



Lección 4

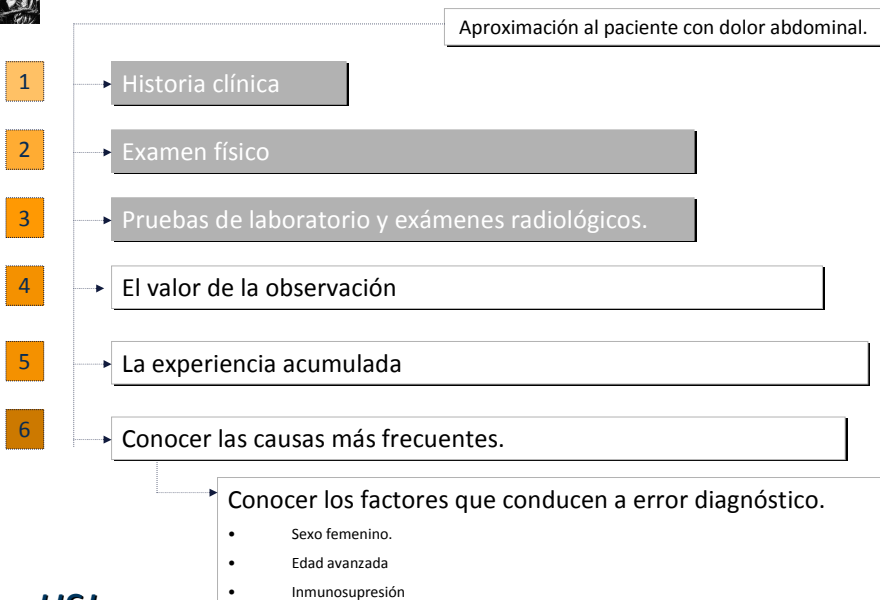
Claves proporcionadas por el laboratorio y las pruebas de imagen.

Lección 5

Actitud ante el dolor abdominal agudo

Lección 6

Diverticulitis aguda





Seminarios sobre dolor abdominal agudo
Grupo de trabajo para el manejo del dolor abdominal agudo en el Hospital San Jorge de Huesca

Aproximación al paciente con dolor abdominal.

1

Historia clínica

2

Examen físico

3

Pruebas de laboratorio y exámenes radiológicos.

4

El valor de la observación

5

La experiencia acumulada

6

Conocer las causas más frecuentes.

Conocer los factores que conducen a error diagnóstico.

- Sexo femenino.
- Edad avanzada
- Inmunosupresión

Formación
Interés
Tiempo

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Actitud ante el dolor abdominal agudo



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Con frecuencia la orientación proporcionada por el examen inicial es confusa, difícil o equívoca. En tales casos, es prudente un tiempo de espera en un área de observación hasta una mejor definición de los síntomas

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Actitud ante el dolor abdominal agudo



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Aproximación al paciente con dolor abdominal.

- 1 Historia clínica
- 2 Examen físico
- 3 Pruebas de laboratorio y radiología
- 4 El valor de la observación
- 5 La experiencia acumulada
- 6 Conocer las causas más frecuentes.

El interés por conocer el diagnóstico final ofrece al clínico la oportunidad de obtener una información de gran utilidad para el futuro y mejora su capacidad para afrontar nuevos casos de DAA

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Aproximación al paciente con dolor abdominal.

- 1 Historia clínica
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- 4 El valor de la observación
- 5 La experiencia acumulada
- 6 Conocer las causas más frecuentes.

El abanico de posibilidades etiológicas del DAA es muy amplio. Sin embargo, en la práctica, sólo un número reducido de ellas es responsable del 90% de los casos

Conocer los factores que conducen a error diagnóstico.

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Actitud ante el dolor abdominal agudo



Causas más frecuentes de dolor abdominal agudo



Dolor abdominal inespecífico
Apendicitis aguda
Colecistitis aguda
Obstrucción intestinal
Cólico nefrítico
Perforación de víscera hueca
Pancreatitis
Diverticulitis



Causas más frecuentes de dolor abdominal agudo en el anciano

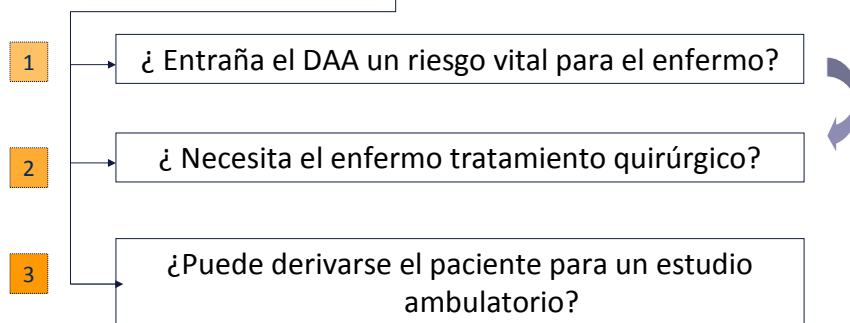


INFLAMACIÓN VISCERAL	OCCLUSIÓN INTESTINAL	VASCULAR
Colecistitis	INTESTINO DELGADO	Infarto de miocardio
Pancreatitis	Bridas	Aneurisma de aorta
Diverticulitis	Hernias	Isquemia mesentérica
Úlcera péptica ¹	INTESTINO GRUESO	
	Cáncer	
	Vólvulo	

(1) Asociada al consumo de AINE.



