
بسم الله الرحمن الرحيم

ACUTE ABDOMEN

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SENIOR REGISTRAR GS
SU1 HFH

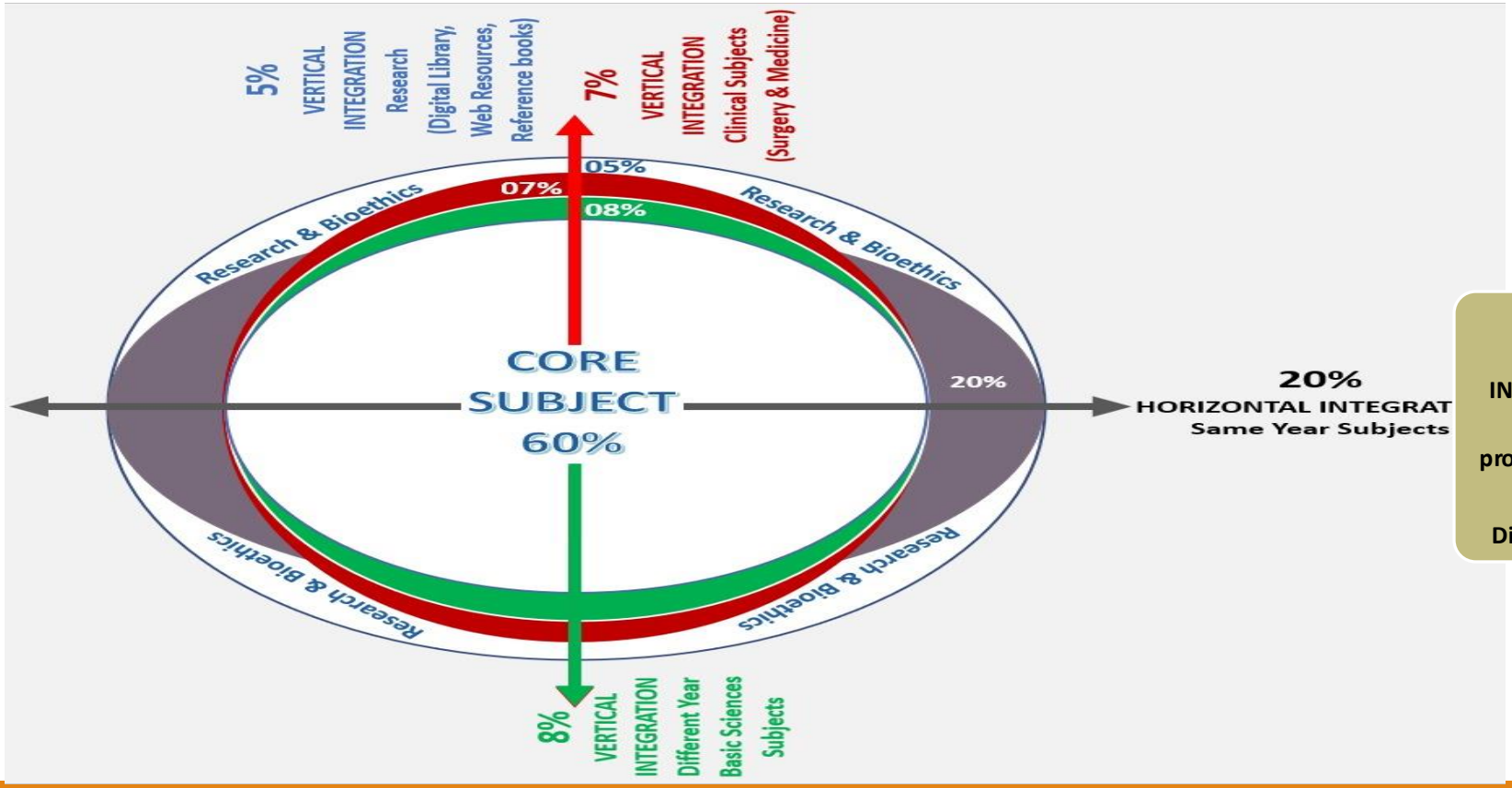
Mission Statement of RMU

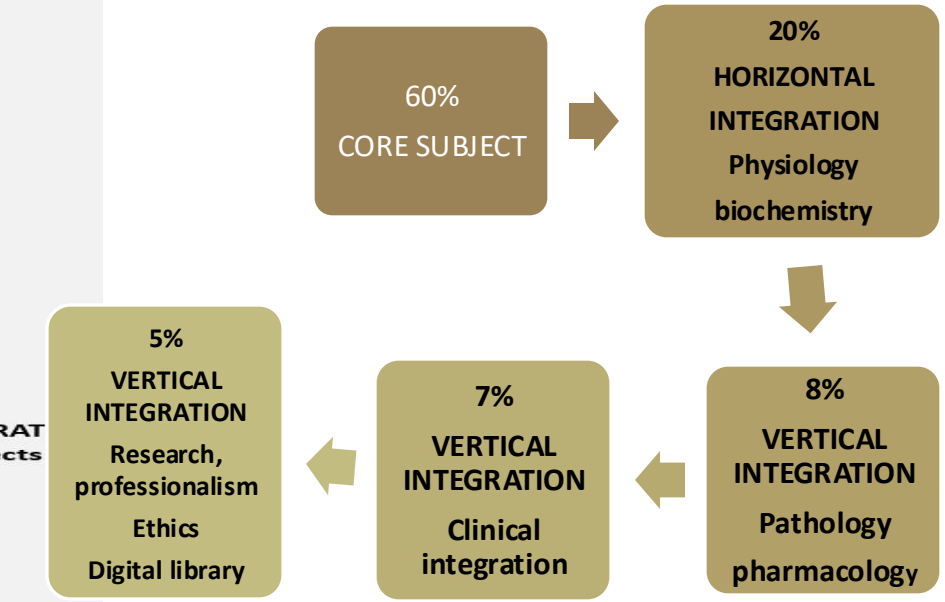
To impart evidence based research oriented medical education

To provide best possible patient care

To inculcate the values of mutual respect and ethical practice of medicine

Professor Umar Model of Integrated Lecture





Learning Objectives

At the end of the lecture, you will be able to:

1. **clinical presentations of acute abdomen**
2. **How to approach A PATIENT WITH SURGICAL ABDOMEN**
3. **Differential diagnosis of acute abdomen**
4. **Management of surgical acute abdomen**

CASE SCENARIO

40 years old male presented to surgical ER with history of **abdominal pain** for last 12 hours.

Initially pain started in epigastrium and then became generalized.

It is associated with 2 episodes of vomiting

There is also history of dyspepsia for last 5 years.

There is no history of fever, cough, altered bowel habits , melena or weight loss

Patient is known smoker for last 20 years

On examination :

Middle aged male lying in distress well oriented in time place and person with vitals of

Pulse 120/min R.R : 24/min

BP : 120/70 Temp: A/F

Abdomen : Tense, generalized tender with absent bowel sounds.

