The Leeds Teaching Hospitals NHS
NHS Trust

Clinical Decision Unit Protocol

ACUTE ABDOMINAL PAIN

Patient Details or Addressograph label	Date & Time of arrival in A&E Date & Time of arrival in CDU	
	Triage category	Bed Number

Inclusion Criteria

- Stable abdominal pain, with a probable benign cause, that requires a short period of observation and/or treatment until symptoms have settled and more serious pathology has been ruled out

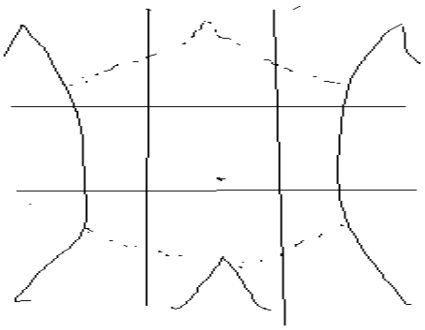
Exclusion Criteria

- Age <16 >60 years
- Trauma
- Haemodynamic instability
- Rebound **and** Guarding
- AAA/Renal colic/Pregnancy
- Defined gynaecological /surgical pathology requiring admission
- Exacerbation of a pre-existing condition already under the care of one of the specialties
- Co-morbidity / social circumstances requiring admission >24 hours
- Immunosuppression

History

PLEASE ENSURE THAT ALL BOXES ARE FILLED OR TEXT IS CIRCLED

PAIN: site	Aggravating factors None Movement Coughing Respiration Food Other (state)	**Relieving factors** None Lying still Vomiting Antacids Food Other (state)



Duration	**Radiation** No Yes (state where)	**Movement** No Yes (state from where)
Type Intermittent Steady Colicky	**Progress** Better Same Worse	**Severity** Moderate Severe

Associated symptoms

General Nausea Vomiting Anorexia for solids for liquids Other (state)	**Gastrointestinal** Normal Constipation for faeces for flatus Diarrhoea Blood PR Mucus PR Other(state)	**Urinary** Normal Frequency Dysuria Haematuria Other(state)	**Gynaecological** Vaginal bleeding Vaginal discharge Other(state) **LMP**

Other history

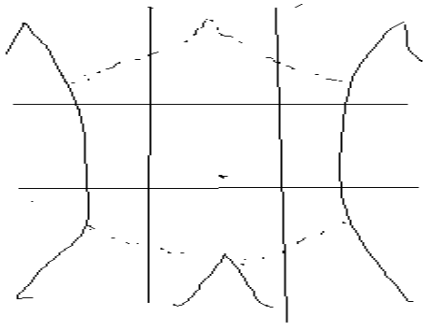
Other symptoms not included above Indigestion Jaundice Other (state)	**Details of previous similar episodes:** **Previous STD** Yes No

Past medical history: **Previous operations:**	**Current medications:** **ALLERGIES**

Physical examination

PLEASE ENSURE THAT ALL BOXES ARE FILLED		
Temp	**Pulse**	**BP**
RR	**O2 sat**	**GCS**
General appearance (including mood, colour and hydration)		

Abdomen

Inspection (including distension and movement)	**Auscultation/bowel sounds**
Palpation (fill/circle accordingly)	
Site of tenderness* 	Rebound Guarding Rigidity Murphy's sign Masses (state) Hernial orifices Normal/abnormal (state abnormality) Genitalia Normal/abnormal (state abnormality)
PR	**PV** (if indicated)
Other physical findings:	

Diagnosis and management plan:

What do you think is most likely diagnosis? (Please tick or fill in)				**Is there another possible diagnosis**(more serious pathology) **that needs to be ruled out?**
Gastritis		UTI		
Mesenteric adenitis		Non-specific abdominal pain		
Constipation				
Biliary colic				
Manage using algorithm on next 2 pages as a guide but please use your common sense and clinical acumen as well				

General management algorithm

Ensure inclusion and **exclusion** criteria applied.
Admit CDU.

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TESTS

BM, FBC, U&E, CRP, urinalysis, microscopy and culture in all patients.
Pregnancy Test in females.
Amylase and LFTS if upper abdominal pain.
Sickle test if appropriate.
Other tests as indicated on next page.

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CDU MANAGEMENT

Nil by mouth and analgesia for **all patients**. **IV fluids as appropriate.**
Further management as indicated for **the different individual diagnoses** on **next page.**
Collate results.
Reassess if **tests abnorma**l or if **clinical concern** and at **4 and 8 hours** post admission.
Urgent referral to the **appropriate specialty** if **any** of **general or specific referral criteria met at any point.**

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GENERAL REFERRAL CRITERIA

- **Clinically worse.**
- **Increasing pain.**
- **Haemodynamic instability.**
- **Rebound and guarding.**
- **Abdominal rigidity.**
- **Results of investigations indicate another diagnosis.**

Specific referral criteria are on next page.

