

Nonspecific Abdominal Pain in the Acute Setting: Do I have to Allocate a Specific diagnosis for Every Patient with Belly Pain?

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Introduction

Around one third-to one half of patients with Abdominal Pain (AP) admitted to hospitals do not receive a significant diagnosis, and thus these patients are diagnosed with Nonspecific Abdominal Pain (NSAP). This phenomenon is closely linked to age, sex and historical features of a given patient. For example, as age progresses, certain diseases such as biliary system diseases, malignancy, ischemic bowel disease, and intestinal obstruction take predominance as etiologies of AP. In general, Acute Appendicitis (AaP) (28%) follows the NSAP group (the largest one); biliary system diseases (10%), acute gynecological diseases (4%), intestinal obstruction (4%) as the diagnoses in this context.

Before diagnosing a patient with NSAP, serious causes of AP which mandate emergency surgical intervention must be excluded from the long list of Differential Diagnosis (DD). A significant decline in the rate of NSAP has been marked with the increased accessibility of laboratory and radiological modalities within the last decades, especially after 1990s. Bedside, point-of-care USG represents a revolution in practical and rapid imaging and diagnostic decision making. This modality can be complemented with Computed Tomography (CT), laboratory adjuncts and other necessary investigations tailored for the patient. Such an integrated approach creates an expedient path to the operation room in most cases within the context of AP (e.g., ectopic pregnancies, aortic catastrophes, visceral perforations etc.).

The female-to-male ratio in those considered to have NSAP is around 2.4 to 3 in some studies [1]. The average age is between 38 and 41. While 90% of patients with NSAP recover in the first few weeks or remain asymptomatic, up to 10% may have some disease, for example, 1/3 of them develop AaP (Gallagher, 2004). In the doctorate thesis study which had been conducted in Izmir/Turkey, it is shown that 46% out of 684 AP patients were discharged from the university-based ED with the diagnosis of NSAP. Of note, 9% of them were re-admitted within the first 3 days and there were several patients with de novo diagnoses of acute abdominal conditions [2].

The rate of specific diagnoses and need for surgery boost with the advancing age. For example, vascular causes such as aortic dissection, aneurysm and mesenteric infarction have a considerable share of 10% of all AP in people over 65 years of age. Only one tenth of this age group is discharged without specific diagnosis, a.k.a., with NSAP. Surgical intervention requirement in patients with AP is 33% in those over 65 years of age, while only 16% in the others. In patients around 80 years of age, mortality due to AP is around 7%, which is 70 times higher than that of young adults.

The most important strategies in the approach are obtaining an elaborate history and a thorough systemic examination.

In other words, a well-received history and a detailed physical examination are mostly sufficient to establish the preliminary diagnosis of around 80% to 90% of the patients presenting with AP. The biggest mistake that can be made is to order biochemistry and imaging studies to approach a diagnosis without full history and examination. In this way, a patient who can be diagnosed with myocardial infarction by examining his/her ECG can even be sent to radiology unit for abdominal CT and his death can be caused. Men over the age of 40 must be thought to have a heart attack until proven otherwise. Always ask for an ECG and assume coronary syndrome. Or, the patient, whose chronic constipation can be relieved by evacuating the fecaloma, may be left unnecessarily waiting for hours with fancy investigations.

An important pearl to keep in mind is not to send the patient home with her/his pain, saying that there is nothing wrong. If you have to discharge, give her/him your phone to be awakened in the dawn.

In brief, management of a patient with AP is a real stomach ache in medicine, and requires experience and expertise which are gained in years. Paying attention to some specific clues will protect the physicians from major misdiagnoses.

References

1. Lukens, W.T., et al. "The natural history and clinical findings in undifferentiated abdominal pain." *Ann Emerg Med* 22.4 (1993): 690-696.
2. Koyuncu, N., et al. "Nonspecific abdominal pain: A follow-up survey." *Niger J Clin Pract* 21 (2018): 332-336.

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