Diffuse (generalised) peritonitis

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This normally signifies the occurrence of a life-threatening pathology . It means that regions (not just focal areas) of the parietes (parietal peritoneum) are inflamed. It normally arises as a result of pressure-related perforation of a viscus (e.g. in the setting of an obstructed colon), when large volumes of blood abruptly enter the peritoneal cavity (ruptured aortic aneurysm) or when substantial volumes pour incessantly (albeit not under pressure) into the peritoneal cavity (e.g. perforated duodenal ulcer or anastomotic leak). The patient may describe acute or gradual onset abdomi nal pain of considerable intensity . The pain may be localised at first and then become di ff use. The patient is gravely ill looking (Hippocratic facies) and usually lies as still as possible to mini mise fluid movement within the peritoneal cavity . The entirety Hippocrates of Kos , Greek physician and surgeon, and by common consent ‘the father of medicine’, was born on the island of Kos, o ff Turkey , about 460 /uni00A0 and probably died in 375 /uni00A0 /b.sc/c.sc/e.sc . and feels board-like on palpation (‘board-like’ rigidity). In a thin patient, contraction of the rectus abdominis muscles may be reflected in a scaphoid appearance of the abdomen (see Chapter 63). A generalised ileus occurs and the abdomen may become distended. Vital signs are usually deranged. In advanced cases the patient is hypotensiv e, tachycardic and pyrexial. At first the - patient may seem confused, dr owsy and disoriented. If the underlying pathology is not corrected the patient will lose con - sciousness. Signs may be limited in obese patients or in patients on immunosuppressive medications. Investigation and treatment must be undertaken expedi - ently as the time available to salvage ma y be limited. Inves - tigations aim to identify the underlying cause and to guide p- treatment. An erect chest radiograph can be useful in identify - - ing subdiaphragmatic gas (Figure 65.7). If a patient is particu - larly unwell and a CT is not available, then a lateral decubitus radiograph serves the same purpose as an erect radiograph (provided the patient has been appropriately positioned for long enough for the gas to rise within the peritoneal cavity). tion, . Summary box 65.4 - Clinical features of peritonitis /uni25CF). /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF - /uni25CF /uni25CF /uni25CF m to Summary box 65.5 Management of peritonitis /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF - /uni25CF /uni25CF - /b.sc/c.sc/e.sc

Abdominal pain, worse on movement, coughing and deep respiration Constitutional upset: anorexia, malaise, fever, lassitude Gastrointestinal upset: nausea +/– vomiting Pyrexia (may be absent) Raised pulse rate Tenderness +/– guarding/rigidity/rebound of abdominal wall Pain/tenderness on rectal/vaginal examination (pelvic peritonitis) Absent or reduced bowel sounds ‘Septic shock’ (systemic in /f_l ammatory response syndrome [SIRS] and multiorgan dysfunction syndrome [MODS]) in later stages General care of patient Correction of /f_l uid and electrolyte imbalance Insertion of nasogastric drainage tube and urinary catheter Broad-spectrum antibiotic therapy Analgesia Vital system support Surgical treatment of cause when appropriate ‘Source

control’ by removal or exclusion of the cause Peritoneal lavage +/– drainage

(b) Figure 65.7 Intraperitoneal perforation. (a) Erect chest radiograph demonstrating air under the diaphragm on the right side. computed tomography image showing a segment of sigmoid divertic ulosis with localised perforation (arrow).

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