Acute Abdomen

REFRESHER

RECOGNIZE IT

- Sudden, severe abdominal pain requiring immediate medical attention
- Visceral pain: dull, deep-seated, vaguely localized; organs sense tension, spasm, and ischemia — not touch or heat
- Parietal (somatic) pain: sharp and well localized; irritation causes guarding and skin hyperaesthesia
- Signs: McBurney's tenderness (appendicitis), Grey-Turner's flank bruising, Cullen's umbilical bruising

ASSESS

- History: where is the pain, bowel movements and their color, nausea/vomiting and vomit color, urinary problems, events leading up, last ate
- Referred, radiating, or shifting pain? Anything like this before? Past abdominal surgeries, medications, medical history
- Exam: distention, surgical scars, asymmetry, skin discoloration, palpate for rigidity and pain, guarding
- Ask yourself: is the patient critically ill? Do symptoms fit a known disease pattern? Risk factors — age, drug use, pain medications?

ACT — FIRST MOVES

1. Support ABCs
2. Pain management
3. Patient comfort positioning

PEARLS

- Differential spans systems: inflammation (appendicitis, cholecystitis, diverticulitis, peritonitis, IBD), perforation (peptic ulcer), ischemia (mesenteric), obstruction (biliary/ureteric colic, urinary retention)
- Don't anchor on GI/GU: also MI/ischemia, gastritis, hepatitis, UTI, pyelonephritis, metabolic causes, and gynecological causes (ectopic pregnancy, ovarian cyst, PID, endometriosis)
- Central diaphragmatic irritation refers pain to the shoulder; peripheral irritation causes local tenderness and rigidity

Take Home Message:

Work the acute abdomen with a thorough history and exam, keep the differential wide across systems, support ABCs, and treat pain.