**Adult Emergency Nurse Protocol**

### ABDOMINAL PAIN

**Aim:**
- Early identification and treatment of life threatening causes of Abdominal Pain, escalation of care for patients at risk.
- Early initiation of treatment / clinical care and symptom management within benchmark time.

### Assessment Criteria:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>Pain to the abdomen (localized)</td>
<td>Notify CNUM and Escalation Criteria</td>
</tr>
<tr>
<td>Diarrhoea or constipation</td>
<td>Notify CNUM and Focused abdominal Systems Assessment</td>
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<tr>
<td>Urinary symptoms</td>
<td>Notify CNUM and Focused abdominal Systems Assessment</td>
</tr>
<tr>
<td>Fever or chills</td>
<td>Focused abdominal Systems Assessment</td>
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</tbody>
</table>

### Escalation Criteria:

Immediate life-threatening presentations that require escalation and referral to a Senior Medical Officer (SMO):
- Acute confusion / agitation
- Hyperactive / absent bowel sounds
- Abdominal distension / rigidity
- Recent abdominal or gynecological surgery
- Suspected ectopic pregnancy

### Primary Survey:

- Airway: patency
- Circulation: perfusion, BP, heart rate, temperature
- Disability: GCS, pupils, limb strength
- Breathing: resp rate, accessory muscle use, air entry, SpO2.
- Pain: how, where, radiation
- Disability: GCS, pupils, limb strength

### Notify CNUM and SMO if any of the following red flags is identified from Primary Survey and Between the Flags criteria:

<table>
<thead>
<tr>
<th>Flag</th>
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</thead>
<tbody>
<tr>
<td>Airway – at risk</td>
<td>Breathing – respiratory distress</td>
</tr>
<tr>
<td>Partial / full obstruction</td>
<td>RR &lt; 5 or &gt;30 /min</td>
</tr>
<tr>
<td>SpO2 &lt; 90%</td>
<td>Circulation – shock / altered perfusion</td>
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<tr>
<td>Disability – decreased LOC</td>
<td>Exposure</td>
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<tr>
<td>GCS ≤ 14 or a fall in GCS by 2 points</td>
<td>Temperature &lt;35.5°C or &gt;38.5°C</td>
</tr>
<tr>
<td>BGL &lt; 3mmol/L or &gt; 20mmol/L</td>
<td>HR &lt; 40bpm or &gt; 140bpm</td>
</tr>
<tr>
<td>BP &lt; 90mmHg or &gt; 200 mmHg</td>
<td>Postural drop &gt; 20mmHg</td>
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<tr>
<td>Capillary return &gt; 2 sec</td>
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</table>

### History:

- Presenting complaint
- Allergies
- Medications: Anticoagulant Therapy, Anti-hypertensives, Diabetic meds, Analgesics, Inhalers, Chemotherapy, Non-prescription meds, Any recent change to meds
- Past medical past surgical history relevant
- Last ate / drank & last menstrual period (LMP)
- Events and environment leading to presentation
- Pain Assessment / Score: PQRTST (Palliating/ provoking factors, Quality, Region/radiation, Severity, Time onset)
- Associated signs / symptoms: nature of pain / radiation, nausea, vomiting, nature of stool, symptoms of pregnancy, urinary symptoms and weight loss or anorexia.
- History: family, trauma and travel (gastroenteritis & infectious colitis)

### Systems Assessment:

Focused abdominal assessment:
- **Inspection:** Scars, masses, distention, bruising, discoloration, midline pulsations, devices and movement of patient
- **Auscultation:** Bowel sound; hyperactive, reduced or absent
- **Palpation:** tenderness, guarding, rebound tenderness, masses, pulses – signs of peritonism; Identify location of pain

### Notify CNUM and SMO if any of the following red flags is identified from History or Systems Assessment:

<table>
<thead>
<tr>
<th>Flag</th>
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</thead>
<tbody>
<tr>
<td>Referred pain – shoulder / back</td>
<td>Hyperactive or absent bowel sounds</td>
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<tr>
<td>Abdominal distension</td>
<td>Peritonism – rigidity / guarding</td>
</tr>
<tr>
<td>Elderly &gt; 65 years</td>
<td>Acute confusion / agitation</td>
</tr>
<tr>
<td>Confirmed pregnancy / +ve BHCG</td>
<td>Immunosuppressed / steroids</td>
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<tr>
<td>Decreased urine output - oliguria</td>
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### Investigations / Diagnostics:

**Bedside:**
- BGL: If < 3mmol/L or > 20mmol/L notify SMO
- ECG: [as indicated] look for Arrhythmia, AMI
- Urinalysis / MSU (if urinary symptoms)

