Abdominal pain

Abdominal pain

Pain is the most common of all abdominal symptoms and may be due to inflammatory , infective, obstructive, neurogenic, neoplastic or ischaemic pathology . Sometimes no organic cause can be found, a situation often labelled as ‘functional or - non-specific abdominal pain’. Improved understanding of pain pathways and the relationship with the gastrointestinal micro - biome is likely to provide a more precise diagnosis, particularly in common ‘functional’ disorders such as non-ulcer dyspepsia and irritable bowel syndrome (IBS) (see Chapter 73). It is essential to establish the site, nature and radiation of the pain, the rapidity of onset and associated or relieving fea - tures such as food intake and or vomiting. Thus biliary colic will classically result in colicky pain in the right upper quadrant of the abdomen that radiates to the angle of the scapula and is associated with food intake (which results in cholecystokinin release and gallbladder contraction). The pain of acute appen - dicitis starts around the umbilicus and then shifts and localises to the right iliac fossa. Acute pancreatitis often has an abrupt onset of severe epigastric pain radiating to the back, which may be similar to pain emanating from peptic ulcer perfora tion or a leaking aortic aneurysm. Intestinal colic is most frequently - associated with periumbilical pain and abdominal distension: the more distal in the intestine the pathology , the greater the degree of distension. V omiting is an early feature of proximal small bowel obstruction, whereas absolute constipation is an early feature of colonic obstruction. Renal or ureteric colic is intense, located in the flanks and radiating towards the lower midline and scrotum. It is usually associated with either macro - - scopic or microscopic haematuria. duration, type of alteration (constipation or diarrhoea) and its relationship to abdominal pain will help to di ff erentiate organic pathology causing obstruction or inflammation (colon cancer or inflammatory bowel disease [IBD]) from functional conditions such as IBS. When patients complain of diarrhoea, they may imply di ff erent meanings – some use the term for loose stools, others may mean frequent but normal stools. A longstanding increase in frequency of stools, with left-sided abdominal pain before defecation that eases after defecation, is suggestive of IBS. However, if such symptoms are of recent onset or are associated with blood or mucus in the stools, colonic carcinoma or IBD is more likely . A history of progres sive change in bowel habit with an acute presentation with abdominal pain, distension and absolute constipation suggests acute-on-chronic intestinal obstruction, often from a stenotic left colon cancer. Marked distension with tenderness ov caecal area suggests a closed-loop obstruction with impending caecal rupture. Ileocaecal tuberculosis may present as a mass in the right iliac fossa with a ball of wind and gurgle suggestive of ileal stricture. Summary box 63.3 Classic presentations of abdominal pathology /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF

Obstructive and in /f_l ammatory pathology must be excluded in patients with abdominal pain and altered bowel habit as these require urgent care Closed-loop obstruction with tenderness in the right iliac fossa is indicative of imminent caecal rupture Caecal and ascending colon cancers classically present with anaemia Patients who have had previous abdominal surgery may have adhesions Check carefully for small incarcerated hernias, particularly femoral in obese patients as these may be hidden by ‘abdominal panniculus’

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