



Surgical presentations

▼ Common surgical presentations

Appendicitis: Swelling of the appendix which can lead to rupture. Pain generally starts in central abdomen and migrates towards right iliac fossa. Associated with severe pain, loss of appetite, fever, vomiting and diarrhoea.

Biliary colic (gallstones): Biliary colic is caused by the blockage of the bile ducts by gallstones. Presents as severe, sudden onset pain that can last minutes or hours, with pain-free episodes. Can be triggered by fatty food, and may happen very sporadically. If the bile duct becomes permanently blocked, this can lead to **acute cholecystitis** (inflammation of the gallbladder) or **acute cholangitis** (inflammation of the bile ducts). Either of these presentations will see patients with fever, vital sign instability and commonly jaundiced.

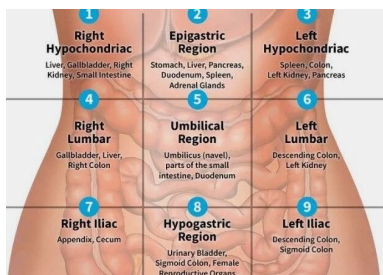
Pancreatitis: Presents as central abdo pain with nausea/vomiting and fever. Pancreatitis is most commonly linked to gallstones and excess alcohol use. Patients may develop chronic pancreatitis.

Diverticulitis: Generally linked to diverticular disease (long term disease) but patients may present with acute diverticulitis - severe abdo pain (generally LLQ), fever, diarrhoea or constipation and PR bleeding.

Perianal abscess: Painful, swollen, red area close to anus that has worsened over time and has caused systemic symptoms such as fever and tachycardia. Will likely require IVABx and incision and drainage.

Pilonidal sinus: 'Pocket' in the skin that develops most commonly at cleft of buttocks that fills with hair and skin debris and forms abscess. Can be chronic or acute. Requires incision and drainage.

There are many other acute surgical presentations that present to ED - this purely focuses on the more 'ambulatory' patients



▼ Initial ED Assessment

Taking a history:

- Abdo pain - assess using OLDCARTS, enquire about radiation of pain
- Bowel and bladder habits - last bowels open, any PR bleeding, passing urine
- Vomiting and nausea - content of vomit, frequency
- Previous surgical history

Assessment:

- Vital signs - assess for signs of shock (hypotension, tachycardia) and infection (hyperthermia)
- Bloods and access - gain patent IV access and send full set of bloods including group and screen - also send amylase and CRP for abdo pain. Ensure you have VBG checked by SHO/Reg in ED
- ECG - if tachycardic, gain an ECG for completeness - have signed by ED Reg
- Pain relief - ensure adequate analgesia given in ED
- Antiemetics - ensure antiemetic given ASAP to vomiting patients
- Urine dip and bHCG - gain urine sample ASAP, ensure consent for HCG
- **REMEMBER - if clinical concern about patient (high NEWS score, severe pain, looks unwell) escalate ASAP to senior nurse and senior ED doctor**

▼ You've completed the assessment, what next?

If you believe you are able to identify a surgical differential diagnosis, the patient can be referred to the Surgical SHO via extension 26462 or bleep 4049

If no answer from surgical SHO after 5-10 minutes, try once more and then attempt to bleep Surgical Reg on 6829

▼ You've successfully referred the patient and they've been accepted, now what?

- Discuss with NIC of the area to let them know the patient has been accepted
- The patients will need an 'R' put on EPR and an 'A' for the accepting team
- Handover to the accepting ward (SEU Triage)
- Is the patient safe for transfer? Any vital sign instability? If any clinical concerns ensure patient is accompanied on transfer or kept in ED until stable - if the patient is needing resus request that the team review patient in ED and escalate to ED Reg/Consultant
- If safe for transfer, book porter and inform patient