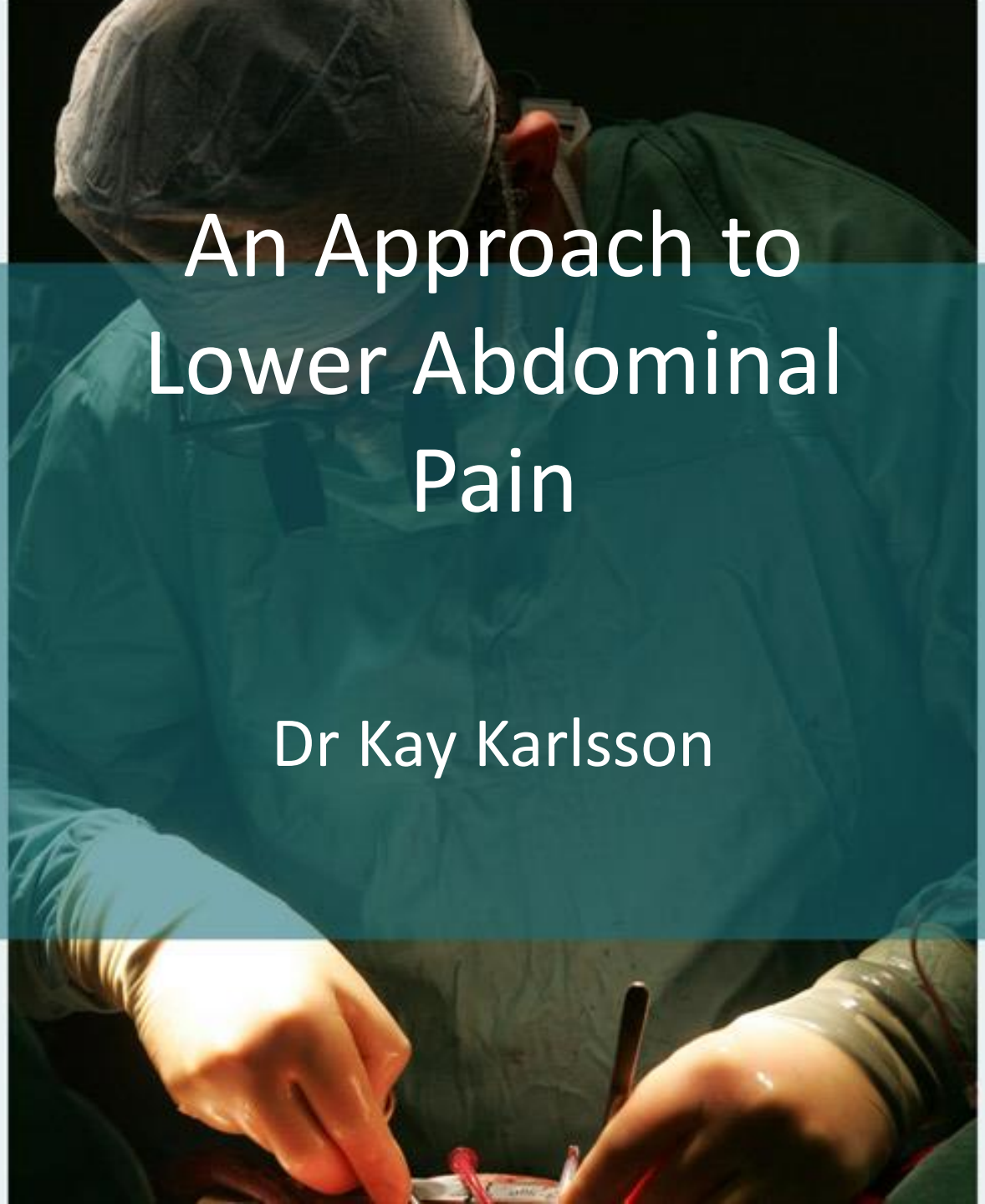

# An Approach to Lower Abdominal Pain

Dr Kay Karlsson

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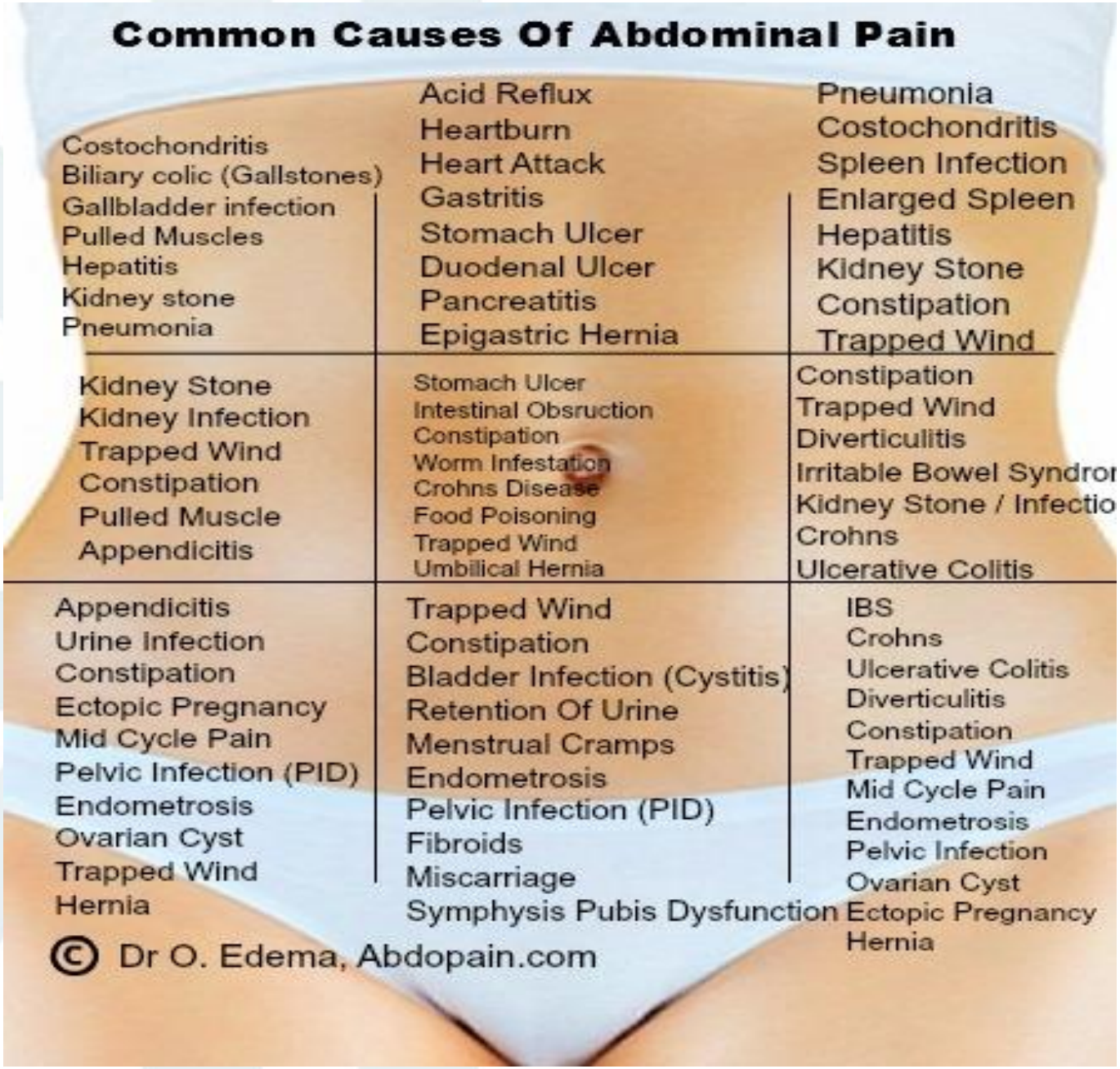
- Causes of abdominal pain
- Commonest causes
- My approach

- A few unusual cases

- Diverticulitis and current management


Common Causes Of Abdominal Pain
Costochondritis
Biliary colic (Gallstones)
Gallbladder infection
Pulled Muscles
Hepatitis
Kidney stone
Pneumonia
Acid Reflux
Heartburn
Heart Attack
Gastritis
Stomach Ulcer
Duodenal Ulcer
Pancreatitis
Epigastric Hernia
Pneumonia
Costochondritis
Spleen Infection
Enlarged Spleen
Hepatitis
Kidney Stone
Constipation
Trapped Wind
Kidney Stone
Kidney Infection
Trapped Wind
Constipation
Pulled Muscle
Appendicitis
Stomach Ulcer
Intestinal Obsruction
Constipation
Worm Infestation
Crohns Disease
Food Poisoning
Trapped Wind
Umbilical Hernia
Constipation
Trapped Wind
Diverticulitis
Irritable Bowel Syndror
Kidney Stone / Infectio
Crohns
Ulcerative Colitis
Appendicitis
Urine Infection
Constipation
Ectopic Pregnancy
Mid Cycle Pain
Pelvic Infection (PID)
Endometrosis
Ovarian Cyst
Trapped Wind
Hernia
Trapped Wind
Constipation
Bladder Infection (Cystitis)
Retention Of Urine
Menstrual Cramps
Endometrosis
Pelvic Infection (PID)
Fibroids
Miscarriage
Symphysis Pubis Dysfunction
IBS
Crohns
Ulcerative Colitis
Diverticulitis
Constipation
Trapped Wind
Mid Cycle Pain
Endometrosis
Pelvic Infection
Ovarian Cyst
Ectopic Pregnancy
Hernia
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# Most Common Causes

