The Corner

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11. Abdominal pain in the ED

Resident: Dr. Smith, I have a complicated patient that looks unwell, could you please come and examine him?

Brian is a 3 year old boy with a complicated past medical history. He is a full term baby, delivered by C-section, who was discharged home after 48 hours. At 7 days of life he came to the ED due to constipation. Per mum he had had no bowel movements since the one at the hospital. At examination he had a distended abdomen. A plain abdominal film was done showing dilated bowel loops. He was admitted and diagnosed with Hirschsprung disease. He underwent surgery. Since then he has been doing well, he has 1-2 bowel movements a day. No other relevant issues in his past medical history.

Attending: Ok. What prompted his visit to the ED?

Resident: Two days ago he started having diarrhea and abdominal pain which has been progressing since. Mum describes small watery stools, about 4-5 a day, no blood. Today he has vomited once after lunch. No objective fevers, mum has been checking every four hours, and no other symptoms according to the history. At examination the patient is pale and sweaty, his vitals are within normal range for his age except his heart rate and temperature, he's taquicardic and febrile, 38ºC. He has symmetric pulses and a capillary refill <2 sec, mucous membranes are moist and oropharynx is clear. His abdomen is impressively distended and very tender to palpation, specially the lower right quadrant. He has no hepatosplenomegaly and the rest of the exam shows nothing relevant.

Attending: Let's go and see him, but from what you told me we should place an IV and obtain a CBC and blood culture now. He´s probably going to need a plain abdominal radiograph and an ultrasound. What would be on your differential diagnosis?

Resident: Well appendicitis would be high on my differential, being that the abdominal pain seems to be localized in the lower right quadrant and he has started with fever. It could also be an intussusception, given the age range and the history, although the fever would not be explained. It could also just be a gastro intestinal infection.

Attending: Good. But the key thing about this patient is his past medical history. A patient with Hirschsprung who comes to the ED with diarrhea and abdominal pain is an enterecolitis until proven otherwise. These patients have increased susceptibility to bacterial translocation, the pathophysiology seems to be multifactorial. This entity which is called Hirschsprung's associated enterocolitis, is very important because it has high rates of mortality and morbidity. These patients deteriorate quickly and often require intensive care unit admission.

Resident: Oh, I wasn´t aware of this. I thought that after the removal of the aganglionic bowel the patients had no further risks.

Attending: Actually the incidence of Hirschsprung's associated enterocolitis appears to be unchanged from the pre-operative to the post-operative period, so patients can present at any time during their childhood.

KEY WORDS:

Full term baby: bebé a término.

Delivered by C-section: parto por cesárea.

Constipation: estreñimiento.

Bowel movements: deposición.

Plain abdominal film/radiograph: radiografía simple de abdomen.

What prompted his visit to the ED: que propició su visita a urgencias.

Progressing since: empeorando desde entonces.

No objective fevers: no fiebre termometrada.

Vitals are within normal range for his age: constantes vitales en rango normal para edad.

Tender to palpation: doloroso a la palpación.

CBC (complete blood count) and blood culture: hemograma y cultivo.

Ultrasound: ecografía.

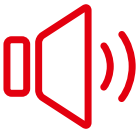
Intussusception: invaginación.

Until proven otherwise: hasta que se demuestre lo contrario.

Mortality and morbidity: mortalidad y morbilidad.

Removal of the aganglionic bowel: resección del segmento intestinal agangliónico.

Patients had no further risks: el paciente no presenta más riesgos.



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