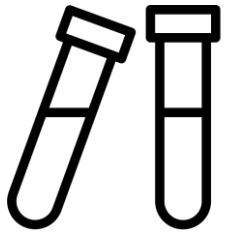
A **B** Airway patent, chest clear

C HS normal. CRT <2s. Calves SNT

D GCS 15. PEARL

E Tender +++ in the epigastric region
Voluntary guarding, however abdomen otherwise soft and not peritonitic. Bowel sounds quiet

Investigations



From yesterday:

Bloods

Raised **CRP** and **WBC**

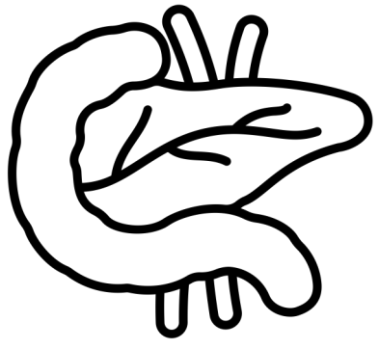
Raised **Alk Phos**

Scenario 5

Impression?

Scenario 5

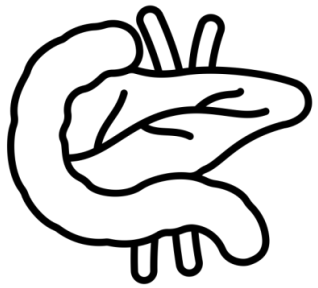
Impression



Gallstone pancreatitis

How do you **confirm**?

Impression



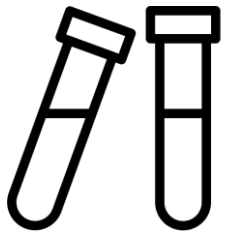
Gallstone pancreatitis

Send off a fresh set of bloods including **amylase**. Send it as urgent (result w/in 1hr)

Looking for >300 or >400

Can also send off urinary amylase, which is raised for 2/52 post-acute pancreatitis (serum amylase peaks at 12-72 hours)

Investigations



From yesterday:

Bloods

Raised **CRP** and **WBC**

Raised **Alk Phos**

From today:

Bloods

Amylase 421

How do you **manage** this patient?

Management

Oxygen

Increase the frequency of observations

IV fluids - need to watch carefully for shock

Catheter and strict input/output monitoring

Management

Analgesia - don't be stingy, give opiates. Anti-emetic

NBM and NG tube - why? Because ileus is common. This patient is throwing up suggestive of ileus

NB If vomiting is controlled with anti-emetics then no need for NBM and encourage early feeding which can speed recovery

MRCP if there is obstructive picture in LFTs to raise suspicion for choledocholithiasis. If this is the case then they would need an urgent ERCP to prevent life threatening septic shock from ascending cholangitis

Scenario 5

1. What is the **Glasgow-Imrie** score?

2. How is it **calculated**?

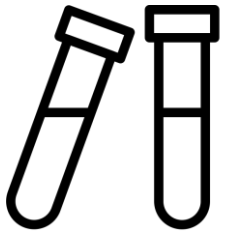
3. What **purpose** does it serve?

Scenario 5

Glasgow-Imrie score

A predictor of severity in pancreatitis

Look it up on MDCalc



- **WBC**
- **LDH**
- **Albumin, urea, AST, calcium**

Score of 3 or more means consideration for ITU admission

ABG – **PaO_2** and (fasting) **glucose**

Age >55

Scenario 5

How should the patient be **monitored** over the next few days?

Key indicators of **progress/decline** are:

- CRP trend
- Repeat Glasgow score
- General, clinical assessment i.e. EWS/haemodynamic stability, pain, urine output etc
- Amylase can be repeated in cases of clinical deterioration
- CT scan is not usually done on initial onset, unless there is no diagnosis. However after 72 hrs it can be useful to prove oedema, necrosis or collections. A CT scan may be indicated by e.g. rising CRP trend and worsening pain.

Scenario 5

Are **antibiotics** needed for acute pancreatitis?

(Let's forget for the moment that this patient is on IV Abx anyway for cholecystitis)

Scenario 5

Not usually, only if **necrotic cysts** develop on the pancreas and the patient becomes **septic** from it.

However this is sometimes an area of disagreement between medics and surgeons.

Escalation of an unwell surgical patient

- CCOT team for support
- Your own surgical SpR — *Consider putting on scrubs to go into theatre to discuss if very concerned*
- On-call surgical SpR — *If your own is unavailable*
- ITU SpR — *Usually a SpR to SpR referral but they will sometimes take referrals from FY1s/SHOs depending on the circumstances*

NB *Make sure you know all the details of the patient before discussing*

Feedback

Icon artist credit

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