No visceromegaly

Chest: B/L clear

CVS: S1+S2+0

INVESTIGATIONS

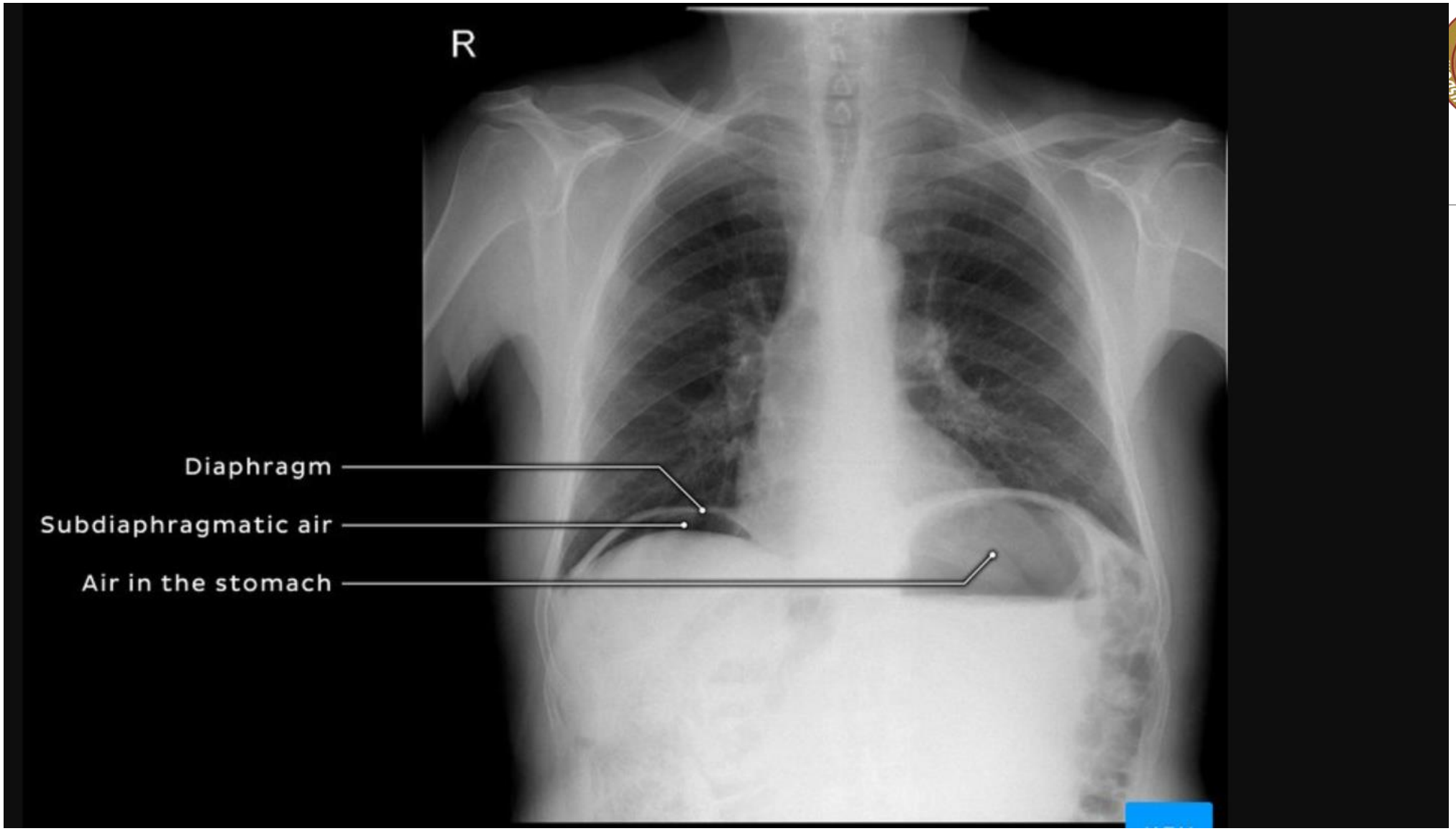
CBC:

TLC 18.0 x 10^3/uL

Hb: 11.3 g/dL

Plts : 225 x 10^3/ uL

RFTs, LFTs, S/E , CLOTTING PROFILE: within normal limits


R
Diaphragm
Subdiaphragmatic air
Air in the stomach

USG Abdomen and pelvis

Minimal amount of free fluid in abdomen and pelvis

What are the differential diagnosis?