El uso juicioso de estas herramientas proporciona las claves necesarias para responder a tres cuestiones básicas en la evaluación del enfermo:



1 ¿ Entra el DAA un riesgo vital para el enfermo ?

Algunas entidades comportan un riesgo vital:



- IAM,
- Rotura del esófago,
- Perforación de una víscera hueca,
- Pancreatitis necrotizante
- Isquemia mesentérica aguda
- Rotura de un aneurisma de aorta,
- Obstrucción intestinal con estrangulación.
- Rotura de un embarazo ectópico



2 ¿ Necesita el paciente tratamiento quirúrgico urgente?

1. Ante un deterioro clínico rápidamente progresivo con neumoperitoneo, peritonitis difusa aguda o inestabilidad hemodinámica incontrolable (sugestiva de rotura del bazo o de aneurisma de la aorta abdominal).
2. En cualquier caso de peritonitis localizada por apendicitis, pelviperitonitis, oclusión intestinal (estrangulación) o IMA.
3. Ante una diverticulitis aguda que debuta con perforación a peritoneo libre, oclusión completa del intestino o complicación supurativa que no responde al drenaje percutáneo.
4. La colecistitis aguda no constituye una emergencia quirúrgica (salvo en casos de gravedad extrema), pero sí una urgencia diferida (< 24 horas) siempre que el diagnóstico se haya efectuado en un intervalo inferior a 72 horas.



3 ¿ Puede ser el enfermo derivado para un estudio ambulatorio?

Un paciente puede ser derivado para un estudio ambulatorio cuando reúne las características de un proceso banal:



1. Intensidad leve o moderada,
2. Mal delimitado.
3. No asociado a síntomas relevantes,
4. Ninguna alarma en el examen físico y
5. Pruebas complementarias básicas, normales.



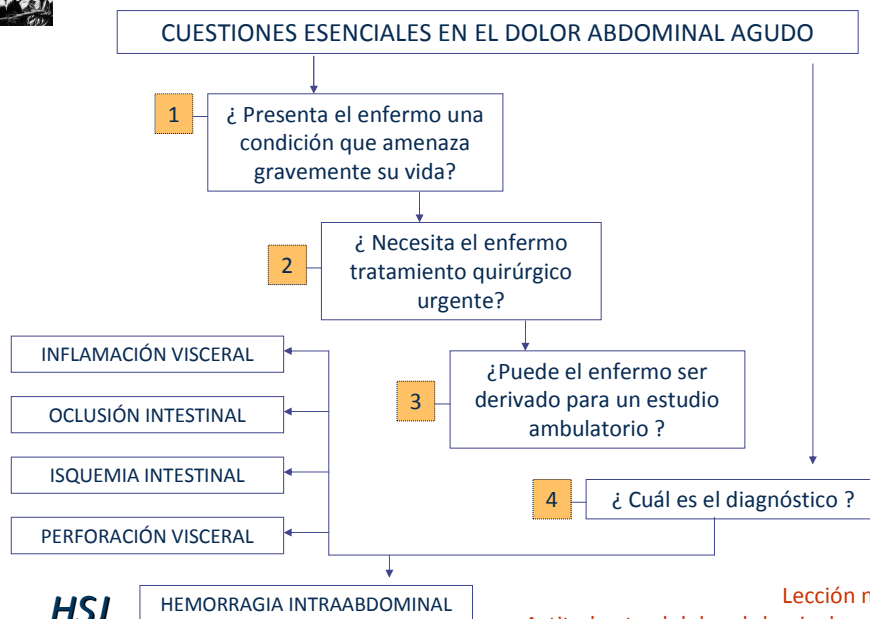
4 ¿ Puede establecerse una hipótesis diagnóstica?

Plantear siempre la posibilidad de clasificar al paciente en uno de estos 4 grandes grupos síndrómicos:



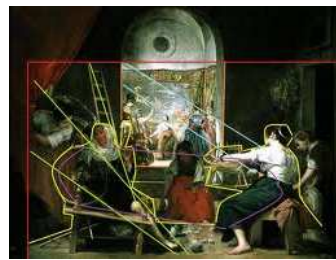
1. Inflamación visceral.
2. Oclusión intestinal.
3. Isquemia intestinal.
4. Perforación visceral.

