

Abdominal Pain

A more direct approach

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Background

Most providers understand what causes abdominal pain-- but they were not trained on how to work it up efficiently.

Background

ZoomCare developed pathways that make the work up for abdominal pain easier and safer.

Observations:

1. longer visit durations don't lead to us getting closer to the diagnosis

Observations:

2. We struggle with knowing which tests to order. If we could perfect this, we could cut to the chase.

How we do it:

1. 15 minute visit: Use the algorithm

2. Have the patient return in 1 - 2 days

You can't cram more into 15 minutes



More in 15 minutes?

Instead, do it more scientifically.

Simple Work-ups:

The case is rarely straightforward, but the work-up should be.

First things first: Focused Hx
Ask the right 10 - 12 HPI questions

First things first
From the history flows Acuity & Location

First things first
Don't ask about things that don't matter at *this stage*

Then. . .

A *focused* exam. . . and you've got what you need to do the work-up

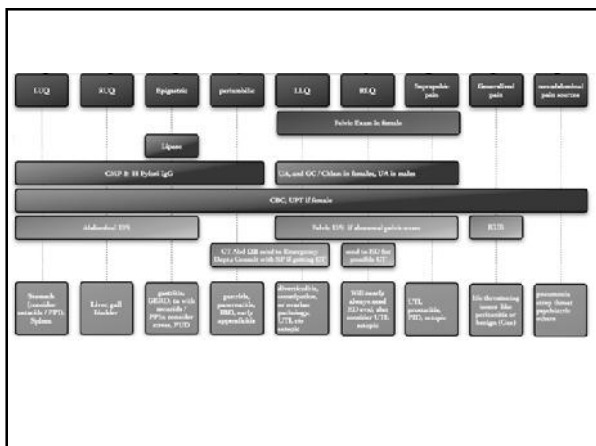
HPI:

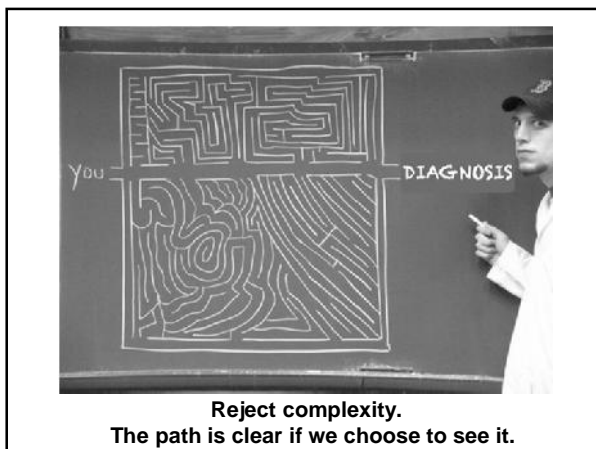
- fevers
- diarrhea or constipation
- blood in stool or black stool
- nausea or vomiting
- location of pain
- quality: sharp or dull, colicky or steady
- duration: how long? worsening?
- associated with meals or BM?
- any other symptoms?
- any bladder or vaginal sx's?
- dyspareunia?
- last menstrual period?

FHx:
Any family hx of GI problems?

SHx:
Alcohol use?

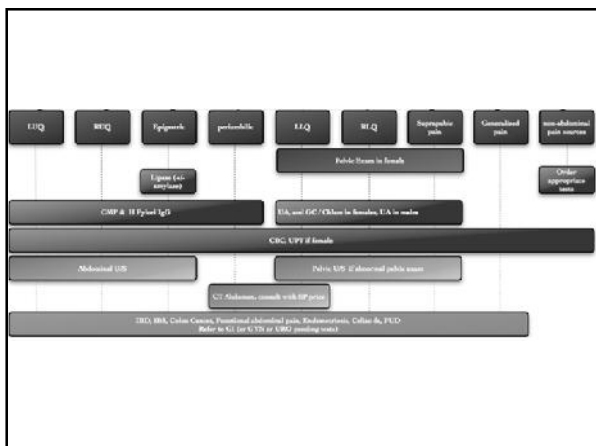
MEDS:
NSAID use?
Other meds?





The goal of the first visit. . .

- 1) Rule out emergencies
- 2) Get a clear plan, not a clear diagnosis (because you often can't)
- 3) Communicate that plan



Acute vs Subacute vs Chronic Abdominal Pain

Acute: less than a few days

Chronic: pain for 12 weeks

Subacute: in the middle

For acute abdominal pain:

focused history + focused physical

Diagnose if you can

Rx

order tests or send to ED

For sub-acute abdominal pain:

focused history + focused physical

Diagnose if you can

Rx

order tests or refer

For chronic abdominal pain:

focused history + focused physical

Diagnose if you can

Rx

order tests or refer

We are blindfolded without labs and imaging



Let's stop negotiating our clinical advice.