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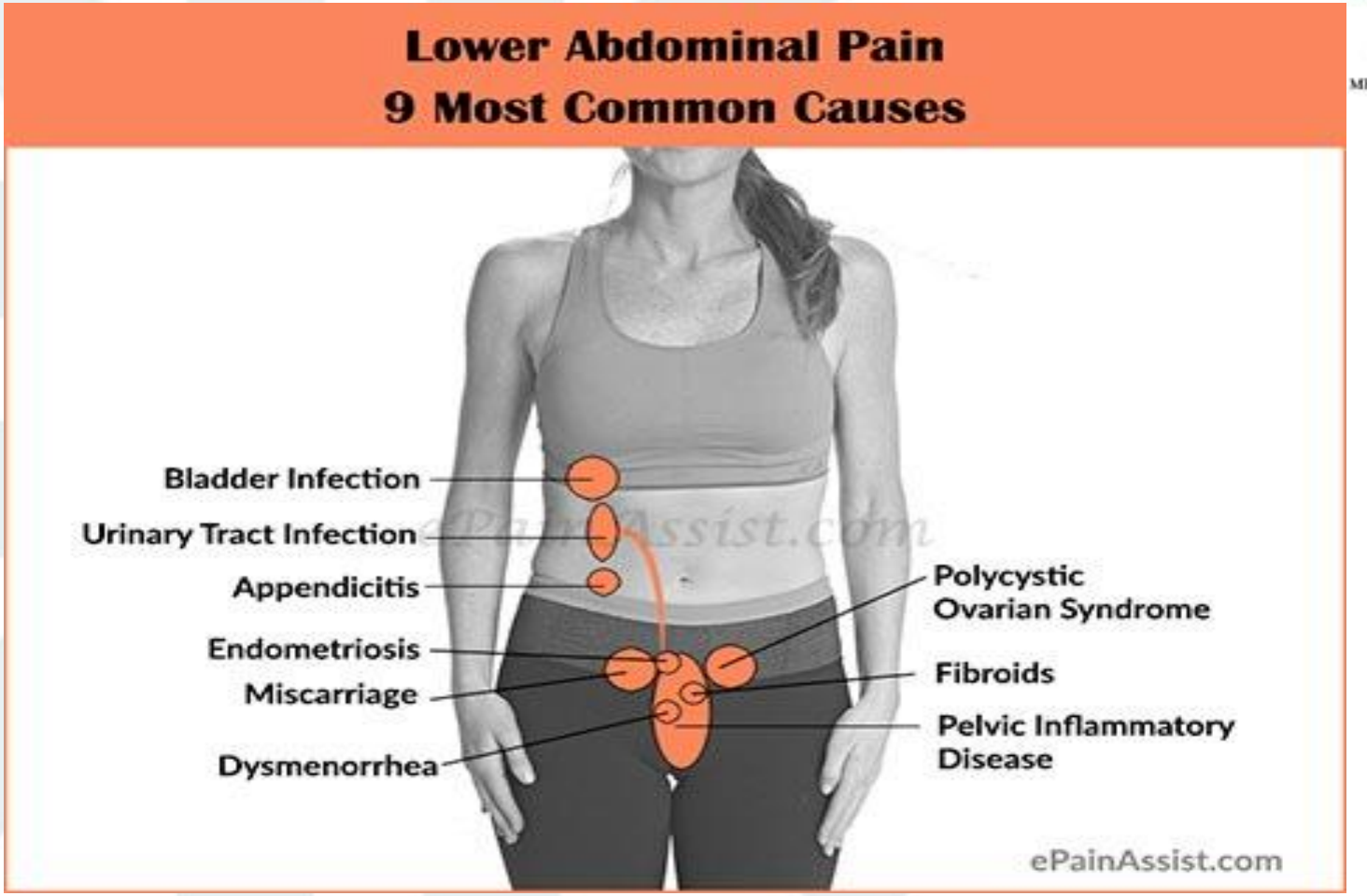

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# My Approach

# History of pain

- Frequency and duration
- Character of the pain
- Relation to menses
- Site and radiation
- Aggravating or relieving factors

- Past history of similar pain

# Further History

- Associated change in bowel habits
- Weight loss
- Bleeding
- Jaundice
- Family history (porphyria, Familial mediteranean fever, sickle cell disease, diabetes)

# Examination

- General –temp, pulse rate, palor

- Inspection
- Palpation
- Auscultation

- Do not forget….hernial orifices, PR, spine
- Urine dipstick

# Investigations

- ????
- FBC, ESR, CRP, U&E, glucose
- Abdo and pelvic U/S
- AXR

- CT abdo/scopes/MRI

# Mrs ST

- 27 year old female
- No past history of note.
- April 2017 presented to GP RIF pain and pus per rectum

# What would you do as the GP?

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1. Treat empirically…if so with what and for what?

2. Do further tests…if so which tests?

3 Refer on…if so to whom and explain why?

4 Other?

# What I would Have Done

- FBC, CRP
- Urine dipstick
- U/S abdo and pelvis
- Considered colonoscopy

# What was actually done

- Augmentin

- Referred to gynae
- Vaginal ultrasound

- Prescribed anti-inflammatories

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# What happened

- Pain settled
- Pus continued
- Stool sample sent for M,C &S

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- Was the stool test necessary?
- How would it change management?