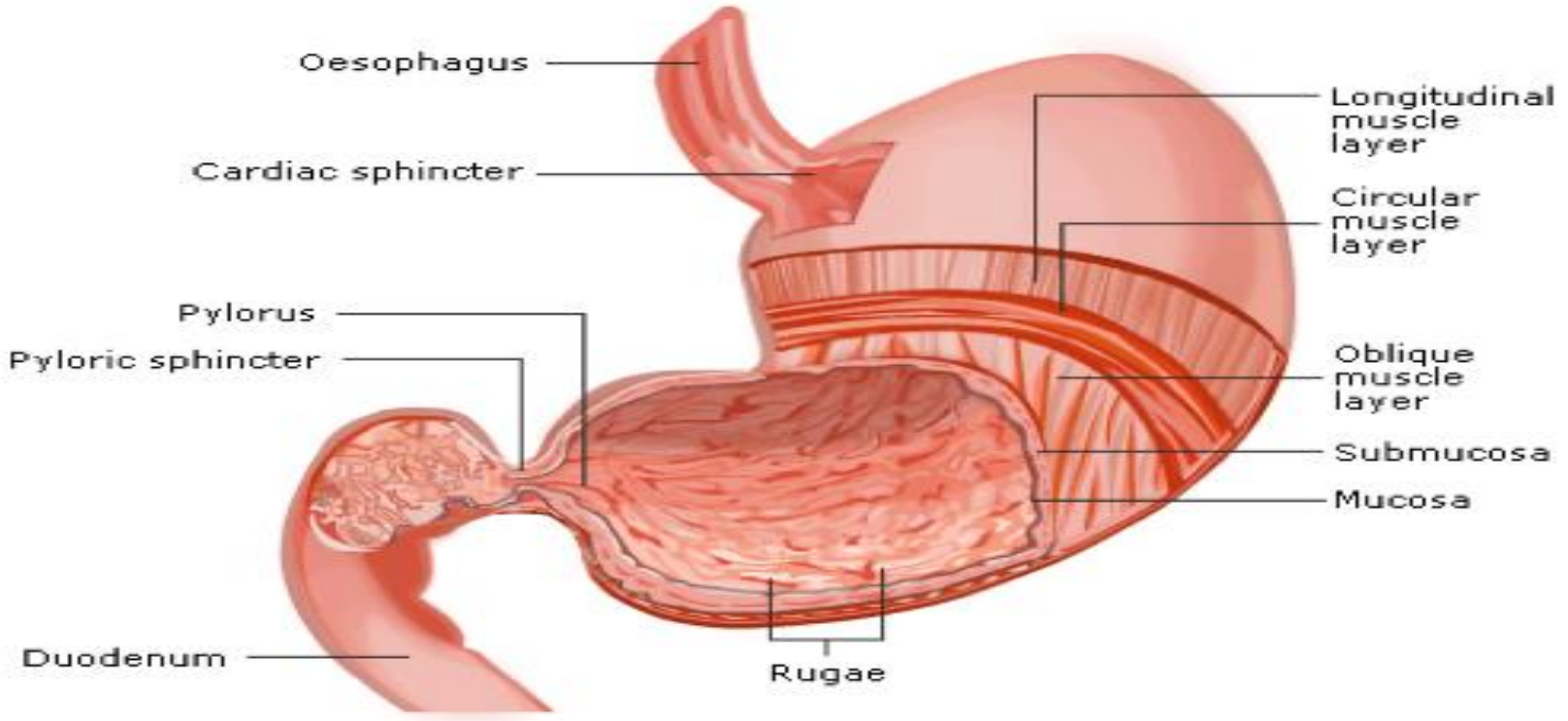
DIFFERENTIAL DIAGNOSIS:

1. PERFORATED PEPTIC ULCER