Illustrative Case: Melissa

42 yo female patient c/o abdominal pain x 1 day. Constant pain LLQ. Associated nausea, no vomiting.

No fevers. Feels fatigued. No urinary frequency, urgency or hematuria. The pain feels like labor pains.

No blood or mucous in the stool. No vaginal dc or bleeding. No URI s/s. Menses irregular. Had Pelvis US recently which showed cyst on the right.

Illustrative Case: Melissa

BP: 126.0/84.0

Pulse: 84.0/min

Resp: 16.0/min

Pulse Ox: 98.0 on Room Air

Temperature: 99.5 f

LMP Date: 3 weeks prior (has an IUD in place)

Illustrative Case: Melissa

GI: Generalized nonspecific TTP, worse LLQ with deep palpation.

no CVA tenderness, no masses, non-distended, no organomegaly, normal bowel sounds, soft abdomen, negative rebound, negative Rovsing's, negative psoas and obturator signs, negative Murphy's.

Illustrative Case: Melissa

UA:
Blood- Non-Hemolysis: 10
Bilirubin: 0 - neg
Urobilinogen: 0.1 (+-)
Ketones: 0 - neg
Protein: 0 - neg
Nitrite: 0 - Neg
Glucose: 0 - neg
pH: 8
Specific Gravity: 1.010
Leucocytes: 25

Illustrative Case: Melissa

Send out tests:

urine culture

KUB

Illustrative Case: Melissa

Assessment and Plan:

Rx: none

Dx: LLQ pain

Illustrative Case: Melissa

Plan: Abdominal pain LLQ. Patient afebrile w/o acute abdominal signs. Probable viral gastroenteritis.

Less likely DDx includes: nephrolithiasis, diverticulitis, ovarian cyst. No UTI s/s. UA equivocal with mild hematuria. Will check urine culture and order KUB and abdominal films to further evaluate. Discussed BRAT diet and hydration. RTC or call if any worsening s/s.

Illustrative Case: Melissa

The next day she returns, sees a provider #2:

Was seen yesterday - had xray which was normal
Abd pain - constant 6/10, radiates to back
feels kind of like labor pains
no fever, no vomiting, appetite poor

gyn appt 1 month ago, US 2 weeks ago - R sided ovarian cyst
has copper IUD - was in place at US
has had irregular bleeding for 5 months
GYN recommended that IUD come out but not able to get in to schedule it

Illustrative Case: Melissa

vitals unremarkable

GI:
no masses, non-distended, non-tender, normal bowel sounds, soft abdomen, no CVAT

GUF:
no cervical motion tenderness
bimanual exam: fullness on left adnexa

Provider proceeded with IUD removal

Illustrative Case: Melissa

In house tests:

UA: negative

UPT: negative

Send-out tests:

none

Imaging:

Pelvic U/S

Illustrative Case: Melissa

Assessment and Plan

Rx:

Tramadol

Cyclobenzaprine

Dx: Abd pain, LLQ

Illustrative Case: Melissa

Assessment and Plan

Plan: PARQ diff dx LLQ pain. PARQ IUD removal, plan pelvic US, pain relief rx as above, ER and f/u precautions reviewed - suspect Gyn pathology based on pain pattern. Will contact pt w imaging results

Illustrative Case: Melissa

Final Dx: left sided hemorrhagic ovarian cyst
pain was not due to IUD, or renal stone, or A.G.E.

Illustrative Case: Melissa

1) at the 1st visit the diagnosis was not based on the
history or exam

Illustrative Case: Melissa

2) at the first visit, the wrong tests were ordered. We
should have cut to the chase-- order the pelvic u/s
(+/- do a pelvic)

Illustrative Case: Melissa

3) a UPT should have been done at first visit

Illustrative Case: Melissa

4) at the second visit, a long visit was spent searching, but in the end, an ultrasound was performed and a diagnosis was not clear until the results returned

Result:

We spent over 60 minutes with a patient. . . yet we lead her down a wandering path and she felt lost.

In the end, no money was saved, no frustration was spared, no heroes were made.

It's okay not to have a dx. You often can't. UpToDate supports our own data:

"the overall sensitivity and specificity of the history and physical examination in diagnosing the different causes of abdominal pain is poor, particularly for benign conditions. Fortunately, studies of the accuracy of history and physical examination for the more serious causes of abdominal pain (eg, acute appendicitis), alone or in combination with focused investigations, have yielded better results"

References

ZoomCare Patient Data, analyzed July, 2011
Penner RM, Majumdar SR; Diagnostic approach to abdominal pain in adults. UpToDate; 10/2011.
Fishman MB, Aronson MD; Differential diagnosis of abdominal pain in adults. UpToDate; 10/2011.
FPNotebook.com article on Abominal Pain evaluation, 2012