# What next?

- Stool showed blood
- Started to lose weight
- Referred to general surgeon for colonoscopy

# Colonoscopy result

- “Colitis”
- Biopsies from transverse, descending, sigmoid colon and rectum.
- ? Right colon ? TI
- “Mild non specific chronic colitis”
- Normal architecture, no crypt abscesses, no intraepithelial lymphocytes
- Mild increase in chronic inflammatory cells

# Progress

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- Commenced on pentasa suppositories
- Comments

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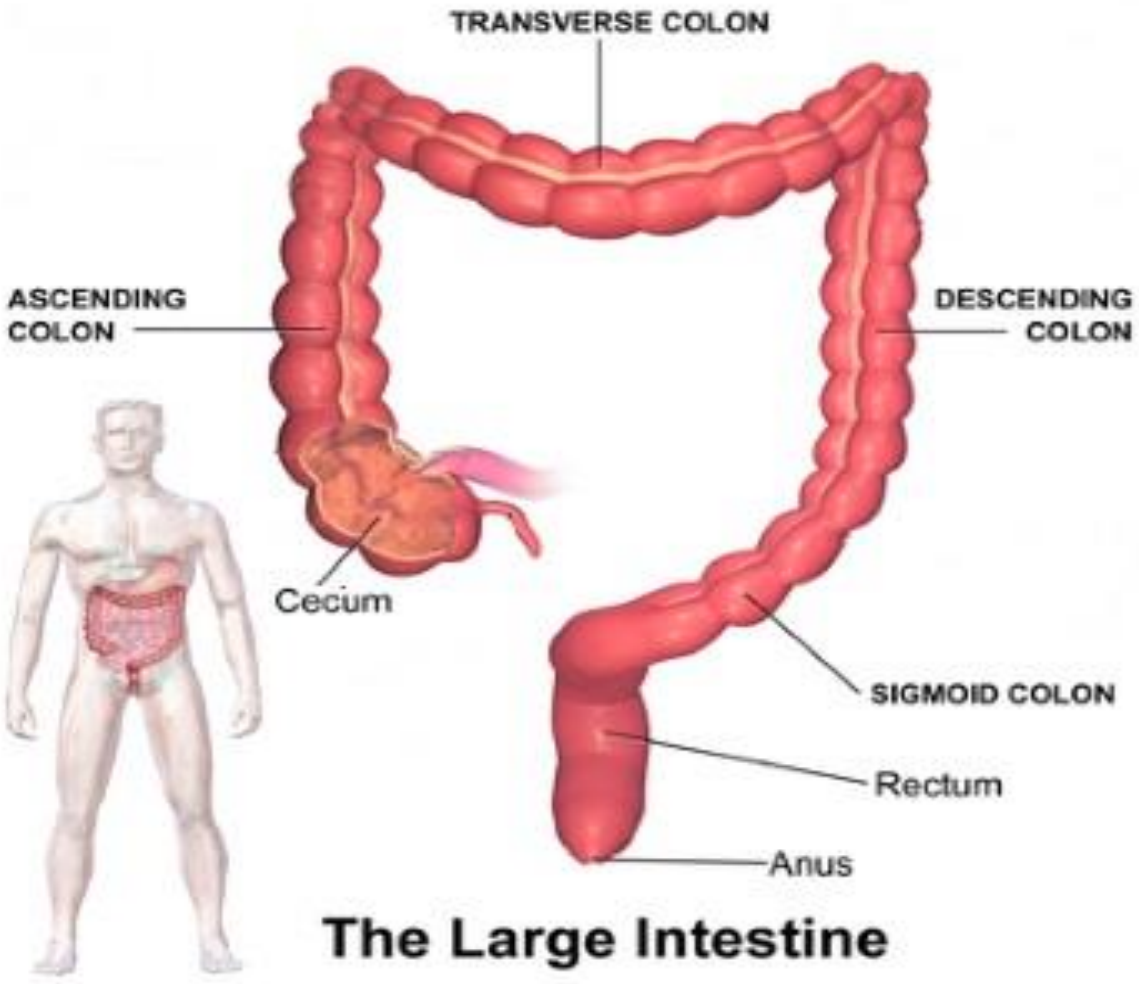


The Large Intestine

# Colitis Therapy

- Rectum suppositories
- L sided disease enemas
- Beyond splenic flexure oral medication

- THEN
- Middle May, worsening anal symptoms and underwent anal fistula repair
- Anal discharge ceased

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# Thoughts and suggestions

# Progress continued

- Then developed upper abdominal pain
- Nexium, UTI diagnosed on dipstick and prescribed urizone
- 5 days later seen in casualty with severe epigastric pain. Again told UTI, added buscopan and perfalgon
- 2days later still had severe upper abdominal pain. Saw GP…told UTI prescribed Zanor.
- Referred to clinical psychologist

- Saw psychologist the next day
- Not a psychological issue
- GP 3 days later, given librax and bevispas

- Passed no stool for 7days.
- By now lost 10kg in weight

- Presented to casualty with acute obstruction requiring emergency surgery

# At Surgery

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- Obstructed small bowel with mass in TI
- TI and caecal resection with primary anastomosis.
- Breakdown of anastomosis, intra-abdominal sepsis requiring further surgery

- Ileostomy and ascending colon stapled.

- Discharged early August ( 3months after admission)
- 6 days later vaginal discharge treated for thrush
- Sought second opinion
- Remained unwell
- 30mg prednisone ? why
- Electrolyte disturbances, elevated inflammatory markers, draining sinus on abdomen

# MRI

- Pelvic collection, fistula into vagina
- Fistula between small bowel loops
- Sinus tract confirmed, not communicating with bowel
- Perianal fistula with small collection

- Drainage of collections, fistula laid open and seton inserted

# Outcome

- December 2017 sepsis controlled
- Commenced on immunosuppression and subsequently biologics

- November 2018  ileostomy reversed

- January 2019 recovered from surgery and wanting to start a family

# Learning points

- If patient keeps coming back think and look again

- Not all white cells in urine = UTI
- If recurrent look for other causes

- Just because you have referred to a specialist it doesn't mean the specialist is right.