2. TYPHOID PERFORATION
3. TUBERCULOUS PERFORATION

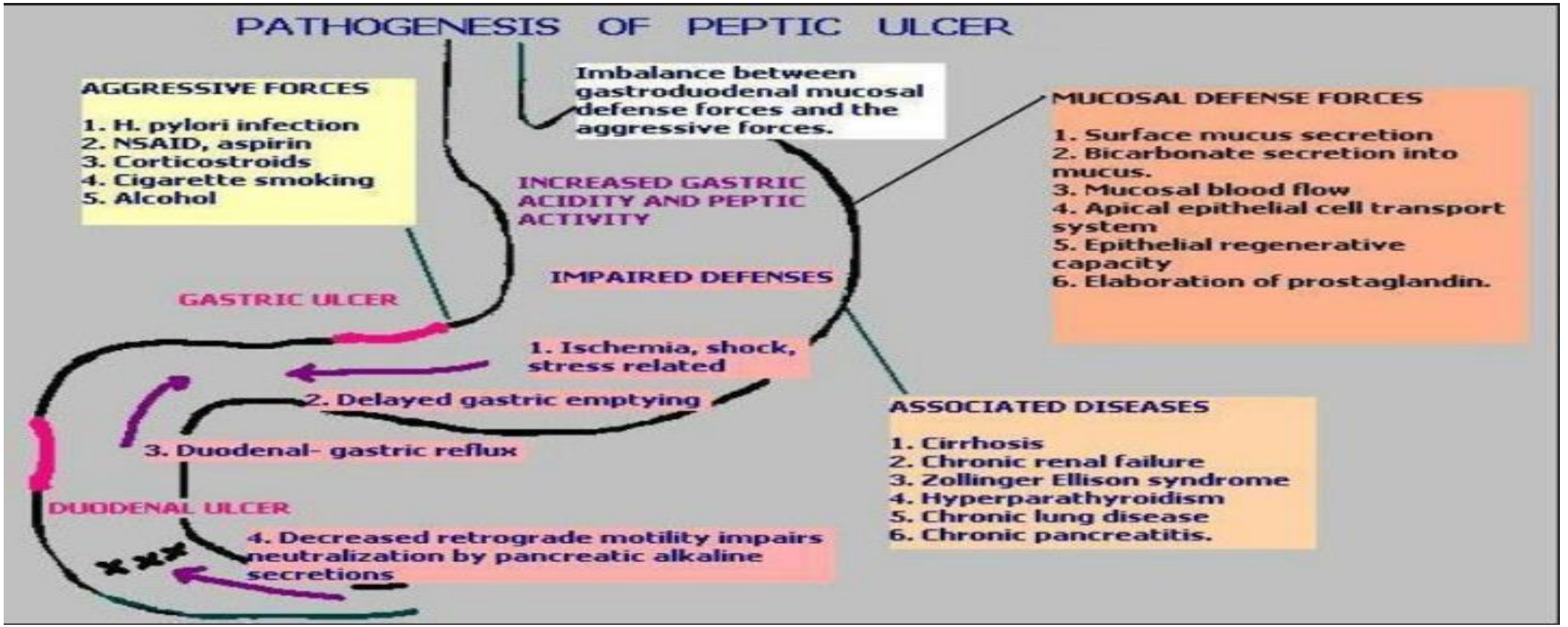
Clinical features:

