Emergency Care Institute
NEW SOUTH WALES

ACI NSW Agency for Clinical Innovation

GUT FEELING

Learning from our Incidents:

RED FLAGS in the Emergency Department

The case

76yo male was brought into a local district hospital ED by ambulance at midnight with abdominal pain.

The paramedics report the observations were found to be in normal range except for BP 170/80 and pain score 7/10.

The case

He complained of constipation and abdominal pain for 4 days, described as sharp in nature, but had increased significantly overnight prompting his relatives to call an ambulance.

He was given morphine for analgesia.

Observations were unchanged from time of ambulance assessment.

What are your differential diagnoses?

The case

Within 30mins, patient was reviewed by a medical officer and given a provisional diagnosis of constipation.

Patient was charted for aperients, analgesia and a fleet enema, which resulted in a small bowel motion.

Nil further analgesia was given as ambulance morphine had successfully eased the pain.

The case

At 0200, there was discussion between medical staff and the patient and carer regarding patient's disposition. A plan was devised to discharge the patient home and have them return later in the morning for further investigation.

At 0230, patient was discharged home into the care of his family.

What are the key principles that determine readiness for departure from ED? Have they been addressed in this case?

The case

Patient returned to attend a CT later in the day.

Whilst in the radiology department, patient collapsed at 1130. On arrival of the Rapid Response Team, patient found to have GCS 3.

Patient was given fluid bolus with improvement of GCS to 14 by the time the patient was transferred to ED.

The case

On examination, patient noted to be pale, cold and clammy with a pulsatile abdominal mass palpable in the patient's epigastric region.

Patient received further fluid resuscitation and transfusion of four units of blood.

At 1330, patient was transferred to a tertiary facility for consideration of urgent definite management.

The case

During transit in the ambulance, patient suffered a cardiorespiratory arrest.

With respect to patient and family's previously discussed wishes, CPR was not commenced and patient returned to referring hospital for certification.

Cause of death found to be due to: **ruptured AAA**.

What is the lesson here?

For elderly patients with abdominal pain, it is NOT constipation or gastroenteritis until other serious diagnoses have been actively sought and excluded.

What's the evidence?

- Abdominal pain is the main presenting problem in 3-13% of ED presentations for elderly patients[1,2].

- Older patients with abdominal pain have been found to have higher mortality rates: Lewis et al.[3] found 5% of elderly patients presenting to ED with abdominal pain had died within two weeks.

What's the evidence?

- Studies have found greater inaccuracy of diagnoses for elderly patients with abdominal pain when compared to younger patients[3].

- Multiple factors cause the elderly patient with abdominal pain to pose a significant diagnostic challenge: increased comorbidities, unreliability of physical examination findings, and lack of sensitivity of laboratory testing[4].

- Clinicians should be mindful that a lack of findings in the history, normal vital signs, and laboratory values that are seemingly normal are common among older adults[4].

What's the evidence?

- **The elderly are likely to have more subtle presentations of diseases with significant morbidity and mortality**, and clinicians should avoid labelling undifferentiated abdominal pain with a more benign diagnosis, such as constipation or gastroenteritis[4].

- Emergency clinicians should more readily perform abdominal CT, consult surgical services, and admit older patients for further observation, diagnostic tests, and treatment[5].

- A systematic approach should be adopted, keeping the differential diagnosis broad and searching for potentially life-threatening aetiologies[4].

Access the ECI Clinical Tool:

AAA

http://www.ecinsw.com.au/node/433

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References

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3. Lewis, L.M., Banet, G.A., Blanda, M., Hustey, F.M., Meldon, S.W., Gerson, L.W. *Etiology and clinical course of abdominal pain in senior patients: a prospective, multicentre study*. Journals of Gerontolgy Series A-Biological Sciences & Medical Sciences, 2005. 60 (8): pp. 1071-1076.
4. Tazkarji, M.B., *Abdominal Pain Among Older Adults*. Geriatrics and Aging, 2008. 11(7): 410-415.
5. Samaras, N., Chevalley, T., Samaras, D., Gold, G. *Older Patients in the Emergency Department: A Review*. Annals of Emergency Medicine, 2010. 56(3): pp. 261-269.

Another case

72yo male, brought in by ambulance following sudden onset of non-specific generalised abdominal pain and dyspnoea.

PMH:
AF, ex-smoker, myocardial infarction, CCF, chronic renal failure, diabetes mellitus, hypertension, osteoarthritis, peptic ulcer disease.

Another case

At triage, he was noted to have distended and rigid abdomen. Difficult historian secondary to being from non-English-speaking background (NESB).

Medical assessment found patient to be hypoxic with SaO2 89% on room air. Nasal prong oxygen applied with improvement of SaO2 to 94%.

ECG showed 1st degree heart block and slight bradycardia – consistent with patient's previous ECGs.

Another case

CXR showed cardiomegaly.

AXR showed faecal loading.

Diagnosed with constipation, and given laxatives with good effect.

Patient remained in ED for 5hrs of observation, after which he was discharged home with a prescription for aperients.

Another case

Seven hours later, patient was brought back to hospital by police deceased. A post-mortem was not carried out.

Access the ECI Clinical Tool:

Abdominal Emergencies

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What is the lesson here?

Elderly abdominal pain patients are more likely to present with vague and nonspecific symptoms while harbouring serious disease processes.

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For elderly patients with abdominal pain, it is NOT constipation or gastroenteritis until other serious diagnoses have been actively sought and excluded.