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# Management of Acute Abdominal Pain



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Acute abdominal pain is the most common presenting complaint in patients with surgical disease of abdomen. Occasionally, it is necessary to act upon the acute nature of a “Surgical Abdomen” without an exact diagnosis. Failure to intervene invites the mortality of delay, whereas a differential diagnosis of likely abdominal pain causes based on a carefully performed history and physical examination will lead to diagnosis. Generally, analgesics should be withheld while evaluating a patient with abdominal pain

Ascertaining the cause of acute abdominal pain is similar to solving a puzzle. Pieces of data (history and physical examination, laboratory and radiological evaluation) are assembled so that a reasonable picture of problem results. Solutions do not require all the pieces of puzzle in all circumstances to arrive at a reasonably correct diagnosis. After gathering the data from history and physical examination as given below, the treating physician needs to be selective about the relevant investigations as outlined later in these guide lines to make diagnosis fairly accurately



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**Age/ Sex:**

**Vitals:** Pulse:    /min.    RR:    /min.

BP :    mm.    Tem.



# History

- ❖ Onset -sudden or insidious
- ❖ Site
- ❖ Duration
- ❖ Type of pain (1) Colicky, (2) Continuous
- ❖ Severity
- ❖ Referred to / Radiation
- ❖ Aggravating factors - coughing
- ❖ Relieving factors
- ❖ Vomiting, frequency, nature of vomitus bilious/  
nonbilious/feculent.



## Drugs steroids, NSAID, Thiazide diuretics

- ❖ Alcohol intake.
- ❖ Drug taken to reduce pain (before presentation)
- ❖ Previous medical history of pain
  - HT/DM/TB/CAD/Abdominal Operation
  - Similar episodes of pain.
  - Menstrual history & vaginal discharge in females
  - LMP date

## Observation

- ❖ Position (1) restless (rolling around), (2) Lying motionless, (3) Sitting (Fetal position).
- ❖ Appearance.
- ❖ Dehydration (dryness of tongue / mucosa)
- ❖ Pallor

## Inspection of Abdomen

- ❖ Shape of abdomen- distended (diffuse/Asymmetric) or scaphoid
- ❖ Visible scar – number & location
- ❖ Movement with respiration – restricted (local or diffuse)/Normal.
- ❖ Hernial sites – Inguinal, femoral & Umbilical



❖ Auscultation

- Bowel sounds , to be listened with a warm stethoscope.
- Absent only if not audible after listening for 2 minutes in all 4 quadrants .
- High pitched ,hyperactive or tinkling
- Bruit in Epigastrium

❖ Percussion

- Liver dullness- absent/ present
- -Note : Tympanitic/ Dull
- Shifting dullness: Present/ Absent





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❖ Palpation : (in the end with warm hands)

Begin in an area remote from the site of pain and last of all palpate the painful area.

Gentle light touch palpation to be done first to delineate the area of maximum tenderness / rigidity.

- Rigidity: present / absent

If present, whether localized or generalized

Differentiate between voluntary guarding & involuntary rigidity by engaging the patient into conversation to divert his attention while palpating, also relax abdomen muscles by flexing the knees & the hips.

- Look for rebound tenderness and its site- diffuse / localised .

Deep palpation to be done last only if indicated after excluding diffuse peritonitis by physical signs.



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❖ Ancillary Findings

Murphy's signs, Rovsign's sign, psoas sign, obturator sign & Kehr's sign in relevant situations

Murphy's sign - Cholecystitis

Rovsign sign - Appendicitis

Psoas sign - Retrocecal appendicitis,  
perinephric abscess,

retroperitoneal hematoma

Obturator sign - Pelvic abscess, pelvic appendicitis,  
salpingitis

Kehr's sign - Splenic injury, subdiaphragmatic  
collection



# Pelvic & Rectal examination

## **In males – Pelvic**

Ext genitalia – Testicular torsion, tumour, epididymitis obstructed hernia (groin).

## **In females – Pelvic examination**

to be done by Gynaecologist if pain is in lower abdomen with /without vaginal discharge (gynae referral by concerned specialist surgeon if necessary).

Rectal Examination for both sexes in cases suspected obstruction, Peritonitis, appendicitis & PID & lower abdomen pain (Cystitis, prostatitis).



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In Rectal Examination look for :-

- a) Anal tone.
- b) Presence of faeces /blood.
- c) Ballooning of rectum.
- d) Tenderness & site.
- e) Fullness / Mass in pouch of Douglas
- f) Intraluminal mass / ulcer if present site, size , consistency, mobility (local), upperlimit & level of lower limit from anal verge.
- g) Prostate examination size surface & tenderness.
- h) Cervical tenderness.



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## **Lab. Investigation :**

- Urine Analysis
- R/E & M/E
  - Urine Pregnancy test –female patients with suspected appendicitis, PID, Ectopic Pregnancy and prior to radiological investigations of abdomen in reproductive age- group
    - Blood Hb, TLC, DLC,
  - Amylase, Lipase (If pancreatitis is suspected.)
  - BS in diabetic patient.
  - Serum Electrolytes in case of obstruction, peritonitis, gastroenteritis with dehydration
  - Blood Urea & Serum Creatinine –whenever necessary
  - LFT if indicated
  - Blood grouping & cross matching.( if need for transfusion is anticipated)



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**(Exclude pregnancy prior to radiation exposure for Radiological evaluation).**

- X-ray – Abdomen – Erect & Supine in suspected peritonitis & obstruction.
- X-ray Chest – upright PA view – perforations.
- Ultrasound – Cholecystitis (Upper)
  - Urinary calculi – whole
  - Appendicitis – Lower
  - PID – Lower
  - ? Pancreatitis.





- SpiralCECT
  - UGI Studies
  - Ba Enema
  - Radionuclide studies (HIDA)
  - Angiography treating

In specific conditions on recommendation of the surgeon.

- Diagnostic Lap.
  - Female with right lower abdomen pain.
  - When investigations are inconclusive and there is no improvement on conservative management.





# Initial Treatment

1. NPO
2. Intracath insertion for IV access
3. Analgesia : Anti spasmodic for colicky pain - Inj. Buscopan 1ml amp.(20mgm.) i.v  
  
Non Narcotic analgesics for non colicky pain  
  
-Inj. Diclofenac Sodium  
3ml.(75 mgm.) i.m
4. Antiemetic in cases of gastritis or gastroenteritis – Inj Emeset 4mg I.V.
5. IV Fluids start with Ringers lactate solution
6. Nasogastric tube to be put in suspected obstruction/ peritonitis.
7. Antibiotics in inflammatory/ infective conditions as per antibiotic guidelines
8. Urinary catheterization in selected situations.



**Thank You**