# Leucocytes in the Urine

- Inflammation in urinary tract, interstitial cystitis etc
- Pelvic & intra-abdominal infections/inflam
- Radiation cystitis
- Urinary fistula
- Intrinsic renal disease
- TB
- Auto-immune diseases
- Drugs (diuretics, NSAIDS, olsalazine, antibiotics)

# Other Learning Points

- Anyone with “colitis” and perianal disease should be investigated for crohns

- Basic bloods can assist with diagnosis

# Mrs C W

- 37 year old lady
- 4 month history of episodes of severe abdominal pain associated with elevated WCC and CRP
- G and C scope, CT, MRI
- Labelled WC scan – increased uptake in R colon

# On review

- Also complained of fevers, joint pains

- Smoker
- obese

- Microcytosis on FBC
- ↑ GGT

# Further investigations

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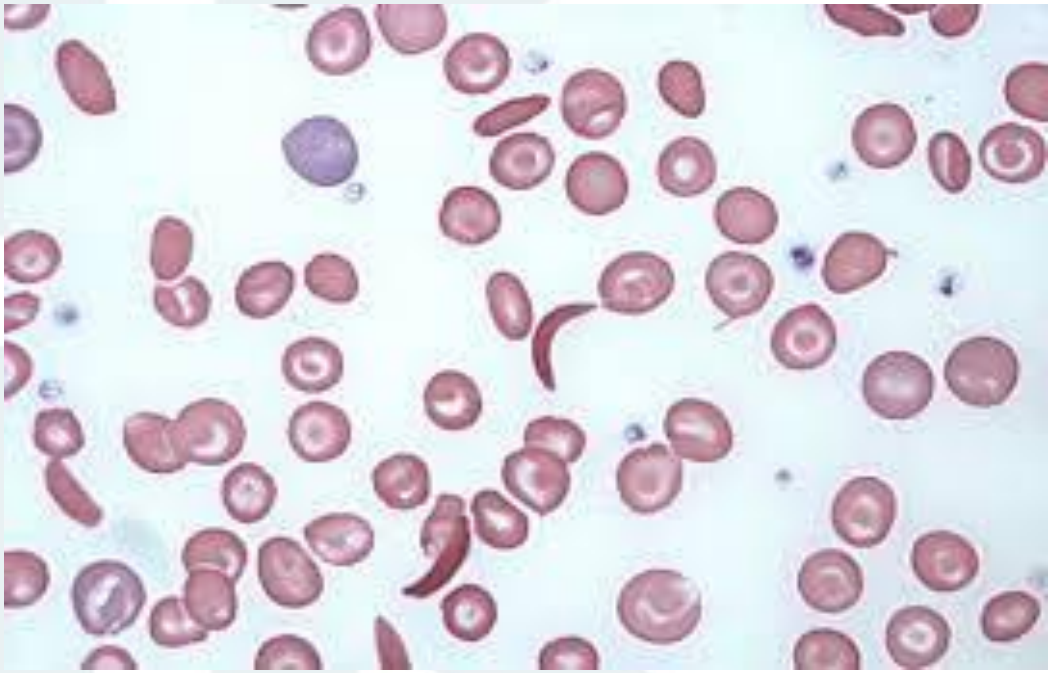
- Repeated G and C scope
- FBC and film
- Iron study

# Blood Film



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# Blood Film

- Microcytosis
- Sickle cells
- Iron studies normal

# Causes of microcytosis

- Iron deficiency
- Anaemia of chronic disorder

- Thalassaemia

- Sideroblastic anaemia
- Lead poisoning
- Copper deficiency

# Diagnosis

- Combined sickle cell disease and thalaesaemia trait
- Episodes of pain were sickle cell crises
- Advised to stop smoking, maintain hydration