**Laboratory / Radiology:**
- **Pathology:** Refer to local nurse initiated STOP - FBC, UEC, LFTs
- Urine βHCG & Quantitative hHCG if positive
- Group and Hold (if bleeding suspected)
- Blood Cultures (if Temp≥38.5 or ≤35°C)
- **Radiology:** Discuss with SMO
ABDOMINAL PAIN

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Nursing Interventions / Management Plan:

Resuscitation / Stabilisation:
- Oxygen therapy & cardiac monitor [as indicated]
- IV Cannulation (16-18gauge if unstable)
- IV Fluids: Sodium Chloride 0.9% 1 L IV stat versus over 8 hours (discuss with SMO)

Symptomatic Treatment:
- Antiemetic: as per district standing order
- Analgesia: as per district standing order
- IV Fluids: as per district standing order

Supportive Treatment:
- Nil By Mouth (NBM)
- Monitor vital signs as clinically indicated (BP, HR, T, RR, SpO2)
- Monitor pain assessment / score
- Bowel chart [as indicated]
- Fluid Balance Chart (FBC)
- Consider devices: IDC, Nasogastric tube [as indicated]

Practice Tips / Hints:
- Anorexia is a common symptom of an acute abdomen (2)
- Atypical presentations or a pain free abdomen can occur in the elderly, immunocompromised, or pregnant patients (2)
- A leaking abdominal aortic aneurysm can mimic renal colic in elderly patients (2)
- Migration of pain from the periumbilical region to the RLQ, rebound tenderness and anorexia can indicate *serious abdominal pathology (3)
- Referred right scapula pain can indicate gallbladder or liver disease (2) Referred left scapula pain can indicate cardiac, GIT, pancreatic or splenic disease (2); Referred scrotal or testicular pain can indicate renal colic or urethral (2)
- Epigastric pain can indicate gastric ulcer (long-term), pancreatitis, perforated oesophagus, Mallory-Weiss tear, cholelithiasis or AMI (2)
- Left upper quadrant can indicate splenic infarct or injury, pyelonephritis or renal colic (2); Right upper quadrant can indicate cholelithiasis, cholecystitis, pyelonephritis, renal colic, hepatitis and appendicitis (in pregnancy) (2); Left and right lower quadrant (LLO) (RLQ) can indicate diverticulitis, gynecological issues (ovarian torsion, cyst, PID or ectopic pregnancy) Crohn’s, ulcerative colitis, renal colic, appendicitis (RLQ) malignancy or hernia (2)
- Abdominal pain lasting > 48 hours is less likely to require surgery (2)
- History of abdominal surgery increased likelihood of adhesions (2)
- Cullen’s sign: periumbilical discoloration (2); Grey Turner’s sign: bruising of the flanks, indicating haemorrhagic pancreatitis (3); Murphy’s sign: RUQ tenderness on inhalation during palpation
- Narcotic analgesia does not hinder diagnosis (2,3)
- Hyperactive bowel sounds may indicate early bowel obstruction (2); Absent or diminished bowel sounds may indicate constipation, a bowel obstruction, perforated viscus (2)

Further Reading / References:
1. SESLHD Patient with Acute Condition for Escalation (PACE): Management of the Deteriorating Adult and Maternity Inpatient

Acknowledgements: SESLHD Adult Emergency Nurse Protocols were developed & adapted with permission from:
- Murphy, M (2007) Emergency Department Toolkits. Westmead Hospital, SWAHS
- Hodge, A (2011) Emergency Department, Clinical Pathways. Prince of Wales Hospital SESLHD.

Revision & Approval History

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision No.</th>
<th>Author and Approval</th>
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<tbody>
<tr>
<td>September 2013</td>
<td>0</td>
<td>Developed by Lauren Neuhaus - Nurse Educator, Emergency St George Hospital.</td>
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<tr>
<td>December 2013</td>
<td>1</td>
<td>Edited by Leanne Horvat - Clinical Stream Nurse Manager, Emergency / Critical Care &amp; Emergency Stream CNC/ NE Working Group SESLHD</td>
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<tr>
<td>February 2014</td>
<td>2</td>
<td>Endorsed by: SESLHD Emergency Clinical Stream Committee on 20 February 2014</td>
</tr>
<tr>
<td>May 2014</td>
<td>3</td>
<td>Endorsed by: SESLHD District Clinical &amp; Quality Council meeting on 14 May 2014 (T14/36288)</td>
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<tr>
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<td>4</td>
<td>Endorsed by: SESLHD District Drug &amp; QUM Committee meeting on 11 September 2014</td>
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