

A Clinical Study Of Acute Abdomen and Management-A Study of 100 Cases

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Abstract:Acute abdomen is a common surgical/medical emergency.Most of the patients complain of pain abdomen of severe onset .In surgical emergency, perforation of hollow viscous is the main cause followed by acute appendicitis, acutecholecystitis and other causes.Every patient should be thoroughly investigated and managed on priority basis and immediate surgical intervention be done should to decrease the morbidity and mortality.

Material and methods:This study was done on 100 cases admitted in Department of surgery ,Govt.MedicalCollege,Amritsar with the diagnosis of Acute abdomen.The study was done to know the differential diagnosis of the acute abdomen and to study the pattern of presentation of the disease.

Summary and conclusion:The presentationof acute abdomen in our emergency is mostly of the cases of perforation peritonitis followed by acute cholecystitis and appendicitis now.Every case of acute abdomen should be thoroughly investigated and managed accordingly.

Key words:Acute,Appendix,Appendicitis,Perforation,Cholecystitis

I. Introduction:

The term **acute abdomen** refers to a sudden, severe abdominal pain of unclear etiology that is less than 24 hours in duration. **Acute abdomen (surgical abdomen)** an acute intra-abdominal condition of abrupt onset, usually associated with severe pain due to inflammation, perforation, obstruction, infarction, or rupture of abdominal organs, and usually requiring emergency surgical intervention.Acute abdomen is occasionally used synonymously with peritonitis. While this is not entirely incorrect, peritonitis is the more specific term,referring to inflammation of the peritoneum.

An acute abdomen requires immediate evaluation and diagnosis because it may indicate a condition that calls for surgical intervention. Information about the onset, duration, character, location, and symptoms associated with the pain is critical in making an accurate diagnosis. The patient is asked what decreases or increases the pain; constant, increasing pain is generally associated with appendicitis and diverticulitis, whereas intermittent pain more likely indicates an intestinal obstruction, ureteral calculi, or biliary calculi. Appendicitis may often be differentiated from a perforating ulcer by the slower onset or development of pain. Although the patient's report of the location of the pain is sometimes misleading because of referral, radiation, or reflection of pain, it may serve to identify a specific organ or system. Factors in the patient's history that are useful in the diagnosis and management of an acute abdomen include changes in bowel habits, weight loss, bloody stool, diarrhea, menses, vomiting, clay-colored stool, and previous abdominal surgery.

If surgery carried no risk and did not adversely affect the course of some diseases, it would be safe to say "if in doubt, operate." Unfortunately, laparotomy itself carries risks and the course of some disorders such as acute pancreatitis and paralytic ileus is adversely influenced by anesthesia.

An Approach to the Acute Abdomen

1. Define the acute abdomen.
2. Describe the cause and pathophysiology of acute abdominal diseases:
3. Identify and describe the symptoms, signs, clinical course and laboratory and x-ray findings for the acute abdominal diseases listed under Objective 2.
4. Identify the clinical features that help to distinguish the surgical from the non-surgical acute abdomen.
5. Construct an approach to evaluation and management of the acute abdomen.

Patients presenting with severe abdominal pain will almost always have an Abdominal x-ray and / or a CT scan. These tests can provide a differential diagnosis between simple and complex pathologies. It can also provide evidence to the doctor whether surgical intervention is necessary.

The urgency usually precludes prolonged investigation and there are few specific tests or examinations which may be relied upon to give clear-cut answers as to the exact cause of the acute condition. Careful and complete data collection by history and physical exam is the prime diagnostic aid to avoid errors of omission and to separate those conditions which require immediate surgery from those which require watchful expectancy, or those which require medical rather than surgical management. Often the patient's condition is such that extensive laboratory investigation requiring many hours would compromise the patient's life and thus the outcome often depends on a precise and detailed history and physical examination.

II. Aims and Objectives:

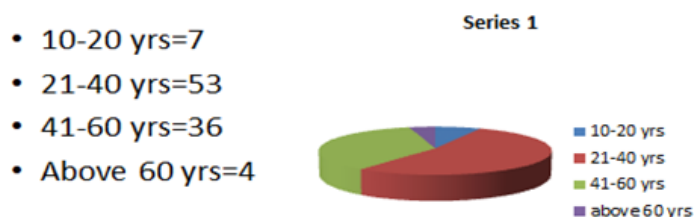
To find out the cause of acute abdomen and planning the management in study group of cases.

