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Acute Abdomen and Surgical Case Presentation

Practical 04 / Supervised clinical examination

Aim

Obtain a focused history, examine the abdomen and communicate signs needing surgical review.

Principle

Timing, site, radiation, systemic signs and prior operations guide the differential. Observation trends and peritoneal findings influence the urgency of assessment.

Materials and Requirements

- Fictional case record or supervised patient
- Vital-sign chart, examination couch and investigation request sheet

Procedure

1. Assess immediate stability and symptoms. Ask about onset, migration and severity, bowel and urinary symptoms, medicines, operations and pregnancy possibility when relevant.
2. Check vital observations, perfusion and alertness early. Establish when pain began, its course and associated vomiting, bleeding, urinary or bowel features, and alert the team promptly for instability.
3. Inspect for distension, scars and visible changes. Examine gently, beginning away from pain. Note focal tenderness, guarding and other clinically appropriate signs.
4. With permission inspect contour, respiratory movement, scars and distension. Begin gentle assessment away from the most painful site and observe the patient’s reaction to light palpation.

Continue with step 5 on the next page.

Procedure Continued

Acute Abdomen and Surgical Case Presentation

5. Consider hernial sites and extra-abdominal causes when indicated. Record the general examination and peripheral perfusion.
6. Record location and distribution of tenderness, whether guarding is voluntary or involuntary when safely assessed and the limits of the exam. Consider relevant thoracic, urinary or hernial clues.
7. Discuss the investigations that would change management. Include the reason for each test and its urgency.
8. Choose case-appropriate investigations and write the reason and urgency for each. Confirm pregnancy-related considerations and what requires prompt surgical review before completing routine steps.
9. Give a timed handover covering stability, onset, examination, differential and what help is required.
10. Give a timed report including earlier and current observations, pain evolution, leading concern and actions so far. Confirm which results are pending and who is reviewing the patient.

Precautions

- Stop repeated palpation if it causes distress or does not add information.
- An unstable patient requires escalation before routine history completion.

Observations and Interpretation

Acute Abdomen and Surgical Case Presentation

Observations and Record

Item	What to record	What it tells you
History	Pain course, associated symptoms and prior surgery	Guides the differential
Examination	Vital signs, tenderness and guarding	Assesses severity and possible peritoneal irritation
Work-up	Test, purpose and escalation	Prioritises next action

Worked Example

A young adult reports pain moving to the right lower quadrant, with fever and localised guarding. The pregnancy status is unknown.

Result and Interpretation

Request prompt surgical assessment and consider relevant pregnancy and other investigations under supervision. Document the clinical reasoning and changes in observations.

Viva Questions and Answers

Why ask about prior abdominal operations?

They raise the possibility of adhesions and inform examination of scars and hernial sites.

What does involuntary guarding suggest?

It may indicate peritoneal irritation and warrants clinical assessment.

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