- Extremely rare

- Learning point…if things unclear review even the basics

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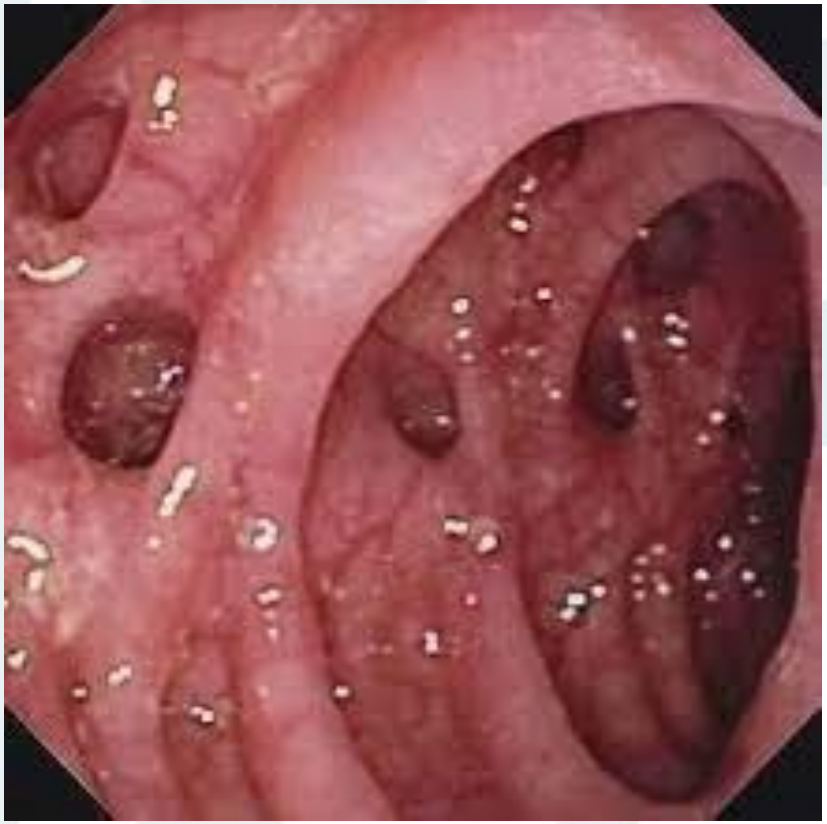
# Diverticular Disease



# Diverticulitis

- Inflammatory process that most commonly affects the sigmoid colon
- Diverticulae occur where blood vessels enter colonic wall
- Uncomplicated
- Complicated (abscess, fistula, stricture, perforation)
- 5% < 40 years, 50% > 60 years

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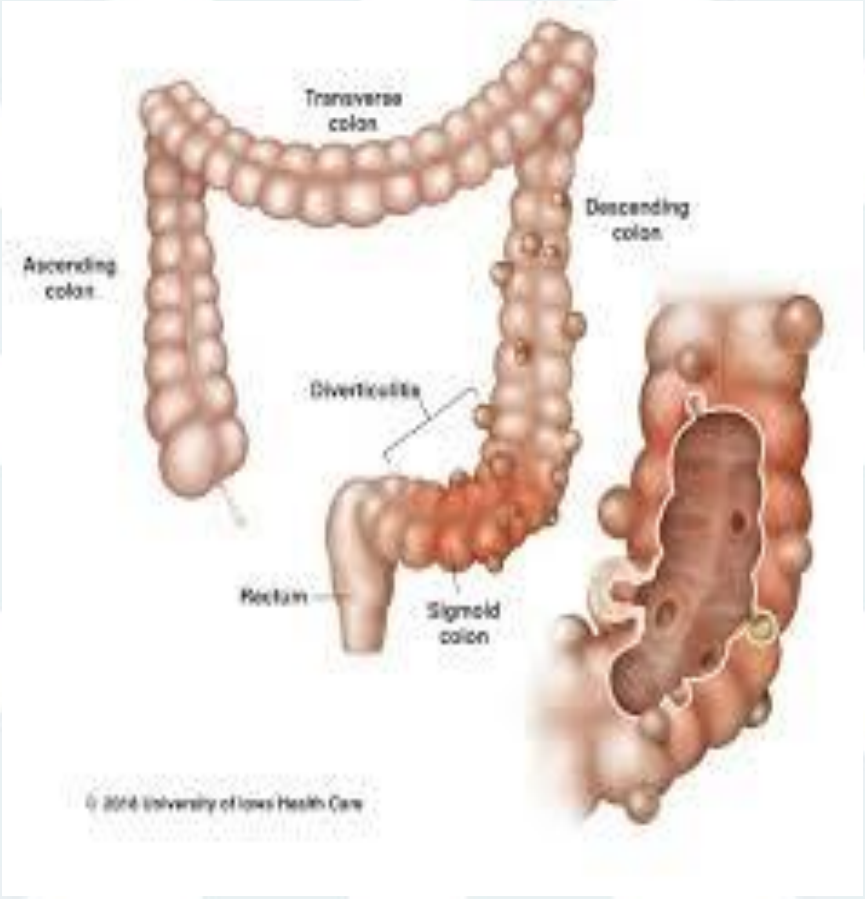