1. **Abdomen doesn't move with respiration**
2. The patient with history of peptic ulceration develops **sudden severe generalized abdominal pain.**
3. May present with pain epigastrium and right iliac fossa
4. Tachycardia and shock
5. Pyrexia
6. **Board- like rigidity**

Surgical anatomy:



PATHOPHYSIOLOGY



RISK FACTORS

Lifestyle

smoking, acidic drinks, medication

H.pylori infection

90% have this infection, passed from fecal-oral route

Age

duodenal 30-50

gastric above 60

Gender → increasing in older women

Genetic factors

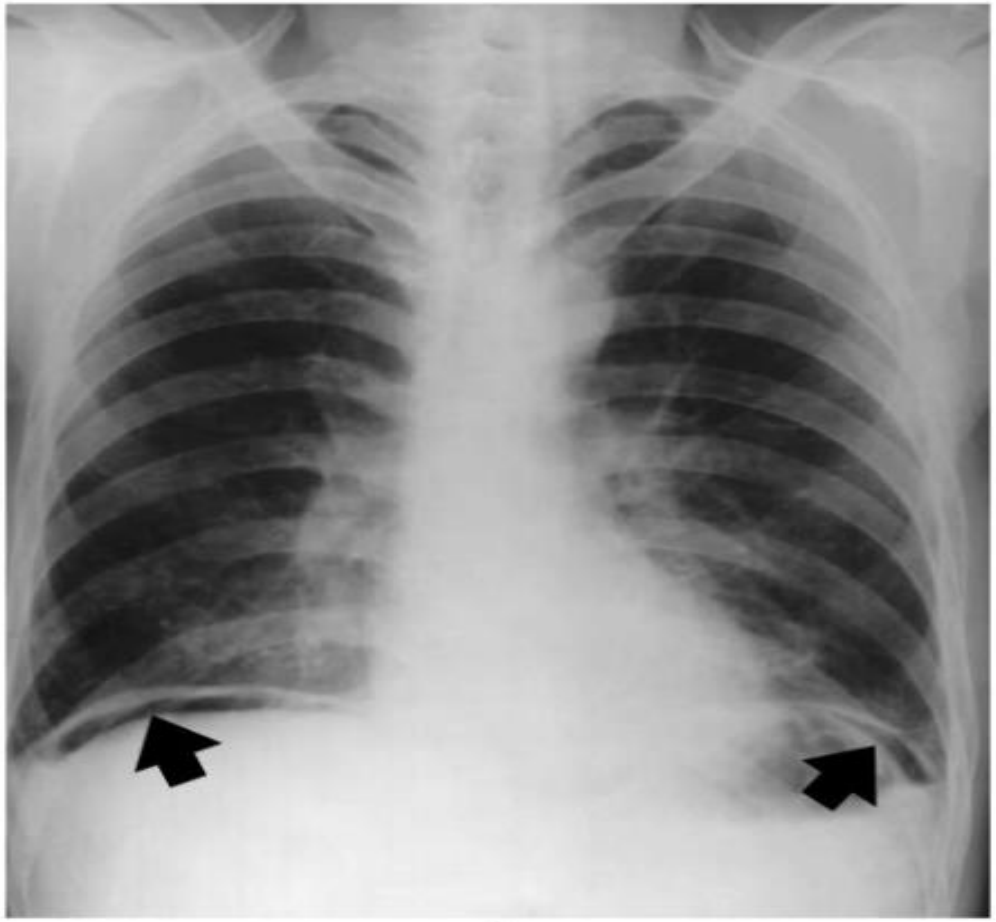
Others e.g stress

INVESTIGATIONS

CXR

CT ABDOMEN AND PELVIS

SERUM AMYLASE



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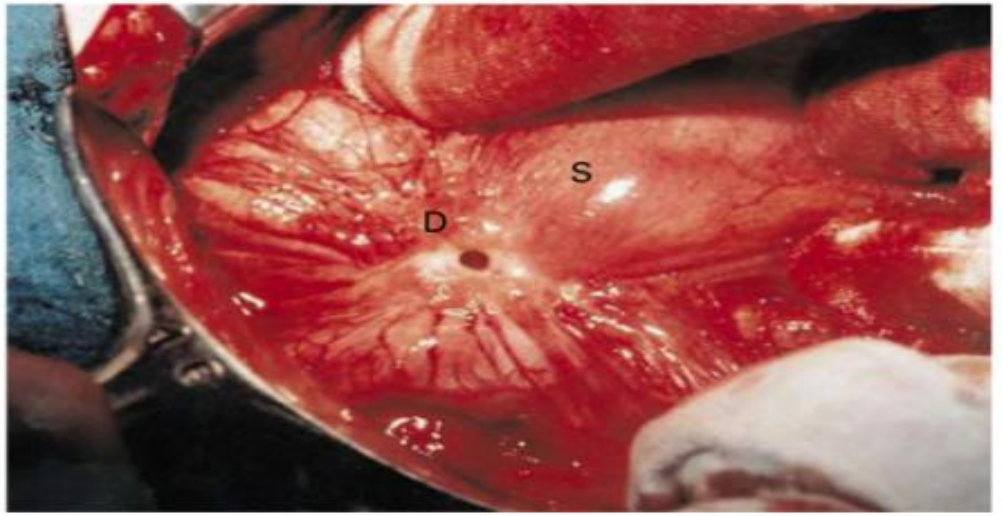

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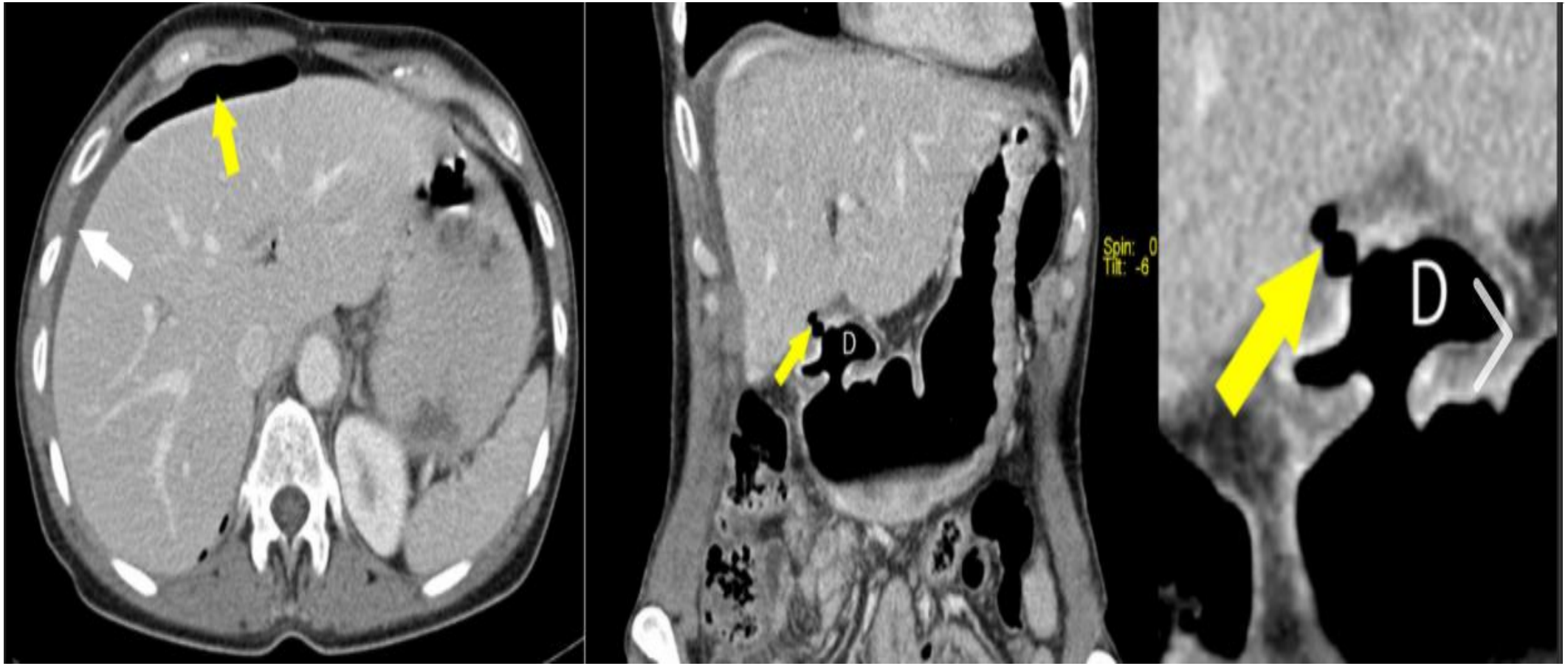

