Abdominal Pain Case Conference

Student Material
(Faculty member will bring additional material as indicated.)

Ambulatory Component of the Internal Medicine Clerkship
Yale University School of Medicine

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INSTRUCTIONS FOR STUDENTS

A. Please read the following book chapters to help you prepare for the classroom discussion. Both are available as electronic books on the Yale Library Web Site.

Glasgow RE, Mulvihill SJ. Abdominal Pain Including the Acute Abdomen. In *Sleisenger and Fordtran's Gastrointestinal and Liver Diseases. 7th Edition* WB Saunders, 2002. Pages 71-81.

Mertz, HR. Irritable Bowel Syndrome, *NEJM*, 2003. Pages 2136-2146.

Meurer, LM, Bower, DJ. Management of *Helicobacter pylori* Infection, *American Family Physicians*, April 2002.

Johnson, CD. Upper Abdominal Pain: Gall bladder. *BMJ*, 2001. Pages 1170-1173.

B. Read the case descriptions and work through your answers before class.

C. If you bring food, bring enough for the faculty facilitator.

GOALS AND OBJECTIVES FOR STUDENTS

By the end of the conference students will be able to:

1. Describe and differentiate the etiologies and presentations of the acute abdomen, chronic abdominal pain, and the surgical abdomen.

2. Describes the mechanisms of abdominal pain, including visceral and referred pain.

3. Explain the importance of a detailed history in the evaluation of a patient with abdominal pain.

4. Identify urgent and serious conditions requiring immediate referral.

5. Describe a diagnostic approach to abdominal pain, including laboratory testing, radiological imaging and referral for endoscopic evaluation.

6. Describe an approach to the initial management of patients with common syndromes producing abdominal pain.

Case 1

This 28 year-old mechanic is seen in your office for recurrent abdominal pain. He complains of an aching sensation in the upper abdomen, and prefers not to use the word “pain” to describe his symptom, referring to it as an ache or gnawing feeling. It gets worse when he skips a meal, and gets better with a meal and antacids. When you question him about nocturnal symptoms, he reports that he frequently wakes up in the early mornings with “hunger pains”.

Recently he has had some nausea associated with early satiety and has lost 8 pounds over 3 months.

The patient smokes one pack of cigarettes daily and consumes a six pack of beer a week.

He lost his job three months ago.

Questions:

1) What is this patient’s clinical syndrome?
2) What additional information may be important?

Students: Faculty facilitator will provide a handout with Part II of this case

Case 2

The patient is a 32 year-old lawyer with abdominal pain. She is in her seventh month of pregnancy. Since 10 pm last night she complains of severe constant epigastric pain. The pain now radiates to her back and she has found that curling up in bed on her left side makes the pain somewhat bearable. The pain persists this am, and is now accompanied by nausea. She has vomited small amounts of yellow fluid. She denies fevers, chills, rigors, or melena.

Several times over the past 2 years she has had episodes of epigastric pain, usually awaking her at night. The pain builds gradually, becomes steady and severe, lasts 1-2 hours and occasionally radiated to her right scapula. Food does not make the pain worse. She has visited the emergency room for one of her previous attacks, but the pain subsided as she waited to see a physician and she returned home without being seen. She is well between attacks.

<u>Questions:</u>

1. What is the cause of her previous bouts of abdominal pain?
2. Why did the pain radiate to the right scapula? What is this type of pain called?
3. What do you think is the cause of her pain on this admission and why?
4. What would you look for on physical examination?

Students: Faculty facilitator will provide a handout with Part II of this case

Case 3

A 69 year-old woman presents to your office with pain in her left lower abdomen. The pain is severe, continuous, and non-radiating. It worsens intermittently in bursts she describes as "cramps". She has had several loose bowel movements. The patient is usually constipated. She also c/o nausea and sweats. She gives a history of a similar episode one year ago that resolved spontaneously. There is no history of weight loss, her appetite is good and her symptoms are not exacerbated by food.

PMH: atrial fibrillation, CAD, and diabetes mellitus.

MEDS: Coumadin, insulin, nitroglycerine, and lisinopril.

ROS: Unremarkable

PE:

Vitals: T 101F, irregular pulse at 80/mt, BP 160/90.

Abdomen: Flat, soft. Bowel sounds are normal. Tenderness to palpation in the left lower quadrant, without guarding or rigidity.

Rectal: Brown heme-positive stools.

Questions:

1. What is the most likely diagnosis? What other diagnosis should be considered?
2. What complications may occur?
3. What investigation may help clarify the diagnosis?
4. What management plan would you advise?

Case 4

A 25 year old female executive is seen in your office with worsening abdominal pain. Since about the age of 20, she has experienced intermittent burning, crampy pain in the lower abdomen. She saw a generalist physician two years ago who found no specific etiology and referred her to a gastroenterologist. Her symptoms improved temporarily and she did not see the specialist. She reports temporary relief of her symptoms following a bowel movement. Her longest pain free interval has been one month. In the past 6 months, the pain has been more severe and is associated with bloating. She moves her bowels two to three times a day and describes them as small in volume, frequently loose, and associated with passage of mucus.

PMH: Unremarkable

Medications: multivitamin, oral birth control pills, vitamin B complex.

FH: Father died of colon cancer at age 64 years.

SH: A college graduate who specialized in accounting and business management, she works in corporate finance for a fast-growing entertainment company. The company is in merger talks with an industry competitor. She is engaged to be married. She exercises regularly and does not smoke cigarettes. She drinks alcohol about two nights a week, never more than one drink in a night.

Questions:

1. What is your differential diagnosis at this point?
2. What additional history would you need to narrow the differential diagnosis?

Students: Faculty facilitator will provide handouts with Parts II and III of this case.