III. Material and Methods:

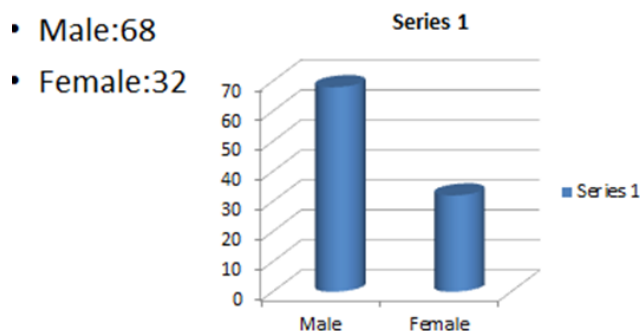
The study was conducted on 100 cases of severe pain abdomen (2012-2014) presented to emergency surgery/medicine department of Govt. Medical College/Guru Nanak Dev Hospital, Amritsar, India. There was no exclusion criteria regarding the age and sex. Only cases presenting within 24 hours of initiation of pain were considered and evaluated for the study.

Observations.

Age distribution



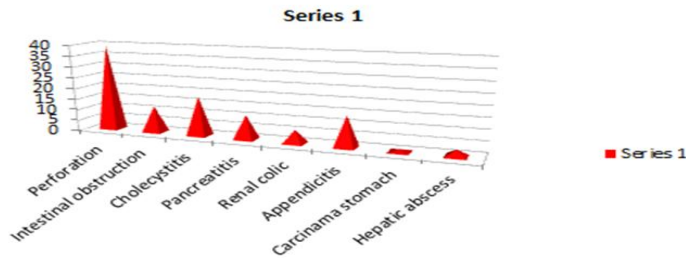
Sex Ratio



Etiology

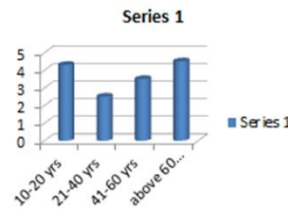
- 1. Perforation(39)
- 2. Intestinal Obstruction(12)
- 3. Cholecystitis(18)
- 4. Pancreatitis(11)
- 5. Renal colic(6)
- 6. Appendicitis(14)
- 7. Carcinoma stomach
- 8. Hepatic Abscess(3)

Etiology



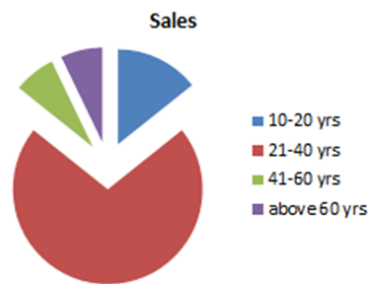
Perforation

- 10-20 years:4
- 21-40 years:21
- 41-60 years:13
- Above 61 years:1



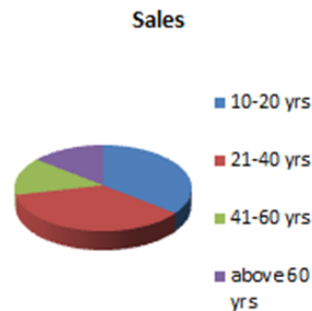
Appendicitis

- 10-20 years:2
- 21-40 years:10
- 41-60 years:1
- Above 60 years:1



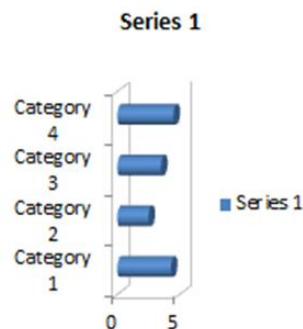
Cholecystitis

- 10-20 years:0
- 21-40 years:10
- 41-60 years:4
- Above 60 years:4



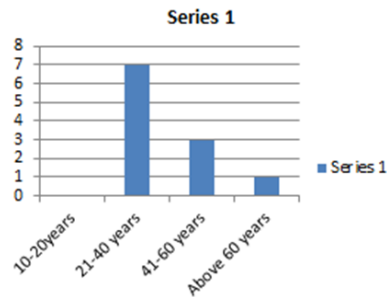
Intestinal Obstruction

- 10-20 years:1
- 21-40:2
- 41-60years:8
- Above 60 years:1



Pancreatitis

- 10-20 years:0
- 21-40 years:7
- 41-60 years:3
- Above 60 years:1



Should be treated as

IV. Discussion

Acute abdomen is a commonest emergency in surgical practice. Majority of the patients are male and in the age group of 20-40 years. Etiology of most of the cases is perforation peritonitis followed by acute appendicitis and acute cholecystitis. All cases should be thoroughly investigated by history taking and investigations like plain x-ray abdomen and hematological investigations. No case should be managed conservatively without excluding the cause for surgical interventions it may lead to gross negligence and morbidity and even mortality of the patient.

V. Conclusion

Acute abdomen should be treated as a surgical emergency unless proved otherwise. No case should be neglected until fully investigated for the emergency surgical intervention to avoid the complications and mortality.