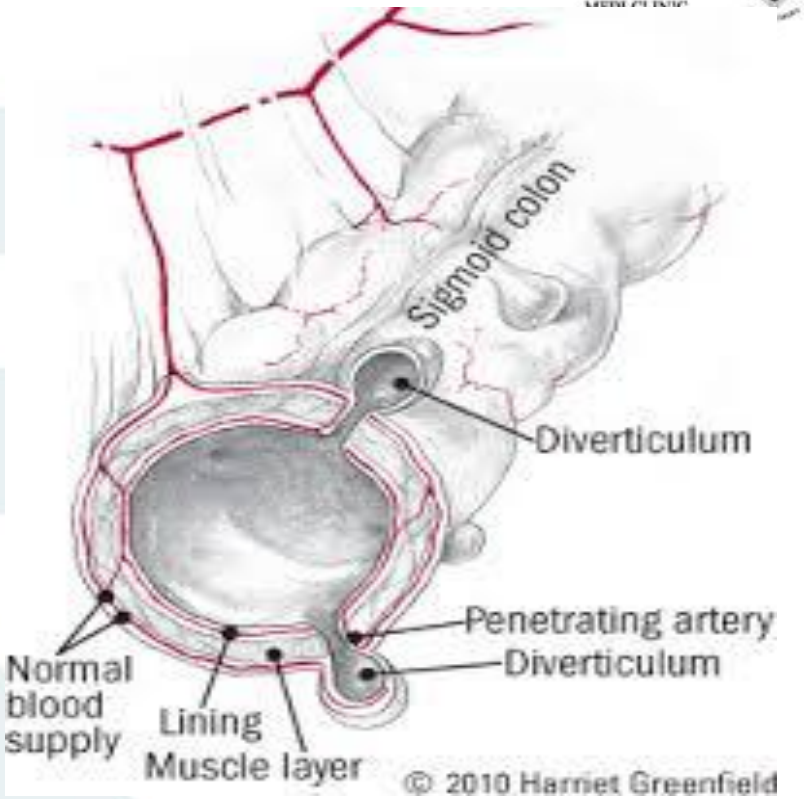

# Risk Factors

- Smoking
- NSAIDS
- Physical inactivity
- Obesity

- Low fibre diets associated with higher rates of diverticulitis

# Presentation

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- LIF pain
- Fever
- Change in bowel habit
- Mass in LIF

- CT thickening of colonic wall, fat stranding, micro perforations, abscesses

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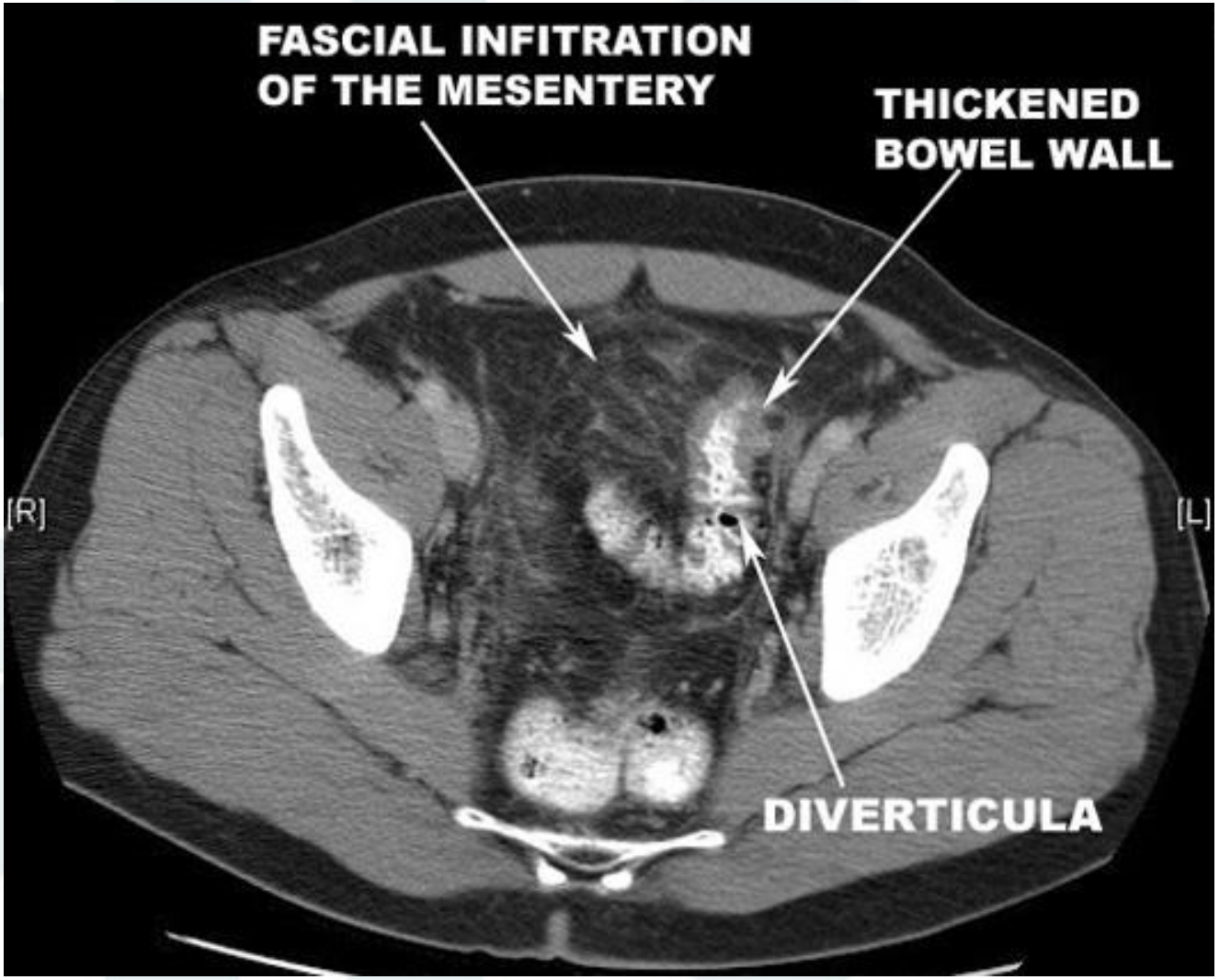

