# Abdominal Emergencies Quick-Cases

## Case 1: Esophageal Varices

A 64 y/o M presents CAOx4 sitting at a kitchen table vomiting copious amounts of BRB. Pt describes acute onset of vomiting about 20 minutes prior, was "feeling fine" prior. Pt also c/o dizz and weakness since he started vomiting. He denies CP, diff brth, abd pn, headache, weakness, or syncope. You note that his skin is cool, pale, and slightly diaphoretic. PMH: Alcoholism, cirrhosis, ulcers. Meds: propranolol, prilosec. NKDA. VS: HR = 102/min and regular, BP = 96/50mmHg, RR = 14/min and reg c GTV, $SpO_2$ = 97% RA.

**Shock = yes! Decompensated. Hypovolemic hemorrhagic shock.**

**Treatment:**

- **Call ALS**
- **Position of comfort, supine or lat recumbent if possible**
- **Protect airway**
- **Oxygen via NRM blow-by, don;t want to trap vomit**
- **Keep warm**
- **Rapid transport to ED**

**Differential**

Pancreatitis
Diverticulitis/LGIB
Gastric Ulcer/UGIB
Cholecystitis
Mallory-Weiss Tear
Appendicitis
Esophageal Varices

## Case 2: Gastric Ulcer/UGIB

38 y/o M presents CAOx4 in NAD lying in bed c/o dizz and near-syncope c exertion. Pt states symptoms have been "getting worse" since onset 5 days ago. Pt states he has been experiencing ULQ abd pn over same time period. Pn described as gnawing, constant, worse on an empty stomach, non-radiating, rated 6 on scale of 0-10. Pt ⊕ for melena over same time period, denies CP, diff brth, syncope, weakness, headache, N/V, back or flank pn. ∅PMH, ∅meds, NKDA. Skin noted to be pale, cool, dry. VS: HR = 92/min and regular, BP = 114/70mmHg, RR = 12/min and reg c GTV, $SpO_2$ = 96% RA.

**Shock = yes! Compensated. Hypovolemic hemorrhagic shock from GI bleed.**

**Treatment:**

- **Call ALS**
- **Position of comfort, supine if possible**
- **$O_2$ via NC 1-6 lpm or NRM 10-15 lpm**
- **Keep warm**
- **Rapid transport to ED**

## Case 3: Diverticulitis/LGIB

64 y/o F presents CAOx4 in NAD c/o rectal bleeding. Pt states she noticed BRB on toilet paper over past 2 days. She denies any active hemorrhaging or frank blood from rectum. Pt also describes a 3-day history of bloating, diarrhea, and LLQ abdominal pn described as constant, crampy, reproducible c palp, non-radiating, rated 4 on scale of 0-10. ⊕ guarding c palp of LLQ. Skin cool, pale, dry. PMH: Diverticulosis, Meds: colace, NKDA. VS: HR = 98/min and irregular, BP = 104/60mmHg, RR = 14/min and reg c GTV, $SpO_2$ = 96% RA. Oral temp = 100.2°F.

**Shock = yes! Compensated. Hypovolemic hemorrhagic shock from GI bleed.**

**Treatment:**

- **Call ALS**
- **Position of comfort, supine if possible**
- **$O_2$ via NC 1-6 lpm or NRM 10-15 lpm**
- **Keep warm**
- **Rapid transport to ED**

| Differential |
|---|
| Pancreatitis |
| Diverticulitis/LGIB |
| Gastric Ulcer/UGIB |
| Cholecystitis |
| Mallory-Weiss Tear |
| Appendicitis |
| Esophageal Varices |

## Case 4: Mallory-Weiss Tear

16 y/o F presents CAOx4 c/o hematemesis. Pt admits to hx of bulimia, states she induced vomiting after a binge, experienced hematemesis p 3-4 episodes of “hard vomiting and retching”. Skin warm, pink, dry. PMH also includes depression, Meds = zoloft, NKDA. VS: HR = 68/min and regular, BP = 124/80mmHg, RR = 10/min and reg c GTV, $SpO_2$ = 96% RA.

**Shock = Nope. Doesn’t seem that she’s lost a lot of blood, no compensation via tachycardia.**

**Treatment:**

- **Position of comfort**
- **$O_2$ via NC 1-6 lpm or NRM 10-15 lpm**
- **Keep warm**
- **Transport to ED**

## Case 5: Cholecystitis

42 y/o F presents CAOx4 c/o abd pn. Pt describes acute onset of URQ pn approximately 1 hr after dinner at McDonald's. Pn described as constant, sharp, radiating to right shoulder and back, reproducible with palpation of URQ, rated 7 on a scale of 0-10. ⊕ guarding noted c palp of URQ, ⊕ Murphy's sign. Skin cool, pale, dry. PMH = gallstones. ∅meds, NKDA. VS: HR = 104/min and regular, BP = 132/90mmHg, RR = 16/min and reg c GTV, $SpO_2$ = 99% RA.

**Shock = Nope.**

**Treatment:**

- **Position of comfort**
- **$O_2$ via NC 1-6 lpm or NRM 10-15 lpm**
- **Keep warm**
- **Transport to ED**

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## Case 6: Appendicitis

19 y/o M presents CAOx4 c/o abdominal pn. Pt describes a gradual onset of diffuse abd pn over the past 3 days. Pn is constant, non-reproducible, non-radiating, rated a 3 on a scale of 0-10. Pt also describes a loss of appetite and nausea over past 2 days. Mild pn with palp noted over all 4 abd Q's. Skin cool, pale, dry. ∅PMH, ∅meds, NKDA. VS: HR = 100/min and regular, BP = 130/88mmHg, RR = 14/min and reg c GTV, $SpO_2$ = 98% RA. Oral temp = 100.9°F.

**Shock = Probably nope. Tachycardia is probably from pain.**

**Treatment:**

- **Position of comfort**
- **$O_2$ via NC 1-6 lpm or NRM 10-15 lpm**
- **Keep warm**
- **Transport to ED**

## Case 7: Pancreatitis

52 y/o M presents CA&O to person and place only. c/o abdominal pn. Pt is an admitted homeless alcoholic, describes acute onset of epigastric pn after ingestion of "a lot" of burbon. Pn described as severe, constant, radiating to his back, feels better when he is sitting up and forward, rated a 8 on an scale of 0-10. ⊕Pn c palp to UQ's. Skin cool, pale, dry. LS c ⊕ rhonchi to LLL. Unk PMH, unk meds, unk allergies. VS: HR = 102/min and irregular, BP = 142/98mmHg, RR = 10/min and reg c GTV, $SpO_2$ = 94% RA.

**Shock = Nope.**

**Treatment:**

- **Position of comfort**
- **$O_2$ via NC 1-6 lpm or NRM 10-15 lpm**
- **Keep warm**
- **Transport to ED**

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