D
Spin: 0
Tilt: -6
D

MANAGEMENT

Initial resuscitation with I/V fluids

CVP line for monitoring

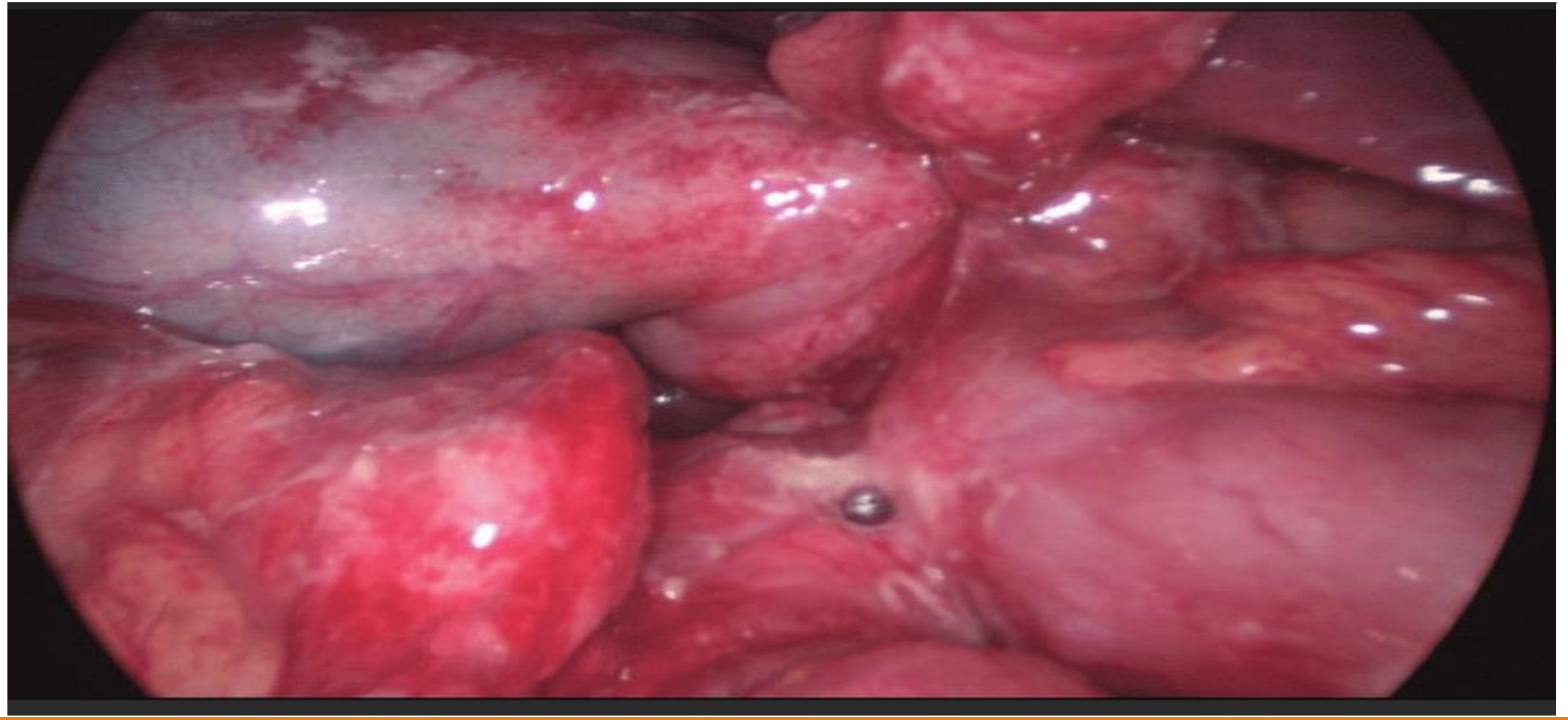
Folleys catheterization for urine output monitoring.