# Surgery as Treatment

- Evidence of sepsis or peritonitis
- If patients fail to respond or deteriorate with medical treatment (antibiotics and/or drainage)
- 20% of all patients

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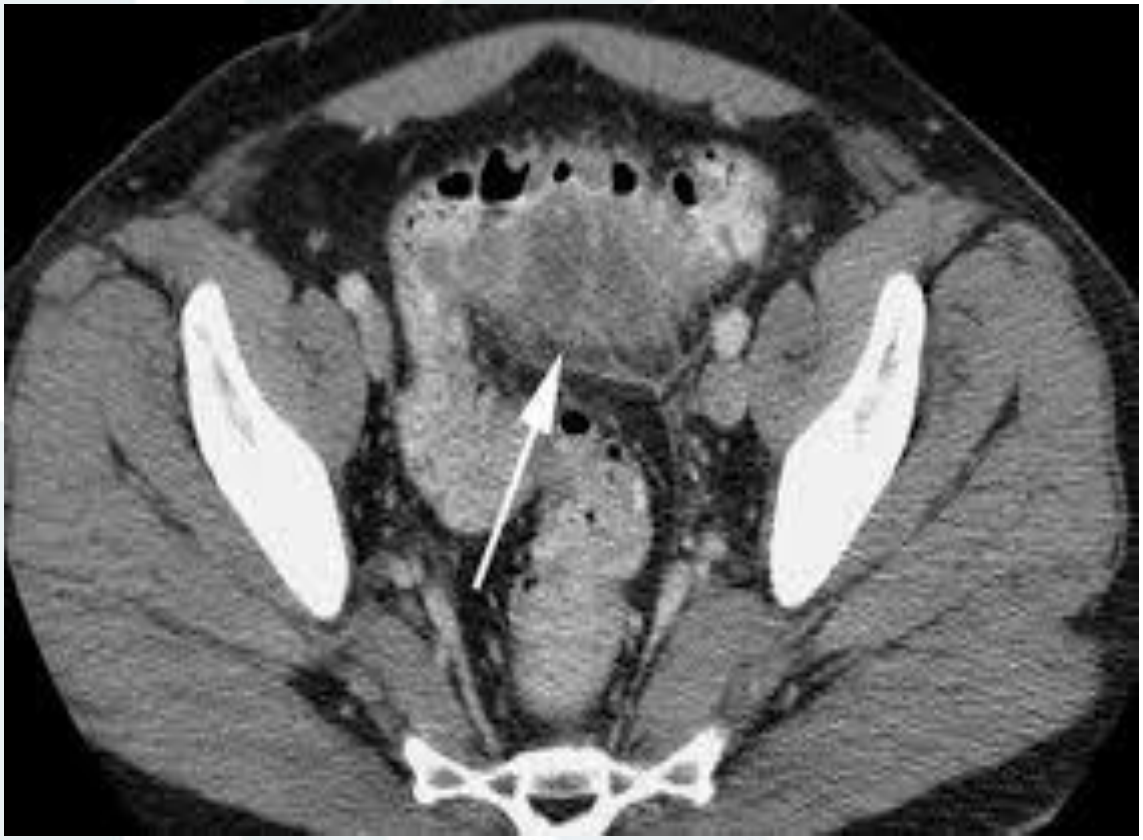

# Simple Diverticulitis

- Absence of high fever, no significant lab or radiological abnormalities.
- Not immunosuppressed
- Outpatient
- ? Antibiotics

# Cochrane Database Systematic Review, 2012:11

- 3 RCTs  Xray confirmed, L sided disease

- Complications
- Emergency surgery
- Recurrence
- Length hospital stay

- Conclusion  no difference between antibiotics and no therapy

Daniels L, Onlu C, de Korte N et al

# Randomised Controlled Trial of observational V Antibiotic Treatment for a first episode of CT-Proven uncomplicated acute diverticulitis

Br J Surg 2017; 104: 52-61

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- L sided disease
- 528 patients from 22 sites in Netherlands
- Followed for 6 months
- Median time to recovery 14 V 12 days but with a shorter hospital stay if no antibiotics
- No difference in recurrent episodes, readmission rates, sigmoid resection, development of complicated disease or mortality

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- Antibiotic or no antibiotic?
- Ciprofloxacin and flagyl….but now?
- Augmentin
- Liquid diet

- High fever, leucocytosis, immunosuppression, serious co-existing conditions……admit

# Post an episode of diverticulitis

- Consider colonoscopy to excluded concomitant colon ca especially if no imaging performed

- At least 6-8weeks post

- Low pickup rate for ca

# Risk of recurrence

- Varies widely  10-35%
- Severity likely to be similar to first episode
- High fibre diet may reduce frequency

- No supportive evidence to exclude popcorn, seeds and nuts

# ? surgery for recurrent disease

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- Decisions should be individualised

- Severity and frequency of attacks
- Co existing conditions
- Laparoscopic V open – cochrane review, meta-analysis

# Other Treatments

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- 5 ASAs
- Rifaxamin
- Probiotics

# Summary

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- Categorise simple V complicated
- Antibiotic or no antibiotic
- Monitor
- Liquid diet followed by high fibre

- Interval colonoscopy

- Stop smoking, exercise, avoid NSAIDS