5. Hemorragia incontrolable asociada a grave inestabilidad hemodinámica.





Las cosas se ven de un modo diferente según los ojos con las que las miramos



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“A 76-Year-Old Woman With Abdominal Pain”

A 76-year-old woman presents to the emergency department (ED) with intense abdominal pain. She describes the pain as a diffuse, severe, constant ache throughout her abdomen. The pain woke her from sleep several hours ago; she felt well when going to bed last night, with no discomfort or other preceding symptoms. Today, she feels nauseous and has had 2 liquid bowel movements that were dark brown in color. She has never had similar pain before. She denies having any fever, trauma, urinary symptoms, vaginal discharge, or bleeding. There has not been any chest pain, shortness of breath, or back pain. She has a medical history of atrial fibrillation, a myocardial infarction 2 years ago with 2 stents placed, hypertension, and chronic obstructive pulmonary disease (COPD). She admits to being a life-long smoker and has smoked 1-2 packs daily for at least 50 years. She has a glass of **sherry** nightly, but she denies ever using drugs. She has no history of abdominal surgery. She is a **widowed homemaker** who lives alone, but she has 2 daughters who live nearby. She has been prescribed multiple medications, including warfarin, atenolol, an ipratropium/salbutamol inhaler, lisinopril, a multivitamin, and hydrochlorothiazide. She admits to frequently missing doses of her medications and recently **ran out** of warfarin. She has no known drug allergies.

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(2) Physical examination

On physical examination, the patient appears to be in intense pain. She has an oral temperature of 99.4°F (37.4°C). She has an irregularly irregular heart rhythm, with a rate of 118 bpm. Her blood pressure is 101/68 mm Hg, and her respiratory rate is 22 breaths/min. Her pulse oximetry reading is 93% on room air. In general, she appears older than her stated age. She is appropriately alert and oriented. She has **slight expiratory wheezing throughout** the bilateral lung fields. No murmurs are appreciated on cardiac auscultation, and her abdomen has only mild tenderness to palpation diffusely. No peritoneal signs on examination, palpable masses, or abnormal pulsations are noted. Rectal examination reveals dark-brown stool that is negative for occult blood. **She has no costovertebral angle tenderness.** Her extremities are warm, with 1+ bilateral dorsalis pedis pulses.



(3) In the “room emergency”.

The patient is placed on a cardiac monitor, 2 large-**bore** peripheral IVs are placed, and fluid resuscitation with normal saline is started. The patient is given two 8-mg doses of morphine, with some pain improvement. She is given 4 mg of ondansetron for her nausea. A bedside laboratory test shows a hemoglobin level of 12.1 g/dL (121 g/L). A bedside ultrasound shows no free fluid in the abdomen. An electrocardiogram (ECG) demonstrates rapid atrial fibrillation, without an acute injury pattern. A stat upright chest x-ray is obtained that demonstrates hyperinflated lung fields, but no free air under the diaphragm or other acute abnormalities are seen. Laboratory studies, including electrolytes, a hepatic panel, lipase, cardiac enzymes, and a complete blood count, are performed and found to be without significant abnormalities. Her international normalized ratio (INR) is subtherapeutic at 1.4. An abdominal computed tomographic (CT) angiography scan is ordered; representative images are shown (Figures 1 and 2).



(I) Claves que aporta la historia clínica.

1. Descripción del síntoma guía.
2. Síntomas acompañantes (síntomas negativos)
3. Escenario sobre el que se desarrolla el acontecimiento.



“ El cuadro de Velázquez ”



1. She describes the pain as a diffuse,^{3,4} severe, constant ache throughout her abdomen. The pain woke her from sleep several hours ago²; she felt well when going to bed last night, with no discomfort or other preceding symptoms¹.
2. Today, she feels nauseous and has had 2 liquid bowel movements that were dark brown in color⁵. She has never had similar pain before.
3. ⁶ She denies having any fever, trauma, urinary symptoms, vaginal discharge, or bleeding. There has not been any chest pain, shortness of breath, or back pain.
4. ⁷ She has a medical history of atrial fibrillation, a myocardial infarction 2 years ago with 2 stents placed, hypertension, and chronic obstructive pulmonary disease (COPD). She admits to being a life-long smoker and has smoked 1-2 packs daily for at least 50 years. She has a glass of sherry nightly, but she denies ever using drugs. She has no history of abdominal surgery. She is a widowed homemaker who lives alone, but she has 2 daughters who live nearby. She has been prescribed multiple medications, including warfarin, atenolol, an ipratropium/salbutamol inhaler, lisinopril, a multivitamin, and hydrochlorothiazide. She admits to frequently missing doses of her medications and recently ran out of warfarin. She has no known drug allergies.



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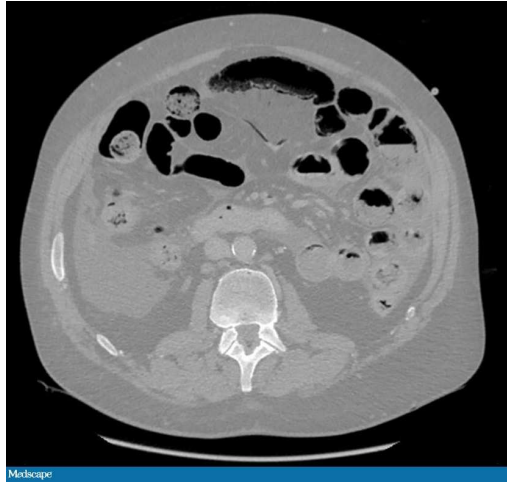


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