Oxygen via mask

Analgesics

Nasogastric intubation

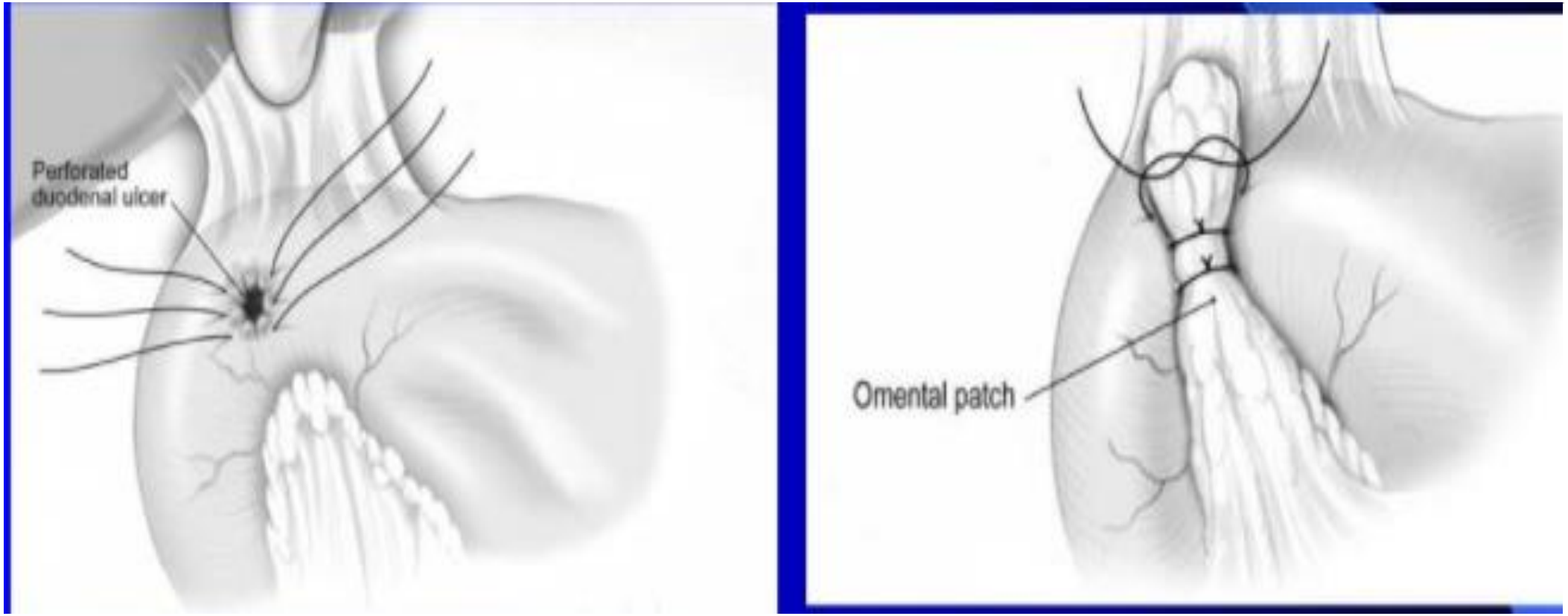
Antibiotics



MANAGEMENT

An operative approach (closure of the perforation and peritoneal lavage) is strongly recommended .

Followed by H. pylori eradication therapy and endoscopy in case of gastric perforation.


Perforated
duodenal ulcer
Omental patch

RECENT ADVANCES

1. Fda has approved glycopyrrolate orally disintegrating tablets for peptic ulcer treatment
2. Endoscopic treatment of perforated peptic ulcer

TAKE HOME MESSAGE

duodenal > stomach

H.pylori is a major risk factor and requires treatment

In perforation :

Non-operative therapy appropriate for selected patients

Open surgery if unstable

Laparoscopic surgery if stable

Avoid smoking, NSAIDS AND JUNK FOOD


Thank
you!