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4 AND 8 HOUR REVIEWS

Look for **general and specific referral criteria** and **refer to the appropriate specialty** if **any of these** are met**.**
If still symptomatic but improving consider a **further short period of observation** if you are confident with initial diagnosis. **Otherwise refer** to the **appropriate specialty.**
If symptoms settled and **investigations normal discharge** with advice.
If symptoms settled but some **investigations abnormal review case** and **all results** and **ensure another diagnosis** has not been **missed** prior to **discharge.**

Specific management

Diagnosis	Additional tests	Specific treatment	Specific criteria for urgent referral at any point	Follow up if successful discharge
Gastritis	ECG. Blood serology for helicobacter pylori.	Antacid. PPI.		Serology result for helicobacter pylori to GP to consider eradication therapy.
Mesenteric adenitis				GP
Constipation	Abdominal x-ray if need to rule out obstruction	Laxatives		GP
Biliary colic	ECG	Paracetamol 1g 6 hourly. Codeine 30-60mg 6 hourly.	**Fever.**	GP
UTI	Urgent urine microscopy and culture Diagnostic criteria in women **> or equal to 10^5 org/ml** or **10^2 coliforms/ml and >10 WCC/mm^3** Diagnostic criteria in men **> or equal to 10^3 org/ml** Urgent ultrasound/IVP if obstruction suspected.	IV fluids. Antibiotics after confirmation of UTI on urinalysis and microscopy.	**Calculus or obstruction on ultrasound/IVP**	GP to check post-treatment urine. GP to organise IVP if male or > 2 UTIs in a female and not previously investigated.
Non-specific abdominal pain		Antispasmodics		GP

Observations

Please document pulse, BP, RR, SpO2, HOURLY or if clinical situation changes.

TIME																	
Pulse																	
BP																	
Temp.																	
FiO2 (% or l/min)																	
SpO2																	
RR																	

TIME																	
Pulse																	
BP																	
Temp.																	
FiO2 (% or l/min)																	
SpO2																	
RR																	

Waterlow Pressure Sore Prevention Score

Gender		**Appetite**		**Skin type – visual appearance in risk areas**	
Male	1	Average	0	Healthy	0
Female	2	Poor	1	Tissue paper	1
		Nasogastric tube	2	Dry	1
		Fluids only	2	Oedematous	1
		Nil by mouth/anorexic	3	Clammy	1
Age		**Continence**		Discoloured	2
14-49	1	Complete/Catheter	0	Broken area	3
50-64	2	Occasional incontinence	1		
65-74	3	Catheter & faecal incontinence.	2		
75-80	4	Doubly incontinent	3		
81+	5				
Build weight for height		**Mobility**		**Score**	**Risk**
Average	0	Fully mobile	0		
Above average	1	Restless or fidgety	1	<10	Low
Obese	2	Apathetic	2	10-14	At risk
Below average	3	Restricted	3	15-19	High
		Inert or in traction	4	>=20	Very high
		Chair-bound	5		
Special Risk Factors					
Terminal cachexia	8	*Neurological deficit:		**Score for patient on assessment:**	
Cardiac failure	5	Moderate	4		
Peripheral Vasc Dis.	5	Moderate-to-severe	5		
Anaemia	2	Severe	6		
Smoking	1	Medications:		**Time/date:**	
Major surgery/trauma	5	Cytotoxics/steroids/	4		
		High dose anti-inflammatories	4	**Signature:**	

*Neurological deficit includes stroke, diabetes, multiple sclerosis, and motor/sensory loss.

Record on arrival and reassess at each 24 hour interval

Investigations	**Time requested**	**Time result available**	**Results**	
Blood BM FBC U&E CRP Sickle test LFTS Amylase			BM	Ur
			WCC	Cr
			HB	Na
			Plts	K
			CRP	Sickle test
			LFTS	Amylase
Pregnancy test				
Serology for Helicobacter pylori				
Urine Urinalysis Microscopy Culture			Nitrites	RCC
			Leu	WCC
			Protein	Organisms
			Glucose	Culture
ECG				
Stool				
Radiology (details)				

Multidisciplinary Notes

Date and Time	Comments / notes	Signature

Discharge Arrangements

Admitted to Ward		Discharged home	
Which Ward?		Time and date discharged home	
TCI date and time		Outpatient clinic	
Time actually left CDU		(specify)	

Letter to G.P. Y / N Signature: _____

TTOs: _____ Prescription: Inpatient/Outpatient

Discharge advice given to patient Y / N Signature _____

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CLINICAL DECISION UNIT MEDICAL PATIENT DISCHARGE SUMMARY
ACUTE ABDOMINAL PAIN

PATIENT NAME

ADDRESS

DATE OF BIRTH

Dear Dr_____

Your patient attended the Clinical Decision Unit at SJUH/LGI with ABDOMINAL PAIN.

Diagnosis	Normal tests	Abnormal tests and details

Your patient was admitted and treated on the unit and was discharged after fulfilling the discharge criteria below

- ❑ Abdominal pain resolved and results of investigations consistent with diagnosis
- ❑ Apyrexial
- ❑ Pulse and blood pressure within normal limits
- ❑ Diagnosis and treatment explained to patient
- ❑ Tolerating diet and fluids
- ❑ Social circumstances permit discharge

ADDITIONAL COMMENTS

_____

_____

(Tick as appropriate)

- ❑ Your patient has been referred for further reassessment, to see Dr. _____
  at _____ Hospital on / / at

- ❑ Your patient has been has been advised to contact yourself or the Department of Accident & Emergency Medicine should there be any further problems.

Thank you

Signed_____ Name_____

Designation _____ Date_____

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CDU Discharge Instructions

Discharge instructions for patients with abdominal pain

You have been observed and investigated on the Clinical Decision Unit following your abdominal pain. There have been no signs of complications and you are now ready to return home.

We suggest that you should rest quietly for 24hours. It is better if a responsible adult can remain with you for that period.

You should return to the Hospital immediately if your pain returns and does not resolve with simple painkillers.

A letter will be sent to your GP regarding your observation and care on the CDU.

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You can telephone for advice if you are unsure:

CDU: 0113 2065090 **A&E: 0113 2065879**

NHS Direct: 0845 4647 **or contact your G.P.**